2026 Kaiser Permanente Southern California

Network Development and Administration

Contracted Institutional Providers

HMO Provider Manual

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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 80 years 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 <u>Exclusive Provider Organization (EPO)</u>

- 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 <u>Point of Service (POS) – Two Tier</u>

- 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.
KP SCAL Regional Credentialing	Credentialing	626-405-3147
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 visit Providers.KP.org where the information can be viewed using the Online Affiliate or Guest portal.

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. The provider portals can be used 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 o r 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: Claim Billing and Payment Policies and Procedures

10.0 INTRODUCTION

This section of the Provider Manual serves as a guide to KP's billing and payment policies and procedures, including relevant contacts and resources, with the exception of KP's Washington Region which can be found at:

Provider Manual | Kaiser Permanente Washington

10.1 PROVIDER RESPONSIBILITIES TO ENSURE PROMPT BILLING AND PAYMENT

Providers are responsible for submitting itemized claims for services rendered to Members in a timely manner, and in accordance with your Agreement, this Provider Manual, and applicable law.

10.2 CLAIM PAYMENT POLICY

You will be compensated for Covered Services provided to eligible Members based on the compensation arrangement and subject to the terms of your Agreement, this Provider Manual and applicable law.

To ensure prompt adjudication and payment of your claims, do the following:

- Verify the Member's eligibility and benefits coverage before providing non-emergency services, as required by your Agreement and applicable law. Claims should be submitted to the Member's home KP Region.

- For those Covered Services that require prior authorization, obtain authorization for non-emergency services, including post-stabilization services, and include the authorization number in your submitted claim. Claims for non-emergency services that require an authorization and are submitted without authorization will be denied, unless required by law.

10.3 ELECTRONIC CLAIM SUBMISSION

KP requests Providers submit claims electronically via Electronic Data Interchange (EDI).

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 adjudication and payment.

Providers must submit their EDI claim through a clearinghouse. Each clearinghouse assigns a unique payer identifier (Payer ID) for KP. The table below lists Payer IDs for KP's affiliated direct clearinghouses.

If your current clearinghouse is not listed below, it is still possible to send EDI claims to KP. Clearinghouses have channel partner agreements that allow them to route claims to KP. Please contact your clearinghouse for guidance on which of the below clearinghouses they partner with, and which Payer ID to use.

Clearing House	Northern CA	Southern CA	Hawaii	Georgia	Northwest	Mid-Atlantic	Colorado
Office Ally	94135	94134	94123	21313	NW002	52095	91617
Navicure	N/A	N/A	N/A	21313	N/A	N/A	N/A
Availity (formerly Realmed)	N/A	N/A	N/A	N/A	N/A	54294	N/A
SSI	NKAISERCA	SKAISERCA	N/A	21313	SS002	52095	999990273
Relay Health	RH009	94134	RH0011	RH008	RH002	RH010	RH003
Optimum Insight/ Ingenix	N/A	N/A	N/A	NG010	NG009	NG008	COKSR

NOTE: Office Ally offers the required PC software to enable Direct Data Entry in the Provider's office.

Looking for a free electronic claim solution? Visit page 4 of our EDI/EFT/ERA Guide for more information: https://online.flippingbook.com/view/704125376/i/

10.3.1 EDI Claims Acknowledgement

When KP receives an EDI claim, we transmit to the applicable clearinghouse, an electronic acknowledgement (277CA transaction), which is then forwarded to the Provider from the clearinghouse. This acknowledgement includes information about whether the claim was accepted or rejected and specific errors on rejected claims. Once the claims listed on the reject report are corrected, the Provider should resubmit these claims electronically. Providers are responsible for reviewing clearinghouse acknowledgment reports. If the Provider is unable to resolve EDI claim errors, please contact EDI Support by submitting a support case to: https://kpnationalclaims.my.site.com/EDI/s/

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

Click here to access KP's EDI Guide and a listing of KP contracted clearinghouses by region: https://online.flippingbook.com/view/704125376/i/

10.4 SUPPORTING DOCUMENTATION

When submitting claims electronically, the 837 transaction contains data fields for supporting documentation through free-text format (the exact system data field may vary). When additional information is required, it will be requested.

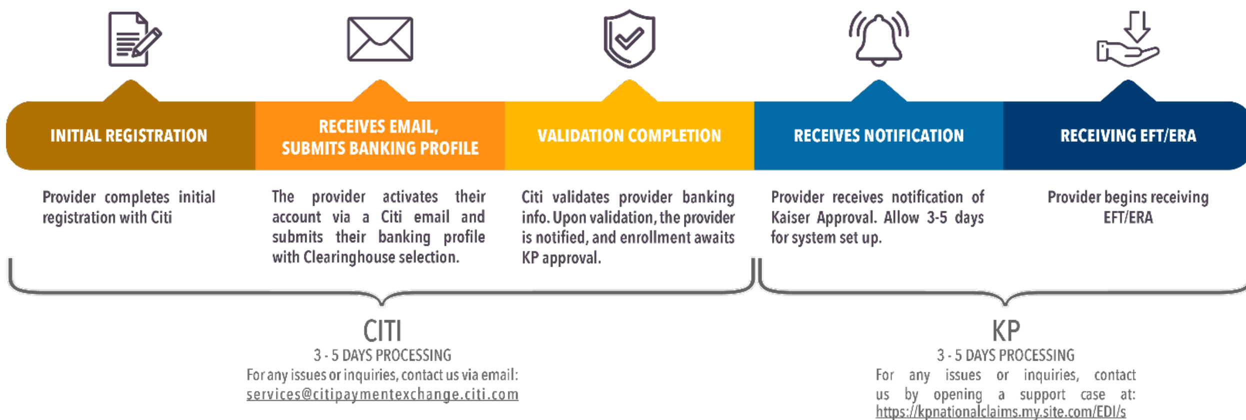
Examples of additional information include but are not limited to:

- Discharge summary and/or progress notes
- Operative report(s)
- Emergency room records with respect to all emergency services

Additional claim-supporting documentation and request for information (RFI) can be submitted via KP Online Affiliate, after your claim has been submitted electronically. Refer to section 5.6 for information on additional features and how to enroll with KP Online Affiliate.

10.5 ELECTRONIC PAYMENT AND REMITTANCE ADVICE ONLINE ENROLLMENT

To reduce turn-around time for claim payments and eliminate manual posting of remittances, KP collaborates with **Citi Payment Exchange** to provide a portal for enrolling in Electronic Fund Transfer (EFT) or direct deposit and Electronic Remittance Advice (ERA).



KP requests that all Providers utilize the **Citi Payment Exchange** portal for new enrollment and changes to existing enrollment. If you experience any issues enrolling in ERA or EFT, please contact Citi's helpdesk at: services@citipaymentexchange.citi.com or **1-877-930-2111**.

To get started, find your KP Region in the table below, click the link to begin the **Citi Payment Exchange** registration, and follow the instructions. If you operate in multiple KP Regions, enroll separately for each one using the information provided:

Enrollment URL	Activation Code
Colorado https://b2bportal.citipaymentexchange.citi.com/enroll/CO-KFHP-ACH	YJRWT6
Georgia https://b2bportal.citipaymentexchange.citi.com/enroll/GA-KFHP-ACH	KYP6BZ
Northwest (Oregon) https://b2bportal.citipaymentexchange.citi.com/enroll/NW-KFHP-ACH	R3ML96
Mid-Atlantic States (Maryland, Virginia, Washington D.C.) https://b2bportal.citipaymentexchange.citi.com/enroll/MAS-KFHP-ACH	R4GWM4
Hawaii https://b2bportal.citipaymentexchange.citi.com/enroll/HI-KFHP-ACH	3PZFK2
Northern California https://b2bportal.citipaymentexchange.citi.com/enroll/NCAL-KFHP-ACH	6WLKT7
Southern California https://b2bportal.citipaymentexchange.citi.com/enroll/SCAL-KFHP-ACH	MN4WX2
Washington – See KP WA Region provider manual for more information	N/A

NOTE: **To receive electronic payments or Electronic Remittance Advices, Providers MUST be contracted with KP or MUST have successfully submitted a claim to the applicable KP Region.**

For additional enrollment information, please click on the following link: https://online.flippingbook.com/view/704125376/i/.

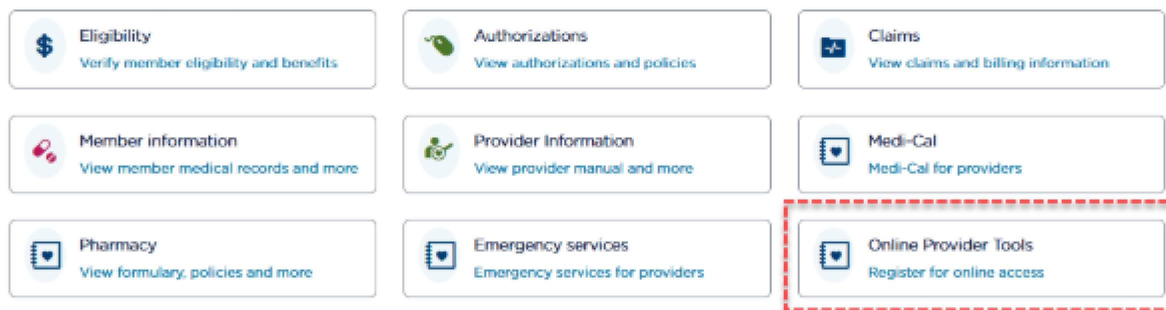
For questions regarding enrollment status or failure to receive EFT payments and ERAs,

after allowing 7-10 business days for initial enrollment, please contact KP EDI Support team by clicking on the following link: https://kpnationalclaims.my.site.com/EDI/s/.

10.6 SELF-SERVICE PROVIDER PORTAL (KP ONLINE AFFILIATE) ENROLLMENT

KP offers an online Provider portal for both contracted and non-contracted Provider groups to help streamline the claims process.

KP requests that all Providers utilize KP Online Affiliate to confirm Member eligibility and benefits, check claim status, and submit online disputes, appeals and claim supporting documentation/Requests for Information. To become a KP Online Affiliate portal user in two simple steps, visit the following link, choose your KP Region, and navigate to the **Online Provider Tools** section as shown below:
kp.org/providers



The KP Online Affiliate portal includes several **time-saving features**, such as:

- Accessing patient eligibility, benefits, and demographics
- Viewing referrals and authorizations (access varies by Region, contract status and job role)
- 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 a request for 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

Virginia Only – Electronic Provider Correspondence: Beginning no later than January 1, 2026, all written communications, explanations, notifications, and related Provider responses with Providers whose claims are subject to Virginia law shall be delivered electronically per Code of Virginia § 38.2-3407.15. Ethics and fairness in carrier business practices.

For questions regarding KP Online Affiliate, please contact KP OLA Support team by clicking on the following link: https://kpnationalclaims.my.site.com/support/s/.

10.7 PAPER CLAIM SUBMISSION

10.7.1 Methods of Paper Claims Submission

KP requests (and your Agreement may require) electronic submission of claims; however, if electronic claim submission is not possible, paper claims may be submitted.

Providers must submit itemized claims for Covered Services provided to Members using a Centers for Medicare & Medicaid Services (CMS)-approved Claims Billing Form. KP does not accept claims that are handwritten, faxed, or photocopied. All claims must be submitted with appropriate coding.

For Institutional claims, use preprinted OCR red-lined UB-04 (or successor form). For professional claims, use preprinted OCR red-lined CMS-1500 v 0212 (or successor form). All entries must be completed in accordance with National Uniform Billing Committee (NUBC) for Institutional claims and National Uniform Claim Committee (NUCC) for Professional claims.

For more information visit WWW.NUBC.ORG and WWW.NUCC.ORG

All Claims should be sent to the appropriate KP Region as listed in section 10.24.1 in the Appendix.

10.8 CLAIM SUBMISSION REQUIREMENTS

10.8.1 Member Information

Submit claims using only the **patient's** details (name, date of birth, KP medical record number, and Authorization number if applicable). Do not use the subscriber's information. Each KP Member has a unique medical record number for electronic transmissions. Therefore, the patient relationship should be marked as SELF (18).

