2026 Kaiser Permanente Southern California

Network Development and Administration

Contracted Institutional Providers Self-Funded Provider Manual

Administered by Kaiser Permanente Insurance Company (KPIC)

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Introduction

It is our pleasure to welcome you as a Provider for the Kaiser Permanente Self-Funded Program. We want this relationship to work well for you, your medical support staff, and our Members.

This Provider Manual is to help guide you and your staff in understanding Kaiser Permanente Insurance Company's policies and procedures for the Self-Funded Program and related administrative procedures, including those related to claims for compensation for which an Other Payor is financially liable.

If, at any time, you have a question or concern about the information outlined in this Provider Manual, you can reach our Network Development and Administration Department by calling (626) 405-3240. Capitalized terms in this Provider Manual which are used in describing the Self-Funded Program are defined herein or in your Agreement. Where there is a conflict between the definitions herein and in your Agreement, the terms of the Agreement will control.

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 HealthPlan. If there is a conflict between this Provider Manual and your Agreement, the terms of the agreement will control.

Section I: Self-Funded Program Overview

1.1   KAISER PERMANENTE INSURANCE COMPANY (KPIC)

Kaiser Permanente Insurance Company (KPIC), an affiliate of Kaiser Foundation HealthPlan, Inc., will be administering Kaiser Permanente's (KP) Self-Funded Program. Each Self-Funded Plan Sponsor (an "Other Payor" under your Agreement) will contract with KPIC to provide administrative services for the Plan Sponsor's Self-Funded plan. KPIC has a dedicated administrative services team to coordinate administration with the Plan Sponsors. KPIC will provide network administration services and certain other administrative functions through an arrangement with Kaiser Foundation HealthPlan, Inc.

1.2   THIRD PARTY ADMINISTRATOR (TPA)

KPIC has contracted with a Third-Party Administrator (TPA), HealthPlan Services, (HPS) Inc. (formerly Harrington Health), to provide certain administrative services for Kaiser Permanente's Self-Funded Program, including claims processing and verification of Eligibility and Covered Benefits.

HPS, Inc. administers the Self-Funded Customer Service System, with automated functions as well as access to customer service representatives that allows you to check eligibility, benefit, and claim(s) information for Self-Funded Members.

The automated system (interactive voice response or IVR) is available 24 hours a day, 7 days a week. Customer Service Representatives are available Monday - Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET).

1.3   SELF-FUNDED PRODUCTS

Kaiser Permanente offers a Self-Funded Exclusive Provider Organization (EPO) product administered by KPIC.

Exclusive Provider Organization (EPO)
- Mirrors Health Maintenance Organization (HMO) product, offered on a Self-Funded basis
- Self-Funded EPO Members choose a Kaiser Permanente primary care Provider and receive care at Kaiser Permanente or other identified medical facilities
- Self-Funded EPO Members are covered for non-emergent care only at designated plan medical facilities and from designated plan practitioners (unless referred by a KP primary care Provider)

1.4   SELF-FUNDED IDENTIFICATION CARDS

Each Self-Funded Member will be issued a Self-Funded Identification Card (Self- Funded ID card). Self-Funded Member should bring their Self-Funded ID card and photo identification when they seek medical care.

Each Self-Funded Member is assigned a unique Health/Medical Record Number, which is used to locate membership and medical information. Every Self-Funded Member receives a Self-Funded ID card that shows his or her unique number. If a replacement card is needed, the Self-Funded Member can order a Self-Funded ID card online.

The Self-Funded ID card is for identification only and does not give a Self-Funded Member rights to services or other benefits unless he or she is eligible. Anyone who is not a member will be billed for any services provided.

Examples of Self-Funded ID cards for various regions are on the following pages.

Please note the actual membership card may vary slightly from the images shown on the next page.

1.4.4 Southern California Exclusive Provider Organization (EPO)

Section II: Key Contacts and Tools

2.1   KEY CONTACTS

Below are key contacts for Self-Funded Member inquiries.

Department	Contact information	Type of Help or Information from this Department
Self-Funded Customer Service	Customer Service Representatives are available Monday to Friday 7 a.m. to 9 p.m. EST. Self-Service Interactive Voice Response (IVR) System available: 24/7 days a week (866) 213-3062 Website available: 24/7 days a week https://kpclaimservices.com/	• General enrollment questions • Eligibility and benefit verification • Claims management • Billing and payment inquiries • EDI questions • Appeal and claims dispute questions • Co-pay, deductible, and coinsurance information • Self-Funded Members terminated greater than 90 days • Self-Funded Members presenting with no Kaiser Permanente identification number • Verifying Self-Funded Member's PCP assignment • Electronic Funds Transfer (EFT) Agreement authorization form
Network Development and Administration Department	Network Development and Administration Available Monday to Friday 8 a.m. to 5 p.m. PST (626) 405-3240	• Provider education and training • Send Provider demographic updates such as Tax ID changes, address changes to this Department.

Emergency Prospective Review Program (EPRP)	Available: 24/7 days a week (800) 447-3777	• Emergency Department notifications • Medical information and history • Post-stabilization services authorization for patients stabilized in Emergency Department
Outside Utilization Resource Services (OURS)	Available: 24/7 days a week (800) 225-8883	• Post-stabilization services authorization for patients stabilized after inpatient admission • All inpatient admissions • Authorizations for referred services and non-emergent services
Outside Referrals Department:	Antelope Valley Baldwin Park Downey Coachella/Yucca Valley San Bernardino County Kern/Bakersfield Los Angeles Orange County Panorama City Riverside South Bay San Diego West Los Angeles West Ventura Woodland Hills	(661) 729-7108 (562) 622-3880 (562) 622-3880 (951) 602-4294 (909) 609-3262 (661) 852-3482 (323) 783-4401 (714) 564-4150 (818) 375-2806 (951) 602-4294 (310) 816-5324 (619) 589-3360 (323) 783-4401 (844) 424-1869 (844) 424-1869

Please contact the service area for Self-Funded Members by calling the number listed on their Member ID Card.

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2.2   SELF-FUNDED CUSTOMER SERVICE IVR SYSTEM

Self-Funded Customer Service Interactive Voice Response system (IVR) can assist you with a variety of questions. Call (866) 213-3062 to use this service. Please have the following information available when you call into the system to provide authentication:
- Provider 9-digit Tax ID Number (TIN)
- Self-Funded Members medical record number (MRN) or Self-Funded Member's health record number (HRN) as printed on the Medical Identification Card
- Self- Funded Member's date of birth
- Self- Funded Member Zip code
- For Claims—Providers will also need to know the date of service

The IVR can assist you to verify eligibility, benefits, authorizations, and referrals; check a Self-Funded Member's accumulator (amount applied to deductible); inquire about claims and payments; or speak to a customer service representative. Follow the prompts to access these services.

2.3   WEBSITE

HealthPlan Services, Inc., KPIC's Third Party Administrator, maintains a Website that will allow you easily to access Claims/Benefits/Eligibility Information for our Self-Funded Members. The website has been redesigned to enable easier access to information and also is Mobile compatible.

A formal user guide is included at the end of this Provider Manual.

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

The HealthPlan Services, Inc. website, once available, can be directly accessed at https://kpclaimservices.com

Section III: Eligibility and Benefits Determination

3.1   ELIGIBILITY AND BENEFIT VERIFICATION

You are responsible for verifying Kaiser Permanente Self-Funded Members' eligibility and benefits. Each time a Self-Funded Member presents at your office for services, you should:
- Verify the patient's current eligibility status
- Verify covered benefits
- Obtain necessary authorizations (if applicable)

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Do not assume that eligibility is in effect because a person has a Kaiser Permanente Self-Funded ID card. You must check a form of photo identification to verify the identity of the Self-Funded Member. The effective date of eligibility varies according to the terms of the contract between the Plan Sponsor and Kaiser Permanente Insurance Company. Therefore, you must verify that the Self-Funded Member has a benefit for the service prior to providing such service to a patient.

Certain services require prior authorization. The Utilization Management section of this Provider Manual (Section 4) provides further details on which services require authorization and the process for obtaining referrals and authorizations.

Contact Self-Funded Customer Service at (866) 213-3062 or through one of the methods detailed below to verify the validity of the Self-Funded ID card/number and benefits. Otherwise, you provide services at your own financial risk.

Option	Description
1	HealthPlan Services, Inc. https://kpclaimservices.com 24 hours / 7 days a week To verify Self-Funded Member eligibility, benefit, and claim(s) information for Self-Funded Members.
2	Self-Funded Customer Service Department Telephone (866) 213-3062 Monday - Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET). To verify Self-Funded Member eligibility, benefits, or PCP assignment, you may speak with a customer service representative by calling the Self-Funded Customer Service Line at (866) 213-3062. Please provide your Organization's Tax Identification Number (TIN), the Self-Funded Member's name, Medical Record Number (MRN), Date of Birth, (which is located on the Kaiser Permanente Insurance Company Self-Funded ID Card), and Member Zip code.
Note:	**Due to HIPAA regulations, you must keep your office's user information current. User ID and passwords are unique. New staff members are required to obtain their own unique user ID's and passwords.**

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3.2   BENEFIT EXCLUSIONS AND LIMITATIONS

Self-Funded 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 Self- Funded Member can be informed of any potential payment responsibility.

Contact Self-Funded Customer Service to verify and obtain information on Self-Funded Member benefits at (866) 213-3062.

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

3.3   DRUG BENEFITS

The drug benefits, drug formulary and the procedures for formulary exception may vary based on the benefit plan.

To verify a Self-Funded Member's drug benefit, to obtain a Self-Funded Member's drug formulary, or for general questions, please contact the Self-Funded Customer Service at (866) 213-3062.

3.4   RETROACTIVE ELIGIBILITY CHANGES

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

If you provide services to a Self-Funded Member and the service is not a benefit, or the benefit has been exhausted, denied, or not authorized, you do so at your own financial risk.

Section IV: Utilization Management

INTRODUCTION

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

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

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

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

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

4.1   INVOLVEMENT OF CONTRACTED PROVIDERS

We expect our Providers to make medical decisions based on the appropriateness of care for a Self-funded Member's medical needs and clinical condition. Kaiser Permanente does not compensate anyone for denying services or benefits. Kaiser Permanente does not use financial incentives to encourage denials.

Kaiser Permanente allows, and we expect our Providers to allow, open communication regarding appropriate treatment alternatives without regard for a Self-Funded Member's benefit plan. We do not penalize providers for discussing medically necessary or appropriate care with Self-Funded Members.

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

UM processes also collect evidence about medical necessity and medical appropriateness of health care services. Appropriate licensed health care professionals supervise all UM evaluations. A licensed physician reviews any denial of a health care service when that denial is based on medical appropriateness or medical necessity.

4.2 UTILIZATION MANAGEMENT AND DISCHARGE PLANNING PROGRAM

Continuing Care Coordinators are registered nurses who coordinate ongoing medical care after discharge of Self-Funded Members from inpatient settings, including home health services, rehabilitation services, and/or preventive services. Continuing Care Coordinators work within the Kaiser Permanente UM Program.

They work with all providers of health care to a Self-Funded Member including the Providers, the primary care provider, discharge planners, and ancillary support professionals.

A major goal of Kaiser Permanente's Discharge Planning Program is to assure that Self-Funded Members receive appropriate medical care, as needed, after an inpatient stay to facilitate the recovery process. Continuing Care Coordinators work with the provider's staff and the Self-Funded Member's attending physician to facilitate discharge planning and post-inpatient care. This process will include making arrangements for medically necessary transportation.

Unless the Provider has received prior authorization to furnish follow-up care, that provider must contact Kaiser Permanente to arrange for and to coordinate covered medically necessary care after discharge.

