



2026 Kaiser Permanente Hawaii Network Development and Administration Contracted HMO Provider Manual



Welcome From Kaiser Permanente

Introduction

Aloha! It is our pleasure to welcome you as a contracted provider (Provider) participating under HMO plans offered by the Kaiser Permanente (KP) Medical Care Program. We want this relationship to work well for you, your medical support staff, and our members.

This Provider Manual was created to help guide you and your staff in working with Kaiser Permanente's various systems and procedures, and not to replace or supersede, the agreement between you and KP. Updates to the Provider Manual will be provided on a periodic basis in accordance with the agreement and in response to changes in operational systems and regulatory requirements. Please continue to consult your Provider Agreement for more information.

During the term of your Provider Agreement, you are responsible for (i) maintaining copies of the Provider Manual and its updates as provided by Kaiser Permanente, (ii) providing copies of the Provider Manual to its subcontractors, and (iii) ensuring that provider and its practitioners and subcontractors comply with all applicable provisions. The Provider Manual, including but not limited to all updates, shall remain the property of Kaiser Permanente.

As a service to our contracted providers, we offer a Hawaii Community Provider Portal where you may obtain real-time information online, including Kaiser member eligibility and claims status by registering for Online Affiliate. Please visit providers.kp.org to learn more or sign up for the Online Affiliate Program.

If you have questions or concerns about the information contained in this Manual, you can reach our Network Development & Administration Hawaii by email: Hawaii-ndanda-providerrelations@kp.org

Additional Provider resources can be found on the Hawaii Community Provider Portal website 24/7 at: providers.kaiserpermanente.org/hi.

Table of Contents

<u>SECTION I: HOW THIS PROVIDER MANUAL IS ORGANIZED</u>	<u>13</u>
1.1 YOUR RESPONSIBILITIES.....	13
1.2 PROVIDER CHANGES THAT MUST BE REPORTED.....	13
1.2.1 RELOCATIONS.....	13
1.2.2 ADDING/DELETING NEW PRACTICE SITE OR LOCATION.....	13
1.2.3 CHANGES IN TELEPHONE NUMBER.....	13
1.2.4 FEDERAL TAX ID NUMBER AND NAME CHANGE.....	13
1.2.5 MERGERS AND OTHER CHANGES IN LEGAL STRUCTURE.....	14
<u>SECTION II: KAISER PERMANENTE MEDICAL CARE PROGRAM</u>	<u>14</u>
2.1 HISTORY.....	14
2.2 ORGANIZATIONAL STRUCTURE.....	14
2.3 INTEGRATION.....	15
2.4 PREVENTIVE HEALTHCARE.....	15
<u>SECTION III: CONTRACTING FOR MEDICAL SERVICES</u>	<u>16</u>
<u>SECTION IV: KEY CONTACTS</u>	<u>16</u>
4.1 KEY CONTACTS NUMBERS	17
4.2 PROVIDER CONTRACTING.....	18
4.3 MEMBER SERVICES INTERACTIVE VOICE RESPONSE SYSTEM (IVR)	18
4.4 HAWAII COMMUNITY PROVIDER PORTAL.....	19
<u>SECTION V: MEMBER ELIGIBILITY AND BENEFITS</u>	<u>20</u>
5.1 VERIFICATION OF ELIGIBILITY.....	21
5.2 AFTER-HOURS REQUEST.....	21
5.3 BENEFIT COVERAGE DETERMINATION.....	21
5.4 BENEFIT EXCLUSIONS AND LIMITATIONS.....	21
5.5 DRUG BENEFITS.....	22
5.6 MEMBER IDENTIFICATION.....	22