10.8.2 Record Authorization Number

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

Maryland HealthChoice Only - KP may not refuse to pre-authorize a service because the member has other insurance. Even if the service is covered by the primary payer, you must follow our prior authorization rules. Preauthorization is not a guarantee of payment. Except for prenatal care and Healthy Kids/EPSDT screening services, you are required to bill other insurers first. For these services, we will pay you and then seek payment from the other insurer.

10.8.3 One Member and One Provider per Claim Form

Complete separate claim forms for each Member and each Provider.

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

Enter the TOTAL CHARGE on the last page of your claim submission, leaving the TOTAL CHARGE on preceding pages blank.

10.8.5 Billing Inpatient Claims That Span Different Years

For institutional, inpatient claims spanning different years, submit all services on one claim form, reflecting the actual admission and discharge dates.

For professional fees on a CMS-1500 form, submit separate claims based on the year of service.

10.8.6 Billing Outpatient Claims That Span Different Years

Expense incurred in different calendar years must be processed as separate claims. Splitting claims ensures proper recording of deductibles, separates expenses payable on a cost basis from those on a charge basis, and serves accounting and statistical purposes. Accordingly, split all outpatient and SNF claims billed on an interim basis at the calendar year end.

10.8.7 Interim Inpatient Bills

Claims that do not comply with the following guidelines will be denied:

- Follow CMS billing requirements for interim inpatient facility claims.
- Use the same patient control number/account number for interim facility claims as on the initial claim.
- KP accepts the initial interim claim with Bill Type 112.

- Subsequent interim claims must be billed as adjusted claims with Bill Type 117, including cumulative charges up to each "through" date.
- Original claim must be finalized before submitting additional replacement/adjusted interim claims.
- **Northern CA and Southern CA Only -** for inpatient services, submit separate claims weekly as required by California Law (28 CCR 1300.71 (a)(7)(B)).

10.8.8 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 Agreement 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.

It is essential to reference applicable **Federal and State laws**, as well as specific contractual guidelines, according to each **line of business** to ensure compliance with regulations and billing practices.

Northern CA and Southern CA Only - KP will follow the Knox-Keene Act, Medicare, or Medi-Cal requirements for claim processing, as applicable.

- Submit all claims for services provided to KP Members within 90 calendar days after the date of service or discharge, unless a different submission period is specified in your Agreement or required by law.
- Claims denied for being filed beyond the deadline may be accepted and adjudicated. See Provider Dispute Section of the Provider Manual for more information.

10.9 CORRECTED CLAIMS PROCESSING GUIDELINES

10.9.1 Claim Corrections

When a claim is received within the contractual timely filing period but is received with missing information, the Provider will be required to submit a corrected claim to

KP within 90 calendar days (Colorado), 365 calendar days (Georgia, Hawaii, Mid-Atlantic States, Northwest), or same limits applicable to the original claim (California) from the date of the original Remittance Advice, unless a different timeline is specified in your Agreement or required by state or federal rule.

10.9.2 Correcting a Previously Submitted Claim

If your claim requires correction, you will receive a notice detailing the error along with the denied claim. The timeframe for submitting corrections will be specified in the notice or, if not specified, will default to the timely filing limit specified by in your Agreement or by applicable law. Replacement claims should only be submitted after the original claim has been processed (paid, denied or otherwise finalized).

10.9.3 Justifications for Claim Corrections

Providers can submit a claim correction for the following reasons:

- Incorrect diagnosis
- Incorrect procedure(s)
- Incorrect Member
- Incorrect date of service
- Incorrect rates applied
- Authorization obtained
- Any other added/corrected information on the original claim

10.9.4 Electronic Replacement/Corrected Claim Submissions

- The KP claims system recognizes electronic claim submission types by the frequency code.
- The ANSI X12 837 claim format allows Providers to submit changes not included in the original claim adjudication. Submit corrected 1500 claims via EDI when possible.
- Enter Claim Frequency Type code 7 for a replacement/correction in the 2300 loop in CLM*05 03.
- Enter the original claim number in the 2300 loop in REFF8.
- Claims submitted without a valid original claim number will be rejected. Obtain the DCN/original claim number from the 835 Electronic Remittance Advice (ERA) or the Provider's EOP.

10.9.5 Paper Replacement/Corrected Claim Submissions

Corrected claims should be submitted using the appropriate frequency code (7 or 8) and providing the original KP Claim number that you want corrected.

- Frequency Code
  - UB Claim – Field 4-Bill Type (xx7/xx8)
  - CMS Claim – Field 22 (RESUB CODE)
- Original Claim Number/DCN should be included in the following field:
  - UB Claim - Field 64 (Document Control Number)
  - CMS Claim – Field 22 (Original REF No.)

10.10 CLAIMS REVIEW AND ADJUSTMENTS

KP reviews claims based on accepted coding and billing standards, adjusting payments according to your Agreement, the provisions below and applicable law. If you believe a claim adjustment is incorrect, please refer to the section of the Provider Manual for dispute information. Clearly state the reasons for disputing the adjustment in your documentation.

10.11 COMPENSATION METHODOLOGIES

The terms of your Agreement and this Provider Manual determine payment amounts for services. Refer to your Agreement for detailed information on applicable compensation methodologies.

10.12 CODE REVIEW AND EDITING

The standards for determining payable items or services are outlined in the following policies, which are attached in Appendix 1:

- POL-020.1, Clinical Review Itemized Bill Review Payment Determination Policy
- POL-020.2 Clinical Review Medical Record Review Payment Determination Policy
- POL-020.3 Clinical Review Coding Payment Determination Policy
- POL-020.4 Clinical Review Implant Payment Determination Policy
- POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy
- POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

These policies are also available on the provider portal at:
https://healthy.kaiserpermanente.org/southern-california/community-providers/claims

10.13 CLINICAL REVIEW

Institutional and professional claims may be reviewed by physicians or appropriate clinicians to ensure compliance with coding and billing standards, medical appropriateness, medical necessity, and to ensure payment is supported by your Agreement, the Provider Manual, and KP claims payment policies.

The standards for determining payable items or services are outlined in POL-020, Clinical Review Payment Determination Policies. Providers must code and bill according to laws, regulations, contracts, and industry standards, including KP's Payment Determination Policies. Commonly accepted standards come from sources such as CMS, the National Uniform Billing Committee (NUBC), the NCCI, and professional journals. KP reviews claims for items or services that are inclusive of or integral to another procedure and may deny payment accordingly.

KP claims payment policies are available on the Community Provider Portal website. Website links can be found at section 10.24.2 of the Appendix.

If additional information is needed to adjudicate a claim, KP will request specific medical records or itemized bills. For transplant services, itemized bills and medical records are always required. When medical records are requested, the following documents may be needed:

- History reports
- Physical reports
- Consultant reports
- Discharge summaries
- Emergency department reports
- Diagnostic reports
- Progress reports
- CDI coding queries to physicians and physician responses

10.14 PROHIBITED MEMBER BILLING PRACTICES

Providers cannot bill, charge, collect deposits, impose surcharges, or seek recourse against Members or their representatives for Covered Services under the Agreement. Balance billing for Covered Services is prohibited by applicable state and federal law, as well as your Agreement.

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. These are the only situations in which a Health Plan Member can be billed for Covered Services.

Except for Member Cost Share (defined below) and as expressly permitted by your

Agreement and applicable law, Providers must seek compensation for Covered Services from KP or other responsible payers (e.g., Medicare).

Fees for missed appointments, "no-show" fees, and late cancellation fees cannot be charged to or paid by KP. These fees also cannot be charged to Medicaid/ Medi-Cal Members. Medicare members may be charged a fee for missed appointments only if the Provider has an established policy for doing so, that policy is applied to all patients equally, and the member is billed directly. For Commercial Members, these fees may be collected only if the Provider has a written policy detailing the circumstances under which such fees may be imposed, and the Commercial Member has agreed in writing to be financially responsible for these fees before receiving services.

10.14.1 Member Cost Share

Depending on the benefit plan, KP Members may be responsible to share some cost of the services provided. Copayment, co-insurance and deductible (collectively, "Member Cost Share") are the fees a Member is responsible to pay a Provider for certain Covered Services. This information varies by plan and all Providers are responsible for collecting Member Cost Share in accordance with Member's benefits.

Please verify applicable Member Cost Share at the time of service. Member Cost Share information can be obtained from:

- ***Member ID Card***: Copayments, co-insurance and deductible information are listed on the front of the Member ID card when applicable.
- ***KP Online Affiliate***: Follow the instructions in section 5.5 to access KP Online Affiliate to check Member Cost Share.

NOTE: As required by Medicare regulations and as outlined in your Agreement, Providers are prohibited from collecting cost-sharing for Medicare Covered Services from Members dually enrolled in the Medicare and Medicaid programs. This requirement also applies to individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program, a program that pays for Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries.

Accordingly, it is imperative that you take steps to avoid inappropriate billing/collection of cost-sharing from dual eligible beneficiaries, including QMB enrollees. KP's contract with the Medicare program requires that we actively educate contracted Providers about this requirement and promptly address any complaints from dual-eligible beneficiaries/Members alleging that cost-sharing was inappropriately requested or collected.

If you are presented with a Member complaint or inquiry regarding any direct Member billing (including any billing for Member Cost Share or other Member liability described above) you should direct the Member to contact KP Member Services in the appropriate region as listed section 10.24.1 of the Appendix.

10.15 DO NOT BILL EVENTS (DNBE)

KP follows CMS guidelines and policies for DNBEs for all lines of business. The DNBE policy waives fees for healthcare services related to certain adverse events, as defined by CMS National Coverage Determinations (NCD) for surgical errors and the CMS Hospital Acquired Conditions (HACs) list. Providers may not be compensated for services related to these events and must report all DNBEs and healthcare-acquired conditions (HCACs).

The DNBE policy applies to all claims for services provided to Members that **include Provider Preventable Conditions**. Provider Preventable Conditions (PPCs) are adverse medical conditions that could have been avoided with proper care. These include HCACs and other Provider-preventable conditions (OPPCs). Examples include surgical errors, infections due to improper procedures, and serious reportable events.

CMS-defined HCACs are updated annually and include:

- Wrong surgery or invasive procedure on a patient
- Surgery or invasive procedure on the wrong patient
- Surgery or invasive procedure on the wrong body part
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma (e.g., fractures, dislocations, intracranial injuries, crushing injuries, burns)
- Manifestations of poor glycemic control (e.g., diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis or hyperosmolarity)
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infections (e.g., mediastinitis following coronary artery bypass graft, infections following bariatric surgery, orthopedic procedures, cardiac implantable electronic devices)
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures (e.g., total knee replacement, hip replacement)
- Latrogenic pneumothorax with venous catheterization

Any new Medicare fee-for-service HCACs added by CMS not listed here are also included.

10.16 CLAIMS SUBMISSION FOR HAC (HOSPITAL ACQUIRED CONDITIONS), DNBE, OR NEVER EVENT:

UB-04 Claims: For inpatient or outpatient facility services involving a HAC, include the

following:

- **DRG Reimbursement**: If services are reimbursed on a DRG basis, include applicable ICD-10 codes, present on admission (POA) indicators, and modifiers as required by Medicare fee-for-service.
- **Other Payment Methodologies**: If services are reimbursed differently and your Agreement states no compensation for DNBE or HAC-related services, split the claim:
  - **TOB '110' (no-pay bill)**: List all services related to the DNBE or HAC with applicable ICD-10 codes, POA indicators, and modifiers.
  - **TOB '11X' (excluding 110)**: List all Covered Services not related to the DNBE.

5.16.1 Additional Requirements

- **Present on Admission (POA)**: Required for all primary and secondary diagnoses for inpatient services. Any condition with a POA indicator other than 'Y' is deemed hospital acquired.

HCPCS Modifiers: Use applicable modifiers with associated charges on all lines

Maryland Only - Do Not Bill Event Policy Exception: Participating Maryland hospitals are required to adopt the Maryland Health Services Cost Review Commission (HSCRC) payment policy for preventable hospital acquired conditions.

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

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

10.17 COORDINATION OF BENEFITS (COB)

COB determines the order and amounts payable when a Member is covered by multiple parties responsible for the Member’s medical coverage. It ensures Members receive maximum benefits from both primary and secondary plans and prevents duplication of benefits.