4.3 UTILIZATION MANAGEMENT INFORMATION

Upon request from Kaiser Permanente, the Provider may be requested to provide other reasonable information for the Kaiser Permanente UM activities concerning Self-Funded Members in the provider's facility. Such additional information may include, but is not limited to, the following data:

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

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4.4 REFERRAL AND AUTHORIZATION

The terms "Referral" and "Authorization" are used interchangeably in your Agreement and in this Provider Manual.

4.4.1 Authorization Procedures

A prior authorization must be obtained for all admissions and the provision of services, except for Emergency Services. If you conclude that the Self-Funded Member after stabilization for an emergency condition requires continued hospitalization in addition to the Services Authorized, Provider shall contact OURS at 1-800-225-8883. If Provider requires additional authorization for non-emergency care, Provider shall call the applicable Outside Referral Services office. The Kaiser Permanente Utilization Management and Discharge Planning staff oversees review and coordination of inpatient care in conjunction with a Self-Funded Member's attending physician.

If hospitalization or other care seems inappropriate or other services exist to better meet the Self-Funded Member's clinical condition and needs, the Utilization Management representative shall notify the relevant physician to discuss alternative treatment plans.

4.4.2 Required Documentation When Requesting Authorization

Provider must contact Outside Referrals Department at the Self-Funded Member's Service Area telephone number listed herein at Section 2.

4.4.3 Admission to Skilled Nursing Facility (SNF)

A SNF stay may be authorized when a PMG Physician admits a Self-Funded Member at a skilled level of care to a SNF bed. Such authorization will include a description of specific, approved therapies and other appropriate skilled nursing services.

The Continuing Care Coordinator performs utilization review for skilled level of care weekly, either by telephone or by personal on-site evaluation.

Other services are authorized when either the Self-Funded Member's PMG Physician PCP other PMG Physician expressly orders such services. These services may include, but are not limited to, the following items:

- Laboratory services
- Special supplies or DME
- Ambulance transport (when Self-Funded Member meets medical necessity)

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4.4.4 Home Health/Hospice Services

Authorization for home health or hospice services is based on some of the following information:

- A PMG Physician must order and direct the requests for home health and hospice services.
- The Kaiser Permanente Continuing Care staff review referral requests from PMG Physicians.
- The patient is a Self-Funded Member.
- The Self- Funded Member requires the care in the Self-Funded Member's place of residence within the Kaiser Permanente Service Area. Any place that the Self-Funded Member is using as a home is considered the Self-Funded Member's residence.
- For home health services, the Self-Funded Member, because of illness or injury, is confined to home. The Self-Funded Member is not considered homebound when s/he 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 s/he would otherwise tolerate an absence from the home when receiving medical care.
- The home environment is a safe and appropriate setting to meet the Self-Funded Member's needs and provide home health Services.
- There is a reasonable expectation that the needs of the Self-Funded Member can be met by the provider.
- Medically necessary care must be provided by a registered nurse or therapist.
- The Self-Funded Member and caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals.
- Services are provided under the Health Plan and benefit guidelines.

Such Home health or hospice services are authorized for a Self-Funded Member only if the services are appropriate for the Self-Funded Member's clinical condition.

The PMG Physician develops a plan of care in collaboration with the provider.

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Home health and hospice staff coordinate care with the Provider. Home health and hospice manage the Member's plan of care through on site visits with the member and telephone encounters to assess the Self- Funded 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 as needed to meet the needs of the Self-Funded Member.

Discharge planning begins when the applicable plan of care is initiated during the start of care of Home Health or Hospice service.

4.4.5   Durable Medical Equipment (DME)

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

- The Self-Funded Member's care needs
- The application of specific Health Plan and benefits guidelines
- Utilization of formulary guidelines

4.5   NON-EMERGENCY TRANSFERS

To serve Self-funded members and to coordinate care with our contracted providers, Kaiser Permanente has a twenty-four hour, seven-day per week, centralized medical transportation department called the "HUB", to coordinate and to schedule non-emergency medical transportation.

If a Self-Funded 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 non-emergent transport before the HUB is contacted to coordinate the transportation 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.

The Kaiser Permanente Discharge Planner or Continuing Care Coordinator can assist in obtaining necessary clinical review and a pre-service decision (a transport order or a pre- service denial).

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

4.7   POST STABILIZATION AUTHORIZATIONS AND ADMISSIONS

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 agreed-upon services and give you a confirming authorization number. If requested, Kaiser Permanente will also provide a written confirmation of the services authorized and the confirmation number. This authorization number must be included with the claim for payment for the authorized services. The authorization 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 Self-Funded 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), Case Manager will follow that Self- Funded Member's care in your facility, including any authorization of subsequent care, until discharge or transfer.

If the Self-Funded Member is admitted to your facility as part of the stabilizing process and you have not yet been in contact with the EPRP, you must call Outside Utilization Resource Services (OURS), in order to discuss authorization for continued admission as well as any additional appropriate post-stabilization care once the Self-Funded Member's condition is stabilized. After you have notified Kaiser Permanente and received authorization, you will be contacted by a nurse in OURS Case Management, to provide updates on the Self-Funded Member's clinical progress.

> ## OURS NOTIFICATION (800) 225-8883
> ## Available 7 days a week 24 hours a day

OURS may deny authorization for some or all post-stabilization services. The verbal denial of authorization will be confirmed to you in writing. OURS may request that the Self-Funded 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 and who has contracted with Kaiser Permanente to manage the care of our Self-funded Members being treated in community hospitals.

If OURS denies authorization for requested post-stabilization care, Kaiser Permanente has no financial responsibility if you nonetheless choose to provide the care. If the Self-Funded Member insists on receiving such unauthorized post-stabilization care from your facility, we strongly recommend that you require that the Self-Funded 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.

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Note: If the Self-funded Member wishes to discuss the process of filing a claim with Kaiser Permanente, please refer the Self-funded 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 Self-funded Member.

4.8   GRIEVANCES

If a Self-Funded Member raises a question about grievances or with your office, please refer the Self-Funded Member to the Self-Funded Customer Service Department at (800)788 – 0710. The phone number is also located on the back of the Self-Funded Member's identification card. Self-Funded Customer Service will provide information to the Self-Funded Member on grievances.

4.8.1   SELF-FUNDED MEMBER APPEALS

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

Self-Funded Members are made aware of their right to appeal through their Benefit Booklet known as Summary Plan Description (SPD) provided by the Plan Sponsor, or by calling Kaiser Permanente Member Relations, Appeals at (800) 788-0710- which can provide information about the time frames for submitting appeals and for responses. Time frames may vary, depending on whether the adverse benefits determination relates to urgent care, or a pre-service or post-service claim.

4.8.2   NON-URGENT SELF-FUNDED MEMBER APPEALS

An appeal may be initiated by the Self-Funded Member or the Self-Funded Member's authorized representative, who may be a Provider who is authorized in writing by the Self-Funded Member to act on behalf of the Self-Funded Member.

Formal appeals should be submitted using one of the options provided below with the following information included:
- All related information (any additional information or evidence)
- Name and identification number of the Self-funded Member involved
- Service that was denied
- Name of initial Kaiser Permanente reviewing physician, if known

Opti	Description
#1	By mailing directly to: Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566
#2	By calling or faxing the following number: Phone: (800) 788-0710 Fax: (888) 987-2252 Attention: Member Relations

KPIC will provide a complete review of the claim and will notify the Self-Funded Member and any authorized representative of the decision in writing. If the initial denial is upheld following the review of the appeal, KPIC will send an explanation of the decision and any further appeal rights.

4.8.3 URGENT SELF-FUNDED MEMBER APPEALS

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

Please call the Member Appeals Department at (800) 788-0710 to initiate an urgent appeal.

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

Section V: Billing and Payment

For Self-Funded products, Kaiser Permanente Insurance Company (KPIC) utilizes a Third-Party Administrator (TPA), HealthPlan Services, Inc., to process claims.

The TPA's claim processing operation is supported by a set of policies and procedures which directs the appropriate handling and reimbursement of claims received.

It is your responsibility to submit itemized claims for services provided to Self-Funded Members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. The Self-Funded Member's Plan Sponsor is responsible for payment of claims in accordance with your Agreement.

5.1   WHOM TO CONTACT WITH QUESTIONS

If you have any questions relating to the submission of claims for services to Self-Funded Members for processing, please contact Self-Funded Customer Service at (866)-213-3062. Claims may be submitted by mail or electronically.

5.2   PAPER CLAIM FORMS

The current CMS-1500 (08/05) version will accommodate the reporting of the National Provider Identifier (NPI).

The National Uniform Billing committee (NUBC) has approved the UB-04 (CMS-1450) as the replacement for UB-92
- For Self-Funded paper claims submission, only the current CMS-1500 form (08/05 version), which accommodates the reporting of the NPI, will be accepted for professional services billing.
- For Self-Funded paper claims submission, only the current UB-04 (CMS-1450) form will be accepted for facility services billing.

5.3   RECORD AUTHORIZATION NUMBER

All services that require prior authorization must have an authorization number reflected on the claim form or a copy of the authorization form may be submitted with the claim.

CMS 1500 Form
If applicable, enter the Authorization Number (Field 23) and the Name of the Referring Provider (Field 17) on the claim form, to ensure efficient claims processing and handling.

5.4   ONE SELF-FUNDED MEMBER/ PROVIDER PER CLAIM FORM

- One Self-Funded Member per claim form/One Provider per claim form
- Do not bill for different Self-Funded Members on the same claim form
- Do not bill for different Providers on the same claim form.
- Separate claim forms must be completed for each Self-Funded Member and for each Provider

5.5   SUBMISSION OF MULTIPLE PAGE CLAIM

If due to space constraints you must use a second claim form, please write "continuation" at the top of the second form and attach the second claim form to the first claim with a paper clip. Enter the TOTAL CHARGE (Field 28) on the last page of your claim submission.

5.6   BILLING INPATIENT CLAIMS THAT SPAN DIFFERENT YEARS

When an inpatient claim spans different years (for example, the patient was admitted in December and was discharged in January of the following year), it is NOT necessary to submit two claims for these services. Bill all services for this inpatient stay on one claim form (if possible), reflecting the correct date of admission and the correct date of discharge.

5.7   INTERIM INPATIENT BILLS

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

5.8   SUPPORTING DOCUMENTATION FOR PAPER CLAIMS

Self-Funded claim submission requires supporting documentation for the following services:
- After Hour Medical Services
  - Supporting documentation is necessary in order to consider After Hours Medical Services and should include the following:
- Office notes
- Patient sign in sheet
- Normal office hours
- Anesthesia

Please bill with physical status codes whenever necessary for anesthesia services.

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

5.9   WHERE TO MAIL PAPER CLAIMS

Paper claims are accepted; however, EDI (electronic) submission is preferred. **No handwritten claims are accepted.** Paper claims are not accepted via fax due to Health Insurance Portability and Accountability Act (HIPAA) regulations.

> **Mail all paper claims to:**
> KPIC Self-Funded Claims Administrator
> PO Box 30547
> Salt Lake City, UT 84130-0547

5.10   ELECTRONIC DATA INTERCHANGE (EDI)

KPIC encourages electronic submission of claims. Self-Funded claims will be administered by HealthPlan Services, Inc., our contracted Third-Party Administrator (TPA). HealthPlan Services, Inc. has an exclusive arrangement with Change HealthCare for clearinghouse services. Providers can submit electronic claims directly through Change HealthCare or through another clearing house that has an established connection with Change HealthCare will aggregate electronic claims directly from Providers and other clearinghouses to route to HealthPlan Services, Inc. for adjudication.