5.7 MEDICAL RECORD NUMBER.....	22
5.8 KAISER PERMANENTE MEMBERSHIP TYPE.....	23
5.9 KAISER PERMANENTE ID CARD.....	23
5.9.1 SENIOR ADVANTAGE ID CARD.....	24
5.9.2 QUEST INTEGRATION ID CARD.....	25
5.9.3 ADDED CHOICE POS PLAN.....	26
5.9.4 SENIOR ADVANTAGE ID CARD WITHOUT PART D.....	28
5.9.5 CONGRESSIONAL ID CARD CVS ID CARD.....	30
5.9.6 CVS ID CARD.....	31
5.9.7 DUAL COMPLETE.....	32
SECTION VI: QUEST Integration	33
SECTION VII: MEMBER RIGHTS AND RESPONSIBILITIES	33
7.1 MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT	
7.2 PARTICIPATE IN A CANDID DISCUSSION OF APPROPRIATE OR MEDICAL NECESSARY TREATMENT OPTIONS FOR THEIR CONDITION(S), REGARDLESS OF COST OR BENEFITS	34
7.3 PARTICIPATE WITH PRACTITIONERS AND PROVIDERS IN MAKING DECISIONS ABOUT THEIR HEALTHCARE.....	35
7.4 HAVE ETHICAL ISSUES CONSIDERED.....	35
7.5 RECEIVE PERSONAL MEDICAL RECORDS.....	35
7.6 RECEIVE CARE WITH RESPECT AND RECOGNITION OF THEIR DIGNITY.....	36
7.7 USE INTERPRETER SERVICES.....	36
7.8 BE ASSURED OF PRIVACY AND CONFIDENTIALITY.....	37
7.9 PARTICIPATE IN PHYSICIAN SELECTION WITHOUT INTERFERENCE.....	38
7.10 RECEIVE A SECOND OPINION FROM AN APPROPRIATELY QUALIFIED MEDICAL PRACTITIONER.....	38

7.11 RECEIVE AND USE MEMBER SATISFACTION.....	38
7.12 KAISER PERMANENTE ARE RESPONSIBLE FOR.....	38
7.12.1 KNOWING THE EXTENT AND LIMITATIONS OF THEIR HEALTH CARE BENEFITS.....	38
7.12.2 NOTIFYING THE HEALTH PLAN IF THEY ARE HOSPITALIZED IN A NON-KAISER PERMANENT HOSPITAL.....	38
7.12.3 IDENTIFYING THEMSELVES.....	38
7.12.4 KEEPING APPOINTMENTS.....	39
7.12.5 PROVIDING ACCURATE AND COMPLETE INFORMATION.....	39
7.12.6 PARTICIPATING IN UNDERSTANDING THEIR HEALTH PROBLEMS.....	39
7.12.7 FOLLOWING THE PLANS AND INSTRUCTIONS FOR CARE.....	39
7.12.8 RECOGNIZING THE EFFECT OF LIFESTYLE ON THEIR HEALTH.....	39
7.12.9 BEING CONSIDERATE OF OTHERS.....	39
7.12.10 FULFILLING FINANCIAL OBLIGATIONS.....	39
7.12.11 KNOWING ABOUT AND USING THE MEMBER SATISFACTION.....	39
7.13 NON-COMPLIANCE WITH MEMBER RIGHTS AND RESPONSIBILITIES.....	40
7.13.1 PROVIDERS.....	40
7.13.2 KAISER PERMANENTE RESERVES THE RIGHT TO.....	41
7.14 ACCESS TO CARE DECISIONS.....	41
7.15 ADVANCE DIRECTIVES.....	42
7.16 MEMBER COMPLAINT AND GRIEVANCE PROCESS.....	42
7.17 PROVIDER PARTICIPATION IN MEMBER COMPLAINT RESOLUTION.....	43
7.18 MEMBER COMPLAINT AND GRIEVANCE RESOLUTION PROCEDURE.....	43
7.19 COMPLAINT PROCEDURES.....	44
7.20 GRIEVANCE PROCEDURES.....	44