With the exception of California, COB information must be submitted within 12 months of the request for Commercial Member’s claims and 24 months for Medicare/Medicaid

Member's claims, unless otherwise stated in your Agreement. If the request is made in the last three months of the year, Medicare/Medicaid Members have 27 months. COB information for California should be submitted within 90 calendar days from date of the primary carrier's EOB, unless otherwise stated in your Agreement, Delays in processing may occur if COB information is not received within these timeframes.

10.17.1 Provider Responsibilities

- **Identify Primary Payer**: Bill the appropriate party.
- **Submit Claims**: If KP is not the primary payer, submit the claim to the primary payer first. If KP is secondary, include primary payer payment details and patient responsibility in the EDI claim submission. For paper claims, attach an Explanation of Payment (EOP).

10.17.2 Payment Determination

- **Secondary Payer**: When KP is secondary to another payer, KP will coordinate benefits and determine the amount payable to the Provider in accordance with the terms of your Agreement. The standard payment determination methodology is to pay up to the primary payer's allowable, not to exceed what KP would have paid as a primary payer.

10.17.3 Cooperation Requirements

- **Authorization**: Seek authorization from the other payer if required.
- **Medical Records**: Respond to requests for medical records.

10.17.4 Determining the Primary Payer

Primary coverage is determined by applicable law and the Member's benefit plan. While examples of common scenarios are provided below, always reference applicable law and Member's benefit plan when determining the primary payer.

- **Adults**

  The plan covering the person as an employee, Member, subscriber, policyholder, or retiree is primary. The plan covering the person as a dependent is secondary. For Adult Medicare beneficiaries, CMS guidelines apply and can be found at: **https://www.cms.gov/medicare/coordination-benefits-recovery/overview**

- **Dependent Children**

  Married or Living Together Parents: The "birthday rule" applies. The parent whose birthday (month and day) falls earlier in the calendar year is the primary payer.

  Joint Custody: The birthday rule above still applies.

  Separated or Divorced Parents: Court Agreement: Follow the Court

Agreement or decree stipulating parental healthcare responsibilities for a dependent child.

No Court Order: Apply benefits in this order:

- Natural parent with custody pays first.
- Step-parent with custody pays next.
- Natural parent without custody pays next.
- Step-parent without custody pays last.

- **Medicare Members**

  Large Employer Group Health Plan (EGHP): A commercial benefit plan is primary to Medicare Fee-For-Service or Medicare Advantage when the beneficiary is covered by an EGHP due to their own or a family Member's current employment status, under CMS Working Aged or Disabled Beneficiaries provisions.

  Retiree Coverage: Medicare Fee-For-Service or Medicare Advantage is primary when the beneficiary is covered by an EGHP whose subscriber is a retiree, under CMS Working Aged or Disabled Beneficiaries provisions.

  End-Stage Renal Disease (ESRD): Medicare Fee-For-Service or Medicare Advantage is primary to Group Health Plans (GHPs) for individuals eligible for Medicare based on ESRD, after the coordination period specified by Medicare Secondary Payer Provisions.

10.17.5 Workers' Compensation/Third Party Liability (TPL)

- **Work-Related Injuries:** Workers' Compensation is primary unless coverage for the injury has been denied.
- **Vehicle and Other Accidents**: In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payer status is determined on a jurisdictional basis. Submit the claim as if the benefit plan is the primary payer. For additional information regarding Third Party Liability, see below.

KP Colorado Transplant Services Only - If KP is the secondary payer, any Coordination of Benefits (COB) claims must be submitted for processing within 90 calendar days of the date of the Explanation of Benefits (EOB).

For questions regarding COB please contact KP Member Services for the appropriate KP Region as listed in section 10.24.1 of the Appendix.

Maryland HealthChoice Only - Providers are responsible for determining the primary payer and for billing the appropriate party. Maryland HealthChoice will always be the payer of last resort

Virginia Medicaid and FAMIS Only - Commercial plans will always be primary for those members enrolled in Medicaid and FAMIS programs. For members who have dual entitlement, the Medicaid program supplements Medicare coverage by providing services

and supplies that are available under their state Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the state's payment limit.

10.18 COB CLAIMS SUBMISSION REQUIREMENTS AND PROCEDURES

If a claim is submitted to KP without the necessary primary payment information and Member responsibility details, or without the primary payer's Explanation of Payment (EOP), KP will deny the claim. Providers must first submit the claim to the primary payer. Within the timelines outlined in section 5.17 (or longer if required by law or your Agreement) after the primary payer has paid, resubmit the claim to KP with the primary payer payment information. KP will then review the claim and determine the payment amount based on your Agreement.

10.18.1 Members Enrolled in Two KP Plans: (Dual Coverage)

- **Two Fully Funded or Two Self-Funded Plans**: Submit one claim under the primary plan to KP.
- **One Fully Funded and One Self-Funded Plan**: Submit claims separately. First, send the claim to the primary insurance. Then, submit the primary payment information to the secondary insurance, either electronically or with a copy of the Explanation of Benefits (EOB) for paper claims.

10.18.2 Secondary Claims Submission via EDI

- **Provider-to-Payer-to-Provider Model**
  - **837 Submission**: The Provider sends the 837 claim to the primary payer.
  - **835 Payment Advice**: The primary payer adjudicates the claim and sends an 835 Payment Advice, including claim adjustment reason codes and remark codes.
  - **Second 837 Submission**: The Provider sends a second 837 with COB information in Loops 2320, 2330A-G, and/or 2430 to the secondary payer.
  - **Secondary Adjudication**: The secondary payer adjudicates the claim and sends an 835 Payment Advice.

  KP recognizes 837 transactions with data from the previous payer's 835 and adjudicates claims without needing a paper copy of the Explanation of Benefits.

- **Multiple Payers**
  - **Data Elements**: Include data elements from all prior payers. Missing elements will result in claim denial.

Contact your cleaning house for assistance with electronic COB claims.

10.19 THIRD PARTY LIABILITY (TPL)

KP may seek reimbursement from a Member’s settlement or judgment for injuries or illnesses caused by a third party. Providers must assist KP in identifying TPL situations and provide supporting information.

First Party Liability: When a Member’s other insurance (e.g., automobile policy) covers costs related to injuries or illnesses from an accident, regardless of fault. Submit claims with the automobile carrier name, amount paid, and Explanation of Benefits (EOB).

KP Hawaii and Northwest (KP No Fault markets) only – KP denies external motor vehicle accident claims pending receipt of Personal Injury Protection (PIP) exhaust. Once KP receives evidence of PIP exhaust, KP pays the motor vehicle accident claim as primary and applies a reduction for any reported PIP payment.

KP Northern California, Southern California, Colorado, Georgia and Mid-Atlantic States (Subrogation markets) only – KP pays external motor vehicle accident claims and applies a reduction for any reported MedPay/PIP payment.

KP Colorado only - Any amount paid by the automobile carrier will first be applied to the Member’s cost share before it is applied to the KP allowable amount.

Third Party Liability: When a third party’s insurance covers healthcare costs for injuries or illnesses caused by the third party.

Guidelines (Information Required)

Providers must enter the following on the billing form:

- Automobile carrier information and payment details
- ICD-10 diagnosis data
- Accident-related claim codes (e.g., occurrence codes, condition codes)
- KP may investigate TPL recoveries through retrospective review of ICD-10 and CPT-4 codes on billing forms.

10.20 WORKERS’ COMPENSATION

If a Member indicates their illness or injury occurred "on the job," follow these steps:

- **Document the Claim**: Note that the Member reported the illness or injury as work-related.
- **Billing Form**: Complete the fields indicating a work-related injury.
- **Submit to Workers' Compensation**: Send the claim to the Member’s Workers' Compensation carrier/plan.
    - **If Workers' Compensation Denies the Claim:**
        - **Resubmit to KP**: Submit the claim to KP as you would for other services, including a copy of the denial letter or Explanation of Payment from the Workers' Compensation carrier.

If Authorized by KP

Submit to KP: If you have authorization to provide care, submit the claim to KP as usual. Note that your Agreement may specify a different payment rate for these services.

10.21 Copayments, Coinsurance and Deductibles

Copay Collection Responsibilities

Providers must collect Member Cost Share according to Member benefits, unless stated otherwise in your Agreement.

Claims Submission

- **Payment**: Claims will be paid at the applicable rate under your Agreement, minus the Member Cost Share due from the Member.
- **Waiving Member Cost Share**: Do not waive Member Cost Share amounts, including but not limited to copays, unless expressly permitted by law and your Agreement.

Verification

- **Verify Member Cost Share**: Contact KP Member Services for the appropriate Region as listed in section 10.24.1 of the Appendix to verify applicable Member Cost Share at the time of service.

10.22 Overpayment Policy

Notification and Return

- **Prompt Notification**: Notify KP immediately upon discovering an overpayment.
- **Return Overpayment**: Return the overpayment as soon as possible.

Overpayment Identified by KP

- **Return Within 30 Business Days**: Return any overpayment identified by KP within 30 business days of receiving the notice, unless contested.

Contesting Overpayment

- **Written Notice: If contesting, send a written notice or dispute via Provider Portal within 30 business days, identifying the contested amount and the basis for the contest.**
- **Compliance**: Follow the terms of your Agreement or the instructions in the notice of overpayment.

Information Required for Returning Uncontested Overpayments

- Member Name: Name of each Member who received care.
- Remittance Advice: Copy of each applicable remittance advice.

- Primary Carrier Information: If applicable.
- Explanation of Payment (EOP): Copy of EOP with an explanation of the erroneous payment.
- Medical Record Number (MRN): Each applicable Member's KP MRN.
- Authorization Numbers: For all applicable non-emergency services.
- Claim Numbers: Relevant claim numbers.
- Dates of Service: Dates when the services were provided.

10.23 Overpayment Recoupment

KP will recoup an uncontested overpayment from a Provider's current claim submissions only if:

- The Provider fails to reimburse KP within the specified timeframe.
- The Agreement authorizes recoupment from current claims or KP has obtained other written offset authorization from the Provider.

Evidence of Payment (EOP)

Recoupment Detail Report: Provides details about the vendor balance and offset, including the claims to which the recoupment was applied.

For additional information on CMS Guidelines for Coordination of Benefits, visit the following site: https://www.cms.gov/medicare/coordination-benefits-recovery/overview

KP California (Northen and Southern) Only - Medi-Cal Cost Avoidance

You are responsible for identifying the primary payer, seeking authorization from the primary payer (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 KP.

In connection with any denied claim for services due to the presence of OHC for Medi-Cal Members, KP will include OHC information in its payment denial notification. If you believe payment on a claim was adjudicated incorrectly, please see the Provider dispute resolution process section of the Provider Manual for more information.

10.24 Appendix

10.24.1 KP Contact Information

National Claims Administration by Region					
Region	**Phone**	**Address**	**City**	**State**	**Zip Code**
California - NCAL	800-464-4000	PO Box 8002	Pleasanton	CA	94588-8602
California - SCAL	800-464-4000	PO Box 7004	Downey	CA	90242-8004
Colorado	303-338-3800	PO Box 373150	Denver	CO	80237-3150
Georgia	888-865-5813	PO Box 370010	Denver	CO	80237-0010
Hawaii	800-966-5955	PO Box 378021	Denver	CO	80237-8021
Mid-Atlantic (Maryland, Virginia, Washington D.C.)	800-777-7902	PO Box 371860	Denver	CO	80237-5860
Northwest (Oregon)	503-813-2000	PO Box 370050	Denver	CO	80237-0050
Washington State	888-901-4636	PO Box 30766	Salt Lake City	UT	84130-0766
KPIC Self-Funded	800-533-1833	PO Box 30547	Salt Lake City	UT	84130-0547
Ambulance Claims		Relations Insurance - KP Ambulance Claims PO Box 853915	Richardson	TX	78085-3915

10.24.2 Community Provider Portal (CPP)

Community Provider Portal Website
Colorado https://healthy.kaiserpermanente.org/colorado/community-providers/claims
Georgia https://healthy.kaiserpermanente.org/georgia/community-providers/claims
Northwest (Oregon) https://healthy.kaiserpermanente.org/oregon-washington/community-providers/claims
Mid-Atlantic States (Maryland, Virginia, Washington D.C) https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/claims
Hawaii https://healthy.kaiserpermanente.org/hawaii/community-providers/claims
Northern California https://healthy.kaiserpermanente.org/northern-california/community-providers/claims
Southern California https://healthy.kaiserpermanente.org/southern-california/community-providers/claims
Washington https://wa-provider.kaiserpermanente.org/billing-claims/claims

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 mail. 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 recommend 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 indicated 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 (KFHP) has developed and implemented credentialing and re-credentialing policies and procedures for Health Delivery Organizations ("HDO").