- Optum Payor ID – 94320 (EDI claims/835 remittance)
- Navicure Payor ID – 21313 (EDI claims no 835 remittance)
- Office Ally Payor ID – 21313 (EDI claims no 835 remittance)

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

Benefits of EDI Submission
- Reduced Overhead Expenses: Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated.

- Improved Data Accuracy: Because the claims data submitted by the Provider is sent electronically, data accuracy is improved, as there is no need for re-keying or re-entry of data.

- Low Error Rate: Additionally, "up-front" edits applied to the claims data while information is being entered at the Provider's office, and additional payor-specific edits applied to the data by the Clearinghouse before the data is transmitted to the appropriate payor for processing, increase the percentage of clean claim submissions.

- Bypass US Mail Delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system.

- Standardized Transaction Formats: Industry-accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple Plan Sponsors.

5.11   SUPPORTING DOCUMENTATION FOR ELECTRONIC CLAIMS

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

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

Coordination of Benefits (COB) claims may be submitted electronically if you include primary payor payment info on the claim and specify in the notes that Explanation of Payment (EOP) is being sent via paper.

Mail all supporting documentation to:
KPIC Self-Funded Claims Administrator
PO Box 30547
Salt Lake City, UT 84130-0547

5.12   TO INITIATE EDI SUBMISSIONS

Providers initiate EDI submissions. Providers may enroll with Change HealthCare to submit EDI directly or ensure their clearinghouse of choice has an established connection with Change HealthCare. It is not necessary to notify KPIC or the TPA when you wish to submit electronically.

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

5.13   EDI SUBMISSION PROCESS

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

Providers are responsible for working their reject reports from the clearinghouse. Exceptions to TPA submission:

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

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

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

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

In addition, clearinghouses:
- Frequently supply the required PC software to enable direct data entry in the Provider's office.
- May edit the data which is electronically submitted to the clearinghouse by the Provider's office, so that the data submission may be accepted by the appropriate Plan Sponsor for processing.
- Transmit the data to the correct payor in a format easily understood by the payer's computer system.
- Transmit electronic claim status reports from Plan Sponsors to providers.

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

5.14 REJECTED ELECTRONIC CLAIMS

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

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

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

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

5.15 HIPAA REQUIREMENTS

All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and electronic loops and segments. If a Provider does not have internet access, HIPAA Implementation Guides can be ordered by calling Washington Publishing Company (WPC) at (425)562-2245.

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

5.16 COMPLETE CLAIM

A claim is considered "complete" when the following requirements are met:
- Correct Form: all professional claims should be submitted using the CMS Form 1500 and all facility claims (or appropriate ancillary services) should be submitted using the CMS Form CMS 1450 (UB04) based on CMS guidelines
- Standard Coding: All fields should be completed using industry standard coding
- Applicable Attachments: Attachments should be included in your submission when circumstances require additional information
- Completed Field Elements for CMS Form 1500 Or CMS 1450 (UB-04): All applicable data elements of CMS forms should be completed

A claim is not considered to be "complete" or payable if one or more of the following are missing or are in dispute:
- The format used in the completion or submission of the claim is missing required fields or codes are not active.
- The eligibility of a Self-Funded Member cannot be verified.
- The service from and to dates are missing
- The rendering physician is missing
- The vendor is missing
- The diagnosis is missing or invalid
- The place of service is missing or invalid
- The procedures/services are missing or invalid
- The amount billed is missing or invalid
- The number of units/quantities is missing or invalid
- The type of bill, when applicable, is missing or invalid
- The responsibility of another payor for all or part of the claim is not included or sent with the claim.
- Other coverage has not been verified.
- Additional information is required for processing such as COB information, operative report, or medical notes (these will be requested upon denial or pending of claim).
- The claim was submitted fraudulently.

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

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For further information and instruction on completing claims forms, please refer to the CMS website (www.cms.gov), where manuals for completing both the CMS 1500 and CMS 1450 (UB04) can be found in the "Regulations and Guidance/Manuals" section.

5.17   CLAIMS SUBMISSION TIMEFRAMES

Timely filing requirement for Self-Funded claim submission is based on Payor contract specifications and may vary from Payor to Payor (contract to contract). The standard timeframe for claim submission is 12 months (365 days) from the date of service, although the timeframe canvary with each Plan Sponsor.

Please contact Self-Funded Customer Service (866) 213-3062 to obtain Payor-specific information.

5.18   PROOF OF TIMELY CLAIMS SUBMISSION

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

5.19   CLAIM ADJUSTMENTS / CORRECTIONS

A claim correction can be submitted via the following procedures:
- Paper Claims – Write "CORRECTED CLAIM" in the top (blank) portion of the CMS-1500 (08/05 version) or UB-04 claim form. Attach a copy of the corresponding page of the KPIC Explanation of Payment (EOP) to each corrected claim. Mail the corrected claim(s) to KPIC using the standard claims mailing address

- Electronic Claims (CMS-1500) – Corrections to CMS-1500 claims which were already accepted (regardless of whether these claims were submitted on paper or electronically) should be submitted on paper claim forms. Corrections submitted electronically may inadvertently be denied as a duplicate claim. If corrected claims for CMS-1500 are submitted electronically, Providers should contact Self-Funded Customer Service to identify the corrected claim electronic submission.

- Electronic Claims (UB-04) – Please include the appropriate Type of Bill code when electronically submitting a corrected UB-04 claim for processing. IMPORTANT: Claims submitted without the appropriate 3rd digit (XXX) in the "Type of Bill" code will be denied.

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

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5.20   INCORRECT CLAIMS PAYMENTS

Please follow the following procedures when an incorrect payment is identified on the Explanation of Payment (EOP):

- Underpayment Error – Write or call Self-Funded Customer Service (866) 213-3062 and explain the error. Upon verification of the error, appropriate corrections will be made by the TPA, and the underpayment amount owed will be added to/reflected in the next payment.

- Overpayment Error – There are two options to notify the TPA of overpayment errors:
  - Write or call Self-Funded Customer Service and explain the error. Appropriate corrections will be made, and the overpayment will be automatically deducted from the next payment.
  - Write a refund check to Kaiser Permanente Insurance Co. (KPIC) for the exact excess amount paid by KPIC within the timeframe specified by the Agreement. Attach a copy of the KPIC Explanation of Payment (EOP) to your refund check, as well as a brief note explaining the error.

    Mail the refund check to:

    Kaiser Permanente Insurance Co.
    P.O. Box 741025, Los Angeles, CA 90074-102

    You may also explain the error by writing to:
    Kaiser Permanente Insurance Company
    Attn: Provider Reconsideration
    PO Box 30547
    Salt Lake City, UT 84130-0547

If for some reason an overpayment refund is not received by KPIC within the terms and timeframe specified by the Agreement, the TPA on behalf of KPIC may deduct the refund amount from future payments.

Additional specifications with other Plan Sponsors for Self-Funded products will supersede terms specified here.

5.21   FEDERAL TAX ID NUMBER

The Federal Tax ID Number as reported on any and all claim form(s) must match the information filed with the Internal Revenue Service (IRS).
1. When completing IRS Form W-9, please note the following:
   - Name: This should be the equivalent of your "entity name," which you use to file your tax forms with the IRS.
   - Sole Provider/Proprietor: List your name, as registered with the IRS.

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- Group Practice/Facility: List your "group" or "facility" name, as registered with the IRS.

2. Business Name: Leave this field blank unless you have registered with the IRS as a "Doing Business As" (DBA) entity. If you are doing business under a different name, enter that name on the IRS Form W-9.

3. Address/City, State, and Zip Code: Enter the address where Kaiser Permanente should mail your IRS Form 1099.

4. Taxpayer Identification Number (TIN): The number reported in this field (either the social security number or the employer identification number) MUST be used on all claims submitted to Kaiser Permanente.

- Sole Provider/Proprietor: Enter your taxpayer identification number, which will usually be your social security number (SSN), unless you have been assigned a unique employer identification number (because you are "doing business as" an entity under a different name).

- Group Practice/Facility: Enter your taxpayer identification number, which will usually be your unique employer identification number (EIN).

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

www.irs.gov/formspubs

Completed IRS Form W-9 should be mailed to the following address:

Kaiser Permanente
Network Development & Administration
393 E. Walnut Street, Pasadena, CA 91188

IMPORTANT: If your Federal Tax ID Number should change, please notify us immediately, so that appropriate corrections can be made to Kaiser Permanente's files.

5.22 SELF-FUNDED MEMBER COST SHARE

Please verify applicable Self-Funded Member cost share at the time of service.

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

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Cost Share information can be obtained from:

OPTION	DESCRIPTION
#1	Self-Funded Customer Service Department Telephone (866) 213-3062 Monday - Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET). Self-Service IVR System is available 24 hours / 7 days a week
#2	HealthPlan Services, Inc. Website https://kpclaimservices.com/ 24 hours / 7 days a week
#3	Self-Funded ID card may include Co-payments, co-insurance and deductible information are listed on the front of the Self-Funded ID card

5.23   SELF-FUNDED MEMBER CLAIMS INQUIRIES

Call the Self-Funded Customer Service Department at (866) 213-3062, Monday - Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET).

5.24   BILLING FOR SERVICES PROVIDED TO VISITING SELF-FUNDED MEMBERS

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

- Claims must be submitted to the "Mail claims to" in back of the Self-Funded Member's Health Insurance ID Card.

    If the Member does not have their Health Insurance ID Card, submit your claims to:
    KPIC Self-Funded Claims Administrator
    P.O Box 30547
    Salt Lake City, UT 84130-0547

- **Always** use the visiting Member's "Host" region (the region the Member is visiting and where the services are rendered) MRN (ID number on the card) on the claim form.

- Claims for services requiring prior KP authorization **must** include the authorization number. Please contact KPIC Self-Funded Claims Administrator Customer Service at (866) 213-3062 during the hours of 7:00 am to 9:00 pm EST.

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5.25   CODING FOR CLAIMS

The terms of your Agreement govern the amount of payment for services provided under your Agreement. The following general rules apply to our payment policies.

Kaiser Permanente's claims policies for provider services follow industry standards as defined by the AMA and CMS and including those specified in Section 5.27 below. Routinely updated code editing software from a leading national vendor is used for processing all relevant bills in a manner consistent with the Medicare Correct Coding Initiative and CPT guidelines. Our claims adjudication systems accept and identify all active CPT and HCPC Codes as well as all coding modifiers. Payment for services such as multiple procedures, bilateral procedures, assistant surgeons, co-surgeons, and application of modifiers are paid in accordance with Medicare guidelines. When applicable, we request supportive documentation for "unlisted" procedure codes and the application of Modifier 26.

Incorrect and invalid coding, and coding that does not comply with commonly accepted standards adopted by Kaiser Permanente, may result in delays in payment or denial of payment. We do not allow code unbundling for procedures for which Medicare requires all-inclusive codes, and we will re-bundle the procedures and pay according to Medicare's all-inclusive codes.

If your Agreement so provides, Kaiser Permanente uses reasonable and customary rates to pay for those services that are not subject to contracted rates. Reasonable and Customary rates are determined using a statistically credible database updated at least annually.

5.26   CODING STANDARDS

Coding

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

ICD-10

To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 10th Revision-Clinical Modification (ICD-10-CM) developed by the Commission on Professional and Hospital Activities.

CPT-4

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

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If you would like to request a new code or suggest deleting or revising an existing code, obtain and complete a form from the AMA's Web site at https://www.ama-assn.org/practice-management/cpt/code-change-instructions or submit your request and supporting documentation to:

CPT Editorial Research and Development American Medical Association
515 North State Street Chicago, IL 60610

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

Revenue Code
Approved by the Health Services Cost Review Commission for a hospital located in the State of Maryland, or of the national or state uniform billing data elements specifications for a hospital not located in that State.

