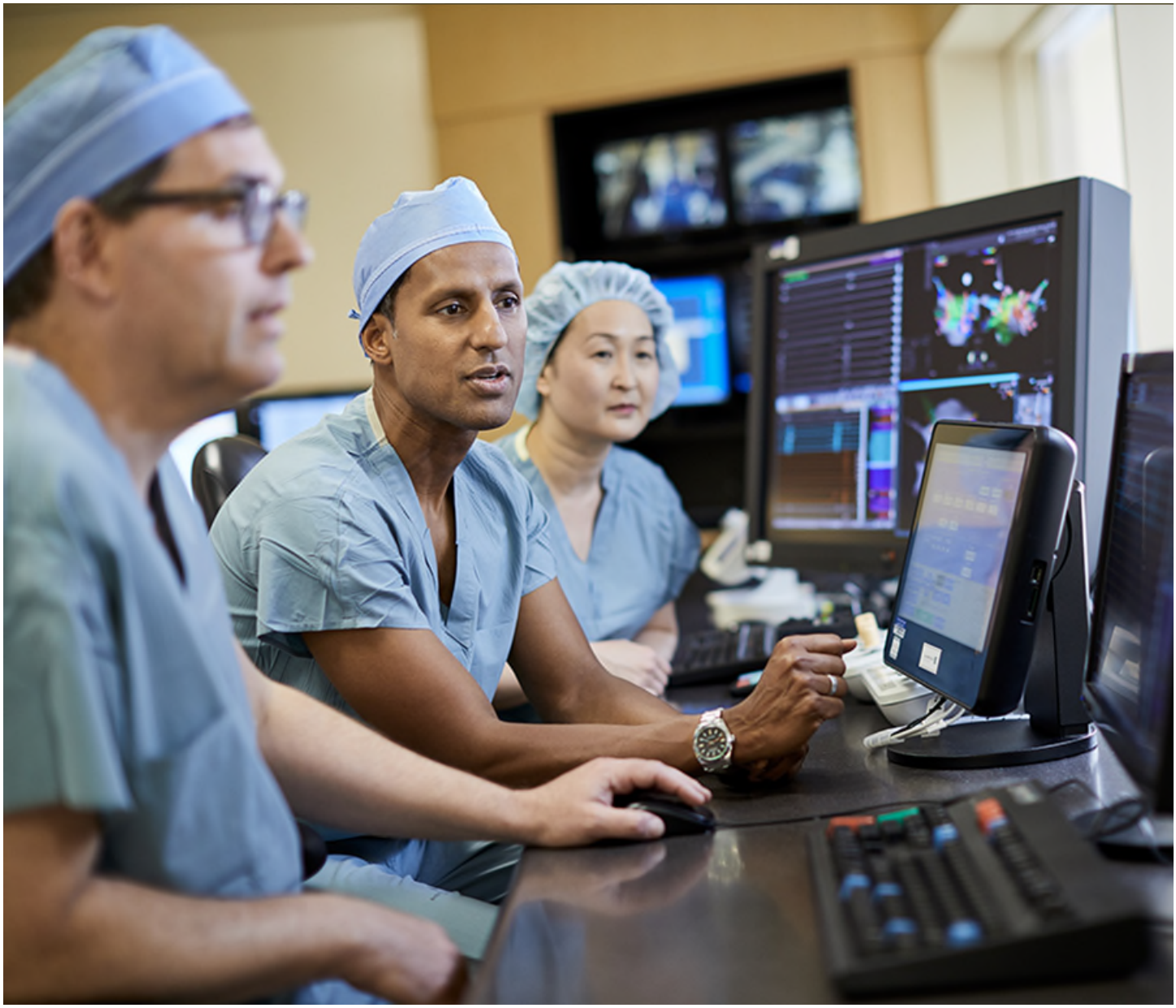


2025 Kaiser Permanente Southern California Network Development and Administration Contracted Institutional Providers HMO Provider Manual

Table of Contents

Introduction

It is our pleasure to welcome you as a contracted provider with Kaiser Permanente (KP). We want this business relationship to work well for you, your medical support staff, and our Health Plan members.

This Provider Manual was created to help guide your staff in working with KP's various systems and procedures. It is intended to supplement, and not to replace or supersede, the Agreement between you and KP. Updates to the Provider Manual will be provided on a periodic basis in accordance with the Agreement and in response to changes in operational systems and regulatory requirements.

There are attachments, exhibits and forms appearing throughout this Provider Manual, so please feel free to reproduce them as necessary. 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 Health Plan. If there is a conflict between this Provider Manual and your Agreement, the terms of the Agreement will control.

Section I: How This Provider Manual Is Organized

This Provider Manual has been developed to assist you with understanding the administrative processes related to accessing and providing comprehensive, effective and quality medical services to KP members. Kaiser Permanente's goal is to make this Provider Manual as helpful and easy to use as possible.

The contents of this Provider Manual have been organized according to similar topics and functions. A complete "Table of Contents" is located at the beginning of the Provider Manual and includes the subheadings of topics included within each section. The "Key Contacts" section includes names, departments, and telephone numbers that will assist you in obtaining answers to questions or rendering services under KP procedures.

You may wish to make copies of specific pages or reference tables that are used frequently and place them in the front of the Provider Manual.

1.1 YOUR RESPONSIBILITIES

This Manual, including all updates, shall remain the property of Kaiser Permanente. While you have the Provider Manual, you are responsible for maintaining it and its updates and also for providing copies of the Provider Manual to all subcontractors who provide services to Health Plan members.

1.2 PROVIDER CHANGES THAT MUST BE REPORTED

Please remember to send written notification to KP's Network Development and Administration department when you have important changes to report.

Relocations:
Notify Provider Relations at least ninety (90) days prior to relocation to allow for the transition of Members to other Providers, if necessary.

Adding/Deleting New Practice Site or Location:
Notify Provider Relations at least ninety (90) days prior to opening an additional practice site or closing an existing service location.

Changes in Telephone Numbers:
Notify Provider Relations at least thirty (30) days prior to the implementation of a change in telephone number. If the initial notification is given verbally, you must send written confirmation of what was verbally conveyed.

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

Mergers and Other Changes in Legal Structure:
Please notify us in advance and as early as possible of any planned changes to your legal structure, including pending merger or acquisition in writing.

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

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

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

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

Other Required Notices:
You are required to give KP notice of a variety of other events, including changes in your insurance, ownership, adverse actions involving your license, participation in Medicare or Medicare certification, and other occurrences that may affect the provision of services under your Agreement. Your Agreement describes the required notices and manner in which notice should be provided.

Kaiser Permanente – SCAL Region
Network Development and Administration
393 East Walnut Street
Pasadena, CA 91188-8116
1-626-405-3240

Section II: Kaiser Permanente Medical Care Program

The KP Medical Care Program is a cooperative endeavor among representatives of medicine and management, sharing responsibilities for organizing, financing, and delivering high quality health care services to its members. Three separate entities comprise the KP Medical Care Program: Kaiser Foundation Health Plan, Inc. (KFHP); Kaiser Foundation Hospitals. (KFH); and Southern California Permanente Medical Group (SCPMG). For purposes of this Provider Manual, the terms Kaiser Permanente or KP mean KFHP, KFH, and SCPMG, collectively.

2.1 HISTORY

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

Today, Kaiser Foundation Health Plan is one of the country's largest nonprofits, independent, prepaid group practice health maintenance organizations. We are proud of eight decades of providing quality health care services to our members and of the positive regard we've earned from our members, peers, and others within the health care industry.

2.2 ORGANIZATIONAL STRUCTURE

Kaiser Permanente's Southern California Region is comprised of three separate entities that share responsibility for providing medical, hospital and business management services. These groups of entities are referred to in this Provider Manual as Kaiser Permanente. The entities are:

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

2.3 SOUTHERN CALIFORNIA REGION

The Southern California Region is one of Kaiser Permanente's eight regions within the United States. Covering an area from Bakersfield to San Diego, the Kaiser Permanente Southern California Region spans more than six counties.

2.4 INTEGRATION

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

2.5 PREVENTIVE HEALTH CARE

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

2.6 OTHER PRODUCTS

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

2.6.1 Exclusive Provider Organization (EPO)

- Mirrors our HMO product, offered on a fully insured or self-funded basis
- EPO Members choose a KP primary care provider (PCP) and receive care at KFH or contracted medical facilities
- Except when referred by a SPMG physician or designee (Plan Physician), EPO Members will be covered for non-emergency care only at designated plan medical facilities and from designated plan practitioners

2.6.2 Point of Service (POS) – Two Tier

- Tier 1 is the EPO provider network
- Tier 2 is comprised of all other contracted providers

- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance and/or deductibles when they use Tier 2 benefits
- The POS-Two Tier product is offered on a fully insured or self-funded basis

2.6.3 Point of Service (POS) – Three Tier

- Tier 1 is the EPO provider network
- Tier 2 is comprised of our contracted PPO network providers
- Tier 3 includes non-contracted providers
- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance and/or deductibles when they self-refer to a contracted PPO network provider (Tier 2)
- Generally, the out-of-pocket costs will be highest for self-referred services received from non-contracted providers (Tier 3)
- The POS-Three Tier product is offered on a fully insured or self-funded basis

2.6.4 Out of Area Preferred Provider Organization (PPO)

- The PPO is offered to Members living outside the KP EPO service area. Members receive care from our PPO provider network, e.g. PHCS.
- PPO Members may choose to receive care from a non-network provider; however, their out-of-pocket costs may be higher
- There are no requirements for PCP selection
- The Out of Area PPO is offered on a fully insured or self-funded basis

Section III: Contracting for Medical Services

Network Development and Administration Department (ND&A) is responsible for the contracts between KFH and community hospitals, skilled nursing facilities and other facility providers to provide services for our members. ND&A handles the day-to-day operational maintenance of the contracts, including, but not limited to, relocations, additions/deletions of practice site/location, changes in telephone numbers, federal tax ID number and name changes, and mergers and other changes in legal structure.

For more information regarding this section, please contact us at the number listed in the “Key Contacts” section of this Provider Manual.

Section IV: Key Contacts

INTRODUCTION

At Kaiser Permanente, we believe in clear, open, and frequent communication with our contracted providers. The following are the key departments and individuals available to assist you with questions or clarification of any issues regarding your association with Kaiser Permanente. Please feel free to call them as the need may arise.

For clarification, questions, or comments about your role as a contracted provider for Kaiser Permanente, please contact Network Development and Administration at 1-626-405-3240.