12.1 CRITERIA FOR INITIAL CREDENTIALING

As a contracted HDO, each facility must meet minimum criteria for initial credentialing which includes a current license issued by the state and/or local agency with jurisdiction, current liability insurance, good standing with state and federal regulatory bodies (e.g. absence of Medicare and Medicaid sanctions and exclusions), and accreditation by a recognized accrediting body. If the facility is not accredited, a site visit performed by KFHP or a survey performed by the state within 36 months is required with a passing score of 85% or higher. The facility must have a process to ensure all physicians/practitioners who provide services to Members are credentialed, and licensed at all times, and, unless your Agreement expressly states otherwise, are enrolled in Medicare and Medicaid.

12.2 ONGOING REQUIREMENTS & RECREDENTIALING

During the period between initial credentialing and recredentialing, the facility is required to continually meet all criteria for initial credentialing. This includes, but is not limited to, submission of copies of current/renewed state or local agency license, accreditation and certificates of liability insurance when requested.

Recredentialing will occur at least every 36 months and may occur more frequently if needed. In addition to the basic initial credentialing criteria, Member grievances, Member satisfaction, quality assurance/improvement will be considered as part of recredentialing.

12.3 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 KFHP, Credentialing at the e-mail address 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 UM criteria. KP expects Providers to allow open provider-patient communication regarding appropriate treatment alternatives without regard to a member’s benefit plan. KP 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.

KP 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 KP 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 KP’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. Non-Kaiser Permanente and out-of-network 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. Once a Member's emergency medical condition is stabilized, prior authorization is required before post-stabilization care is rendered. For Members whose emergency medical condition is stabilized in the emergency department (and prior to admission), authorization for post-stabilization care can be requested by calling KP's Emergency Prospective Review Program (EPRP) by calling [insert]. For Members whose emergency medical condition is stabilized after admission, authorization for post-stabilization care can be requested by calling KP's Outside Utilization Resource Services (OURS) 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) 625-0949
Baldwin Park	(626) 480-5210
Downey	(562) 622-3823
Fontana/Ontario	(909) 609-3500
Kern County	(661) 337-7285
Los Angeles	(323) 783-4600
Ontario/Fontana	(909) 609-3500
Orange County	(714) 734-5500
Panorama City	(818) 815-6370
Riverside	(951) 739-5166
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.
- Referral for Hospice is 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

Propio Language Services(formerly 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 Propio Language Services 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

Propio Language Services customer service can be reached through email (clientservices@propio.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 who are deaf or hard of hearing and require 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 Limited English Proficient (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 Code of Ethical Conduct, KAISER PERMANENTE'S PRINCIPLES OF RESPONSIBILITY [previously known as 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 Code of Ethical Conduct KAISER PERMANENTE'S PRINCIPLES OF RESPONSIBILITY for your reference. You should report to KP any suspected wrongdoing or compliance violations by KP Personnel under the Code of Ethical Conduct KAISER PERMANENTE'S PRINCIPLES OF RESPONSIBILITY. 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
Code of Ethical Conduct
KAISER PERMANENTE'S PRINCIPLES OF RESPONSIBILITY and Vendor Code of Conduct at: http://www.kp.org/compliance. The KP
Code of Ethical Conduct
KAISER PERMANENTE'S PRINCIPLES OF RESPONSIBILITY 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 ACCEPTING EXPRESSIONS OF GRATITUDE

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 are prohibited gifts outlined in the KP Conflict of Interest policy:

- Cash or cash equivalent gifts (e.g. gift certificates, gift cards, discounts or coupons)
- Entertainment that exceeds $25 in value (e.g. amusement park tickets)
- Gifts, meals or entertainment that are provided on a regular basis
- Gifts from government representatives
- Gifts or entertainment could be perceived as a conflict of interest, bribe, payoff, deal or any other attempt to gain advantage are prohibited, in accordance with the Anti-Bribery and Anti-Corruption policy.
- 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

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

1.1.1 Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.

1.1.3 KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

- American Academy of Professional Coders (AAPC)
- American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

1.2.1 This policy provides an overview of KFHP's Clinical Review Itemize Bill Review (IBR) procedures and reimbursement guidelines. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified. Clinical Review is responsible for reviewing facility and professional claims to ensure providers comply with billing and coding standards, that services rendered are appropriate and medically necessary, and that reimbursement is made in accordance with applicable legal and contractual/ provider manual requirements.

2.0 Rules

2.1 The Clinical Review department will review the itemized bill, and if applicable, in the reviewer's discretion, the medical records to determine whether the billed services are medically appropriate, correctly coded for reimbursement, and are not inclusive of, or an integral part of another procedure or service.

2.1.1 The review is conducted on a pre-adjudication basis.

2.1.2 Reimbursement is made in accordance with industry standard billing guidelines, regulatory guidance, and applicable provider contract and/or provider manual requirements.

2.1.3 Clinical Review staff will submit a request for information (RFI) to the provider, requesting an itemized bill and/or medical records.

2.1.4 The IBR review will be completed upon receipt of the itemized bill and, or medical records. If the itemized bill and/ or medical records are not received timely a denial will be rendered.

2.1.5 For Inpatient facility services that are reimbursed under a prospective payment system, the payment amount for a particular service is based on the classification system of that service. In addition to the basic prospective payment, an outlier payment is made for certain claims that incur costs above the facility-specific threshold. DRG cost outlier claims are repriced based upon the IBR results.

2.1.6 KFHP will apply commonly accepted standards to determine which of the billed items or services are eligible for appropriate reimbursement. Commonly accepted standards include, without limitations, CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (NCCI) standards, and various professional and academic journals and publications as outlined above. KFHP clinicians will interpret these standards and apply them to claims using clinical discretion and judgment.

2.2 Reimbursement Guidelines

2.2.1 Clinical Review will not reimburse providers for items or services that are considered inclusive of, or an integral part of another procedure or service. Such services will be paid as part of the larger related service and are not eligible for separate reimbursement. Services to be considered for separate reimbursement should be clearly documented on the itemized bill and medical record. The Clinical reviewer will review the itemized bill and/or medical records for these charges.

2.2.1.1 The following types of charges are examples of charges that a KFHP clinician may determine to be inclusive of, or an integral part of another procedure or service and therefore not separately payable. KFHP will use clinical discretion and judgment and will consider commonly accepted standards as applicable to the facts and circumstances of each case.

2.2.2 Charges for the use of capital equipment, whether rented or purchased, can be denied as not separately reimbursable. The use of such equipment is part of the administration of a service. Examples include, without limitation, the following:

- Anesthesia Machines
- Balloon Pumps
- Instruments/Instrument Trays
- IV/feeding pumps
- Furniture (including bed, mattress, sheets, pillows etc.)
- Monitors (Blood Pressure, Cardiac, Fetal, EMG, Temperature, Apnea, Neuro, Oximetry, Cautery Machines, Hemodynamic Monitoring Catheters)
- Scopes/Microscopes
- Specialty Beds
- Thermometers, Temperature probes etc.
- Ventilators
- Video or digital equipment used in the operating room (including batteries, anti-fogger solution, tapes, cell savers, lasers etc.)

2.2.3 Charges for IV flushes (for example, heparin and/or saline) and solutions to dilute or administer substances, drugs, or medications, can be denied as not separately reimbursable. The use of these is part of the administration of a service. Examples include, without limitation, the following:

- Access of indwelling catheter, subcutaneous catheter or port
- IV start/flushes at the beginning and end of an infusion
- Preparation of IV prescribed drugs
- Standard tubing/syringes/supplies

2.2.4 Charges for hydration are not separately payable unless the hydration services are therapeutic, in which case consideration for reimbursement can be made, based on the medical record documentation.

2.2.5 Charges for services that are necessary or otherwise integral to the provision of a specific service and/or delivery of services in a specific location are considered routine services and are not separately reimbursable. This applies to both the inpatient and outpatient settings.

These services are part of the room and board charges. Examples include, without limitation, the following:

- Administration of medications (IV, PO, PMIM, chemotherapy)
- Incremental nursing care
- Infusion of IV fluids
- Insertion of tubes (IV lines, PICC lines, tube feeding)
- Measuring blood oxygen levels
- Misc. charges (dressing changes, specimen collection, balloon pumps)
- Nasogastric tube (NGT) insertion
- Point of care testing
- Respiratory treatment (sputum treatment, airway clearance (For example, suctioning), incentive spirometer, nebulizer treatment)
- Saline flushes
- Urinary catheterization
- Venipuncture

2.2.6 Charges that are considered bundled or packaged into another service or procedure can be denied as not separately reimbursable, as they are considered integral to the primary service or procedure. Examples include, without limitation, the following:

- Guidewires
- Lidocaine used for procedures
- Ultrasound guidance for placement of line
- Xray confirming placement of PICC line, central lines, and NG tubes

2.2.7 Under the Outpatient Prospective Payment System (OPPS), any charges for line items or Healthcare Common Procedure Coding System (HCPCS) codes that are bundled together under a single payment for surgical procedures should not be reimbursed separately. Costs for these items and services are inclusive of overall payment in the Ambulatory Payment Classification (APC).

2.2.8 KFHP follows the Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS) Fee Scheduled for

all codes that are covered but not separately reimbursed. Examples include but are not limited to:

2.2.8.1

Status Indicator	Item/Code/Service	OPPS Payment Status
D	Discontinued codes	Not paid under OPPS or any other Medicare payment system.
N	Items or services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment

2.2.9 Charges for personal care items do not contribute to the meaningful treatment of the patient's condition. Examples include, without limitation, the following:

- Admission kits
- Band aids
- Footies/slippers
- Oral swabs/mouthwash
- Other patient convenience items (such as diapers, deodorant, hair care items, mouthwash, toothbrush and toothpaste)

2.2.10 Charges for respiratory therapy services provided at a Specialty Care Unit (such as ICU, Pediatric ICU, CCU, ED, or intermediate intensive care units) are generally not separately reimbursable. The use of these services is part of the administration of care at a Specialty Care Unit. Examples include, without limitation, the following:

- Arterial punctures
- CO2 monitoring/trending
- Endotracheal suctioning
- Extubation
- Heated aerosol/heated aerosol treatments while patient on ventilator
- Oxygen
- Ventilator supplies

2.2.11 Allow one daily ventilator management charge or BiPAP while the patient is in the specialty care unit.

2.2.12 Allow Continuous Positive Airway Pressure (CPAP) while the patient/neonate is in the neonatal intensive care unit (NICU).

2.2.13 CPAP for routine use, including use for obstructive sleep apnea is not separately payable.

2.2.14 Charges for respiratory services provided in the inpatient setting other than at a specialty care unit are limited to one unit/charge per date of service regardless of the number of respiratory treatments and/or procedures provided. Examples include, without limitation, the following:

- Chest percussions if done by a respiratory therapist
- Demonstration of Metered Dose Inhaler (MDI) use or respiratory equipment by a respiratory therapist
- Heated aerosol and oxygen
- Nebulizers

2.2.15 Charges for Routine Floor Stock items and supplies necessary or otherwise integral to the provision of a specific service or delivery of service in a specific location are considered routine and are not separately reimbursable. The use of these services is part of the administration of care at a hospital or skilled nursing facility and are used during the normal course of treatment, which may be related to and/or part of a separately reimbursable treatment.

2.2.16 Charges for Point of Care (POC) tests are generally not separately reimbursed. These tests are performed by facility nursing staff, at the site where patient care is provided as part of the room and board services.

2.2.17 KFHP follows commonly accepted standards to not reimburse for duplicative charges and claims. Such duplicative charges and claims are not reimbursable. According to Medicare guidelines, the hospital must install adequate billing procedures to avoid submission of duplicate charges or claims.