7.21 DEMAND FOR ARBITRATION.....	44
<u>SECTION VIII: PROVIDER RIGHTS AND RESPONSIBILITIES</u>	46
8.1 PROVIDER RESPONSIBILITIES.....	46
8.2 COMPLAINT AND MEMBER PROBLEMS.....	47
<u>SECTION IX: CLAIM BILLING AND PAYMENT POLICIES AND PROCEDURES</u>	48
9.1 PROVIDER RESPONSIBILITIES TO ENSURE PROMPT BILLING AND PAYMENT...	48
9.2 CLAIM PAYMENT POLICY.....	48
9.3 ELECTRONIC CLAIM SUBMISSION.....	48
9.3.1 EDI CLAIMS ACKNOWLEDGEMENT.....	49
9.4 SUPPORTING DOCUMENTATION FOR ELECTRONIC CLAIMS.....	50
9.5 ELECTRONIC PAYMENT AND REMITTANCE ADVICE ONLINE ENROLLMENT.....	51
9.6 SELF-SERVICE PROVIDER PORTAL (ONLINE AFFILIATE).....	52
9.7 PAPER CLAIM SUBMISSION.....	53
9.7.1 METHODS OF PAPER CLAIM SUBMISSION.....	53
9.8 CLAIM SUBMISSION REQUIREMENTS.....	54
9.8.1 SUBSCRIBER INFORMATION.....	54
9.8.2 RECORD AUTHORIZATION NUMBER.....	54
9.8.3 ONE MEMBER AND ONE PROVIDER PER CLAIM FORM.....	54
9.8.4 SUBMISSION OF MULTIPLE PAGE CLAIM.....	54
9.8.5 BILLING INPATIENT CLAIMS THAT SPAN DIFFERENT YEARS.....	54
9.8.6 BILLING OUTPATIENT CLAIMS THAT SPAN DIFFERENT YEARS.....	54
9.8.7 INTERIM INPATIENT BILLS.....	55
9.8.8 TELEHEALTH.....	55
9.9 CORRECTED CLAIMS PROCESSING GUIDELINES.....	56
9.9.1 CLAIMS CORRECTIONS.....	56
9.9.2 CORRECTING A PREVIOUSLY SUBMITTED CLAIM.....	56

9.9.3 JUSTIFICATION FOR CLAIM CORRECTIONS.....	56
9.9.4 ELECTRONIC REPLACEMENT / CORRECTED CLAIM SUBMISSIONS.....	57
9.9.5 PAPER REPLACEMENT/ CORRECTED CLAIM SUBMISSIONS.....	57
9.10 CLAIMS REVIEW AND ADJUSTMENTS.....	57
9.11 COMPENSATION METHODOLOGIES.....	58
9.12 CODE REVIEW AND EDITING.....	58
9.13 CLINICAL REVIEW.....	58
9.14 PROHIBITED MEMBER BILLING PRACTICES.....	59
9.14.1 MEMBER COST SHARE.....	59
9.15 DO NOT BILL EVENTS (DNBE).....	60
9.16 CLAIMS SUBMISSION FOR HAC (HOSPITAL ACQUIRED CONDITIONS), DNBE, OR NEVER EVENT.....	61
9.16.1 ADDITIONAL REQUIREMENTS.....	61
9.17 COORDINATION OF BENEFITS.....	62
9.17.1 PROVIDER RESPONSIBILITIES.....	62
9.17.2 PAYMENT DETERMINATION.....	63
9.17.3 COOPERATION REQUIREMENTS.....	63
9.17.4 DETERMINING THE PRIMARY PAYOR.....	63
9.17.5 WORKERS COMPENSATION/ THIRD PARTY LIABILITY (TPL).....	64
9.18 COB CLAIMS SUBMISSION REQUIREMENTS AND PROCEDURES.....	65
9.18.1 MEMBERS ENROLLED IN TWO KAISER PERMANENTE PLANS (DUAL COVERAGE).....	65
9.18.2 SECONDARY CLAIMS SUBMISSION VIA EDI.....	65
9.19 THIRD PARTY LIABILITY (TPL).....	66
9.20 WORKERS COMPENSATION.....	66
9.21 COPAYMENTS, COINSURANCE AND DEDUCTIBLES.....	67