4.1 KEY CONTACTS

Southern California Region – Key Contact

Department	Area of Interest	Contact Information
Emergency Prospective Review Program (EPRP)	Emergency Notification	1-800-447-3777 Available 24 hours a day 7 days a week
Outside Utilization Resource Services (OURS)	Authorizations for Post Stabilization Management after Emergency Medical Services	1-800-225-8883 Available 24 hours a day 7 days a week
California Claims Administration Department	Billing Questions Claims Inquiries	1-800-390-3510 Send Claims: Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004

Department	Area of Interest	Contact Information
KP Member Services	General Enrollment Questions Eligibility and Benefit Verification Co-pay, Deductible and Co-insurance Information Members presenting without KP identification number Member grievance and appeals	1-800-464-4000 (English) 1-800-788-0616 (Spanish) 1-800-757-7585 (Cantonese & Mandarin) 1-800-777-1370 (TTY) Monday – Friday 7 a.m. to 7 p.m. Saturday – Sunday 7 a.m. to 3 p.m.
Medicare Member Service		1-800-443-0815 Monday – Sunday 7 a.m. to 8 p.m.
Outside Referral Department	Authorizations/Referrals	See Section V
Network Development and Administration (Provider Contract Management and Provider Relations)	Contract Interpretation Updates to provider demographics (such as Tax ID and ownership changes, address changes) Provide Education and Training Form Request Billing Dispute Issues	1-626-405-3240 Regional Office Monday – Friday 8:30 a.m.to 5 p.m.
Medical Transportation Non-Emergent "The Hub"	Coordinate / Schedule Non-Emergency Transportation	1-877- 227-8799 Available 24 hours a day Seven Days a Week

Department	Area of Interest	Contact Information
Utilization Management Care Coordination & Discharge Planning	Care Coordination	1-800- 464-4000 Monday – Friday 7 a.m. to 7 p.m. Saturday – Sunday 7 a.m. to 3 p.m.
72 hour Expedited Appeals	Expedited Review	1-888-987-7247 Monday – Saturday 8:30 a.m.to 5 p.m.
Behavioral Health Care Behavioral Health Utilization Management	Behavioral Health Services	1-866- 465-7296 7 a.m. – 5:30 p.m. Monday – Sunday

Member Services Interactive Voice Response System (IVR)

KP Member Services IVR can assist you with a variety of questions. Call (888) 576-6789 to use this service. Please have the following information available when you call into the system to provide authentication:

- Provider Tax ID or National Provider Identifier (NPI)
- Member's MRN and/or Policy Number
- Member's date of birth
- Date of service for claim in question

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

Section V: Outside Referral Departments

The Outside Referral Department (ORD) is responsible for processing, distributing documents, and verifying status of authorized referrals. Prior authorization is a prerequisite before payment can be made for any inpatient or outpatient services which would otherwise be covered by a Member's benefit plan, except for emergency services and other situations expressly allowed by your Agreement or this Provider Manual.

If you have not received an authorization document from us and are unsure about the appropriate Referral location, please contact the Outside Referral Department in your Service Area.

Referral Departments may be reached at the following telephone numbers:

Outside Referral Departments	Telephone Number
Antelope Valley	1-661-729-7108
Baldwin Park	1-562-622-3880
Downey	1-562-622-3880
Coachella and Yucca Valley	1-951-602-4294
San Bernardino County Service Area	1-909-609-3262
Kern County	1-661-852-3482
Los Angeles	1-323-783-4401
Orange County	1-714-564-4150
Panorama City	1-818-375-2806
Riverside	1-951-602-4294
San Diego	1-619-589-3360
South Bay	1-310-816-5324
West Ventura	1-844-424-1869
West Los Angeles	1-323-783-4401
Woodland Hills	1-844-424-1869

Section VI: Member Eligibility and Benefits

INTRODUCTION

This section describes the requirements for verifying Member eligibility and Kaiser Permanente benefit coverage.

You are required to verify eligibility each time a Member presents for services so that services are only provided to someone who is eligible. This ensures that you can be compensated by Kaiser Permanente for services you provide to our Health Plan members. Members are issued identification cards, but the ID Card alone is not a valid verification of eligibility.

You are also responsible for confirming that services provided to a Member are covered benefits.

Both requirements and verification tools are described in more detail in this section.

For specific questions regarding eligibility or a Member's benefit plan and coverage for services, please call Member Services. The Member Services telephone number is located in the "Key Contacts" section of this Provider Manual.

6.1 KAISER PERMANENTE MEMBERSHIP TYPE

Membership Type	Membership Defined	Covered Benefits Defined by:
Commercial	Members* who purchase Health Plan coverage on an individual basis (other than Medicare and Medicaid) Members who are covered as part of an employer group and are not Medicare- eligible or Medicaid-eligible	Membership Agreement/ Evidence of Coverage Membership Agreement
Medicare Advantage (Senior Advantage)	Individual Medicare beneficiaries who have assigned their Medicare benefits to Kaiser Permanente by enrolling in the Kaiser Permanente Senior Advantage Program (formerly Medicare +Choice) Employer group retirees or otherwise Medicare-eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to Kaiser Permanente by enrolling the Kaiser Permanente Senior Advantage Program	Medicare, with additional benefits provided by Kaiser Permanente Medicare and Membership Agreement

Regular Medicare (Medicare unassigned)	Members (i) entitled to coverage under Part A only or Part B only or Parts A and B of Medicare but (a) are not enrolled under a Medicare Advantage contract between Health Plan (or another Kaiser Payor) and CMS and (b) for whom the Medicare program is the primary payor for Medicare-covered services under Medicare reimbursement rules, or (ii) enrolled under a Medicare Advantage contract and are hospice patients receiving care from Provider for services unrelated to the hospice patient's terminal condition.	Dual Coverage: Two separate plans – the primary Medicare benefits are defined by Medicare; the secondary Health Plan benefits are defined by the Membership Agreement (and the Employer Group if applicable).

* In each case, "Member" includes the subscriber and any eligible dependents, in accordance with the terms of the applicable membership agreement.

Membership Type	Membership Defined	Covered Benefits Defined by:
State Programs (Medi-Cal, Healthy Families)	Contact Member Services for detailed information specific to your geographic area.	Contact Member Services for detailed information specific to your geographic area.
Added Choice (POS)	Members who are working and part of an employer group	Health Plan (HMO) benefits determined by the Membership Agreement. Allows members to choose from three provider options to obtain health care coverage that best meets their needs. Your Agreement and this Provider Manual apply only to services that are Health Plan covered benefits.

6.2 MEMBER IDENTIFICATION CARDS

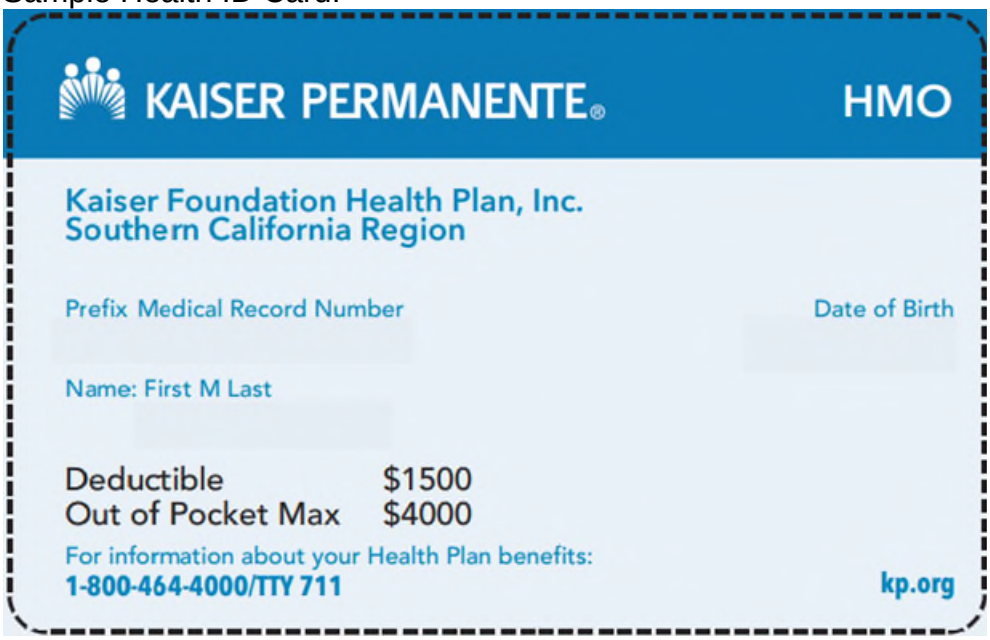
Kaiser Permanente issues a Health Plan Member Identification (ID) card to each Member. The ID card for the appropriate benefit plan/type of coverage is included in the New Member Enrollment Packet sent to members. Members are instructed to present their ID card and Photo Identification each time they access services.

All Kaiser Permanente ID cards include:

- Member name
- Medical Record Number (MRN)
- Emergency information for non-Kaiser Permanente facilities

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

Sample Health ID Card:



6.3 MEDICAL RECORD NUMBER

A unique Medical Record Number (MRN) is assigned to each Member and is listed on the front of the Member's identification card. The MRN is used by Kaiser Permanente to identify the Member's medical record, eligibility, and benefit level. If a Member's enrollment terminates and the Member re-enrolls at a later date, the Member retains the same MRN although employer or other information may change, including but not limited to their benefit information. The MRN enables medical records/history to be tracked for all periods of enrollment.

Note: The MRN should be used as the "Member ID" when submitting bills or encounter data. Please refer to the "Billing and Payment" section of this Provider Manual for additional information.

6.4 VERIFICATION OF ELIGIBILITY

You must verify the Member's eligibility each time a Member presents for services. After receiving the health plan identification card, Members may lose their eligibility or change health plans. Unless a referral and/or authorization have been received, you must verify the Member's eligibility before rendering the service prior to the Member presenting for services.

Please do not assume that because a person has a Kaiser Permanente ID Card that coverage is in effect. Please check a form of photo identification to verify the identity of the Member. Member Services can always be contacted to verify the validity of the ID card/number; otherwise, you provide services at your own financial risk.

Verification of eligibility may be done quickly and easily, 24/7, by going online to our provider portal website at https://healthy.kaiserpermanente.org/community-providers. If the information you need is not available on our provider website, you can contact Member Services:

Member Services Contact Center
1-800-464-4000
Monday – Friday 7 a.m. to 7 p.m.
Saturday – Sunday 7 a.m. to 3 p.m.

Medicare Member Services Contact Center
1-800-443-0815
Monday – Sunday 7 a.m.to 8 p.m.

6.5 AFTER HOUR ELIGIBILITY REQUESTS

Members who require medical care after normal business hours must have their eligibility verified during the next business day. During the interim, you must request that the Member complete a financial responsibility form that places payment responsibility on the patient in the event that they are later found to be ineligible. Eligibility verification or a financial responsibility form is not required for provision of emergency services; however, Kaiser Permanente will not pay for services provided if the person is not a Health Plan member.

6.6 BENEFIT COVERAGE DETERMINATION

In addition to eligibility, you must determine that the Member has coverage for services prior to providing such services to a Member, usually by an authorization or referral from Kaiser Permanente. The "Utilization Management" and "Billing and Payment" sections of this Provider Manual provide information regarding authorizations and referrals.

6.7 BENEFIT EXCLUSIONS AND LIMITATIONS

KP benefit plans may be subject to limitations and exclusions. 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.

Please visit our Provider Portal website at https://healthy.kaiserpermanente.org/community-providers.

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

Section VII: Member Rights and Responsibilities

INTRODUCTION

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

Individuals enrolled in Kaiser Permanente Health Plans have certain rights that are protected during their encounters with Kaiser Permanente representatives who consist of participating providers, contracted providers, and their employees, as well as Kaiser Permanente employees.

By the same token, Members are expected to assume responsibility for their knowledge, attitudes, and behavior related to the health care services they receive while enrolled in a Kaiser Permanente Health Plan.

This section addresses a Member's rights and responsibilities; in addition to avenues available to remedy any situation the Member feels they have not received appropriate services, care, or treatment.