2.2.18 Over the counter drugs (OTC) or, drugs which can be self-administered by the patient, are often not separately reimbursed in an inpatient setting. OTC drugs are typically included in the overall inpatient reimbursement.

2.2.19 Routine administrative services are included in the room and board or outpatient facility reimbursement. Routine services in a hospital are those services included by the provider in a daily service charge, commonly referred to as "room and board" charge. Examples include, without limitation, the following:

- Room and board supplies
- Nursing administered services, such as medication administration, blood glucose monitoring, occult blood testing, wound care (including cleaning, dressing changes, and monitoring for infection), pulse oximetry, urine/blood specimen collection etc.
- Routine medical and surgical supplies, such as alcohol wipes, bed pans, blood pressure monitors/cuffs, cardiac monitors, cotton balls, gloves/gowns used by staff, ice bags/packs, heating pads, IV pumps, masks used by staff, saline solutions, syringes, thermometers, and patient gowns.

2.3 Implants - For more information please refer to POL 020.4 Clinical Review Implant Payment Determination Policy.

2.3.1 According to the Food and Drug Administration (FDA), implants are devices or materials placed surgically inside the body or surface of the body. Many implants are intended to replace body parts, monitor body functions or provide support to organs or tissues. KFHP does not allow reimbursement for implants that are not implanted in the member, deemed contaminated or considered waste.

2.3.2 Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition, implants must also remain in the member's body upon discharge from the inpatient stay or outpatient procedure. Staples, guide wires, sutures, clips, as well as temporary drains, tubes, and similar temporary medical devices are not considered implants. Therefore, no separate reimbursement shall be made.

3.0 Guidelines

N/A

4.0 Definitions

4.1 Centers for Medicare and Medicaid Services (CMS) Part of the Department of Health and Human Services (HHS) responsible for administering programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

4.2 Capital equipment Items that are used by multiple patients during the lifetime of that piece of equipment.

4.3 Routine services Inpatient routine services in a hospital or skilled nursing facility are those services included in the providers daily service charge sometimes referred to as the "room and board" charge. Routine services are composed of two room and board components: (l) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care units (ICU's).

4.4 **Diagnosis Related Group (DRG)** A system of classifying or categorizing inpatient stay into relatively homogenous groups for the purpose of payment by CMS.

4.5 **Personal care items** Items used by the patient for non-medical use such as hygiene and comfort.

4.6 **Point of Care (POC) tests** Tests that are performed at site where patient care is provided. Point of care (POC) tests do not require the equipment or supplies of a CLIA lab nor the skills of licensed or certified technicians or technologists. Under the Clinical Laboratory Amendments of 1988 (CLIA), a POC must have a Certificate of Waiver license in order for the site to allow CLIA- waived POC testing.

4.7 **Routine floor stock** Supplies that are available to all patients in the floor or area of a hospital or skilled nursing facility. These are supplies provided to a patient during the normal course of treatment. Personal care items are non-chargeable because they do not contribute to the meaningful treatment of the patient's condition.

4.8 **Specialty care unit** A specialized unit located within a hospital that must be physically identified as separate from general care areas; the unit's nursing personnel must not be integrated with general care nursing personnel. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive lifesaving nursing services of the type associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. Special life-saving equipment should be routinely available in the unit.

4.9 **Room charge** A room and board or room care charge for a semi-private, private, or 3+ bedroom shall include the room, dietary services, all nursing care, personnel, and routine disposable or reusable equipment, supplies and items appropriate for that setting.

4.10 **Inpatient** Patient whose condition requires treatment in a hospital or other health care facility, and when the patient is formally admitted to the facility by a doctor. It involves an overnight stay or prolongs the stay of a patient in a licensed healthcare facility.

4.11 **Outpatient** Patient who receives medically necessary services at a hospital, clinic, or associated facility for diagnosis or treatment but has not formally been admitted on an inpatient basis.

5.0 References

Centers for Medicare & Medicaid Services website. Medicare Benefit Policy Manual. Chapter 1 – Inpatient Hospital Services Covered Under Part A. Section 40 – Supplies, Appliances, and Equipment

Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual. Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS). Section 240 – Inpatient Part B Hospital Services

Centers for Medicare & Medicaid Services website. The Provider Reimbursement Manual – Part 1. Chapter 22 – Determination of Cost of Services. Sections 2202.4, 2202.6, 2202.8 and 2203

Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual. Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Section 210 – CWF Crossover Editing for DMEPOS Claims During an Inpatient Stay

National Uniform Billing Committee | NUBC

Test Complexities | Clinical Laboratory Improvement Amendments (CLIA) | CDC (CLIA section 2.1.1.10)

Implants and Prosthetics | FDA (implants section)

2.1.1.12 over the counter drugs: Medicare Benefit Policy Manual, Chapter 15, Section 50.5.3 and 50.5.4

2.1.1.11 Medicare claims processing manual chapter 1 section 120 for duplicate claims

2.1.1.8 American Association for Respiratory Care aarc-coding-guidelines.pdf

https://www.ssa.gov/OP_Home/ssact/title18/1886.htm

https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2017downloads/r475pr1.pdf

https://www.cms.gov/medicare/payment/prospective-payment-systems

6.0 Related Topics

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/25)

Revision History

Approvals

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

1.1.1 Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all payment policies are routinely updated.

1.1.3 KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

- American Academy of Professional Coders (AAPC)
- American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

1.2.1 This policy provides an overview of KFHP's Clinical Review medical record review. Clinical Review will review the medical records provided for medical appropriateness and/or medical necessity to facilitate accurate claims reimbursement. This policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified.

2.0 Rules

2.1 Clinicians within the Clinical Review department will review the medical records to determine whether the billed services are medically appropriate or necessary, and correctly coded for reimbursement. When medical records or clinical information is requested, all the specific

information required to make the medical determination must be clearly documented in the records. In addition, services must be considered a covered benefit. Determinations of medical necessity adhere to the standard of care and focus on the direct care and treatment of the patient. KFHP Clinical Review follows CMS and other industry guidelines, clinical literature, and accepted medical necessity criteria.

2.2 Each medical record must be documented for the date of services and specific services billed including, but not be limited to physician orders, diagnoses, evaluations, consultations, medications, treatments, test reports and results, history and physical, emergency room records, care plans, discharge plans, and discharge summaries.

2.3 Reimbursement Guidelines

2.3.1 Clinical Review will review the medical records to assess:

2.3.1.1 Whether the provider exercised appropriate clinical judgment and decision-making in evaluating, diagnosing, and treating the member's condition.

2.3.1.2 Whether the treatment provided was appropriate and clearly documented in the medical record.

2.3.1.3 Whether the level of care billed accurately reflects the services rendered.

2.3.1.4 Whether the services are cosmetic, experimental, or investigational in nature.

2.3.1.5 Whether the coding and billing is accurate and appropriate.

2.3.1.6 Whether the authorization reflects what is billed.

2.3.2 Determining medical appropriateness or necessity should follow the standard of care and focus on the direct care and treatment of the patient. This includes, but is not limited to an assessment of the following:

2.3.2.1 Whether treatment of the members' condition, illness, disease, or injury is appropriate and clearly documented in the medical record.

2.3.2.2 Whether services provided are for the diagnosis and direct treatment of the member's medical condition.

2.3.2.3 Whether the services provided meet applicable standards of good medical practice.

2.3.2.4 Based on the review of the medical records, the payment for the service(s) billed may be denied, reduced, or otherwise adjusted, in part or in whole. Medical necessity reviews that result in a partial or full denial of a service require review and approval by a physician.

2.4 Trauma Activation

2.4.1 Trauma activation will be considered for reimbursement only (when all the following criteria are met.

2.4.1.1 To receive reimbursement for trauma activation, a facility must:

2.4.1.2 Have received prehospital notification based on triage information from EMS or prehospital caregivers, who meet either local, state, or ACS field criteria and are given the appropriate team response.

2.4.1.3 Bill for trauma activation costs only. Clinical Review will request records to review for documentation of the team members being called to support the trauma activation.

2.4.1.4 Code the claim with type of admission/visit code 05 (trauma center).

2.4.1.5 Bill evaluation and management codes for critical care under Revenue Code 450. When revenue code series 68x trauma response is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day.

2.5 Level of Care (LOC) Review

2.5.1 LOC Review applies to inpatient facility claims to determine whether the level of care billed matches the LOC that was authorized so that appropriate reimbursement is made.

2.5.2 The review involves assessing whether the billed days for each LOC are both authorized and medically necessary.

2.5.3 If the provider bills additional days or a higher LOC than what is authorized, the claim will be denied, and the provider will need to submit a corrected claim for payment.

2.5.4 LOC will be reviewed based on the patient's specific clinical information, as documented within the medical record.

2.6 Neonatal Intensive Care Level of Care (NICU)

2.6.1 The medical criteria in this section provides guidance for reimbursement of NICU and neonatal care levels 2 through 4. Level 1 admission and discharge criteria such as coupling or mother/baby care was intentionally omitted as it now replaces routine nursery care.

2.6.2 Specific information regarding neonatal level of care may be requested through National Clinical Review.

2.6.3 Level of care will be reviewed/approved based on the patient's specific clinical information as documented within the medical record.

2.7 Post Stabilization

2.7.1 The treating provider or member must contact KFHP to request prior authorization for post-stabilization care before post-stabilization care is provided. Upon request for prior authorization, KFHP may arrange to take over the members care via transfer or authorize post-stabilization care that is medically necessary to maintain the member's stabilized condition. Unauthorized post-stabilization care is not a covered benefit and claims for post-stabilization that are not authorized by KFHP will be denied.

2.8 Short Stay/2 Midnight Rule

2.8.1 KFHP follows Medicare reimbursement guidelines to determine whether inpatient services are reimbursable. If a doctor anticipates a patient will need medically necessary/appropriate hospital care for at least two nights (spanning two midnights), the stay can be billed as inpatient admission and will be reimbursed accordingly. Medical records must support inpatient admission and must be clearly documented. If the anticipated stay is less than two midnight, the care is typically considered outpatient and should be billed accordingly. There are some exceptions to the two-midnight rule, such as:

2.8.2 The patient is discharged against medical advice (AMA).

2.8.3 The patient dies during the stay.

2.8.4 In these cases, the patient may still be classified as an inpatient, even if their stay did not span two midnights if the initial expectation of a longer stay was reasonable and documented in the medical records.

2.9 Present on Admission (POA):

2.9.1 Consistent with Medicare requirements, KFHP requires POA indicator reporting for all claims involving inpatient admissions to general acute care hospitals or other facilities. General requirements to follow are:

2.9.2 Refer to UB-04, also known as the CMS-1450 Data Specifications Manual and the ICD-10-CM guidelines for Coding and Reporting to facilitate the assignment of the

2.9.3 POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claims forms UB-04.

2.9.4 Providers shall ensure any resequencing of diagnosis codes prior to claims submission include a resequencing of POA indicators.

2.9.5 Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.

2.10 Provider Preventable Conditions (PPC)

2.10.1 Clinical Review determines if the service provided meets the clinical guidelines set forth by CMS to ensure PPC services are not reimbursed. PPCs are defined into 2 types – Hospital Acquired Conditions (HACs) and Never Events/Serious Reportable Events (SREs).

2.10.2 Hospital Acquired Conditions (HACs) – These are conditions that could reasonably have been prevented through the application of evidence based clinical guidelines.

2.10.3 Inpatient Acute Care Hospitals are required to document these in the medical records and are reportable as Medicare requirements.

2.10.4 Never Events/SREs – These events are defined by CMS to include:

2.10.4.1 Wrong surgery/invasive procedure.

2.10.4.2 Surgery/invasive procedure performed on the wrong patient.

2.10.4.3 Surgery/invasive procedure performed on the wrong body part.

2.10.5 Providers will not be reimbursed for these services, as these are errors in medical care that are of concern to both the public and health care. Providers must report these when these occur in any health care setting.

2.11 Thirty Day Readmissions

2.11.1 KFHP does not allow separate reimbursement for claims that have been identified as readmission to the same hospital or Hospital System reimbursed by DRG pricing for the same, similar or related condition unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, KFHP will use the following standards: (a) readmission within 30 days from discharge; (b) same diagnosis or diagnoses that fall into the same grouping.