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

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

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

5.27   MODIFIERS IN CPT AND HCPCS

Modifiers submitted with an appropriate procedure code further define and/or explain a service provided. Valid modifiers and their descriptions can be found in the most current CPT or HCPCS coding book. Note CMS-1500 Submitters: The TPA will process up to 4 modifiers per claim line.

When submitting claims, use modifiers to:
- Identify distinct or independent services performed on the same day
- Reflect services provided and documented in a patient's medical record

5.28   MODIFIER REVIEW

The TPA will adjudicate modifier usage based on Current Procedural Terminology (CPT) guidelines. Providers are required to use modifiers according to standards and code(s) set forth in CPT4 manuals.

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

5.29 CODING & BILLING VALIDATION

For Self-Funded products, KPIC utilizes a Third-Party Administrator (TPA), HealthPlan Services, Inc., to process claims. The TPA reviews and adjusts claims in accordance with the terms of your Agreement, this Provider Manual and applicable law.

ClaimCheck release 8.5.39 by McKesson is a commercial code editor application utilized by our TPA for the Self-Funded product to evaluate and ensure accuracy of outpatient claims data including HCPCS and CPT codes as well as associated modifiers. ClaimCheck provides a set of rules with complex coding situations and specifies when certain combinations of codes that have been billed by a Provider are inappropriate. This process is intended to result in accurate coding and consistent claims payment procedures.

5.30 CMS-1500

The fields identified in the table below as "Required" must be completed when submitting a CMS-1500 (08/05) claim form to Kaiser Permanente Insurance Company for processing:

Note: The new CMS-1500 (08/05) form is revised to accommodate National Provider Identifiers (NPI).

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
1	MEDICARE/ MEDICAID/ TRICARE CHAMPUS/ CHAMPVA/ GROUP HEALTH PLAN/FECA BLK LUNG/OTHER	Not Required	Check the type of health insurance benefit applicable to this claim by checking the appropriate box.
1a	INSURED'S I.D. NUMBER	Required	Enter the subscriber's plan identification number.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
2	PATIENT'S NAME	Required	Enter the patient's name. When submitting newborn claims, enter the newborn's first and last name.
3	PATIENT'S BIRTH DATE AND SEX	Required	Enter the patient's date of birth and gender. The date of birth must include the month, day and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006
4	INSURED'S NAME	Required	Enter the name of the insured (Last Name, First Name, and Middle Initial), unless the insured and the patient are the same— then the word "SAME" may be entered.
5	PATIENT'S ADDRESS	Required	Enter the patient's mailing address and telephone number. On the first line, enter the STREET ADDRESS; the second line is for the CITY and STATE; the third line is for the ZIP CODE and PHONE NUMBER.
6	PATIENT'S RELATIONSHIP TO INSURED	Required if Applicable	Check the appropriate box for the patient's relationship to the insured.
7	INSURED'S ADDRESS	Required if Applicable	Enter the insured's address (STREET ADDRESS, CITY, STATE, and ZIP CODE) and telephone number. When the address is the same as the patient's—the word "SAME" may be entered.
8	PATIENT STATUS	Required if Applicable	Check the appropriate box for the patient's MARITAL STATUS, and check whether the patient is EMPLOYED or is a STUDENT.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
9	OTHER INSURED'S NAME	Required if Applicable	When additional insurance benefit exists, enter the last name, first name and middle initial of the insured.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Required if Applicable	Enter the policy and/or group number of the insured individual named in Field 9 (Other Insured's Name) above. NOTE: *For each entry in Field 9A, there must be a corresponding entry in Field 9d.*
9b	OTHER INSURED'S DATE OF BIRTH/SEX	Required if Applicable	Enter the "other" insured's date of birth and sex. The date of birth must include the month, day, and FOUR DIGITS for year (MM/DD/YYYY). *Example*: 01/05/2006
9c	EMPLOYER"S NAME OR SCHOOL NAME	Required if Applicable	Enter the name of the "other" insured's EMPLOYER or SCHOOL NAME (if a student).
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Required if Applicable	Enter the name of the "other" insured's INSURANCE PLAN or program.
10a-c	IS PATIENT CONDITION RELATED TO	Required	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. NOTE: *If "yes" there must be a corresponding entry in Field 14 (Date of Current Illness/Injury).* Place (State) - enter the State postal code
10d	RESERVED FOR LOCAL USE	Not Required	Leave blank.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
11	INSURED'S POLICY NUMBER OR FECA NUMBER	Required if Applicable	If there is insurance primary to Medicare, enter the insured's policy or group number.
11a	INSURED'S DATE OF BIRTH	Required if Applicable	Enter the insured's date of birth and sex, if different from Field 3. The date of birth must include the month, day, and FOUR digits for the year (MM/DD/YYYY). <u>Example:</u> 01/05/2006.
11b	EMPLOYER'S NAME OR SCHOOL NAME	Not Required	Enter the name of the employer or school (if a student), if applicable.
11c	INSURANCE PLAN OR PROGRAM NAME	Required if Applicable	Enter the insurance plan or program name.
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required	Check "yes" or "no" to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If "yes" then fields 9 and 9a-d must be completed.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not Required	Have the patient or an authorized representative SIGN and DATE this block unless the signature is on file. If the patient's representative signs, then the relationship to the patient must be indicated.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not Required	Have the patient or an authorized representative SIGN this block unless the signature is on file.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
14	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	Required if Applicable	Enter the date of the current illness or injury. If pregnancy, enter the date of the patient's last menstrual period. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). <u>Example</u>: 01/05/2006
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	Not Required	Enter the previous date the patient had a similar illness, if applicable. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). <u>Example</u>: 01/05/2006
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not Required	Enter the "from" and "to" dates that the patient is unable to work. The dates must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). <u>Example</u>: 01/05/2003
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required if Applicable	Enter the FIRST and LAST NAME of the referring or ordering physician.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
17a	OTHER ID #	Not Required	In the shaded area, enter the non-NPI ID number of the physician whose name is listed in Field 17. Enter the qualifier identifying the number in the field to the right of 17a. The NUCC defines the following qualifiers: 0B - State License Number 1B - Blue Shield Provider Number 1C - Medicare Provider Number 1D - Medicaid Provider Number 1G - Provider UPIN Number 1H - CHAMPUS Identification Number EI - Employer's Identification Number G2 - Provider Commercial Number LU - Location Number N5 - Provider Plan Network Identification Number SY - Social Security Number X5 - State Industrial Accident Provider Number ZZ - Provider Taxonomy
17b	NPI NUMBER	Required	In the non-shaded area enter the NPI number of the referring
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not Required	Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	RESERVED FOR LOCAL USE	Required if Applicable	If you are "covering" for another physician, enter the name of the physician (for whom you are covering) in this field. If a non-contracted provider will be covering for you in your absence, please notify that individual of this requirement.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
20	OUTSIDE LAB CHARGES	Not Required	
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Required	Enter the diagnosis/condition of the patient, indicated by an ICD-10-CM code number. Enter up to 4 diagnostic codes, in PRIORITY order (primary, secondary condition).
22	MEDICAID RESUBMISSION	Not Required	
23	PRIOR AUTHORIZATION NUMBER	Required if Applicable	Enter the prior authorization number for those procedures requiring prior approval.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24a-g	SUPPLEMENTAL INFORMATION	Required	Supplemental information can only be entered with a corresponding, completed service line.
			The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.
	SUPPLEMENTAL		When reporting additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP – HIBCC codes, OZ – GTIN codes or contract rate, enter the applicable qualifier and umber/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/information.
			The following qualifiers are to be used when reporting these services. 7 - Anesthesia information ZZ - Narrative description of unspecified code N4 - National Drug Codes (NDC) VP - Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard OZ - Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) CTR - Contract rate

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24a	DATE(S) OF SERVICE	Required	Enter the month, day, and year (MM/DD/YY) for each procedure, service, or supply. Services must be entered chronologically (starting with the oldest date first). For each service date listed/billed, the following fields must also be entered: *Units, Charges/Amount/Fee, Place of Service, Procedure Code, and corresponding Diagnosis Code.* IMPORTANT: Do not submit a claim with a future date of service. Claims can only be submitted once the service has been rendered (for example: durable medical equipment).
24b	PLACE OF SERVICE	Required	Enter the place of service code for each item used or service performed.
24c	EMG	Required if Applicable	Enter Y for "YES" or leave blank if "NO" to indicate an EMERGENCY as defined in the electronic 837 Professional 4010A1 implementation guide.
24d	PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER	Required	Enter the CPT/HCPCS codes and MODIFIERS (if applicable) reflecting the procedures performed, services rendered, or supplies used. IMPORTANT: Enter the anesthesia time, reported as the "beginning" and "end" times of anesthesia in military time above the appropriate procedure code.

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FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24e	DIAGNOSIS POINTER	Required	Enter the diagnosis code reference number (pointer) as it relates the date of service and the procedures shown in Field 21, When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained. IMPORTANT: (ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.)
24f	$ CHARGES	Required	Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc.). Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24g	DAYS OR UNITS	Required	Enter the number of days or units in this block. (For example: units of supplies, etc.) When entering the NDC units in addition to the HCPCS units, enter the applicable NDC 'units' qualifier and related units in the shaded line. The following qualifiers are to be used: F2 - International Unit ML - Milliliter GR - Gram UN Unit
24h	EPSDT FAMILY PLAN	Not Required	
24i	ID. QUAL	Required	Enter in the shaded area of 24I the qualifier identifying if the number is a non- NPI. The Other ID# of the rendering Provider is reported in 24J in the shaded area. The NUCC defines the following qualifiers: 0B - State License Number 1B - Blue Shield Provider Number 1C - Medicare Provider Number 1D - Medicaid Provider Number 1G - Provider UPIN Number 1H - CHAMPUS Identification Number EI - Employer's Identification Number G2 - Provider Commercial Number LU - Location Number N5 - Provider Plan Network Identification Number SY - Social Security Number (The social security number may not be used for Medicare.) X5 - State Industrial Accident Provider Number ZZ - Provider Taxonomy

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24j	RENDERING PROVIDER ID #	Required	Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the non-shaded area of the field. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.
25	FEDERAL TAX ID NUMBER	Required	Enter the physician/supplier federal tax I.D. number or Social Security number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. IMPORTANT: The Federal Tax ID Number in this field must match the information on file with the IRS.
26	PATIENT'S ACCOUNT NO.	Required	Enter the Self-Funded Members account number assigned by the Provider's/Provider's accounting system. IMPORTANT: This field aids in patient identification by the Provider/Provider.
27	ACCEPT ASSIGNMENT	Not Required	
28	TOTAL CHARGE	Required	Enter the total charges for the services rendered (total of all the charges listed in Field 24f).
29	AMOUNT PAID	Required if Applicable	Enter the amount paid (i.e., Patient co- payments or other insurance payments) to date in this field for the services billed.
30	BALANCE DUE	Not Required	Enter the balance due (total charges less amount paid).