7.1 MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

Kaiser Permanente has developed a Member Rights and Responsibilities Statement that addresses a member's right to participate in their medical care decisions. These decisions range from selecting a primary care provider to being provided with all information needed to making decisions regarding recommended treatment plans.

This statement also addresses their responsibilities, which include understanding the extent and limitations of their health care benefits, following established procedures for accessing care, recognizing the impact their lifestyle has on their physical conditions, providing accurate information to their caregivers, and following agreed treatment plans.

Kaiser Permanente provides each Member with the Member Rights and Responsibilities Statement upon enrollment in Health Plan. A copy of the statement is included in the Kaiser Permanente Rights and Responsibilities Handbook, the Disclosure Form and Evidence of Coverage booklet, and in new Member materials. Members may call Member Services to obtain additional copies of the above information.

Kaiser Permanente members have the right to:

- **Receive information about Kaiser Permanente, our services, our practitioners and providers, and their rights and responsibilities.** Kaiser Permanente wants its Members to participate in decisions about their medical care. Members have the right and should expect to receive as much information as they need to help them 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 Members 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; and
  - 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 them.

- **Participate in a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.** Members have the right to a candid discussion with their Plan Physician about appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage. Members should ask questions, even if they think they're not important. Members may refuse any recommended treatment if they don't agree with it or if it conflicts with their beliefs.

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

Medical emergencies or other circumstances may limit Member participation in a treatment decision. However, in general, a Member will not receive any medical treatment before they or their representative gives consent. The Member and, when appropriate, their 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 their health care.** Members have the right to choose an adult representative, known as an agent, to make medical decisions for them if they are unable to do so, and to express their wishes about their future care. Instructions may be expressed in advance directive documents such as an advance health care directive.

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

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

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

  To review, receive, or release copies of medical records, Members will need to complete and submit an appropriate written authorization or inspection request to our Release of Information/Medical Correspondence at the facility where they get care. Members can reference to their medical facility by visiting kp.org to find addresses and phone numbers for these departments. If they need help getting copies of their medical records, they can call our Member Services Contact Center at 1-800-464-4000 or TTY: 711.

- **Receive care with respect and recognition of their dignity.** Kaiser Permanente respects cultural, psychosocial, spiritual, and personal values; members beliefs; and

personal preferences.

Kaiser Permanente is committed to providing high-quality care for Members and to building healthy, thriving communities. To help up get to know our Members 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 and want our Members to be satisfied with the health care they receive from Kaiser Permanente.

- **Use interpreter services.** When Members come in for an appointment or call for advice, Kaiser Permanente will speak to them in the language they are most comfortable using. For more about interpreter services, please refer to kp.org or call our Member Services Contact Center at 1-800-464-4000 or TIT: 711.

- **Be assured of privacy and confidentiality.** All Kaiser Permanente employees and physicians, as well as practitioners and providers with whom Kaiser Permanente contracts, are required to keep protected health information (PHI) confidential. PHI is information that includes Members name, Social Security number, or other information that reveals who they are, such as race, ethnicity, and language data. For example, a Member's medical record is PHI because it includes their 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" in the "Guidebook"

  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 kp.org or call our Member Services Contact Center at 1-800-464-4000 or TIY: 711.

- **Participate in physician selection without interference.** Members have the right to select and change their 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 call 888-956-1616 and follow the voice prompts.

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

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

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

  For more information about services and resources, please contact Member Service Contact Center at 1-800-464-4000 (English), 1-800-788-0616 (Spanish), 1-800-757-7585 (Chinese dialects), or i-800-777-1370 or TIY: 711.

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

Kaiser Permanente Members are responsible for:

- **Knowing the extent and limitations of their health care benefits.** A detailed explanation of benefits is contained in the Evidence of Coverage booklet, Certificate of Insurance, or the Federal Employees Health Benefits Program materials. If a replacement is needed, contact local Member Services office to request another copy. If health coverage is provided through an employer, the Member can also contact their employer for a current copy of the Evidence of Coverage booklet or

Certificate of Insurance.

- **Notifying Health Plan if they are hospitalized in a non-Kaiser Permanente hospital.** If a Member is hospitalized in any hospital that is not a Plan Hospital, they are responsible for notifying Kaiser Permanente as soon as reasonably possible, so we can monitor their care. Please contact Kaiser Permanente by calling the number on the Kaiser Permanente ID card.

- **Identifying themselves.** Members are responsible for carrying their KP identification (ID) card and photo identification with them at all times to use when appropriate, and for ensuring that no one else uses their ID card. If someone else used their card, Kaiser Permanente may keep the card and terminate the membership. The Kaiser Permanente ID card is for identification only and does not give rights to services or other benefits unless a Member is an eligible Member of our Health Plan. Anyone who is not a Member will be billed for any services we provide.

- **Keeping appointments.** Members are responsible for promptly canceling any appointment that they do not need or are unable to keep.

- **Providing accurate and complete information (to the extent possible) that Kaiser Permanente and its practitioners and providers need in order to provide care.** Members are responsible for providing the most accurate information about their medical condition and history, as they understand it. Members are to report any unexpected changes in their health to their physician or medical practitioner.

- **Participating in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.** Members are responsible for telling their physician or medical practitioner if they don't clearly understand their treatment plan or what is expected of them. They are also responsible for telling their physician or medical practitioner if they believe they cannot follow through with their treatment plan.

- **Following the plans and instructions for care they have agreed on with their practitioners.** Members are responsible for following the plans and instructions that they have agreed to with their physician or medical practitioner.

- **Recognizing the effect of their lifestyle on their health.** A Member's health depends not only on care provided by Kaiser Permanente but also on the decisions they make in 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.** Members are responsible for treating physicians, health care professionals, and fellow Kaiser Permanente Members with courtesy and

consideration. Members are also responsible for showing respect for the property of others and of Kaiser Permanente.

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

- **Knowing about and using the Member satisfaction resources available to them, including the dispute resolution process.** Providers and their staff are expected to review and abide by the statement. If you have any question regarding its contents, please contact us at the phone number included in the "Key Contacts" section of this Provider Manual.

7.2 NON-COMPLIANCE WITH MEMBER RIGHTS AND RESPONSIBLITIES

Failure to meet the requirements of Kaiser Permanente's Rights and Responsibilities Statement may result in action against the Member, provider, or Kaiser Permanente, as appropriate.

Members

In the event a Member feels the Member's rights have not been upheld, they are instructed in the Member Handbook to discuss the situation with the provider.

If the Member is not comfortable discussing concerns or the Member feels the provider cannot resolve the issue to the Member's satisfaction, the Member may contact Member Services directly via telephone at 1-800-464-4000 or via the web at www.KP.org to file a complaint against the provider and/or staff.

Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.

If you receive a complaint from or on behalf of a Kaiser Permanente Member which, in your reasonable judgment, is not resolved within two working days, please notify Network Development and Administration at the phone number included in the "Key Contacts" section of this Provider Manual.

Providers

If a Member fails to meet his/her obligations as outlined in Kaiser Permanente's Rights and Responsibilities Statement and you have attempted to resolve the issue, please contact Member Services. The phone number is located in the Key Contacts section of this Provider Manual.

Provider should advise Member Services, if a Member:

- Displays disruptive behavior or is not able to develop a provider/Member relationship,
- Unreasonable and persistently refuses to follow provider's instructions to the extent that the Member's health is considered jeopardized,
- Commits belligerent act or threatens bodily harm to physicians and hospital personnel,
- Purposely conceals or misrepresents their medical history or treatment in order to subvert proper treatment planning,
- Uses documents with the provider's signature without proper authorization or forges/falsifies a provider's name to documents, or

- Allow someone to misrepresent him/herself as a Kaiser Permanente Member.

Kaiser Permanente reserves the right to:

- Conduct informal mediation to resolve a relationship issue,
- Move the Member to another hospital or provider, or
- Pursue termination of the Member's coverage with Health Plan, as allowed by the applicable Member "Disclosure Form and Evidence of Coverage."

7.3 ACCESS TO CARE DECISIONS

Kaiser Permanente and affiliated hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for the Member's medical needs. Kaiser Permanente does not compensate anyone for denying coverage or service, and Kaiser Permanente does not use financial incentives to encourage denials. To maintain and improve the health of Members, all providers should be especially vigilant in identifying any potential underutilization of care or service.

Kaiser Permanente allows open provider-Member communication regarding appropriate treatment alternatives, without penalizing providers for discussing medically necessary or appropriate care for Members.

Kaiser Permanente members have the right to choose treatment or service options regardless of benefit coverage limitations. Providers are encouraged to communicate appropriate treatment options, even when the options are not covered by the Member's benefit plan. If the provider and the Member decide upon a course of treatment that is not covered under the Member's Membership Agreement, the Member should be advised to contact Member Services for an explanation of his/her benefits plan. If the Member persists in requesting non-covered services, the Provider's business office should make payment arrangements with the Member in advance of any treatment provided.

Kaiser Permanente's Utilization Management program and procedures are:

- Designed to establish whether services are covered under the Member's benefit plan
- based on objective guidelines adopted by Kaiser Permanente, and
- used to determine medical necessity and appropriateness of care.

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

7.4 ADVANCE DIRECTIVES

An Advance Directive is a written instruction, such as a living will or durable power of attorney for healthcare, recognized under California State and Federal law.

Kaiser Permanente requires that all contracted providers comply with the Federal Patient Self-Determination Act of 1990, which mandates that a Member must have the opportunity to participate in determining the course of their medical care, even when they are unable to speak for themselves. Federal law applies to emancipated minors but does not apply to all other minors.

To ensure compliance with the law, an Advance Directive should be documented in a prominent place in the medical record. The Provider shall provide written information regarding Advance Directives to all Members admitted to the facility and provide staff and Member education regarding Advance Directives.

If a Member requests to formulate or change an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss the decision with the Member. The attending physician will write a progress note in the Member's medical chart to reflect the formulation or change of an Advance Directive.
An Advance Directive may be revoked by the Member at any time, orally or in writing, as long as the Member is capable of doing so. An Advance Directive is automatically invalidated by divorce if the spouse was designated as the surrogate decision-maker.

Members are provided with information regarding Advance Directives in the Disclosure Form and Evidence of Coverage booklet, as well as in new Member materials. Members may also contact Member Services for an informational brochure and appropriate forms.

7.5 MEMBER COMPLAINT AND GRIEVANCE PROCESS

Kaiser Permanente Members are assured a fair and equitable process for addressing their complaints and grievances against contracted providers, provider staff, and Kaiser Permanente employees. Providers may act as a Member's authorized representative if duly appointed in accordance with the Member's applicable EOC. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the Member, the provider and Kaiser Permanente. Members are notified of the processes available for resolving complaints in their EOC.

A Member complaint or grievance may relate to quality of care, access to services, provider or Kaiser Permanente staff attitude, operational policies and procedures, benefits, eligibility, or related issues.

Valid Member complaints and grievances against a provider are included in the providers quality file at Kaiser Permanente and reviewed as part of the re-credentialing

process. Complaints and grievances are tracked and monitored on an on-going basis to identify potential problems with a provider or Kaiser Permanente policies and procedures.