2.12 Chimeric antigen receptor T-cel (CAR-T)

2.12.1 KFHP follows CMS guidelines for CAR-T reimbursement.

3.0 Guidelines

N/A

4.0 Definitions

4.1 Centers for Medicare & Medicare Services (CMS) Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

4.2 Post Stabilization Care Following stabilization of the member’s emergency

medical condition, post-stabilization care are those medically necessary services needed to maintain a member's stabilized condition, or as otherwise defined by applicable law.

4.3 **Clinical Literature** Literature, published in a peer-reviewed journal, describes research specifically designed to answer a relevant clinical question.

4.4 **Generally Accepted Standards of Medical Practice** Standards based on credible scientific evidence published in peer-reviewed medical literature and widely recognized by the relevant medical community. They include recommendations from physician specialty societies, the consensus of medical professionals practicing in relevant clinical fields, and pertinent factors.

5.0 References

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

Eliminating Serious, Preventable, and Costly Medical Errors - Never Events | CMS

Hospital Acquired Conditions | CMS

Hosp. Readmission Reduction | CMS

Medicare.gov: https://www.medicare.org/articles/what-does-medically-necessary-mean/
Frequently Asked Questions CR 7502

National Uniform Billing Committee | NUBC

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/2025)

Revision History

Approvals

POL-020.3 Clinical Review Coding Payment Determination Policy

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

1.1.1 Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim, or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all payment policies are routinely updated.

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- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

1.2.1 This policy provides an overview of coding and payment guidelines as they pertain to claims submitted to KFHP. The policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified. Providers are required to use industry standard compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and revenue codes as defined by the Centers for Medicare and Medicaid Services (CMS), and the American Medical Association's (AMA) CPT Manual. Billed codes must represent the services/procedures performed, and services must be clearly documented in the member's medical record.

2.0 Rules

2.1 KFHP accepts standard diagnosis and procedure codes that comply with HIPAA Health Information Portability and Accountability Act (HIPAA) transaction code set standards KFHP routinely updates all standard code sets, including CPT, HCPCS, and ICD- 10 CM to align with the most current publications released by organizations including but not limited to CMS, and AMA. KFHP complies with applicable state and federal laws regarding coverage of healthcare services, including mental health parity requirements. Types of standard coding include:

2.1.1 CPT codes 5-digit numeric codes maintained by the American Medical Association (AMA). These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.

2.1.2 HCPCS Level II codes Alpha-numeric (1 letter followed by 4 numbers) codes, which are used to identify products, supplies and services not included in Level I CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

2.1.3 International Classification of Diseases, ICD-10-CM codes Used to indicate diagnosis or condition. ICD-10 codes are required on all claims. KFHP follows ICD-10-CM Official Guidelines for Coding and Reporting and may deny claims when billed inappropriately.

2.1.4 NDC (National Drug Code) codes A universal number that identified a drug. The NDC number consists of 11 digits in a 5-4-2 format (Do not bill with hyphens, only the 11-digit NDC).

2.1.5 Revenue codes 4-digit numeric codes used by institutional providers. HCPCS or CPT codes may be required in addition to specific revenue codes to describe the services rendered.

2.2 Reimbursement Guidelines

2.2.1 Supportive documentation may be requested to validate the accuracy of billed services before finalizing reimbursement. These practices apply to both contracted and non-contracted providers, hospitals, and suppliers eligible to bill for services.

2.2.2 Guidelines are based on nationally recognized standards, including but not limited to, CMS, AMA CPT coding guidelines, CMS's National Correct Coding Initiative (NCCI), provider manuals, associated medical societies, and billing and coding sources. As required by the Centers of Medicare and Medicaid Services (CMS) and Health Insurance Portability and Accountability Act (HIPAA), Providers must select CPT/ICD-10/HCPCS/Revenue codes that provide the highest degree of accuracy and completeness.

2.3 Medically Unlikely Edits (MUE)

2.3.1 KFHP applies CMS MUE edits to both facility and professional claims, including DME. In instances where a provider bills above the industry defined MUE for a particular procedure code, KFHP reserves the right to reimburse at the max allowable units to avoid unnecessary denials and delays in reimbursement.

2.4 Bundled Procedures

2.4.1 Facility Claims – OPPS Status Codes KFHP follows the Centers for Medicare and Medicaid services (CMS) Hospital Outpatient Prospective Payment System (OPPS). Reimbursable codes are determined based upon the assigned OPPS Status Indicator(s). CMS assigns Payment Status Indicators, and their definition can be found by accessing Addendum D1.

2.4.2 Professional Claims - Bundled/Unbundled when two or more procedure codes are submitted on a claim, the two codes are reviewed to determine if they are compatible or appropriate when performed together. The review identifies potential instances of unbundling or inappropriate billing, where separate procedures that should be billed together are instead billed separately.

2.5 Modifiers

2.5.1 Modifiers are two-character codes (letters or numbers) that are appended to CPT or HCPCS codes to provide more detail about a medical service. They indicate that a service or procedure has been altered but not changed in definition. Specific modifier reimbursement is found in the claims Modifier Reimbursement Policy.

2.6 Documentation Required:

2.6.1 When billing an E/M service along with a procedure, the documentation in the member’s medical record must clearly demonstrate that:

2.6.1.1 Both the medically necessary E/M service and the procedure are appropriately and sufficiently documented by the physician in the patient’s medical record.

2.6.1.2 The purpose of the evaluation and management service was to evaluate a specific complaint.

2.6.1.3 The key components of the appropriately selected E/M service were actually performed and address the presenting complaint.

2.6.1.4 The purpose of the visit was other than evaluating and/or obtaining information needed to perform the procedure/service.

2.7 Multiple Modifiers:

2.7.1 KFHP accepts the submission of multiple modifiers. Claims filed using multiple site of service modifiers must be filed on separate claim lines.

2.8 Site of Service Modifier:

2.8.1 Site of service modifiers are HCPCS Level II modifiers that include but are not limited to F1-9, E1-4, T1-9.

2.9 TC Technical Component:

2.9.1 TC modifier is used to indicate Technical Component. This refers to certain procedures that are a combination of a physician component and a technical component. KFHP follows CMS guidelines for correct usage of the TC component. The TC modifier should only be appended to health service codes that have a 1 in the PC/TC field on the National Relative Value Field file.

2.10 Modifier 24:

2.10.1 When using Modifier 24 the following shall apply:

2.10.1.1 The primary reason for the service needs to be unrelated to the prior condition. Incidental minor findings or lower levels of medical decision making do not warrant separate E/M reporting. The number and level of E/M in the post-operative period reflects a range of anticipated complexity and number of visits.

2.10.1.2 When eligible to be reported, the basis of code selection shall not include the key components related to the procedure post-operative E/M.

2.11 Modifier 25:

2.11.1 Modifier 25 is used to indicate that on the same date as a procedure or other service, a significant and separately identifiable evaluation and management (E/M) service was performed by the same provider.

2.11.2 Modifier 25 is appropriate only when the documentation clearly supports the distinct nature of the E/M service. KFHP reviews for proper use of Modifier 25 to ensure that the E/M was medically necessary, clearly documented, and not part of the routine care bundled into the procedure. Claims submitted with Modifier 25 that lack sufficient documentation or are appended inappropriately may be denied.

2.12 Modifier 26 Professional Component:

2.12.1 Modifier 26 is used to indicate the professional service associated with a procedure that consists of a combination of both technical and professional services. KFHP follows the CMS guidelines for correct usage of modifier 26.

2.12.2 This modifier should be appended to health service codes that have a 1 in the PC/TC field on the National Relative Value Field file. KFHP will automatically append modifier 26 to services performed in place of service 21, 22, or 23.

2.13 Pre, Post, and Intraoperative Care Modifiers (54, 55, 56):

2.13.1 These modifiers are used to indicate services provided during a global surgical period and are required to ensure accurate reimbursement across providers. For more information, please refer to the Modifier Reimbursement Policy:

2.13.1.1 **Modifier 54:** Used when the same provider completes both the surgery and the preoperative care.

2.13.1.2 **Modifier 55:** Appended when a different provider performs postoperative management.

2.13.1.3 **Modifier 56:** Leveraged when a different provider performs preoperative care.

2.14 Bilateral Surgery (LT/RT/50)

2.14.1 KFHP utilizes Medicare payment indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code. The following are the payment indicators utilized.

2.14.1.1 Indicator 1: This indicator identifies a bilateral service was performed. Providers must bill with the bilateral modifier or reported twice on the same day by any other means (e.g., with RT and LT modifiers, and with 1 in the unit field.

2.14.1.2 Indicator 2: The modifiers 50, -RT, and -LT do not apply.

2.14.1.3 Indicator 3: This indicator does not occur on any surgeries. KFHP requires providers to report using the correct anatomical modifier (-RT/-LT).

2.14.1.4 If a code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral and multiple surgery guidelines will be applied.

2.15 Modifier 59, XE, XS, XP, XU:

2.15.1 Modifier 59 is utilized under certain circumstances to indicate a distinct procedure or service for non-evaluation and management (E/M) services provided on the same date of service.

2.15.2 Modifiers XE (Separate Encounter), XS (Separate Structure), XP (Separate Practitioner), and XU (Separate Unusual Non-Overlapping Service) gives greater detail in place of modifier 59, when specificity is needed. Modifier 59 should be used when no other more specific modifier is appropriate.

2.16 Co-Surgeons (Modifier 62):

2.16.1 KFHP utilizes Medicare payment indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code. The following are the payment indicators utilized:

2.16.1.1 Payment Indicator 0: Co-surgeon not permitted Payment Indicator 1: Co-surgeon may be allowed with supporting documentation to establish medical necessity. Claim requires review and operative notes may be requested by each provider at the time of the claim submission.

2.16.1.2 Payment Indicator 2: Co-surgeons are permitted without submission of documentation if the two specialty requirements are met. Claims submitted by two providers with different specialties will be adjudicated; however, it requires claim review prior to payment. Operative notes must be submitted by each provider at the time of claim submission.

2.16.1.3 Payment Indicator 9: Co-surgery concept does not apply.

2.17 Team Surgery (Modifier 66)

2.17.1 KFHP utilizes Medicare payment indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code. The following are the payment indicators utilized:

2.17.1.1 Payment Indicator 0: Team surgeons not permitted for this procedure.

2.17.1.2 Payment Indicator 1: Team surgeons could be allowed. Supporting documentation is required to establish medical necessity of a team.

2.17.1.3 Payment Indicator 2: Team surgeons are permitted.

2.17.1.4 Payment Indicator 9: Team surgeon concept does not apply.

2.18 Assistant Surgeon (Modifiers 80, 81, 82, AS):

2.18.1 KFHP utilizes assistant surgeon indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file as a guideline to determine reimbursement. When there is an assistant surgeon, the surgeon of record must be listed as the primary surgeon.

2.18.2 The primary surgeon of record should be responsible for identifying the presence of the assistant surgeon and the work performed. The primary surgeon will report the procedures without a modifier and at their applicable fee and the assistant surgeon will append the appropriate assistant modifiers. The following modifiers should be used:

2.18.2.1 Payment Indicator 0: Assistant surgeon may be allowed with supporting documentation to establish medical necessity.

2.18.2.2 Payment Indicator 1: Assistant surgeon not permitted.

2.18.2.3 Payment Indicator 2: Assistant surgeon(s) are permitted.

2.18.2.4 Payment Indicator 9: Assistant surgeon concept does not apply.

2.19 Global Period

2.19.1 KFHP follows the CMS Global Surgery status indicators on the Medicare Physician Fee Schedule. These include:

2.19.2 000 Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

2.19.3 010 Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period are generally not payable.

2.19.4 090 Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

2.19.5 MMM Maternity codes; usual global period does not apply.

2.19.6 XXX Global concept does not apply.

2.19.7 YYY Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

2.19.8 ZZZ Code related to another service and is always included in the global period of the other service.

2.20 Multiple Procedure Payment Rules

2.20.1 The Multiple Procedure Payment Reduction (MPPR) is a policy implemented by CMS that reduces the reimbursement for the second and subsequent procedures performed on the same patient during the same encounter. MPPR guidelines are applied to surgery, diagnostic imaging, cardiology and ophthalmology services. MPPR impacts both professional and facility claims. Same providers are defined as physicians/providers in the same group practice who furnish multiple services to the same patient on the same day.