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Required	Enter the signature of the physician/supplier or his/her representative, and the date the form was signed. For claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.
32	SERVICE FACILITY LOCATION INFORMATION	Required if Applicable	The name and address of the facility where services were rendered (if other than patient's home or physician's office). Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code Do not use commas, periods, or other punctuation in the address (e.g., "123 N Main Street 101" instead of "123 N. Main Street, #101"). Enter a space between the town name and state code; do not include a comma. When entering a 9-digit zip code, include the hyphen.
32a	NPI #	Required	Enter the NPI number of the service facility.
32b	OTHER ID #	Required	Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.
33	BILLING PROVIDER INFO & PH #	Required	Enter the name, address, and phone number of the billing entity.
33a	NPI #	Required	Enter the NPI number of the service facility location in 32a.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY — SEX M F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No., Street)

CITY | STATE | 8. PATIENT STATUS Single Married Other | CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( ) | Employed Full-Time Student Part-Time Student | ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F | b. AUTO ACCIDENT? YES NO PLACE (State) | b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE | 20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. _____ 3. _____
2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI
2									NPI
3									NPI
4									NPI
5									NPI
6									NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED _____ DATE _____

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

5.31 CMS-1450 (UB-40) FIELD DESCRIPTIONS

[Note: For Self-Funded paper claims submission, Kaiser Permanente will only accept the UB-04 form for facility services billing.]

The fields identified in the table below as "Required" must be completed when submitting a CMS-1450 (UB-04) claim form to Kaiser Permanente Insurance Company for processing:

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM	INSTRUCTIONS/EXAMPLES
1	PROVIDER NAME and ADDRESS	Required	Enter the name and address of the billing provider which rendered the services being billed.
2	PAY-TO NAME, ADDRESS, CITY/STATE	Required if Applicable	Enter the name and address of the billing provider's designated pay-to entity.
3a	PATIENT CONTROL NUMBER	Required	Enter the patient's account number assigned by the Provider's accounting system, i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider.
3b	MEDICAL/HEALT H RECORD NUMBER	Required if Applicable	Enter the number assigned to the patient's medical/health record by the Provider. (Note: this is not the same as either Field 3a or Field 60)
4	TYPE OF BILL	Required	Enter the appropriate code to identify the specific type of bill being submitted. This code is required for the correct identification of inpatient vs. outpatient claims, voids, etc.
5	FEDERAL TAX NUMBER	Required	Enter the federal tax ID of the hospital or person entitled to reimbursement in NN- NNNNNNN format.
6	STATEMENT COVERS PERIOD	Required	Enter the beginning and ending date of service included in the claim.
7	BLANK	Not Required	Leave blank.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSION	INSTRUCTIONS/EXAMPLES
8a, b	PATIENT NAME/ID	Required	Enter the patient's name, together with the patient's ID (if different than the insured's ID).
9	PATIENT ADDRESS	Required	Enter the patient's mailing address.
10	PATIENT BIRTH DATE	Required	Enter the patient's birth date in MM/DD/YYYY format.
11	PATIENT SEX	Required	Enter the patient's gender.
12	ADMISSION DATE	Required if Applicable	For inpatient and Home Health claims only, enter the date of admission in MM/DD/YYYY format.
13	ADMISSION HOUR	Required	For either inpatient OR outpatient care, enter the 2-digit code for the hour during which the patient was admitted or seen.
14	ADMISSION TYPE	Required	Indicate the type of admission (e.g., emergency, urgent, elective, and newborn).
15	ADMISSION SOURCE	Required	Enter the code for the point of origin of the admission or visit.
16	DISCHARGE HOUR (DHR)	Required if Applicable	Enter the 2-digit code for the hour during which the patient was discharged.
17	PATIENT STATUS	Required	Enter the discharge status code as of the "Through" date of the billing period.
18–28	CONDITION CODES	Required if Applicable	Enter any applicable codes which identify conditions relating to the claim that may affect claims processing.
29	ACCIDENT (ACDT) STATE	Not Required	Enter the two-character code indicating the state in which the accident occurred which necessitated medical treatment.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSION	INSTRUCTIONS/EXAMPLES
30	BLANK	Not Required	Leave blank.
31-34	OCCURRENCE CODES AND DATES	Required if Applicable	Enter the code and the associated date (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
35-36	OCCURRENCE SPAN CODES AND DATES	Required if Applicable	Enter the occurrence span code and associated dates (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
37	BLANK	Not Required	Leave blank.
38	RESPONSIBLE PARTY	Not Required	Enter the name and address of the financially responsible party.
39–41	VALUE CODES and AMOUNT	Required if Applicable	Enter the code and related amount/value which is necessary to process the claim.
42	REVENUE CODE	Required	Identify the specific accommodation, ancillary service, or billing calculation, by assigning an appropriate revenue code to each charge.
43	REVENUE DESCRIPTION	Required if Applicable	Enter the narrative revenue description or standard abbreviation to assist clerical bill review.
44	PROCEDURE CODE AND MODIFIER	Required if Applicable	For ALL outpatient claims, enter BOTH a revenue code in Field 42 *(Rev. CD.),* and the corresponding CPT/HCPCS procedure code in this field.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
45	SERVICE DATE	Required	Outpatient Series Bills: A service date must be entered for all outpatient series bills whenever the "from" and "through" dates in Field 6 (*Statement Covers Period: From/Through*) are not the same. Submissions that are received without the required service date(s) will be rejected with a request for itemization. Multiple/Different Dates of Service: Multiple/different dates of service can be listed on ONE claim form. List each date on a separate line on the form, along with the corresponding revenue code (*Field 42)*, procedure code (*Field 44*), and total charges (*Field 47*).
46	UNITS OF SERVICE	Required	Enter the units of service to quantify each revenue code category.
47	TOTAL CHARGES	Required	Indicate the total charges pertaining to each related revenue code for the current billing period as listed in Field 6
48	NON-COVERED CHARGES	Required if Applicable	Enter any non-covered charges.
49	BLANK	Not Required	Leave blank.
50	PAYER NAME	Required	Enter (in appropriate ORDER on lines A, B, and C) the NAME and NUMBER of each payer organization from which you are expecting payment towards the claim.
51	HEALTH PLAN ID	Not Required	Enter the KP national health plan identification number.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
52	RELEASE OF INFORMATION (RLS INFO)	Required if Applicable	Enter the release of information certification indicator(s).
53	ASSIGNMENT OF BENEFITS (ASG BEN)	Required	Enter the assignment of benefits certification indicator.
54A-C	PRIOR PAYMENTS	Required if Applicable	If payment has already been received toward the claim by one of the payers listed in Field 50 (*Payer*) prior to the billing date, enter the amounts here.
55	ESTIMATED AMOUNT DUE	Required if Applicable	Enter the estimated amount due from patient. Do not report collection of patient's cost share.
56	NATIONAL PROVIDER IDENTIFIER (NPI)	Required	Enter the billing provider's NPI.
57	OTHER PROVIDER ID	Required	Enter the service Provider's Kaiser-assigned Provider ID, if any.
58	INSURED'S NAME	Required	Enter the insured's name, i.e., policyholder.
59	PATIENT'S RELATION TO INSURED	Required	Enter the patient's relationship to the insured.
60	INSURED'S UNIQUE ID	Required	Enter the patient's KP Medical Record Number (MRN).
61	INSURED'S GROUP NAME	Required if Applicable	Enter the insured's group name.
62	INSURED'S GROUP NUMBER	Required if Applicable	Enter the insured's group number. For Prepaid Services claims enter "PPS".

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
63	TREATMENT AUTHORIZATION CODE	Required if Applicable	For ALL inpatient and outpatient claims, enter the KP referral number, if applicable, for the episode of care being billed. Note: this is a 10-digit alphanumeric identifier
64	DOCUMENT CONTROL NUMBER	Not Required	Enter the document control number related to the patient or the claim as assigned by KP.
65	EMPLOYER NAME	Required if Applicable	Enter the name of the insured's (Field 58) employer.
66	DX VERSION QUALIFIER	Not Required	Indicate the ICD version indicator of codes being reported. NOTE: At the time of printing, Kaiser only accepts ICD-9-CM diagnosis codes on the UB-04.
67	PRINCIPAL DIAGNOSIS CODE	Required	Enter the principal diagnosis code, on all inpatient and outpatient claims. The diagnosis code must be carried to its highest degree of detail, including the Present on Admission (POA) indicator, if applicable.
68	BLANK	Not Required	Leave blank.
69	ADMITTING DIAGNOSIS	Required	Enter the admitting diagnosis code on all inpatient claims.
70a-c	REASON FOR VISIT (PATIENT REASON DX)	Required if Applicable	Enter the diagnosis codes indicating the patient's reason for outpatient visit at the time of registration.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
71	PPS CODE	Required if Applicable	Enter the DRG number to which the procedures group, even if you are being reimbursed under a different payment methodology.
FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
72	EXTERNAL CAUSE OF INJURY CODE (ECI)	Required if Applicable	Enter an ICD-10-CM "ECI-code" in this field *(if applicable)*.
73	BLANK	Not required	Leave blank.
74	PRINCIPAL PROCEDURE CODE AND DATE	Required if Applicable	Enter the ICD-10-CM procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed *(if applicable)*.
74a-e	OTHER PROCEDURE CODES AND DATES	Required if Applicable	Enter other ICD-10-CM procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims *(in fields "a" through "e")* for any additional surgical and/or obstetrical procedures which were performed *(if applicable)*.
75	BLANK	Not required	Leave blank.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
76	ATTENDING PHYSICIAN / NPI / QUAL / ID	Required	Enter the individual NPI number and the name of the attending physician for inpatient bills or the KP physician that requested the outpatient services. Inpatient Claims—Attending Physician Enter the full name (*first and last name*) of the physician who is responsible for the care of the patient. Outpatient Claims—Referring Physician For ALL outpatient claims, enter the full name (*first and last name*) of the KP physician who referred the Patient for the outpatient services billed on the claim.
77	OPERATING PHYSICIAN / NPI/ QUAL/ ID	Required If Applicable	Enter the individual NPI number and the name of the lead surgeon who performed the surgical procedure.
78–79	OTHER PHYSICIAN/ NPI/ QUAL/ ID	Required if Applicable	Enter the individual NPI numbers and names of any other physicians.
80	REMARKS	Not Required	Special annotations may be entered in this field.
81	CODE-CODE	Required if Applicable	Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate.

5.32   COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) is a method for determining the order in which benefits are paid and the amounts which are payable when a Patient is covered under more than one plan. COB allows benefits from multiple health benefit plans or carriers to be considered cumulatively so the Member receives the maximum benefit from their primary and secondary health benefit plans together. In addition, it is intended to prevent duplication of benefits when an individual is covered by multiple plans providing benefits or services for medical or other care and treatment.

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

How to Determine the Primary Payer

1. The benefits of the plan that covers an individual as an employee, Patient, or subscriber other than as a dependent are determined before those of a plan that covers the individual as a dependent.

2. When both parents cover a child, the "birthday rule" applies – the payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor.

When determining the primary payor for a child of separated or divorced parents, inquire about the court agreement or decree. In the absence of a divorce decree/court order stipulating parental healthcare responsibilities for a dependent child, insurance benefits for that child are applied according to the following order:

Insurance carried by the
1. Natural parent with custody pays first
2. Stepparent with custody pays next
3. Natural parent without custody pays next
4. Stepparent without custody pays last

If the parents have joint custody of the dependent child, then benefits are applied according to the birthday rule referenced above. If this does not apply, call Self-Funded Customer Service at (866) 213-3062 Mon. – Fri. 7A.M. to 9P.M. EST.

1. The Self-Funded plan is generally primary for working Medicare-eligible Members when the CMS Working Aged regulation applies.

2. In cases of work-related injuries, Workers Compensation is primary unless coverage for the injury has been denied.

3. In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. Submit the claim as if the Self-Funded plan is the primary payor. TPA will follow their standard "pay and chase" procedures.

5.33.1   Description of COB Payment Methodologies

Coordination of Benefits allows benefits from multiple carriers to be added on top of each other so that the Self-Funded Member receives the full benefits from their primary carrier and the secondary carrier pays their entire benefit up to 100% of allowed charges.