7.6 PROVIDER PARTICIPATION IN MEMBER COMPLAINT RESOLUTION

The established procedures for resolving Member complaints may require the provider's participation under certain circumstances. Kaiser Permanente will advise the provider of the involvement required or information that must be provided. Complaints about clinical issues will be reviewed by at least one practitioner provided by Kaiser Permanente and practicing in the same or a similar specialty that typically manages the related medical condition, procedure or treatment who was not previously involved in the patient's care. As a result of this review, you may be asked as part of the investigation to respond by email or by an Investigative Review Form to Member Services with your clinical opinion regarding the Member's concern or request. For additional information regarding provider appeal process, please refer to the "Provider Rights and Responsibilities" section of this Provider Manual.

7.7 MEMBER COMPLAINT AND GRIEVANCE RESOLUTION PROCEDURE

One of the rights that Members are apprised of is that they have the right to participate in a candid discussion with the provider of all available options regardless of cost or benefit coverage. Members are told, "You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they seem silly. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you do not agree with it or if it conflicts with your beliefs." If the issue cannot be resolved in this manner, we encourage the Member to contact the Member Services Department at the local Kaiser Permanente facility or the Member Service Contact Center for assistance.

If the Member or provider feels that the issue is urgent in nature, the Member or provider may call the Expedited Review Unit (ERU). More information regarding Expedited Review may be found in the Utilization Management section of this Provider Manual.

7.8 COMPLAINT PROCEDURES

If the problem/issue is not amenable to immediate resolution at the point of service, the Member may submit a written complaint or grievance with the local Member Services Department, or by calling the Member Services Center at **(800) 464-4000** or **(800) 777-1370** (TTY). Our representatives will advise the Member about our resolution process and ensure that the appropriate parties review the complaint. Members may also submit a

complaint at this link https://healthy.kaiserpermanente.org/southern-california/support/submit-a-complaint#/tellus.

7.9 GRIEVANCE PROCEDURES

If a Member is requesting care or service that is not amenable to immediate resolution at the point of service or the request is monetary in nature, he/she should be advised to contact the Member Service Department at the local Kaiser Permanente facility or to call the Member Service Contact Center to file a formal grievance. A Member may submit a grievance verbally or in writing. The Member's request will be researched and presented to the appropriate decision-makers, and a decision will be rendered within fourteen (14) to thirty (30) days, depending on the type of request and membership. The Member will receive the resolution in writing, and if denied, will be informed of any applicable appeal rights.

7.10 72-HOUR EXPEDITED REVIEW

Members and providers who believe that the Member's health status would be seriously jeopardized by submitting an issue through the standard process may request an expedited review. If the issue is accepted for processing through this procedure, upon receipt of all necessary information, Kaiser Permanente must make a determination as expeditiously as required by the Member's medical condition, not to exceed 72 hours. If the request is denied, the Member will be informed of any applicable appeal rights. If it is determined that there is no serious threat to life or limb, the request will be processed under the standard timeframes, fourteen (14) to thirty (30) days depending on the type of request and membership.

7.11 FRIEDMAN-KNOWLES EXPERIMENTAL TREATMENT ACT

This Act is the California state law that mandates the right to external review by qualified experts when a terminally ill Member has been denied coverage for a drug, device, procedure or other therapy generally considered experimental or investigational, including new technologies.

The request for this review can be requested by the Health Plan physician, a non-Plan physician, or the Member. In any case, Member Services will initiate the process for review, including facilitating the transfer of information to the independent review entity or internally in accordance with designated resolution timeframes.

7.12 DEMAND FOR ARBITRATION

A Member may file a demand for arbitration after he/she has received the appeal decision or at any earlier step in the process. For more information on arbitration procedures, advise the Member to contact the local facility Member Services Department.

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

Section VIII: Provider Rights and Responsibilities

Providers are responsible for the following:

- Provide health care services without discriminating on the basis of health status or any other unlawful category.
- Uphold all applicable responsibilities outlined in the Kaiser Permanente Member Rights & Responsibilities Statement in this Provider Manual.
- Maintain open communication with a Member to discuss treatment needs and recommended alternatives, without regards to any covered benefit limitations or Kaiser Permanente administrative policies and procedures. Kaiser Permanente encourages open provider/Member communication regarding appropriate treatment alternatives and does not restrict providers from discussing all medical necessary or appropriate care with Members.
- Provide all services in a culturally competent manner.
- Provide for timely transfer of Member medical records when care is to be transitioned to a new provider, or if your Agreement terminates.
- Participate in Kaiser Permanente Utilization Management and Quality Improvement Programs. Kaiser Permanente Quality Improvement and Utilization Management 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. Kaiser Permanente will communicate information about the programs and extent of provider participation through special mailings, and updates to the Provider Manual.
- Collect applicable co-payments, deductibles, and coinsurance from Members as required by your Agreement.
- Comply with this Provider Manual and the terms of your Agreement.

- Verify eligibility of Members prior to providing covered services.
- Cooperate with and participate in the Member complaint and grievance process, as necessary.
- Secure authorization or referral from a Medical Group physician prior to providing any non-emergency services except as otherwise provided in your Agreement.
- Encourage all practitioners and provider staff to include Members as part of the Member safety team by requesting Members to speak up when they have questions or concerns about the safety of their care.
- Discuss adverse outcomes related to errors with the Member and /or family.
- Ensure Members' continuity of care including coordination with systems and personnel throughout the care delivery system.
- Foster an environment which encourages all practitioners and provider staff to report errors and near misses.
- Pursue improvements in Member safety including incorporating Member safety initiatives into daily activities.
- Ensure compliance with Member safety accreditation standards, legislation, and regulations.
- Provide 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.
- Notify Provider Relations in writing of any practice change that may affect access for Members.
- Report 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.
- Contact your local county Public Health Department if you treat a Member for a reportable infectious disease.

Providers also have the following rights:

- 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 Kaiser Permanente in accord with your Agreement and applicable law.

Section IX: Complaint and Member Care Problems

Kaiser Permanente will work with a contracted provider to resolve complaints regarding administrative or contractual issues, or problems encountered while providing health care to Health Plan members.

For Referral Related Issues: For assistance with referral or authorization issues, please contact a Referral Coordinator from the referring Kaiser Permanente facility. The telephone number is listed in the "Key Contacts" section of this Provider Manual.

For Contractual Concerns: For assistance in resolving contractual issues, please contact your Network Development and Administration Representative. The telephone number is listed or noted in the “Key Contacts” section of this Provider Manual.

For additional information, please refer to the "Member Rights and Responsibilities” section of this Provider Manual.

For Claim Issues: For assistance in resolving claim-related issues, please refer to the “Billing and Payment” section of this Provider Manual. The telephone number is listed in the "Key Contacts" section of this Provider Manual.

For All Other Issues: If any issue remains unresolved, please contact Provider Relations. The telephone number is listed in the "Key Contacts" section of this Provider Manual.

For assistance in filing a Provider Dispute, please refer to the "Provider Appeals Process" section of this Provider Manual.

Section X: Billing and Payment

INTRODUCTION

The applicable Payor identified in your Agreement is responsible for payment of authorized services and emergency services in accordance with your Agreement and applicable law. It is your responsibility to submit itemized claims for those services provided to Members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. The terms “bill”, “claim” and “invoice” are used interchangeably in this section and should not be interpreted to differ in meaning.

10.1 BILLING REQUIREMENTS

Providers must submit itemized claims for covered services provided to Members on an

appropriate billing form, as follows:

- We urge you to submit claims electronically in either 837I (Institutional) or 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.

All fields that require information regarding the "insured" should be completed based on the Member's data. The Member's Kaiser Permanente medical record number (MRN), the authorization number from the authorization document(s) for non-emergency services, and all other required information, must be included in the appropriate fields. (For services following stabilization of an emergency medical condition, refer to the "Emergency Services" section of this Provider Manual, for information regarding how to obtain an authorization for such services. Note that you must obtain an authorization as a condition to payment for all non-emergency services that require authorization.) All other fields on the applicable form should be completed by your billing office for services provided.

You are also required under your Agreement and/or applicable law to submit certain encounter data for covered services provided to Members. Encounter data must be provided in the applicable EDI claim file or billing form.

10.2 SUPPORTING DOCUMENTATION

It is your responsibility to submit all reasonably relevant information that is required for us to determine payor liability. Where appropriate, we may request additional information in writing, which may include:

- Admitting face sheet,

- Discharge summary,

- Operative report(s),
- Emergency room records with respect to all emergency services,
- Treatment notes as reasonably relevant and necessary to determine payor liability, including a physician report relating to any claim for which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier, and.
- National Drug Code (NDC) for physician administered drugs. Claims for dates of services on or after January 1, 2024, that are submitted without an NDC or an invalid NDC, will be denied. It is the provider's responsibility to resubmit a corrected claim with the valid NDC.

We are pleased to share features of Online Affiliate that will allow you to electronically submit claim-related information. Specifically, new functionality will allow you to:

- Submit supporting documentation with your claim (once the claim is available in the KP system).
- Respond to requests for information when we request additional information necessary to adjudicate the claim.
- File a dispute/appeal of claim decisions.

  To sign on or register for access to Online Affiliate, please visit the following link and navigate to the **Online Provider Tools** section:
  https://healthy.kaiserpermanente.org/southern-california/community-providers

10.3 STANDARD BILLING CODES

Standard codes, and any commonly accepted successor codes, including the following, must be used on all billing forms:

- **REVENUE CODE**: Code used to identify specific accommodation, ancillary service or billing calculation
- **CPT–4**: Physicians Current Procedural Terminology
- **HCPCS**: Health Care Procedure Coding System
- **ICD-10-CM**: Medical Index, for medical diagnostic coding
- **DSM-IV-R**: Codes for mental health diagnostic coding

10.4 CLAIM SUBMISSION REQUIREMENTS

Kaiser Permanente encourages (and if your Agreement requires) electronic submission of claims. Please see detailed information, below, on how to submit electronically.

However, if electronic claim submission is not possible, paper claims may be sent to the address located on the authorization document(s), or to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
Post Office Box 7004
Downey, CA 90242-7004
1-800-390-3510

10.5 ELECTRONIC SUBMISSION OF CLAIMS DATA

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

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

Electronic Data Interchange (EDI) is an automated exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI replaces the submission of physical paper claims and allows for faster and more efficient claims process and payment.

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. Each clearinghouse assigns a unique payor identifier for KFHP.

Payer IDs for KP's direct clearinghouses are listed below:

Clearinghouse	KP Payer ID
Office Ally	94134
SSI	SKAISERCA
Relay Health	94134
Change healthcare	94134

*Clearinghouses have channel partnerships which allow them to route claims to each other. If your current clearinghouse is not listed above, please contact them for guidance on which of the above KP-affiliated clearinghouses they have a channel partnership agreement with, and which payer ID to use.

EDI Submission Process:

(1) Provider sends claims via EDI: Once claim data is entered into the claims processing system, the data is transmitted to a clearinghouse for X12 HIPAA validation.

(2) Clearinghouse sends claims to KP: The clearinghouse receives claims data, "batches", and transmits to KP for processing. It is the responsibility of the provider and the clearinghouse to adhere to HIPAA Transaction rules and requirements.

In addition, clearinghouses may:

- Furnish required software to enable Direct Data Entry (DDE) in the provider's office.
- Modify inbound claims data to facilitate processing.
- Transmit the claims data to KP in a format that is supported by KP.
- Transmit electronic claim status reports from KP to providers.