2.20.1.1 Surgery KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) and CMS I/OCE files to determine which procedures are subject to multiple procedure reduction for professional and facility services.

2.20.1.2 Diagnostic Imaging KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) and CMS I/OCE files to determine which procedures are subject to multiple procedure reduction for professional and facility services.

2.20.1.3 Ophthalmology KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine which procedures are subject to multiple procedure reduction for facility services and services billed with modifier TC.

2.20.1.4 Cardiology KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine which procedures are subject to multiple procedure reduction for facility services and services billed with modifier TC.

2.21 MPFS Status Indicator Codes:

2.21.1 KFHP recognizes the CMS assigned payment indicators as outlined within CMS National Physicians Fee Schedule Relative Value Units (RVU) file.

2.22 Anesthesia

2.22.1 KFHP will not cross walk surgical codes to anesthesia CPT codes. KFHP will not reimburse non-anesthesia services billed by anesthesia provider.

2.23 Emergency Department (ED) Facility Evaluation and Management (E&M) Coding

2.23.1 KFHP utilizes the EDC Analyzer™ tool to determine the appropriate level of facility reimbursement for outpatient emergency department (ED) services.

2.23.2 This policy will apply to all facilities that submit ED claims with level 3, 4, or 5 E/M, regardless of whether they are contracted or non-contracted. The review is based upon presenting problems as defined by the ICD 10 reason for visit, intensity of the diagnostic workup as measured by the diagnostic CPT codes, and based upon the complicating conditions as defined by the ICD 10 principal, secondary, and external cause of injury diagnosis codes.

2.23.3 To learn more about the EDC Analyzer ™ tool, see EDC Analyzer.com.

2.24 Diagnostic Exchange test identification codes (DEX Z-Codes)

2.24.1 KFHP leverages DEX Z-Codes to ensure claims are coding correctly for reimbursement. KFHP utilizes Palmetto GBA, the administrator of the Centers for Medicare & Medicaid Services (CMS) MolDX® Program, which identifies and establishes coverage and reimbursement for molecular diagnostic tests.

2.25 Robotic Assisted Surgery

2.25.1 KFHP does not provide additional reimbursement based upon the type of instruments, technique or approach used in a procedure, such matters are left to the discretion of the surgeon. Additional professional or technical reimbursement will not be made when a surgical procedure is performed using robotic assistance.

2.26 Unlisted Codes

2.26.1 The CPT and HCPCS manuals provide unlisted procedure codes for healthcare providers to report services for which there is no specific code descriptor available. Providers should not use an "unlisted code", unless there is not an established code which adequately describes the procedure. Claims must be submitted with clinical documentation which includes detailed description of the procedure or service.

2.27 Outpatient Observation Services

2.27.1 Observation services are provided in place of inpatient admission. Observation services allow the necessary time to evaluate and provide needed services to a member whose diagnosis and treatment are not expected to be longer than forty-eight (48) hours without discharge or admission. Observation care can, for example, be delivered in a hospital emergency room, an area designated as "observation," a bed within a unit, or an entire unit designated as an observation area.

2.27.1.1 Admission to observation begins at the clock time documented in the medical record when the patient clearly transitions to observation level of care (i.e. Is placed in an observation bed), as confirmed by the initiation of services rendered and documented in accordance with the directions on the physician order.

2.27.1.2 Observation services should not be billed along with diagnostic or therapeutic services for which active monitoring is a part of the procedure. Documented observation time should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., CT scans, MRI, colonoscopy, chemotherapy).

2.27.1.3 Observation time does not include the time patients remain in the hospital after treatment is finished, for reasons such as waiting for transportation home or while awaiting placement to another health care facility.

2.27.1.4 Routine preoperative preparation, monitoring and postoperative recovery is included in the allowance for the procedure. Prolonged services that require placing the patient in observation status are not eligible for payment unless a 6-hour threshold of post-operative monitoring is exceeded, regardless of the location of the postoperative monitoring.

2.28 Diagnosis Related Group (DRG) Payment

2.28.1 DRG validation is to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the facility on the submitted claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. KFHP Clinical Review performs DRG reviews on claims with payment based on DRG reimbursement to determine the diagnosis and procedural information leading to the DRG assignment is supported by the medical record.

2.28.1.1 Validation must ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the facility on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.

2.28.1.2 Reviewers will validate principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

2.28.1.3 Comprehensive review of the patient's medical records will be conducted to validate:

2.28.1.3.1 Physician ordered inpatient status.

2.28.1.3.2 Accuracy of diagnostic code assignment.

2.28.1.3.3 Accuracy of the procedural code assignments.

2.28.1.3.4 Accuracy of the sequencing of the principal diagnosis and procedure codes.

2.28.1.3.5 Accuracy of the present on admission (POA) indicator assignment.

2.28.1.3.6 Accuracy of the DRG grouping assignment and associated payment.

2.28.1.3.7 Accuracy of the Discharge Disposition Status Code assignment.

2.28.1.3.8 Other factors that may impact DRG assignment and/or claim payment.

2.28.1.3.9 Compliance with KP's payment policies including but not limited to those policies that address DRG inpatient facility, never events, hospital-acquired conditions, and readmissions or transfers to another acute care hospital.

3.0 Guidelines

N/A

4.0 Definitions

4.1 Centers for Medicare and Medicaid Services (CMS) Part of the Department of Health and Human Services (HHS) that administers programs such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

4.2 Current Procedural Terminology (CPT) A set of five-digit numeric or alphanumeric codes used to describe medical, surgical, and diagnostic services. These codes provide a uniform language that accurately describes medical services and procedures, facilitating efficient reporting, billing, and data analysis.

4.3 Healthcare Common Procedure Coding System (HCPCS) Level II A standardized alphanumeric coding system used primarily to identify products, supplies, and services not included in the CPT® codes—such as ambulance services and durable medical equipment—for billing purposes. Each code consists of a single alphabetical letter followed by four numeric digits.

4.4 Integrated Outpatient Code Editor (I/OCE) A tool developed by the Centers for Medicare & Medicaid Services (CMS) to validate and edit outpatient claims before they are submitted to Medicare.

4.5 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) A standardized coding system used in the United States to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care. It is used by healthcare providers to document and report diseases and medical conditions (morbidity) for billing, statistical, and administrative purposes.

4.6 International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) A procedure classification system developed by the Centers for Medicare & Medicaid Services (CMS) for use in the United States. It is used to code procedures performed in hospital inpatient settings and is designed to support accurate and consistent reporting of inpatient procedures for billing and statistical purposes.

4.7 Local Coverage Determinations (LCDs) Policies created by Medicare Administrative Contractors (MACs) to decide which services are considered reasonable and necessary for Medicare coverage within their specific jurisdictions.

4.8 Medicare Physician Fee Schedule (MPFS) Medicare uses the MPFS when paying for professional services of physicians and other healthcare providers in private practice, services covered incident to physicians' services, diagnostic tests (other than clinical laboratory tests), and radiology services.

4.9 National Correct Coding Initiative (NCCI)/Correct Coding Initiative (CCI) The Medicare National Correct Coding Initiative (NCCI), also known as CCI, was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. CMS developed the NCCI program to promote national correct coding of Medicare Part B claims.

4.10 National Coverage Determinations (NCD) Policy decisions by the Centers for Medicare & Medicaid Services (CMS) that specify whether a particular item or

service is considered reasonable and necessary for Medicare coverage on a nationwide basis.

4.11 National Uniform Billing Committee (NUBC) An organization established to develop and maintain a standardized billing form and data set—specifically the UB-04—for use by institutional healthcare providers and payers across the United States. Its goal is to ensure uniformity in the data reported on healthcare claims, facilitating efficient processing and accurate reimbursement.

4.12 Outpatient Prospective Payment System (OPPS) CMS generally makes payment for hospital outpatient department services through the Hospital Outpatient Prospective Payment System (OPPS).

4.13 Relative Value Units (RVUs) Relative value units (RVUs) are the basic component of the Resource-Based Relative Value Scale (RBRVS), which is a methodology used by the Centers for Medicare & Medicaid Services (CMS) and private payers to determine physician payment.

4.14 Revenue Codes Four-digit numeric codes used on institutional (facility) claims to indicate the specific department or type of service provided during a patient's visit. These codes help identify where the patient received care (e.g., emergency room, radiology) or what type of item or service was provided (e.g., medical supplies, room and board), and are essential for billing and reimbursement purposes.

4.15 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Establishes federal standards for protecting patients' health information from disclosure without their consent.

5.0 References

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
https://www.cms.gov/medicare/coding-billing/ncci-medicare
https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files

https://www.aapc.com/resources/what-are-relative-value-units-rvus?srsltid=AfmBOooizLh65MIlBqpJ0rYEhtEamQBpt7Lc6_sfJ2hTxMR0bCqsOj0x
https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00097341

https://www.cms.gov/medicare/coverage/determination-process/local
Medicare Coverage Determination Process | CMS

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#page=37 Section 30.6.1.1

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1392FC_Addendum_D1.pdf https://www.cms.gov/status-indicators

Medicare Claims Processing Manual: Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 290 Outpatient Observation Services. Accessed 03/16/2010 at http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf 2

Medicare Benefit Policy Manual: Chapter 6 - Hospital Services Covered Under Part B, Section 20.6 - Outpatient Observation Services (Rev. 107, Issued: 05-22-09, Effective: 07-01-09, Implementation: 07-06-09) A. Outpatient Observation Services Defined. Accessed
03/10/2011. http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf 3

CMS Manual System. Pub. 100-02 Medicare Benefit Policy. December 16, 2005. January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Observation

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/2025)

Revision History

Approvals

POL-020.4 Clinical Review Implant Payment Determination Policy

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

1.1.1 Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.

1.1.3 Kaiser recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

- American Academy of Professional Coders (AAPC)
- American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

1.2.1 This policy provides an overview of Kaisers reimbursement guidelines for devices and implants. The policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified.

2.0 Rules

2.1 Kaiser will not consider implants for reimbursement that do not meet the U.S. Food and Drug Administration (FDA) definition of implants. According to the FDA an implant is defined as:

2.1.1 "A device that is placed into a surgically or naturally formed cavity of the human body and is intended to remain implanted continuously for 30 days or more, unless otherwise determined by the FDA to protect human health."

2.2 Reimbursement Guidelines

2.2.1 Humanitarian Use Device (HUD)

2.2.1.1 KFHP Clinical Review evaluates the use of Humanitarian Use Devices (HUDs) to determine appropriate reimbursement. HUDs will not be reimbursed for investigational or off-label use. The following will be reviewed to determine the appropriate reimbursement.

2.2.1.2 Is the device approved by the FDA under a Humanitarian Device Exemption (HDE).

2.2.1.3 Was the device used strictly in accordance with FDA-approved indications.

2.2.1.4 Was the device administered in a non-research clinical setting with Institutional Review Board (IRB) approval.

2.2.1.5 Was the device deemed medically necessary, with no suitable alternative treatment available.

2.2.1.6 Was there comprehensive supporting documentation provided, including FDA approval, IRB approval, medical necessity justification, and patient consent.

2.2.2 Non-Covered Examples

2.2.2.1 (This is not an exhaustive list, nor is it intended to cover every claim scenario)

2.2.2.2 **Temporary items** Objects that do not remain in the member's body upon discharge are not considered implants.

2.2.2.2.1 Examples include, without limitation, the following: screws, clips, pins, wires, nails, and temporary drains.

2.2.2.3 **Disposable items** Single-use products not intended to remain in the body or be reused.

2.2.2.3.1 Examples include, without limitation, the following: surgical drapes, irrigation tubing, wedge positioning pads, accessory packs, needles and syringes.

2.2.2.4 **Supplies and instruments** Tools or materials used during procedures but not implanted.

2.2.2.4.1 Examples include, without limitation, the following: surgical instruments (e.g., forceps, scalpels), sterile drapes, tubes, guidewires, operating room kits, and diagnostic tools (e.g., endoscopes).