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

5.33.2   COB Claims Submission Requirements and Procedures

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

Electronic Claims:
If the Self-Funded plan is the secondary payor, send the completed electronic claim with the payment fields from the primary insurance carrier entered as follows:

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

Paper Claims:
If the Self-Funded plan is the secondary payor, send the completed claim form with a copy of the corresponding Explanation of Payment (EOP) or Explanation of Medicare Benefits (EOMB)/Medicare Summary Notice (MSN) from the primary insurance carrier attached to the paper claim to ensure efficient claims processing/adjudication. The TPA (Self-Funded) cannot process a claim without an EOP or EOMB/MSN from the primary insurance carrier.

- CMS-1500 claim form: Complete Field 29 (Amount Paid)
- CMS-1450 claim form: Complete Field 54 (Prior Payments)

5.33.3   Self-Funded Members Enrolled in Two Kaiser Permanente Plans

Some Self-Funded Members may be enrolled under two separate plans offered through Kaiser Permanente (dual coverage). In these situations, Providers need only submit ONE claim under the primary plan and send to either HealthPlan Services, Inc. (for Self-Funded

KAISER PERMANENTE.

plan) or Kaiser Permanente (for fully insured plan) depending on which plan is primary.

5.33.4   COB Claims Submission Timeframes

If a Self-Funded plan is the secondary payor, any Coordination of Benefits (COB) claims must be submitted for processing within the timely filing period as specified according to the standard claims' submission timeframe.

5.33.5   COB FIELDS ON THE UB-04 CLAIM FORM

The following fields should be completed on the <u>**CMS- 1500 (UB-04)**</u> claim form to ensure timely and efficient claims processing. Incomplete, missing, or erroneous COB information in these fields may cause claims to be denied <u>or </u>pended and reimbursements delayed. For additional information, refer to the current <u>*UB-04 National   Uniform Billing Data Element Specifications Manual*</u>.

Claims submitted <u>electronically </u>must meet the same data requirements as paper claims. For **electronic claim submissions**, refer to a HIPAA website for additional information on electronic loops and segments.

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2300 H1	**32-35** (UB-92) **31-36** (UB-04)	**OCCURRENCE CODE/DATE**	Enter the appropriate occurrence code and date defining the specific event(s) relating to the claim billing period. <u>**NOTE**</u>: If the injuries are a result of an accident, please complete **Field 77 (E-Code)**

2330B NM	50	PAYER *(Payer Identification)*	Enter the **name** and **number** *(if known)* for each **payer organization** from whom the Provider expects (or has received) payment towards the bill. List payers in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer
837I LOOP #	**FIELD NUMBER**	**FIELD NAME**	**INSTRUCTIONS/EXAMPLES**
2320 AMT	**54**	PRIOR PAYMENTS *(Payers and Patient)*	Enter the **amount(s)**, if any, that the Provider has received **toward payment of the bill** <u>PRIOR</u> to the billing date, by the indicated payer(s). List prior payments in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2330A NM	**58**	INSURED'S NAME	Enter the **name** *(Last Name, First Name)* of the individual in whose name insurance is being carried. List entries in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer <u>**NOTE**</u>**:** For each entry in *Field 58,* there MUST be corresponding entries in *Fields 59 <u>through</u> 62* AND *64 <u>through</u> 65 (Field 65 only on the UB-04).*

2320 SBR	59	Patient's Relationship To Insured	Enter the **code** indicating the **relationship** of the patient to the insured individual(s) listed in **Field 58** *(Insured's Name).* List entries in the **following order:** A = **primary** payer B = **secondary** payer C = **tertiary** payer
2330A NM	60	**CERT. – SSN – HIC – ID NO.** *(Certificate/Social Security Number/Health Insurance Claim/Identificatio n Number)*	Enter the insured person's *(listed in Field 58)* unique **individual member identification number** (medical/health record number), as assigned by the payer organization. List entries in the **following order:** A = **primary** payer B = **secondary** payer C = **tertiary** payer

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2320 SBR	61	**GROUP NAME** *(Insured Group Name)*	Enter the **name** of the **group or plan** through which the insurance is being provided to the insured individual *(listed in Field 58).* Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2320 SBR	62	**INSURANCE GROUP NO.**	Enter the **identification number**, **control number**, or **code** assigned by the carrier or administrator to identify the **GROUP** under which the individual *(listed in Field 58)* is covered. List entries in the **following order**: A = **primary** payer B = **secondary** payer **C =** tertiary **payer**

2320 SBR	64	ESC (Employment Status Code of the Insured) Note: This field was deleted from the UB-04.	Enter the code used to define the **employment status** of the insured individual (listed in Field 58). Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2320 SBR	65	EMPLOYER NAME (Employer Name of the Insured)	Enter the **name of the employer** who provides health care coverage for the insured individual (listed in Field 58). Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2300 H1	67-76 (UB-92) 67 A-Q (UB-04)	DIAGNOSIS CODE	The **primary diagnosis** code should be reported in **Field 67**. Additional diagnosis code can be entered in **Field 68-76.**
2300H1	77 (UB-92) 72 (UB-04)	EXTERNAL CAUSE OF INJURY CODE (E-CODE)	If applicable, enter an ICD-10- CM "ECI-code" in this field.

5.33.6 COB FIELDS ON THE CMS-1500 (08/05) CLAIM FORM

The following fields should be completed on the CMS-1500 (08/05) claim form, to ensure timely and efficient claims processing. Incomplete, missing, or erroneous COB information in these fields may cause claims to be denied or pended and reimbursements delayed.

Claims submitted electronically must meet the same data requirements as paper claims. For electronic claim submissions, refer to a HIPAA website for additional information on electronic loops and segments.

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2330A NM	9	OTHER INSURED'S NAME	When **additional** insurance coverage exists (through a spouse, parent, etc.) enter the LAST NAME, FIRST NAME, and MIDDLE INITIAL of the insured. **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**
2330A NM	9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the policy and/or group number of the insured individual named in **Field 9**. If you do not know the policy number, enter the Social Security number of the insured individual. **NOTE: Field 9a must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).** **NOTE: For each entry in this field, there must be a corresponding Entry in 9d (Insurance Plan Name or Program Name).**

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2320 DMG	9b	OTHER INSURED'S DATE OF BIRTH/SEX	Enter date of birth and sex, of the insured named in **Field 9**. The date of birth must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). **Example: 01/05/1971** **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**
N/A	9c	EMPLOYER'S NAME or SCHOOL NAME	Enter the name of the employer or school name (if a student), of the insured named in **Field 9**. **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**
2330B NM	9d	INSURANCE PLAN NAME or PROGRAM NAME	Enter the name of the insurance plan or program, of the insured individual named in **Field 9** **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**
2300 CLM	10	IS PATIENT'S CONDITION RELATED TO: Employment? Auto Accident? Other Accident? PLACE (State)	Check "yes" or "no" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in **Field 24**. **NOTE: If yes, there must be a corresponding entry in Field 14 (Date of Current Illness/ Injury) and in Field 21 (Diagnosis).** **PLACE (State)** Enter the state the Auto Accident occurred in.

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
N/A	11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Check "yes" or "no" to indicate if there is <u>another health benefit plan</u>. (For example, the patient may be covered under insurance held by a spouse, parent, or some other person). **<u>NOTE</u>: If "yes," then Field Items 9 and 9a-d must be completed.**

2300 DTP	14	DATE OF CURRENT
		  --Illness
		(First symptom)
		  --Injury (Accident)
		  --Pregnancy (LMP)
			Enter the date of the current illness or injury. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY).
			
			Example: 01/05/2004

2300 H1	21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the diagnosis and if applicable, enter the Supplementary Classification of External Cause of Injury and Poisoning Code. **<u>NOTE</u>: This field must be completed when there is an entry in Field 10 (Is The Patient's Condition Related To).**
2320 AMT	29	AMOUNT PAID	Enter the amount paid by the primary insurance carrier in Field 29.

5.33 EXPLANATION OF PAYMENT (EOP)

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Kaiser Permanente Insurance Company
PO BOX 30547
SALT LAKE CITY UT 84130

ATLANTA ORTHOPAEDIC FOOT
550 PEACHTREE ST NE STE 1165
ATLANTA   GA 30306

Client: 4K KAI   WHITE STOCK

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 581080740AA5
TAX#: 581080740
DATE: 05/25/2008
Draft #: 00001481
EDI Payer ID.   95266

PATIENT NAME ACCOUNT #	MEMBER ID # CLAIM #	DATES OF SERVICE	CODE	SUBMITTED CHARGES	NEGOTIATED DISCOUNT	EXPL CODE	NON COVD CHARGES	ALLOWED AMOUNT	COPAY	DEDUCTIBLE	CO-INS	TOTAL BENEFITS
CAROL BRADY 123	123456789 081440139-00	PLAN: TEST100										
		03/03/08 - 03/03/08	POV 99214	257.00	257.00	U24	.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	SUM 20610	218.00	.00	P9	114.09	103.91	15.00	.00	.00	88.91
		03/03/08 - 03/03/08	PHM J3301	16.00	.00	P9	14.56	1.44	1.44	.00	.00	.00
		03/03/08 - 03/03/08	PHM J2001	10.00	10.00	U03	.00	.00	.00	.00	.00	.00
		CLAIM TOTAL		501.00	267.00		128.65	105.35	16.44	0.00	0.00	88.91
							OTHER INSURANCE 0.00			Payment to Provider 88.91		
							Patient Responsibility 16.44			Payment to Member 0.00		
SARAH NELSON 123	4KAB10001 081440079-00	PLAN: TEST100										
		03/03/08 - 03/03/08	POV 99214	257.00	.00	SO	257.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	SUM 20610	218.00	.00	SO	218.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	PHM J3301	16.00	.00	SO	16.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	PHM J2001	10.00	.00	SO	10.00	.00	.00	.00	.00	.00
		CLAIM TOTAL		501.00	0.00		501.00	0.00	0.00	0.00	0.00	0.00
							OTHER INSURANCE 0.00			Payment to Provider 0.00		
							Patient Responsibility 501.00			Payment to Member 0.00		
										TOTAL PAID		88.91

VOID

ENV 2   2 OF 7

KAISER PERMANENTE.
Kaiser Permanente Insurance Company
PO BOX 30547
SALT LAKE CITY UT 84130-0547

ATLANTA ORTHOPAEDIC FOOT
550 PEACHTREE ST NE STE 1165
ATLANTA   GA 30308

Client: 4K KAI   **WHITE STOCK**

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 581080740AA5
TAX#: 581080740
DATE: 05/25/2008
Draft #: 00001481
EDI Payor ID: 95266

PATIENT NAME ACCOUNT #	MEMBER ID # CLAIM #	DATES OF SERVICE	CODE	SUBMITTED CHARGES	NEGOTIATED DISCOUNT	EXPL CODE	NON COVD CHARGES	ALLOWED AMOUNT	COPAY	DEDUCTIBLE	CO-INS	TOTAL BENEFITS

Code Descriptions

****

PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE
THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE
LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT
PAYMENT AMOUNT.

****

(25) P9   ALLOWED AMOUNT REDUCED BY COPAYMENT AS SPECIFIED BY THE PLAN.
SO   SERVICE DATES AFTER TERMINATION OF COVERAGE.
U03   CHARGES FOR THIS PROCEDURE HAVE BEEN CONSIDERED AS PART OF THE
      PRIMARY PROCEDURE.
U24   THIS PROCEDURE IS NORMALLY INCLUDED IN THE COST OF THE PRIMARY
      PROCEDURE WHEN PERFORMED ON THE SAME DAY.