(3) KP receives claims: KP receives/processes claim data and generates an electronic 277CA acknowledgement, which is transmitted back to the clearinghouse. This 277CA acknowledgement includes detailed accept/reject information for transmitted claims. Providers are responsible for reviewing and correcting rejected claims.

Electronic Claims Disposition:

Electronic Claim Acknowledgement: KP sends an electronic 277CA claim acknowledgement to the clearinghouse, which is forwarded to the provider as confirmation of all claims received by KP.

NOTE: Providers are encouraged to notify the clearinghouse if they do not receive 277CA claim acknowledgements.

277CA Detailed Error Report: The electronic claim acknowledgement reports include reject reports that identify specific errors on rejected claims. Once the claims listed on the reject report are corrected, the provider may re-submit these claims electronically through the clearinghouse. Providers are responsible for reviewing and updating their reject reports from the clearinghouse.

Supporting Documentation for Electronic Claims:

If submitting claims electronically, the 837 transaction contains data fields to house

supporting documentation through free-text format (the exact system data field may vary).

Claim-supporting documentation can be submitted via KP Online Affiliate. Once your claim has been submitted electronically, you may submit supporting documents via Online Affiliate.

Otherwise, if additional information is needed for claim processing, you will receive a request for information (RFI) from Kaiser Permanente, that can be furnished via KP Online Affiliate.

Claim Type	Electronic Claim Form	Paper Claim Form
Professional	837 Loop 2300, REF01=9F REF02= Authorization Number	CMS-1500 Box 23
Institutional (Facility)	8371 Loop 2300, REF01=9F, REF02=Authorization Number	UB-04 BOX 63

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

You may also send claim-supporting documentation via mail to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
Post Office Box 7004
Downey, CA 90242-7004

KP Online Affiliate
Online Provider Tools (KP Online Affiliate)

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

- Accessing patient eligibility, benefits, and demographics
- Viewing referrals and authorizations (for contracted providers)
- Viewing and downloading Explanation of Payments (EOP)

- Checking the status of submitted claims and viewing claim details including service date, billed amount, allowed amount, and claim codes.
- Confirming payment information such as check number, payment date, and total amount.

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

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

Electronic Payment and Remittance Advice Online Enrollment

Kaiser Permanente has partnered with Citi Payment Exchange to provide a portal for enrolling in Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA). The reduces turn-around -time for claims payments and removes overhead costs associated with handling paper correspondence.

With this partnership, Kaiser Permanente requests that all vendors utilize the Citi Payment Exchange portal for new enrollment and changes to existing enrollment. The portal is open 24 hours a day and 7 days a week.

Each Kaiser Permanente region requires a separate enrollment.
If you wish to create a new enrollment for EFT/ERA in the Southern California region,
https://b2bportal.citipaymentexchange.citi.com/enroll/SCAL-KFHP-ACH
Activation code MN4WX2 is required at login.

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 425-562-2245.

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

Telehealth:
Telehealth is the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care. Telehealth interactions between Providers and Members are subject to all applicable laws regarding telehealth, including, the confidentiality of health care information and a Member's rights to

the Member's medical information. Telehealth includes synchronous interactions, and asynchronous store-and-forward transfers. Telehealth may be conducted using audio and video or audio only.

For purposes of reimbursement for covered services provided via telehealth, it is important to reference your contract and, to the extent applicable, resources on billing and reimbursement for Medicare, Medicaid, and private insurers. Claims for payment must contain the appropriate CPT-4 or HCPCS codes.

Place of Service –
02 – Telehealth provided other than in Member's home.
10 – Is used for telehealth services provided to a Member located in their home.

Modifiers – The two most commonly used modifiers are the GT modifier for telehealth service rendered via interactive audio and video telecommunications systems, and the 95 modifiers for synchronous telemedicine service rendered via a real-time interactive audio and video communications system.

10.6 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.

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

10.7 CLAIMS PROCESSING GUIDELINES

Kaiser Permanente will follow the Knox-Keene Act, Medicare or Medi-Cal requirements for claim processing, as applicable.

- All claims for services provided to Kaiser Permanente Members must be submitted within ninety (90) days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge if 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 the Provider Dispute Resolution Process section 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.

10.8 CLAIMS PAYMENT POLICY

- Except for emergency services, the Member's eligibility and benefits coverage must have been verified prior to the time of service, in accordance with your Agreement and applicable law.
- All non-emergency services, including post-stabilization services, must be authorized, and the authorization number must be included on field 63 of the form UB-04 (or successor form). Bills for non-emergency services will be denied for payment if an authorization was not obtained in accordance with the requirements of your Agreement.
- Contracted providers will be compensated for covered services based on the compensation arrangement set forth in your Agreement.

10.9 CLAIMS REVIEW AND ADJUSTMENTS; CODING AND BILLING VALIDATION

Kaiser Permanente 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 refer to the Provider Dispute Resolution Process section 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.

10.9.1 Compensation Methodologies

The terms of your Agreement and this Provider Manual govern the amount of payment for services provided under your Agreement. Depending on the terms of your Agreement, 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. 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 admission date or first date of service). This may include application of compensation methodologies such as per diems, percentage of charges, case rates, etc. 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.

10.9.2 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," the link of which is attached hereto as Appendix I. Billed items will be reviewed and/or corrected, and final payment will be based on such reviewed (and, if necessary, corrected) information.

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 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 for all such procedures provided to members. KP will not reimburse for any professional component of clinical diagnostic laboratory services, such as automated laboratory tests, billed with a Modifier 26 code, 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 appropriate facility responsible for providing the laboratory services.

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

10.9.3 Clinical Review

Claims may be reviewed by a physician or other appropriate clinician to ensure that providers comply with commonly accepted standards of coding and billing, that services rendered are appropriate and medically necessary, and that 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: https://healthy.kaiserpermanente.org/southern-california/community-providers/claims

KP will review claims for items or services that are considered inclusive of, or an integral part of, another procedure or service and, where, appropriate, deny payment. 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 I.

10.10 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 applicable Copays (as defined in Section X.1.16 below) 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 XIV.1.3 of this Provider Manual and as may be further required by your Agreement. KP may 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[1] (SE):

- Wrong surgery or invasive procedure[2] on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part;

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
    - Fractures

    - Dislocations
    - Intracranial Injuries
    - Crushing Injuries
    - Burn
    - Other Injuries
- Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization
- Any new Medicare fee-for-service HAC later added by CMS
- Hospital-Acquired Conditions | CMS

[1] 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).

[2] '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."
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).

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 Claims for DNBE:

- 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.

- UB04 – If you submit a UB-04 Claim (or its successor) for inpatient or outpatient facility services provided to a member wherein a HAC (Including a 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.

10.11 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. COB 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. In addition, COB 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 Kaiser Permanente 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 Permanente 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 the other payor (if authorization is required) and/or responding to requests for medical records.

How to Determine the Primary Payor

Primary coverage is determined in accordance with applicable law and the Member's benefit plan. Common examples include:

- With respect to adults, the plan that covers the person other than as a dependent, for example as an employee, Member, subscriber, policyholder, or retiree, but not as a dependent, is the primary plan. The plan that covers the person as a dependent is the secondary plan. If the adult person 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, 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 a 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 current employment status of their own or a family Members' 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 a Group Health Plan (GHP) whose subscriber is a retiree of the GHP when the CMS Working Aged or Disabled Beneficiaries provisions apply.
- Medicare Fee For Service or a Medicare Advantage plan is primary payer to GHPs for individuals eligible for, or entitled to Medicare benefits based on, End-Stage Renal Disease (ESRD) 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 call or contact the Member Services Contact Center (MSCC) with any questions you may have about COB.

COB Claims Submission Requirements and Procedures

If a claim is submitted to KP without the appropriate primary payment information and Member 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 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 to Kaiser Permanente the claim with the primary payor payment information. The claim will be reviewed, and the amount of payment due, if any, will then be determined based on the terms of your Agreement.

Please note that secondary claims can be submitted to Kaiser Permanente via EDI.

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

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

Kaiser Permanente recognizes submission of an 837 transaction to a sequential payer

populated with data from the previous payer's 835. Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier.

When more than one payer is involved on a claim, data elements for all prior payers must be present (i.e., if a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present).

If data elements from previous payer(s) are omitted, Kaiser Permanente will deny the claim.

Contact your clearinghouse for assistance sending COB claims electronically.

10.12 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 VI, "Member Eligibility and Benefits".

In addition, to ensure your continued compliance with Medi-Cal program requirements 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 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, Kaiser Permanente will include OHC information in its payment denial notification. If you believe payment on a claim was adjudicated incorrectly, please refer to Section XI, Provider Appeals Process.

10.13 THIRD PARTY LIABILITY (TPL)

Third Party Liability (TPL)

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

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 that falls under the category of First Party Liability (such as Med Pay, Personal Injury Protection, etc.), please submit your claim and indicate the carrier's name and amount paid along 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 a third party.

Both definitions of alternate liability here shall be considered TPL for the purposes of this Section 10.12.

First and Third-Party Liability Guidelines

Providers are required to assist and cooperate with Kaiser Permanente's efforts to identify these situations by entering the following information on the billing form, if applicable:

- Automobile carrier information in appropriate fields, along with payment information
- ICD-10 diagnosis data in appropriate fields
- Accident-related claim codes (e.g., occurrence codes, condition codes, etc.)

Kaiser Permanente 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.

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 claim, you may submit the claim for covered services to Kaiser Permanente in the same manner as you submit other claims for services. You must also include a copy of the denial letter or Explanation of Payment from the Workers' Compensation carrier.

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

10.14 COPAYMENTS, COINSURANCE AND DEDUCTIBLES

- Contracted providers are responsible for collecting copayments, coinsurance and deductibles (collectively, "Copays") in accordance with member benefits unless explicitly stated otherwise in your Agreement.
- Claims submitted by providers who are responsible for collecting Copays will be paid at the applicable rate(s) under your Agreement less the applicable Copay amount due from the Health Plan member.
- You must not waive Copays you are required to collect, except as expressly permitted under applicable law and your Agreement.

Please verify applicable Copays at the time of service by contacting Member Services at the number listed in the "Key Contacts" section of this Provider Manual.

10.15 OVERPAYMENT POLICY

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

- Please include the following information when returning uncontested overpayments:

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

Mail your refund check (and brief note) to:

Kaiser Permanente
Attn: Regional Claims Recovery
PO Box 741639
Los Angeles, CA 90074-1639

10.16 OFFSETS 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 that 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.

10.17 DIRECT MEMBER BILLING

Health Plan Members may be billed only for copayments, coinsurance and deductibles where applicable according to Member 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 Health Plan Member can be billed for covered services.

10.18 MEMBER CLAIMS INQUIRIES

If you are presented with a Health Plan member complaint or inquiry regarding any direct Member billing (including any billing for Copay or other Member liability described above) you should direct the Member to call:

Member Services Contact Center 1-800-464-4000

Monday – Friday	7 a.m.to 7 p.m.
Saturday – Sunday	7 a.m.to 3 p.m.

Medicare Member Services 1-800-443-0815

Monday – Sunday	7 a.m.to 8 p.m.