2.2.2.5 **Unused or discarded items** Devices or implants that are opened or prepared but not implanted for any reason. This includes surgical changes, complications, or handling errors. All of which are considered waste and are not reimbursable.

2.2.2.5.1 Examples include, without limitation, the following: implantable screw(s) not used due to a change in approach by the treating provider, biologic mesh discarded after plan change, pacemaker lead not implanted due to complications.

2.2.2.6 **Absorbable materials and biological products not classified as implants by the FDA** Includes tissue-based or absorbable products intended for temporary use that do not meet the FDA's definition of an implant.

2.2.2.6.1 Examples include, without limitation the following: absorbable hemostats, and topical thrombin's (e.g., Surgicel®).Temporary wound matrices (e.g., Integra®), amniotic membrane grafts, collagen-based scaffolds, skin substitutes used as temporary coverings, bone putty or cement, and absorbable sutures.

2.2.2.7 **Off-label or non-indicated use** Biological products used outside their FDA-approved purpose—such as absorbable scaffolds or tissue grafts used for structural support—are not covered.

2.2.2.8 **Procedural tools and temporary devices** Devices used during procedures but not intended to remain in the body.

2.2.2.8.1 Examples include, without limitation, the following:Catheter, transluminal atherectomy, rotational, Adhesion barrier, Intracardiac introducer/sheath (non-peel-away), Guide wire, Retrieval device (e.g., for fractured implants), Pulmonary sealant (liquid), and Cryoablation probe/needle.

3.0 Guidelines

N/A

4.0 Definitions

4.1 **Biological Products** Products derived from living organisms (such as human or animal tissue) that are used in the prevention, treatment, or cure of diseases. When not classified as implants by the FDA—such as absorbable or temporary tissue-based products—they are not considered reimbursable implants.

4.2 **Centers for Medicare & Medicaid Services (CMS)** A federal agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare, Medicaid, and other health programs. CMS establishes national coverage policies and reimbursement methodologies, including those related to implantable devices.

4.3 **Disposable Medical Supplies** Single-use items utilized during a procedure that are not retained in the body after discharge. These are not considered implants and are typically not reimbursed separately.

4.4 **HCPCS Code** The Healthcare Common Procedure Coding System (HCPCS) is used to report medical procedures, services, and devices. A valid HCPCS code must be submitted for any implant billed on a claim.

4.5 **Humanitarian Use Device (HUD)** A medical device intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 8,000 individuals in the U.S. per year. HUDs must have FDA approval for the specific indication to be eligible for reimbursement.

4.6 **Implant** A device placed into a surgically or naturally formed cavity of the human body and intended to remain continuously for 30 days or more, as defined by the FDA.

4.7 **Skin Substitutes** Products used to temporarily or permanently replace the skin's structure and function. Only those intended for permanent implantation may be considered for reimbursement; temporary wound coverings or dressings are not reimbursed as implants.

5.0 References

5.1 Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)

5.2 U.S. Food and Drug Administration (FDA). Implants and Prosthetics Guidance https://www.fda.gov

5.3 U.S. Food and Drug Administration (FDA). IDE Definitions and Acronyms IDE Definitions and Acronyms | FDA

5.4 CPT® Manual and CPT® Assistant, published by the American Medical Association (AMA)

5.5 HCPCS Level II Manual, published by CMS

5.6 ICD-10-CM Official Guidelines for Coding and Reporting

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/2025)

Revision History

Approvals

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

1.1.1 Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.

1.1.3 KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

- American Academy of Professional Coders (AAPC)
- American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

1.2.1 This policy provides an overview of KFHP's review of institutional/facility claims that are readmissions for the same member to the same hospital or hospital system, that fall within 30 days of discharge. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified. Clinical Review will review the medical records to determine if the claim is a continuation of care or readmission, unrelated to the first claim for the same hospital or hospital system within 30 days for the same member with the same, similar or related diagnoses.

2.0 Rules

2.1 The Clinical Review department will request/ review medical records to determine if the readmission within 30 days was continuation of care or a readmission to the same hospital or health system. When medical records or clinical information is requested, all the specific information required to make the medical determination must be clearly documented in the records.

2.2 KFHP follows Centers for Medicare and Medicaid Services (CMS) guidelines for Readmissions within 30 calendar days of discharge from the initial admission. Payment for a readmission to the same hospital or hospital system within 30 calendar days may be denied if the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission.

2.3 Reimbursement Guidelines

2.3.1 KFHP does not allow separate reimbursement for claims that have been identified as readmission to the same hospital or hospital system reimbursed by DRG pricing for the same, similar or related condition unless provider contracts, state, federal or CMS requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, KFHP will use the following standards: (a) readmission within 30 days of discharge; (b) for the same member with the same, similar or related diagnoses.

2.3.2 KFHP will use clinical criteria and licensed clinical professionals as part of the review process for readmissions from day 2 to day 30 in order to determine if the second admission is for:

- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge.
- An acute decompensation of a coexisting chronic disease.
- An infection or other complication of care.
- An issue caused by a premature discharge from the same hospital or hospital system.
- Condition or procedure is indicative of a failed surgical intervention.
- The same, similar or related diagnoses or procedure as the prior discharge.

2.4 Preventable/Inappropriate Readmissions

2.4.1 Readmissions which are deemed preventable or considered inappropriate pursuant to the following criteria may be denied:

- A medical complication related to care during the previous admission.

- A medical readmission for a continuation or recurrence for the previous admission or closely related condition
- The readmission resulted from a failure of proper coordination between the inpatient and outpatient health care teams
- An unplanned readmission for surgical procedure to address:
    - Complication or recurrence of a problem causing this admission.
    - Complications related to Serious Reportable Events (SREs)
    - Suspected complication that was not treated prior to discharge.
    - Surgical procedure to address a complication resulting from care from the previous admission.
- The readmission resulted from a failure of proper and adequate discharge planning.
- The readmission resulted from a premature discharge or is related to the previous admission, or that the readmission was for services that should have been rendered during the previous admission.
- If a readmission falls under one of the criteria listed above and KFHP denies the claim, the hospital may not bill the member for the readmission

3.0 Guidelines

3.1 Exclusions

3.1.1 Exclusions from the criteria listed above may apply. Examples include but are not limited to:

- Admissions associated with malignancies (limited to those who are in an active chemotherapy regimen-both infusion and oral), burns, or cystic fibrosis.
- Admissions with a documented discharge status of “left against medical advice.”
- Behavioral health readmissions.
- In-network facilities that are not reimbursed based on contracted DRG or case rate methodology (e.g., per diem).
- Obstetrical readmissions for birth after an antepartum admission.

- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, for similar repetitive treatments, or for elective surgery. These include:
    - Transfers from one acute care hospital to another.
    - Critical Access Hospitals (CAHs).
    - Exclusions for the Washington State region ONLY: (a) Readmission due to patient nonadherence; (b) End-of-life and hospice care; (c) Obstetrical readmissions for birth after an antepartum admission; (d) Neonatal readmissions; (e) Transplant readmissions within 180 days of transplant.
- Substance use readmissions.
- Transplant services (within 180 days of transplant), including organ, tissue, or bone marrow transplantation from a live or cadaveric donor.

4.0 Definitions

1.1 **Centers for Medicare & Medicaid Services (CMS)** Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

1.2 **Readmission** A subsequent inpatient admission to any acute care hospital which occurs within 30 days of the discharge date; excluding any exceptions or planned readmissions.

1.3 **Planned Readmissions** A non-acute admission for a scheduled procedure for limited types of care that may include, obstetrical delivery, transplant surgery, maintenance of chemotherapy/radiotherapy/immunotherapy.

1.4 **Preventable Readmissions** A readmission within a specific time frame that is clinically related and may have been prevented had appropriate care been provided during the initial hospital stay and discharge process.

5.0 References

1.5 Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at: http://www.cms.gov/manuals/downloads/clm104c03.pdf. Accessed September 29, 2011.

1.6 Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available

at: http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf. Accessed September 29, 2011

1.7 Hospital-Acquired Condition Reduction Program | CMS

1.8 Medicare Claims Processing Manual (CMS-Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing)

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/2025)

Revision History

Approvals

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

1.1.1 Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim, or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup payment for claim processed in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.

1.1.3 Kaiser recognizes commonly accepted standards to determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

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- American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

1.2.1 This policy outlines Kaiser's requirements for the review and reimbursement of Intraoperative Neuromonitoring (IONM) services. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified.

1.2.2 Clinical Review will evaluate submitted documentation to determine the medical appropriateness and/or medical necessity of IONM services in accordance with Kaiser medical policy for Intraoperative Neuromonitoring. The review process ensures that claims are submitted in compliance with federal and state regulations, industry-standard coding practices, and evidence-based literature.

1.2.3 Clinical Review will apply Kaiser's IONM Medical Policy criteria, and applicable regulatory, state, and federal guidelines to determine whether IONM services are reimbursable or non-reimbursable, based on the member's benefit plan.

2.0 Rules

2.1 Criteria

2.1.1 This payment policy aligns with Kaisers internal IONM Medical Policy. The criteria was established using evidence-based guidelines and nationally recognized standards to determine the medical necessity of services. Medical necessity and appropriateness requirements apply.

2.1.2 IONM is considered medically necessary only when performed for high-risk surgical procedures with a demonstrated benefit in reducing neurological complications. Standards are reviewed and updated regularly to reflect current clinical evidence and regulatory requirements.

- Charges related to intraoperative monitoring are billed on a HCFA 1500 claim form for professional charges. Any charges related to IONM billed on a UB form are not reimbursable.
- Codes for automated monitoring devices that do not require continuous attendance by someone who is qualified to interpret the information should not be reported separately.
- Kaiser will consider IONM for reimbursement when performed in place of service (POS) 19, 21, 22, or 24.
- Recording and testing are performed either personally by the surgeon or anesthesiologist, or by a technologist who is physically present with the patient during the service.
- Remote monitoring can be performed by a qualified professional using a real-time audio and visual connection.

2.1.3 Kaiser will not consider additional reimbursement when IONM is performed by the surgeon or anesthesiologist. In this case, the professional services are included in the primary service code(s) for the procedure and should not be reported separately.

2.1.4 Accurate coding is essential for appropriate reimbursement of IONM services. Standard coding guidelines should be followed, with all claim information supported by the medical record:

- IONM codes should be reported based upon the time spent monitoring only, and not the number of baseline tests performed, or parameters monitored.

- The monitoring professional should be solely dedicated to the intraoperative neurophysiologic monitoring service, and available to intervene immediately, if necessary, throughout the duration of the procedure.

- Time reported should not include items such as time to set up, record, and interpret baseline studies, time to remove electrodes at the end of the procedure, or standby time.

3.0 Guidelines

N/A

4.0 Definitions

4.1 Intraoperative Neuromonitoring (IONM) The use of electrophysiological techniques to monitor the functional integrity of neural structures (e.g., spinal cord, brain, cranial nerves) during surgical procedures that pose a risk of neurological injury.

4.2 Real-Time Supervision Continuous monitoring and interpretation of IONM data by a qualified physician who is immediately available via telecommunication and in direct communication with the surgical team throughout the procedure.

4.3 Technologist A trained and credentialed individual who performs IONM in the operating room under the supervision of a qualified physician. The technologist must be present for the entire procedure and may not perform other clinical duties.

4.4 Supervising Physician A licensed physician with expertise in neurophysiology who provides real-time interpretation of IONM data. The supervising physician must not be the operating surgeon or anesthesiologist.

4.5 CPT/HCPCS Codes Standardized codes used to report medical procedures and services. For IONM, these include CPT codes 95940, 95941, and HCPCS code G0453.

5.0 References

American Medical Association (AMA). CPT® Manual and CPT® Assistant

CMS Article A56722. Billing and Coding: Intraoperative Neurophysiological Testing

Healthcare Common Procedure Coding System (HCPCS) Manual

International Classification of Diseases, 10th Revision (ICD-10-CM) – Official Guidelines for Coding and Reporting

National Correct Coding Initiative (NCCI) Policy Manual

National Uniform Billing Committee (NUBC) – UB-04 Data Specifications Manual

Medical Policy Manual for Intraoperative Neuromonitoring (found on provider portal)

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Payment Implant Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

(Updated: 09/08/2025)

Revision History

Approvals