Service Code Descriptions   (26)
POV   OFFICE/HOME/CLINIC VISIT
SUM   SURGERY
PHM   MISCELLANEOUS PHYS SERVICE

TEST

VOID

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SCREEN #	FIELD NAME	EXPLANATION
1	Payer Name & Address	Name of the payer issuing the EOP, along with address where applicable claims resubmission, supporting documentation, or overpayment refund check can be sent
2	Provider Name & Address	Name and address of the servicing Provider
3	Provider Number & TIN	Provider number noted on claim and Provider tax ID
4	Payment # & Date	Check or electronic funding transfer (EFT) draft number and date of payment
5	EDI Payer ID	EDI ID for payer issuing the Explanation of Payment (EOP)
6	Patient Name	Name of the patient to whom the services were provided to on the claim
7	Self-Funded Member ID & Claim #	Medical record number (MRN) for the patient and the unique claim number assigned to this claim
8	Date of Service	Date(s) in which services billed were rendered
9	Code	Code for the services rendered
10	Submitted Charges	Amount billed by the Provider for a given service
11	Negotiated Discount	Write-off amount based on claims adjudication outcome
12	Explanation Code	Reason code describing how the claim was processed
13	Non-Covered Charges	Amount billed by the Provider for services that is not covered due to limitations or exclusions defined by the patient's plan benefits
14	Allowed Amount	Amount allowed by contract or plan specification for the given service
15	Copay	Specific dollar amount that is the responsibility of the patient for a given service

SCREEN #	FIELD NAME	EXPLANATION
16	Deductible	Specific dollar amount that is the responsibility of the patient for a given service must be met before benefits for a given service can be paid
17	Co-Insurance	Percentage of the Allowed Amount that is the responsibility of the patient for a given service
18	Total Benefits	Amount paid by the payer for a given service
19	Other Insurance	Amount paid by another insurance under coordination of benefits
20	Patient Responsibility	Dollar amount that is the responsibility of the patient for an episode of care; total amount of copay + deductible + co-insurance
21	Payment To Provider	Amount paid by the Plan Sponsor to the servicing Provider for a given claim
22	Payment To Self-Funded Member	Amount paid by the Plan Sponsor to the Self-Funded Member for a given claim
23	Claim Total	Total amount of a given claim; sum of all submitted charges for an episode of care for a given patient
24	Total Paid	Total amount paid by the payer for all claims submitted and identified on the EOP
25	Explanation Code Description	Description of the reason code
26	Service Code Descriptions	Description of the code denoted for the services rendered

5.34 DO NOT BILL EVENTS (DNBE)

Depending on the terms of your Agreement, you may not be compensated for services directly related to any Do Not Bill Event (as defined below) and may be required to waive applicable Copays (as defined in Section X.1.14 below) associated with, and hold members harmless from, any liability for services directly related to any DNBE. KP expects you to report every DNBE as set forth in Section XIV.1.2of this Provider Manual and as may be further required by your Agreement. KP may reduce compensation for services directly related to a DNBE when the value of such services can be separately quantified in accordance with the applicable payment methodology.

DNBE shall mean the following:

In any care setting, the following surgical errors identified by CMS in its National Coverage Determination issued June 12, 2009[1] (SE):

- Wrong surgery or invasive procedure[2] on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part
- Foreign Object Retained After Surgery
- Air Embolism
- Blood incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes and Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- Surgical Site Infection Following Bariatric Surgery for Obesity
  - Laparoscopic Gastric Bypass

- o Gastroenterostomy
- o Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
  - o Spine
  - o Neck
  - o Shoulder
  - o Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
  - o Total Knee Replacement
  - o Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization
- Any new Medicare fee-for-service HAC later added by CMS
- Hospital-Acquired Conditions | CMS

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

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

[3] See, 73 Federal Register 48433, pages 48471-48491 (August 19, 2008) (http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf ; https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/hospital-acquired_conditions)

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

Removal (if medically indicated) of foreign objects retained after surgery.

Claims for Do Not Bill Events
You must submit claims for services directly related to a DNBE according to the following requirements and in accordance with the other terms of your Agreement and this Provider Manual related to claims.

- **UB04.** If you submit a UB-04 Claim (or its successor) for inpatient or outpatient facility services provided to a member wherein a HAC (Including a RFO-HAC) has occurred, you must include the following information:

- **DRG.** If, under the terms of your Agreement, such services are reimbursed on a DRG basis, you must include the applicable ICD-9 (or its successor, ICD-10) codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.

- **Other Payment Methodologies.** If, under the terms of your Agreement, such services are reimbursed on a payment methodology other than a DRG and the terms of your Agreement state that you will not be compensated for services directly related to a DNBE, you must split the Claim and submit both a Type of Bill (TOB) '110' (no-pay bill) setting forth all services directly related to the DNBE including the applicable ICD-9 (or its successor, ICD-10) codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program, and a TOB '11X (with the exception of 110)' setting forth all covered services not directly related to the DNBE.

5.35   PROVIDER CLAIMS PAYMENT DISPUTES/RECONSIDERATIONS

For Payment Disputes and other payment inquiries, contact Self-Funded Customer Service at (866) 213-3062. Most questions regarding Claim payments can be resolved quickly over the phone, but Providers always may submit a written Payment Dispute with the appropriate medical records to support medical necessity for treatment or to support the Claim. The TPA will review the Claim(s), to verify if the Claim(s) was adjudicated correctly, according to the Self-Funded Member's benefits and the contracted rates. The TPA will issue a written determination to the Provider. If the TPA determines the correct payment was made and a dispute remains related to a contractual payment, please adhere to the contractual dispute process specified in your Agreement. For questions related to such disputes, please contact Network Development & Administration at 626-405-3240. Depending on the Self-Funded plan, providers may have up to 365 days from the date of service to submit a claim. Providers also have 365 days from claim process date to submit a written or verbal Provider Dispute/Reconsideration to challenge a claim determination. If multiple services are included in the provider's request for dispute/reconsideration, the latest date of action on the Claim/Explanation of Payment(s) (EOPs) will be used to start the clock. If additional information is needed, the clock is stopped, and the provider will have 45 days from the date of request to provide

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the information before the clock is restarted.

Submit Written Provider Dispute/Reconsideration to the following address:

> KAISER PERMANENTE INSURANCE COMPANY (KPIC)
> Attn: Provider Reconsideration
> P.O. Box 30547
> Salt Lake City, UT 84130-0537

You may call Customer Service 866-213-3062 (Monday – Friday 7am – 9 pm EST) to verbally submit a Provider Dispute/Reconsideration.

If you have any questions regarding your rights and responsibilities under the Agreement and as described in this section of the manual, we encourage you to call our Provider Relations Department at (626) 405-3240 for clarification.

Please note that you are required to collect cost share amounts, including co-payments, deductibles, and coinsurance from Self-Funded Members, so be sure to:
- verify eligibility of Self-Funded Members prior to providing benefits, and
- collect applicable Self-Funded Member cost share including co-payments, deductibles and coinsurance as required by your Agreement.

5.36   REQUIRED NOTICES

Change of Information

If your office/facility changes any pertinent information such as tax identification number, phone or fax number, billing address, practice address, etc., please mail or fax written notice, including the effective date of the change pursuant to the notice provisions of your Agreement.

Other Required Notices

You are required to give Kaiser Permanente notice of a variety of other events, including changes in your insurance and ownership, adverse actions involving your Practitioners' licenses, participation in Medicare, and other occurrences that may affect the provision of services under your Agreement. Article 8 of your Agreement describes the required notices and manner in which notice should be provided.

Section VI: Quality Assurance

Kaiser Permanente Southern California 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 care issue. The KPSC QM program is described in the "2024 Quality Management 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 patient 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 obtain a copy of the "Quality Program at KP" call our Member Services Call Center at **1-(800) 464-4000** or **TTY 711.**

Patient 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 patient safety efforts.

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

If you would like independent information about KPSC'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 in the ambulatory setting. KP is responsible to manage, measure, and assess patient care in order to achieve NCQA accreditation which includes ensuring that all members are entitled to the same high level of care regardless of the site or provider of care. Kaiser Foundation Health Plan (KFHP) is accredited by the NCQA. You can review the report card for Kaiser Permanente's, Southern California Region at www.ncqa.org.

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The Joint Commission:

The Joint Commission (TJC) is a healthcare accreditation organization that is recognized nationwide as a symbol of quality that reflects an organization's compliance with TJC performance standards. To achieve and maintain TJC accreditations, KP facilities must undergo an onsite survey by The Joint Commission survey team at least every three (3) years. KP has adopted a set of The Joint Commission compliance expectations for contracted practitioners coming into our facilities. For more information on Joint Commission performance standards visit http://www.jointcommission.org.

6.1 QUALITY ASSURANCE AND QUALITY IMPROVEMENT PROGRAM OVERVIEW

Kaiser Permanente's Quality Assurance and Improvement Program uses a multi- disciplinary and integrated approach, which focuses on opportunities for improving operational processes, health outcomes, and patient and provider satisfaction.

With respect to Covered Services provided to Members, Provider shall participate in KPSC'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, patient safety, regulatory indicators and providing performance data), facilitating review of such Covered Services by KPSC's QI committees and staff, and cooperating with any independent quality review and improvement organization or other external review organization evaluating KPSC as part of its QI program (including NCQA).

The quality-of-care Self-Funded Members receive is monitored by Kaiser Permanente's oversight of Providers. You will be monitored for various indicators and required to participate in some Kaiser Permanente processes. For example, we monitor and track the following:
- patient access to care
- patient complaint and satisfaction survey data of both administrative and quality of care issues
- Compliance with Kaiser Permanente policies and procedures
- Utilization management statistics
- Quality of care indicators as necessary for Kaiser Permanente to comply with requirements of Department of Managed Health Care (DMHC),NCQA, Medicare, The Joint Commission TJC , and other regulatory and accreditation bodies
- Performance standards in accordance with your Agreement
- Credentials and re-credentialing of Providers

In any of the above situations, when Kaiser Permanente reasonably determines that the Provider's performance may adversely affect the care provided to Self-Funded Members, Kaiser Permanente may take corrective actions in accordance with your Agreement.

6.2 MONITORING AND REPORTING REQUIREMENTS

The Agreement identifies particular events which must be reported to Kaiser Permanente's QM Program by provider and particular monitoring actions which must be performed by provider in conjunction with Kaiser Permanente's QM Program. In addition, as part of its required participation

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in KP's QM Program and in addition to the claims submission requirements set forth in Section 5 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 5, 5.35) that occurs in connection with services provided to a Kaiser Permanente Health Plan Member.

6.3   PROVIDER CREDENTIALING AND RE-CREDENTIALING

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

As a Provider, your facility has already met the basic criteria for initial credentialing including insurance requirements, absence of Medicare and Medicaid sanctions, current state licensure, certificate of insurance and accreditation. If your facility is not accredited, then it meets the Kaiser Permanente site survey criteria in the areas of appearance, safety, provider and staff availability, emergency preparedness, infection control, medical record, quality assessment and improvement, and utilization management. Your facility and all providers furnishing services to our Self-funded Members are required to meet applicable requirements and be properly certified under the Medicare programs.

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

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

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

Based on a review of a provider's credentialing/re-credentialing information, which includes a completed application, supporting documentation and site visit findings, the Kaiser Permanente Regional Credentialing Committee may accord a facility **Corrective Action Plan Status** (CAP). A provider on CAP is either:

a. newly opened and operational , or
b. found to have deficiencies requiring corrective action.

Newly operational facilities typically are monitored for at least six months. Such providers are

required to provide monthly reports of applicable quality and/or clinical indicators for a minimum of the first 3 months of the Initial Credentialing.