Section XI: Provider Appeals Process

INTRODUCTION

KP actively encourages our contracted Providers to utilize the Online Affiliate Provider Portal to resolve billing and payment issues.

This section of the Provider Manual provides information about our dispute resolution process, but it is not intended to be a complete description of the law or the provisions of your Agreement. Please make sure you review your Agreement and applicable law for a complete description of the dispute resolution process.

11.1 SUBMITTING DISPUTES

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

Directions for Submission of Payment Disputes

The table below outlines the appropriate submission instructions depending on the type of services rendered:

Submission Method	Submit To
Online	For more information or to register for **Online Affiliate**, please visit KP's Southern California **Community Provider Portal** at: https://healthy.kaiserpermanente.org/southern-california/community-providers
US Mail	**Kaiser Foundation Health Plan, Inc.** **Claims Administration Department** **P.O. Box 7006** **Downey, CA 90242-7006**

To inquire about filing a payment dispute and/or the status of previously submitted disputes, contact KP through Online Affiliate or by calling: **(800) 390-3510**.

Disputes Related to Visiting Member Claims

For information concerning provider payment disputes related to claims for services rendered to visiting Members, please contact the Member Services Call Center for the Member's Home region. The specific phone numbers are provided in Section 4.1 of this Provider Manual.

11.2 REQUIRED INFORMATION FOR PROVIDER DISPUTE NOTICES

Your Provider Dispute Notice must contain the required information listed below in order for us to acknowledge your dispute:

- Tax Identification Number (TIN) under which services were billed
- Disputed Claim Number (original assigned claim number by KP)
- Name and KP Medical Record Number (MRN) of the Member
- Date(s) of Service(s)
- Clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect

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

Your Provider Dispute Notice may be submitted by you or by a representative (for

example, a billing service, a collection agency or an attorney) authorized by you to perform this function. If your authorized representative submits your Provider Dispute Notice, that representative will be required to provide confirmation that an executed business associate agreement between you, as the provider of health care services, and such representative is in place and that it complies with HIPAA.

We recommended you or your representative submit each Provider Dispute Notice, related to either an emergency or referred services claim, with KP's Provider Dispute Resolution Request form (PDRR). You may contact KP at the telephone number indicted on the Explanation of Payment (EOP) to obtain the PDRR form. Alternately, you or your representative may submit a payment dispute in writing without a PDRR, including all the required information outlined above.

11.3 PROVIDER DISPUTE PROCESS TIMELINE

Time Period for Submission of Provider Dispute Notices

Provider Dispute Notices must be received by KP **within 365 calendar days** from our action (or the most recent action if there are multiple actions) that led to the dispute.

Timeframes for Acknowledgement of Receipt and Determination of Provider Dispute Notices

If your submission meets all requirements, we will acknowledge receipt of your Provider Dispute Notice within 15 business days after KP's receipt of hardcopy submission, or within two business days after KP's receipt of online submission. KP will issue a resolution letter explaining the reasons for our determination, to the extent required by applicable law, within 45 business days after the date of receipt of the complete Provider Dispute Notice.

11.4 Instructions for Resolving Substantially Similar Payment Disputes

Online Affiliate cannot be utilized to submit batches of substantially similar payment disputes at this time. If you proceed with filing substantially similar multiple disputes, they may be filed in writing in batches, submitted via U.S. Mail. Each claim being disputed must be individually numbered and contain the provider's name and include the following information:

- Tax Identification Number (TIN) under which services were billed
- Disputed Claim Number (original assigned claim number by KP)
- Name and KP Medical Record Number (MRN) of the Member
- Date(s) of Service(s)
- Clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect

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

Section XII: Credentialing and Recredentialing

INTRODUCTION

Kaiser Foundation Health Plan has developed and implemented credentialing and re-credentialing policies and procedures for Health Delivery Organizations.

As a contracted provider, your facility has already met the basic criteria for initial credentialing, including insurance requirements, absence of Medicare and Medicaid sanctions, current state licensure, certificate of insurance and accreditation. If your facility is not accredited, then it had met the accreditation of Kaiser Foundation Health Plan site survey criteria in the areas of appearance, safety, provider and staff availability, emergency preparedness, infection control, medical record, quality assessment and improvement, and utilization management. Your facility and all providers who furnish services to our members are required to meet applicable requirements and, unless your Agreement expressly provides otherwise, be properly enrolled in and certified under the Medicare and Medicaid programs.

12.1 CREDENTIALING AND RE-CREDENTIALING PROCESS

All staff, including employees, contractors and agents of your facility who provide covered services to members, will be at all times properly licensed by the state in which services are rendered, certified, qualified and in good standing in accord with all applicable local, state and federal laws.

During the period between initial credentialing and re-credentialing, your facility is required to continue to meet all initial credentialing criteria. This includes, but is not limited to, submission of copies of current/renewed state license, accreditation and certificates of insurance to Kaiser Foundation Health Plan, when requested.

Re-credentialing will occur at least every thirty-six months and may occur more frequently if needed. In addition to the basic initial credentialing criteria, member grievances, member satisfaction, quality assurance/improvement, and utilization management data will be considered prior to re-credentialing.

12.2 CONFIDENTIALITY OF CREDENTIALING INFORMATION

All information obtained during the credentialing and re-credentialing process is considered to be confidential except as otherwise required by applicable law.

For additional information regarding credentialing and re-credentialing requirements and policies, please contact the Kaiser Foundation Health Plan, Credentialing at the telephone number included in the "Key Contacts" section of this Provider Manual.

Section XIII: Utilization Management

13.1 UTILIZATION MANAGEMENT PROGRAM

Utilization Management ("UM") is a health plan process that reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by the treating provider. The determination of whether a service is medically necessary is based upon criteria that are consistent with and supported by sound clinical principles and processes, which are reviewed and approved annually by Health Plan.

Patient care, including the provision of clinically appropriate services and treatment, is determined by the treating clinician based on their judgement of clinical appropriateness and not by Health Plan UM criteria. Kaiser Permanente expects Providers to allow open provider-patient communication regarding appropriate treatment alternatives without regard to a member's benefit plan. Kaiser Permanente does not penalize providers for discussing available care options with Members. Utilization Management is not employed in the vast majority of services, except as listed in www.kp.org/um.

Kaiser Permanente does not reward or compensate anyone for denying services or coverage. Kaiser Permanente does not use financial incentives to encourage denials of care.

Utilization Management data collected by Kaiser Permanente is used to comply with regulatory and accreditation requirements, to identify areas for improvement in the delivery and management of care for both inpatient and outpatient services, and to coordinate the evaluation of resource management.

Through standardized UM processes, objective information regarding medical necessity of health care services is obtained. Appropriately licensed health care professionals supervise all UM decisions. A licensed physician reviews all full and partial denials of a health care service when the determination is based on medical necessity. The criteria used in the UM review process are available to all practitioners upon request at no cost. For further information about Kaiser Permanente's UM process, please see http://www.kp.org/um.

13.2 REQUEST FOR PRIOR AUTHORIZATION FOR NON-KAISER PERMANENTE (External) AND/OR OUT-OF-NETWORK PROVIDER SERVICES

For health care services provided to a Member by a non-Kaiser Permanente and/or out-of-network provider, prior authorization is required. Contracted providers must contact Kaiser Permanente to arrange for and to coordinate authorized medically necessary care.

13.3 REQUEST FOR INFORMATION

Upon request from Kaiser Permanente, a provider may be asked to provide information concerning Members in the provider's facility. Information may include, but is not limited to, the following data:

- Number of Members admitted
- Number of Members who were inpatients within the previous seven days
- Number of Members who presented to the Emergency Department ("ED") and number of Members admitted through the ED
- Type and number of procedures performed
- Number of Member consults
- Number of Members that expired
- Number of Member autopsies
- Average length of Member inpatient stays
- Provider Quality Assurance/Peer Review processes
- Number of Member cases reviewed
- Final action taken for each Member case reviewed
- Committee Membership (participation as it pertains to Members and only in accordance with the terms of your contract)
- Other information as Kaiser Permanente may reasonably request

13.4 HOSPITAL ADMISSIONS OTHER THAN EMERGENCY SERVICES

Emergency care needed to stabilize an emergency medical condition does not require prior authorization. However, Health Plan reviews and coordinates repatriation for post-stabilization care, pursuant to standards set forth in applicable statutes and regulations. Authorization for post-stabilization care can be requested by contacting the Outside Utilization Resource Services (OURS) office at 1-800-225-8883. Should the Member require continued hospitalization beyond the services authorized, the Provider must contact OURS for further direction.

13.5 ADMISSION TO SKILLED NURSING FACILITY (SNF)

Requests for skilled nursing facility (SNF) placement should be directed to the OURS office at 1-800-225-8883.

Requests for SNF placement by contracted providers should be directed to the Long-Term Care department local to the patient's residence (from the list below).

Area(s)	Phone Number
Antelope Valley	(661) 428-1306
Baldwin Park	(626) 851-7037
Downey	(562) 622-3823
Fontana/Ontario	(909) 609-3500
Kern County	(661) 337-7235
Los Angeles	(323) 783-4600
Ontario/Fontana	(909) 609-3500
Orange County	(714) 734-5500
Panorama City	(818) 375-3758
Riverside	(951) 602-4230
San Diego	(619) 528-1245
South Bay	(424) 251-7875
West Los Angeles	(323) 648-1390
Woodland Hills	(818) 592-2400

13.6 HOME HEALTH/HOSPICE SERVICES

Referral for home health services is based on the following information:

- A Medical Group physician must refer, oversee the plan of care and provide orders for home health services.
- The Member is an eligible Health Plan Member.
- The Member requires skilled care in the Member's place of residence within the Kaiser Permanente Service Area. Any place that the Member is using as a home is considered the Member's residence, as long as care can be safely provided.
- For home health services, the Member, because of illness or injury, is confined to home. The Member is not considered homebound when the Member lacks transportation or is unable to drive. To be considered homebound absence from the home is infrequent and/or short in duration. A Member is not considered homebound if the Member would otherwise tolerate an absence from the home.
- The home environment is a safe and appropriate environment setting to meet the Member's needs and provide home health services.
- There is reasonable expectation that the needs of the Member can be met by the provider.
- Clinically appropriate care must be provided by a registered nurse or therapist.
- The Member and caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals.

- Services are provided under Health Plan coverage and benefit guidelines.
- Such home health services are based on the following information:
    - For Health Plan Members, a prognosis of 12 months or less. For Medicare patients, a prognosis of 6 months or less.
    - The Member must elect the hospice benefit.
    - Care is palliative in nature.
    - All care related to the terminal illness is managed by the hospice provider.

The plan of care is developed and managed by the Member's choice of an attending physician, in collaboration with the Hospice Medical Director. Home health and hospice staff coordinate care with the attending physician. Home Health and hospice staff manage the Member's plan of care through on-site visits with the Member and telephone encounters to assess the Member's progress toward achieving goals in the plan of care. The plan of care is reviewed and, if required, revised with new physician orders at least every 15 days and as needed to meet the needs of the Member.

Discharge planning begins when the applicable plan of care is initiated during the start of care of home health or hospice service.

13.7 DURABLE MEDICAL EQUIPMENT (DME)

Health Plan evaluates authorization requests for durable medical equipment for appropriateness based on, but not limited to, the following information:

- The Member's care needs
- Member's eligibility status
- The application of specific Health Plan formulary guidelines relative to Member's benefit coverage (benefit and medical necessity)

Health Plan DME Formulary information may be available upon request by calling the Regional DME Hub at 855-805-7363 and through the link at: https://cl.kp.org/scal/home.html (Type the DME item into the search box).

13.8 NON-EMERGENT MEMBER TRANSPORTATION SERVICES

To serve Kaiser Permanente Members and to coordinate care with our contracted providers, Kaiser Permanente has a twenty-four hour (24 hour), seven-day per week, centralized medical transportation department called the "HUB", to coordinate and to schedule non-emergency medical transportation (NEMT services).

If a Member is to be transferred from a non-Kaiser Permanente facility to a Kaiser Permanente Medical Center or other location designated by Kaiser Permanente, it is

required that prior authorization be secured for the transport before the HUB is contacted to coordinate the NEMT services.

If a transport order is authorized by an appropriate Southern California Permanente Medical Group or Plan physician, the HUB will make the transportation arrangements.

HUB
1-877-227-8799
Available 7 days a week
24 hours a day

The Kaiser Permanente Discharge Planner or Continuing Care Coordinator will work with the HUB to arrange the transportation of the Member.

Non-emergency medical transportation may or may not be a covered benefit for the Member. In the event any transports of the Member are not coordinated through the HUB, and are not properly documented as authorized referrals, payment for the transport may be denied.

Section XIV: Quality Management Program

INTRODUCTION

Kaiser Permanente Southern California (KPSC) maintains a Quality Management (QM) Program to objectively and systematically monitor and improve the quality, safety, and appropriateness of Member care. The Regional and Medical Center Quality Departments work collaboratively toward the resolution of identified problems and pursue opportunities for continuous improvement in the provision of Member care/ services and Member safety.

You agree to collaborate with Health Plan through provision and sharing of provider-specific quality data/ information. Shared information should include quality/risk data related to the identification, review, and resolution of quality-of-care issues, regardless of the information source, (e.g., Member complaints, clinical department referral, regulatory referral, UM referral etc.), other quality improvement activities, and public reports to consumers.

The KPSC QM Program includes many aspects of clinical and service quality, including patient safety, infection prevention, accreditation and regulatory, and the oversight of access to care opportunities that result in a potential quality of care issue.

The KPSC QM Program is described in the 2024 Quality Program Description: Kaiser Foundation Health Plan Southern California Region, which serves to document

how KPSC is organized to support our commitment to the provision of high quality, safe, outcome-based Member care in accordance with professionally recognized standards.

You can view more about the KPSC QM Program by visiting https://healthy.kaiserpermanente.org/southern-california/pages/quality-safety to find results specific to the Southern California Region.

To obtain a copy of the "Quality Program at KP" call our Member Services Call Center at **1-800-464-4000** or for TTY, call **711**.

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

At KPSC, Member safety is every Member's right and everyone's responsibility. As a leader in Member safety, our strategic plan outlines six (6) focus areas. These themes include safe culture, safe care, safe staff, safe support systems, safe place, and safe Members.

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

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 for managing, measuring, and assessing Member care 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. Health Plan is accredited by NCQA. You can review the report card for Kaiser Permanente's Southern California Region at https://reportcards.ncqa.org/health-plans.

The Leapfrog Group

The Leapfrog Group is a national nonprofit organization founded by large employers and purchasers to drive movement in quality and safety in American health care. The group gathers information about aspects of 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 KFH 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 survey results, visit https://ratings.leapfroggroup.org

The Joint Commission

The Joint Commission (TJC) is an independent, not-for-profit organization and is the nation's largest standards-setting and accrediting body in health care. TJC accreditation is recognized nationwide as a symbol of quality that reflects an organization's compliance with TJC performance standards. To achieve and maintain TJC accreditation, KFH facilities must undergo an onsite survey by TJC survey team at least every three (3) years. Kaiser Permanente has adopted a set of TJC compliance expectations for contracted practitioners coming into our facilities. For more information on TJC performance standards visit: www.jointcommission.org.

14.1 QUALITY ASSURANCE AND QUALITY IMPROVEMENT PROGRAM

KP's Quality Improvement (QI) program uses a multidisciplinary and integrated approach, which focuses on opportunities for improving operational processes including transitions in care, health outcomes, and patient and provider satisfaction.

With respect to covered services provided to Members, Providers shall participate in KP's QI program, as established and amended from time to time, which includes cooperating with KP's QI activities to monitor and evaluate covered services provided to Members (such as tracking and regular reporting on quality, Member safety and regulatory indicators, and providing performance data), facilitating review of such covered services by KP's QI committees and staff, and cooperating with any independent quality review and improvement organization or other external review organization evaluating KP's QI program.

The quality-of-care members receive is monitored by and reported through the Southern California Quality Committee and to the Quality & Healthcare Improvement Committee, a subcommittee of the KFHP Board of Directors. As part of KP's QI program, Providers shall cooperate with providing performance data for use in QI activities. You will be monitored for various indicators and required to participate in some KP processes related to the clinical and service measures of the QI program. 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
- Utilization Management statistics
- Over and under-utilization of services

- Quality of care indicators as necessary for KP to comply with requirements of Department of Managed Health Care (DMHC), NCQA, Medicare, Department of Health Care Services (DHCS), The Joint Commission and other regulatory and accreditation bodies
- Performance standards in accordance with your Agreement
- Credentialing and re-credentialing 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 to 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 regulatory/ accrediting agencies to be unsatisfactory.

14.2 MONITORING AND REPORTING REQUIREMENTS

The Agreement identifies events that must be reported to KP by provider and particular monitoring actions that must be performed by provider in conjunction with KP's QI program. Reportable events are in alignment with the state and federal requirements as well as accrediting body standards. In addition, as part of its required participation in KP's QI program and in addition to the claims submission requirements set forth in Section X of this Provider Manual, and to the extent permitted by state and federal law, Provider must promptly notify KP and, upon request, provide information about any Do Not Bill Event (as defined in Section X.1.11) that occurs in connection with services provided to a Health Plan Member.

Section XV: Emergency Services

When Health Plan Members present in your Emergency Room for treatment, we expect you to triage and treat them in accordance with EMTALA requirements, and to contact Kaiser Permanente's Emergency Prospective Review Program (EPRP) once the member has been stabilized or stabilizing care has been initiated.* You 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 you in your 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. In addition, EPRP can authorize post-stabilization care at your facility, as required under each Member's Evidence of Coverage for non-emergency care to be a covered benefit or assist in making other appropriate care arrangements.

- Please note: Under the EMTALA regulations issued September 2003; 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 provides a statewide emergency services notification system in California for all Health Plan Members. It also provides authorization for requested post-stabilization care and must be contacted prior to a stabilized Health Plan Member's admission to your facility unless your Agreement establishes a different process.

EPRP
1-800- 447-3777
Available 7 days a week
24 hours a day

EPRP PROVIDES:

Access to clinical information 24 hours a day, every day of the year, to help you in evaluating a Member's condition and to enable our physicians and the treating physicians at your facility, to quickly determine the appropriate treatment for the Member.

Emergency physician to emergency physician discussion regarding a Member's case 24 hours a day, every day of the year.

Authorization of post-stabilization care, 24 hours a day, every day of the year, or assistance with making appropriate alternative care arrangements.

15.1 POST STABILIZATION AUTHORIZATIONS

If there is mutual agreement at the time of the phone call as to your provision of post-stabilization services, EPRP will authorize you to provide the post-stabilization services and give you a confirming claims reference number. If requested, Kaiser Permanente will also provide a written confirmation of the services authorized and the confirmation number. This claims reference number must be included with the claim for payment for the authorized services. The claims reference number is required for payment, along with the following:

- All reasonably relevant information relating to the post-stabilization services on your claim submission consistent with the information provided to EPRP as the basis for the authorization; and

- EPRP must have confirmed that the member was eligible for and had

benefit coverage for the authorized post-stabilization services provided.

If EPRP authorizes the admission of a clinically stable Member to your facility, Kaiser Permanente's Outside Utilization Resource Services (OURS), will follow that Member's care in your facility, including any authorization of subsequent care, until discharge or transfer.

15.2 POST STABILIZATION ADMISSIONS

If the Member is admitted to your facility as part of the stabilizing process and you have not yet been in contact with EPRP, you must call Outside Utilization Resource Services (OURS) once the Member's emergency medical condition is stabilized and before providing any post-stabilization care.

OURS NOTIFICATION
1-800- 225-8883
Available 7 days a week
24 hours a day

LIKE EPRP, OURS NOTIFICATION ALSO PROVIDES:

- Access to clinical information 24 hours a day, every day of the year, to help you in evaluating a Member's condition and to enable our physicians and the treating physicians at your facility, to quickly determine the appropriate treatment for the Member.
- Physician-to-physician discussion regarding a Member's case 24 hours a day, every day of the year.
- Authorization of post-stabilization care, 24 hours a day, every day of the year, or assistance with making appropriate alternative care arrangements.
- OURS may request that the Member be transferred to a Kaiser Permanente-designated facility for continuing care or OURS may authorize certain post-stabilization services in your facility on the condition that such services be rendered under the management of a physician who is a member of your facility's medical staff or who has contracted with Kaiser Permanente to manage the care of our Members being treated in community hospitals.
- If the Health Plan Member insists on receiving unauthorized post-stabilization care from your facility, we strongly recommend that you require that the Member sign a financial responsibility form acknowledging and accepting his or her sole financial liability for the cost of the unauthorized post-stabilization care and/or services.

- Note: If the Member wishes to discuss the process of filing a claim with Kaiser Permanente, please refer the Member to Kaiser Permanente's Member Services Department at 800-464-4000, available the days and hours set forth in the "Key Contacts" section of this Provider Manual. A Member Services Representative will explain the claims process to the Member.

Section XVI: Cultural Diversity

At Kaiser Permanente, we are committed to improving the quality of care provided to our increasingly diverse membership. Member's cultural needs are considered and respected at every point of contact. This is integral for providing a culturally competent system of care.

A person's culture is composed of many factors. Examples include:

- Ethnicity
- Gender
- Physical/mental ability
- Race
- Sexual orientation
- Age
- Language
- Education
- Health literacy/beliefs
- Religion/spirituality
- Income

At Kaiser Permanente, we

- Value differences in culture, experience, and perspective
- Seek out and consider differing points of view
- Treat all individuals with dignity and respect
- Make all individuals feel important and welcome
- Seek to understand different medical needs based on diversity and promote culturally and linguistically appropriate care

16.1 NON-DISCRIMINATION

The Kaiser Permanente Medical Care Program (KPMCP) does not discriminate in the delivery of health care based on race/ethnicity, color, national origin, ancestry, religion, sexual orientation (including gender, gender identity, or gender related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth), marital status, veteran's status, age, genetic information, medical

history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment or any other protected status.

It is also the policy of KPMCP to require that facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 ("ADA"), Section 504 of the Rehabilitation Act of 1973, and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability. Kaiser Permanente is committed to providing equal access for members with disabilities.

As a provider for HMO products offered by KP, you are expected to adhere to KP's "Nondiscrimination in the Delivery of Health Care Policy" (as may be amended from time to time) and to all applicable federal and state laws and regulations that prohibit discrimination on the basis of disability. For copy of the most current policy, Providers may contact Member Services. The Member Services telephone number is located in the "Key Contacts" section of this Provider Manual.