Providers found to have deficiencies requiring corrective action such as:
- Regulatory non-compliance
- Member care or safety issues
- KP physician or staff member concern
- Member complaint

must complete a time-phased corrective plan of action that addresses the site visit findings and/or any applicable status of compliance (implemented action plan) with respect to all deficiencies identified in any Medicare Statement of Deficiencies and Plan of Correction (CMS Form 2567), usually within two weeks of notification.

Kaiser Permanente will review the corrective plan of action and determine whether it adequately addresses, in a reasonable time frame, identified issues. If the plan is not acceptable, Kaiser Permanente representatives will jointly work with the facility to make necessary revisions to the plan. Providers needing to submit corrective action plans are typically monitored for a year or less.

Facilities on CAP are notified in writing of the reason(s) for the designation, the time frames, and specific requirements applicable for the monitoring of their facilities.

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

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

Section VII: Compliance

Kaiser Permanente (KP) strives to demonstrate high ethical standards in its business practices. Because Providers are an integral part of KP's business, it is important that we communicate and obtain your support for these standards. The Agreement details specific laws and contractual provisions with which you are expected to comply. This section of the Provider Manual highlights some provisions in the Agreement and provides some additional information about compliance.

7.1   COMPLIANCE WITH LAW

Providers are expected to conduct their business activities in full compliance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing privacy and security regulations.

7.2   KAISER PERMANENTE PRINCIPLES OF RESPONSIBILITY AND COMPLIANCE HOTLINE

The Kaiser Permanente Principles of Responsibility ("POR") is the code of conduct for Kaiser Permanente physicians, employees and contractors working in KP facilities ("KP Personnel") in their daily work environment. You should report to Kaiser Permanente any suspected wrongdoing or compliance violations by KP Personnel under the POR. The Kaiser Permanente Compliance Hotline is a convenient and anonymous way to report a suspected wrongdoing without fear of retaliation. It is available 24 hours per day, 365 days per year. The toll-free Compliance Hotline number is 1-888-774-9100.

7.3   GIFTS AND BUSINESS COURTESIES

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. Even if certain types of remuneration are permitted by law, Kaiser Permanente discourages Providers from providing gifts, meals, entertainment, or other business courtesies to KP Personnel, in particular:
- Gifts or entertainment that exceed $25.00 in value
- Gifts or entertainment that are given on a regular basis
- Cash or cash-equivalents, such as checks, gift certificates/cards, stocks, or coupons
- Gifts from government representatives
- Gifts or entertainment that reasonably could be perceived as a bribe, payoff, deal, or any other attempt to gain advantage
- Gifts or entertainment given to KP Personnel involved in Kaiser Permanente purchasing and contracting decisions.

7.4   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 Self-Funded Members of the same family or household may work for Kaiser Permanente 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 Kaiser Permanente (other than the person who has the relationship with the Provider). You may call the toll-free Compliance Hotline number at 1-888-774-9100 for further guidance on potential conflicts of interest.

7.5   FRAUD, WASTE AND ABUSE

Kaiser Permanente will investigate allegations of Provider fraud, waste, or abuse, related to services provided to Self-Funded 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.

7.6   PROVIDERS INELIGIBLE FOR PARTICIPATION IN GOVERNMENT HEALTH CARE PROGRAMS

Under Kaiser Permanente policy, we will not do business with a provider if it or any of its officers, directors or employees involved in Kaiser Permanente business is, or becomes excluded by, precluded from, debarred from, or ineligible to participate in any federal health care program or is convicted of a criminal offense related to the provision of health care.

Kaiser Permanente expects you to (a) disclose whether any of its officers, directors or employees becomes sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program or is convicted of a criminal offense related to the provision of healthcare and (b) assume responsibility for taking all necessary steps to assure that your employees and agents directly or indirectly involved in Kaiser Permanente business have not or are not currently excluded from participation in any federal program.

7.7   VISITATION POLICY

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

7.8   PROVIDER RESOURCES:

7.8.1   Kaiser Permanente's National Compliance Office (510) 271-4699

7.8.2   Kaiser Permanente's Compliance Hotline (888) 774-9100

Section VIII: 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

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- 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

8.1   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 Self-Funded products offered by KP, you are expected to adhere to KP's "Nondiscrimination In the Delivery of Health Care Policy" and to all other federal and state laws and regulations that prohibit discrimination on the basis of disability.

8.2   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 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. The proactive offer and/or use of language assistance services must be documented in the KP member's medical record, even if the

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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 patient's medical record. Please see the subsection titled "Documentation" below.

8.3   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:

8.3.1   Documented and demonstrated proficiency in both English and the other (target) language;

8.3.2   Fundamental knowledge in both languages of health care, clinical, and medical terminology, and concepts; and

8.3.3   Education and training in interpreting ethics, conduct and confidentiality.

Provider must have a process in place to ensure ongoing competence of staff and to cooperate with KP by providing access to this information upon reasonable notice.
When Qualified Bilingual Staff Is Not Available

In the event that 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 below for interpreter services provided to KP members. Neither members nor Providers will be billed by these companies for interpreter services.

8.4   TELEPHONE INTERPRETATION

Language Select is a company with the capability to provide telephonic interpreter services in two hundred (200) different languages. Phone interpreter services are available twenty-four (24) hours per day, seven (7) days per week through United Language Group by calling: **(855) 701-8100**. This phone number is dedicated to the interpreter needs of members. While no lead time is needed to engage an interpreter through this service, Providers must have the following data elements available before placing the call:

8.4.1 The KP Client ID number. This number will be provided to you, in writing, together with your authorization.

8.4.2   KP referral or authorization number

8.4.3   Member's MRN

8.4.4   Member's language preference

United Language Group customer service can be reached at 855-701-8100. In addition, U n i t e d Language Group offers an email address specific to KP if you wish to submit an issue through email (kp@ulgroup.com). You will receive a follow-up response within 48 hours.

8.5   AMERICAN SIGN LANGUAGE SUPPORT

Interpreters Unlimited is a company with the capability to provide in-person interpreter services for members requiring Sign Language services (i.e., American Sign Languages, Spanish to Sign, etc.). At least one week's advance notification of need for an ASL interpreter is recommended to help ensure an interpreter is available. Please provide as much advance notice as possible when requesting an ASL interpreter. Interpreters Unlimited can be reached by calling: **(844) 855-0249** (option 3, then option 1) seven (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:

8.5.1   KP Client ID number

8.5.2   KP referral or authorization number

8.5.3   Member's MRN

8.5.4   Date(s) of member's appointment(s)

8.5.5   Time and duration of each appointment

8.5.6   Specific address and location of appointment(s)

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

8.5.8   Any cancellation should be made at least twenty-four (24) hours in advance of the scheduled appointment

8.5.9   Key Contact Name and Number for KP inquiries regarding the request for interpreter services

Interpreters Unlimited' s customer service can be reached at **(844) 855-0249**, (option 3 then option1)

twenty-four (24) hours per day, seven (7) days a week.

Note: Interpreters Unlimited' s 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 emailing: Equity-Inclusion-Diversity-SCAL-HI-Rgnl@kp.org

8.6   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.

8.7   DOCUMENTATION:

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

8.7.1   Language assistance was either offered (or requested) to (by) an LEP KP member.

8.7.2   If language assistance was refused by the KP member; the reason why must be noted, i.e used family member.

8.7.3   What type of service was utilized (telephonic, in-person interpreter services or bilingual staff), for those members who accept/use language assistance.

8.7.4   If language assistance was requested and not provided, the reason why must be noted; and

8.7.5   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.

8.8   ONSITE TRANSLATION SERVICES

The requirements set forth above also apply to KP member requests for the onsite verbal translation of documents related to such member's care (i.e., verbal translation of a written document provided

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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 Member Services.

8.9   STAFF TRAINING

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

- Understanding and complying with KP Language Assistance Program
- Working effectively with KP's LEP members;
  Working effectively with interpreters in person and through video, telephone, and other media, as may be applicable; and
  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.

8.10   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 IX: Glossary of Terms

For the purposes of this Provider Manual only, the following definitions apply:

Term	Acronym	Definition
Accumulator		A running total of the expenses that apply to the Self-funded Member's deductible and out-of-pocket expenses maximum. This determines how much the Self- Funded Member cost share will be for current services or treatment.
ClaimCheck		A commercial code editor application utilized by the TPA for the Self-Funded product.

Coordination of Benefits	COB	A method for determining the order in which benefits are paid and the amounts which are payable when a Patient is covered under more than one plan.

Term	Acronym	Definition
Current Procedural Termino	CPT	A standard, universal medical procedures and services coding language developed and maintained by the American Medical Association (AMA). A CPT code usually consists of five digits that indicate a service or procedure. The AMA approves and updates CPT codes annually.
Electronic Data Interchange	EDI	An electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI transactions replace the submission of paper claims. KPIC encourages electronic submission of claims.
Employers Mutual Inc.	EMI	The Third-Party Administrator for ambulance claims.
Explanation of Benefits	EOB	Statement notices from the TPA to the Self-Funded Member which indicates services that were billed and amounts that were paid.
Explanation of Payment	EOP	Statement notices from the TPA to the Provider when a claim is adjudicated.
HealthPlan Services, Inc.		The Third-Party Administrator for the Self- Funded program.
HealthPlan Services, Inc. Website		Website maintained by HealthPlan Services, Inc. that will allow Providers to check eligibility, benefit, and claims information for Self- Funded Members. https://kpclaimservices.com/
In-Network		Refers to the most restrictive level of a HMO or EPO, the only network plan. Customers have limited choice among providers but receive richer benefits and pay less in out-of-pocket expenses than in the other tiers.
Integrated Voice Response System	IVR	A telephone-based voice response system utilized by the TPA to provide Self-Funded related support to Providers.

Term	Acronym	Definition
Kaiser Permanente Insurance Company	KPIC	Kaiser Permanente Insurance Company (KPIC), an affiliate of Kaiser Foundation Health Plan, Inc., will be administering Kaiser Permanente's Self-Funded Program. Each Self-Funded Plan Sponsor will contract with KPIC to provide administrative services for the Plan Sponsor's Self-Funded plan.
Member Cost Share		Any amount a Self-Funded Member owes for a benefited service. This can be a copay, deductible, or coinsurance.
Non-ERISA		Group health plans not regulated by the Employee Retirement Income Security Act of 1974.
Out-of-Network		Out-of-Network refers to the less restrictive level of a POS plan. It requires higher deductibles and co-insurance for services, and usually has restrictions on certain types of benefits (such as transplants). In exchange, the customer can choose to receive care from a much broader range of providers, often from doctors who have not contracted with the insurer for any other services.
Other Payor		For Self-Funded, the Plan Sponsor that is responsible for payment of claims in accordance with your Agreement.
Plan Sponsor		An employer or other entity that has set up a self-funded health benefits plan and has contracted with KPIC to provide administrative services for the plan. (Also referred to as "Other Payor" under your Agreement).
Self-Funded Plan		A health plan under which an employer or other group sponsor is financially responsible for paying plan expenses, including claims made by group plan participants. Under ERISA, Self-Funded or self-insured plans are exempt from many state laws and regulations such as premium taxes and mandatory benefits. Self-Funded plans contract with KPIC for administrative services.

Term	Acronym	Definition
Benefit Booklet known as Summary Plan Description	SPD	A document provided to Self-Funded Members which describes the plan specifications as it relates to benefits and administrative requirements specified by the Plan Sponsor (i.e., employer group).
Third Party Administrator	TPA	A firm that provides such services as actuarial, benefit plan design, claim processing, data recovery and analysis, and stop-loss benefits to a Self-Funded plan. These services are provided on a contract basis to a group or an insurer
Utilization Management	UM	The process of reviewing the use of hospital resources, such as patient days, ancillary tests, medications, and surgical procedures, in order to ensure appropriateness of medical care and level of care.