16.2 KP'S LANGUAGE ASSISTANCE PROGRAM

All Providers must cooperate and comply with KP's Language Assistance Program by assisting any limited English proficient (LEP) KP Member with access to KP's Language Assistance Program services.

Providers must ensure that KP Members or, if applicable, their family, caregivers or legal guardian(s) 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, auxiliary aids and services, including sign language interpreters to KP 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. If facility or place of business is open 24 hours/day, 7 days/week, then language assistance is to be made available 24 hours/day, 7 days/week. Kaiser Permanente also requires contracted providers and their staff to comply with ADA regulations in providing auxiliary aids services, free of charge, for Members and their companions who are deaf or hard of hearing in order to ensure effective communication.

Please refer to the: Qualified Interpreter Services for Limited English Proficient Persons Policy CA.HP.Operations.LA005002, available at https://healthy.kaiserpermanente.org/southern-california/get-care/interpreter-services.

The proactive offer and/or use of language assistance services must be documented in the KP Member's medical record, even if the communication occurred directly with the Provider or Provider's qualified bilingual staff (QBS). If language assistance was utilized

the type of service provided must be documented, along with the type/name of the service and the interpreter's name and ID, either of the Provider, the Provider's QBS or the contracted KP language assistance vendor. Should an LEP KP Member refuse to accept language interpreter services, the Provider must document this refusal in the KP Member's medical record and the reason for such refusal. In addition, if language assistance was requested by the KP Member and not provided the reason for not providing such services must be documented in the Member's medical record. Please see the subsection titled "Documentation" below.

You can review Kaiser Permanente's *Qualified Interpreter Services for Limited English Proficient Persons* policy on the kp.org website at https://healthy.kaiserpermanente.org/southern-california/get-care/interpreter-services or you may contact the SCAL Equity, Inclusion & Diversity department at equity-inclusion-diversity-scal-hi-rgnl@kp.org for questions regarding language services.

16.3 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 (target) language.
- Fundamental knowledge in both languages of health care, clinical, and medical terminology, and concepts; and
- Education and training in interpreting ethics, conduct and confidentiality.

Provider must have a process in place to ensure ongoing competency of staff and to cooperate with KP by providing access to this information upon reasonable notice.

WHEN QUALIFIED BILINGUAL STAFF ARE 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 KP Members. KP will directly reimburse the companies described below for interpreter services provided to KP Members. Neither Members nor Providers will be billed by these companies for interpreter services.

16.4 TELEPHONE INTERPRETATION

United Language Group is a company with the capability to provide telephonic interpreter services in 200 different languages. Phone interpreter services are available 24 hours per day, 7 days per week through United Language Group by calling: **(855) 701-8100**. 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:

- KP Client ID number. This number will be provided to you, in writing, together with your authorization.
- KP referral or authorization number
- Member's MRN
- Member's language preference

United Language Group customer service can be reached through email (customer.care@ulgroup.com). You will receive a follow-up response within 48 hours.

16.5 SIGN LANGUAGE SUPPORT

Interpreters Unlimited is a company with the capability to provide in-person interpreter services for Members requiring sign language services (i.e., American Sign Language, etc.). At least two week's advance notification of need for a Sign Language interpreter is recommended to help ensure an interpreter is available. Please provide as much advance notice as possible when requesting a Sign Language interpreter. Interpreters Unlimited can be reached by calling: **(844) 855-0249** 7 days a week. Providers may arrange in-person interpreter services for multiple dates of service with one call.

Providers must have the following data elements available before placing the request for service:

- KP Client ID number. This number will be provided to you, in writing, together with your authorization.
- KP referral or authorization number
- Member's Medical Record Number (MRN)
- Date(s) of member's appointment(s)
- Time and duration of each appointment
- Specific address and location of appointment(s)
- Any access or security measures the interpreter will need to know and plan for to gain entry to the place of service
- Key contact name and number for KP inquiries regarding the request for interpreter services

Any cancellation must be made at least 24 hours in advance of the scheduled appointment.

Interpreters Unlimited customer service can be reached at **(800) 726-9891**, 24 hours per day, 7 days a week.

Note: Interpreters Unlimited interpreter will provide a verification of service form while onsite. Please ensure the Provider staff verify and sign this form.

Please inform KP of any complaints, concerns or questions that you have with the KP

provided language assistance service vendors by sending an email to equity-inclusion-diversity-scal-hi-rgnl@kp.org.

16.6 FAMILY MEMBERS AND FRIENDS AS INTERPRETERS

The KP Language Assistance Program strongly discourages, but does not prohibit, adult family members and friends (age 18 and over) from serving as interpreters for Members. 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. However, the Provider can still elect to utilize language assistance services to ensure effective, accurate and appropriate communication occurs. 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 member/patient, and only until a qualified interpreter is available. Use of a minor child for interpretation under these circumstances should be documented in the medical record.

16.7 DOCUMENTATION

Providers need to document the following in the KP Member's Medical Record:

- Language assistance was either offered (or requested) to (by) a Limited English Proficient or hearing impaired KP Member.
- If language assistance was refused by the KP Member; the reason why must be noted, e.g., used family member.
- What type of service was utilized (telephonic, in-person interpreter services or qualified bilingual staff), for those Members who accept/use language assistance?
- Name, ID, association, of the vendor, person and/or family member (18 years of age or older) that provided such language assistance.

Providers must document the required information for KP to assess compliance and cooperate with KP by providing access to that information upon reasonable notice.

16.8 ONSITE SIGHT TRANSLATION SERVICES

The requirements set forth above also apply to KP Member requests for the onsite verbal sight translation of documents related to such Member's care (i.e., verbal sight translation of a written document provided to the KP Member and related to services provided to such Member). To the extent a KP Member requests written translation of one or more documents, the Member should be referred to the KP Member Services Department.

16.9 STAFF TRAINING

Providers shall provide adequate training regarding the KP's language assistance program requirements to Provider staff who have contact with KP's LEP members. The training shall include instruction on:

- Understanding and complying with KP's Language Assistance Program
- Working effectively with KP's LEP and hearing-impaired Members
- Working effectively with interpreters in person and through video, telephone, and other media, as may be applicable
- How to access the KP language vendors and how to report any problems
- How to document the use and refusal of language services
- Understanding the cultural diversity of KP's Member population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Providers must document that training has occurred and submit training materials, sign-in sheets, attestations, knowledge checks and other relevant materials to KP to allow KP to assess compliance and cooperate with KP by providing access to that information upon reasonable notice.

16.10 COMPLIANCE WITH LANGUAGE ASSISTANCE

Providers must ensure they comply with KP's Language Assistance Program requirements. Providers must cooperate with KP by providing any and all information necessary to access compliance, including but not limited to, participation in onsite audits and requests for documentation as required by KP.

Section XVII: Compliance

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

17.1 COMPLIANCE WITH LAW

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

17.2 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/have access to 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 Ethics and Compliance Hotline is a convenient and anonymous way to report a suspected wrongdoing without fear of retaliation. It is available twenty-four (24) hours per day, three hundred sixty-five (365) days per year. The toll-free Ethics and Compliance Hotline number is **(888) 774-9100. KP also provides an online resource to report suspected wrongdoing online, at https://compliance.kaiserpermanente.org/**

Providers are encouraged to review the KP POR and Vendor Code of Conduct at: http://www.kp.org/compliance. The KP POR and Vendor 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.

17.3 GIFTS AND BUSINESS COURTESIES

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

- Gifts or entertainment of any 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

17.4 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 Ethics and Compliance Hotline number at **(888) 774-9100** for further guidance on potential conflicts of interest.

17.5 FRAUD, WASTE, AND ABUSE

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). KP Personnel may not be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

17.6 PROVIDERS INELIGIBLE FOR PARTICIPATION IN GOVERNMENT HEALTH CARE PROGRAMS

KP expects 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 State or federal program or is convicted of a criminal offense related to the provision of healthcare and (b) assume full responsibility for taking all necessary steps to assure that your 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.

17.7 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.

17.8 ACCESS AND AVAILABILITY

Provider shall ensure covered services are available (i) during normal business hours, (ii) when medically indicated, on a prompt or same-day basis, and (iii) as otherwise specified in the Agreement, this Provider Manual or applicable laws. Provider shall ensure covered services are readily available and accessible to members; provided in a timely manner, without delays in appointment scheduling and waiting times; and provided in a manner appropriate for the nature of a member's condition, and consistent with applicable recognized standards of good professional practice, Kaiser Permanente

policies and applicable laws. If it is necessary for Provider, a commercial or Medi-Cal member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice, and as otherwise required by applicable law.

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

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

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

Section XVIII: Confidentiality of Member Information

Health care providers, including Kaiser Permanente and you or your facility, are legally and ethically obligated to protect the privacy of Members and patients. Kaiser Permanente requires that you keep its Members' medical information confidential and secure. This requirement is based on state and federal confidentiality laws, as well as policies and procedures created by Kaiser Permanente.

As a contracted provider for Kaiser Permanente, you may not use or disclose the personal health information of a Health Plan 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, including a Member's address and telephone number.

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

18.1 HIPAA AND PRIVACY RULES

As a contracted provider, you may have signed a document that creates a Business Associate (BA) relationship with Kaiser Permanente as such relationship is defined by federal regulations commonly known as "HIPAA" (Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91)). If you are providing standard member care services that does not require a Business Associate Agreement (BAA), you still must preserve the confidentiality and privacy of our Members' medical information as a HIPAA "covered entity".

If you did not sign a BAA, you are a "covered entity" as that term is defined under HIPAA, and the Privacy Rule. As a covered entity, you have specific responsibilities to limit the uses and disclosures of protected health information ("PHI"), as that term is defined by the Privacy Rule (45 CFR Section 164.501).

Certain data which may be exchanged because of your relationship with Kaiser Permanente is subject to the HIPAA regulations. To the full extent applicable by the provisions of 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.

You 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 BAA you may have signed with Kaiser Permanente. You must maintain and distribute a Notice of Privacy Practices (NPP) (45 CFR Section 164.520) to Members using your services. You must distribute your (NPP) to and obtain acknowledgements from Members receiving services from you, in a manner consistent with your practices for other members. You must give Kaiser Permanente a copy of your NPP and give Kaiser Permanente a copy of each subsequent version of your NPP whenever a material change has been made to the original Notice.

You are required by HIPAA to provide a Member with access to his or her PHI, to allow that Member to amend his or her PHI, and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures. You must extend these same rights to Health Plan Members who are your members. If you amend a Member's record, allows a Member to amend their record, or include in your records any statement of a Member pursuant to HIPAA requirements, you must give a copy of such item to Kaiser Permanente.

18.2 CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

In receiving, storing, processing, or otherwise dealing with any member 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 member records, except as permitted by these regulations.

18.3 PROVIDER RESOURCES

- KP's Ethics & Compliance Hotline: (888) 774-9100
- KP's Network Development and Administration: (626) 405-3240

Appendix 1

Please refer to this link for 'POL – 020 Clinical Review Payment Determination Policy' as referenced on page 45 of this HMO Provider Manual.

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/scal/ever/clinical-review-payment-determination-policy-en.pdf