9.22 OVERPAYMENT POLICY.....	67
9.23 OVERPAYMENT RECOUPMENT	68
9.24 APPEDIX.....	69
9.24.1 KP CONTACT INFORMAIOTN.....	69
9.24.2 COMMUNITY PROVIDER PORTAL (CPP).....	70
<u>SECTION X: PROVIDER APPEALS</u>	<u>71</u>
10.1 REQUIRED INFORMATION FOR PROVIDER DISPUTE NOTICES.....	71
10.2 INSTRUCTIONS FOR RESOLVING SUBSTANTIALLY SIMILAR PYMT DISPUTES.....	72
<u>SECTION XI: CREDENTIALING AND RE-CREDENTIALING PROCESS</u>	<u>73</u>
11.1 PROVIDER CREDENTIALING AND RE-CREDENTIALING.....	73
11.2 PRACTITIONERS.....	73
11.3 PRACTITIONER'S RIGHT TO CORRECT ERRONEOUS OR DISCREPANT INFORMATION.....	74
11.4 PRACTITIONER RIGHT TO REVIEW INFORMATION.....	74
11.5 PRACTITIONER RIGHT TO BE INFORMED OF THE STATUS OF THE CREDENTIALING APPLICATION.....	74
11.6 PRACTITIONER RIGHT TO CREDENTIALING AND PRIVILEGING POLICIES.....	75
11.7 ORGANIZATIONAL PROVIDERS (OPs).....	75
11.8 CORRECTIVE ACTION PLAN OR INCREASES MONITORING STATUS FOR	75
11.9 LICENSURE, CERTIFICATION, AND CREDENTIALING.....	76

SECTION XII: UTILIZATION MANAGEMENT

77

12.1 UTILIZATION MANAGEMENT PROGRAM.....	77
12.2 REQUEST FOR AUTHORIZATION FOR CONTRACTED PROVIDER SERVICES...78	
12.2.1 REFERRAL AND AUTHORIZATION.....	78
12.2.2 INPATIENT SERVICES IN THE STATE OF HAWAII.....	78
12.2.3 OUT-OF-PLAN REFERRAL PROCESS.....	78
12.3 REQUEST FOR INFORMATION.....	79
12.4 HOSPITAL ADMISSIONS OTHER THAN EMERGENCY SERVICES.....	79
12.5 ADMISSION TO SKILLED NURSING FACILITY (SNF).....	79
12.6 HOSPICE AND SKILLED NURSING FACILITY (SNF) SERVICES.....	80
12.7 HOME HEALTH AND HOSPICE SERVICES.....	81
12.8 HOME HEALTH ONLY.....	81
12.9 RERERRAL TO COMMUNITY HOSPICE AGENCIES.....	82
12.10 DURABLE MEDICAL EQUIPMENT (DME).....	83
12.11 PSYCHIATRIC HOSPITAL SERVICES.....	83
12.12 NON-EMERGENCY TRANSPORTATION.....	84
12.12.1 NON-EMERGENCY MEDICAL TRANSPORT.....	84
12.12.2 NON-EMERGENCY AMBULANCE TRANSPORT.....	84
12.13 CONCURRENT REVIEW PROGRAM.....	84
12.14 DISCHARGE PLANNING.....	84
12.15 CASE MANAGEMENT.....	85

<u>SECTION XIII: PHARMACY SERVICES/ DRUG FORMULARY</u>	<u>86</u>
13.1 PRESCRIBING NON-FORMULARY DRUG.....	86
13.2 PHARMACIES.....	87
13.3 TELEPHONE AND INTERNET REFILLS.....	87
13.4 MAIL ORDER.....	88
13.5 RESTRICTED USE OF DRUGS.....	88
13.6 EMERGENCY SITUATIONS.....	88
<u>SECTION XIV: EMERGENCY AND URGENT CARE SERVICES</u>	<u>89</u>
14.1 EMERGENCY ADMISSIONS & SERVICES HOSPITAL REPAATRIATION POLICY.	89
14.2 EMERGENCY SERVICES.....	89
14.3 AUTHORIZATION FOR KP EMERGENCY DEPARTMENT VISITS.....	90
14.4 EMERGENCY TRANSFERS TO: Kaiser Foundation Hospital Moanalua Medical Center.....	90
14. 5 POST-STABILIZATION CARE.....	90
14.6 URGENT CARE.....	91
<u>SECTION XV: QUALITY MANAGEMENT PROGRAM</u>	<u>92</u>
15.1 QUALITY ASSURANCE AND IMPROVEMENT PROGRAM OVERVIEW.....	93
15.1.1 PRACTITIONER OFFICE SITE QUALITY.....	94
15.2 MONITORING QUALITY.....	94
15.2.1 COMPLIANCE WITH LEGAL, REGULATORY, AND ACCREDITING BODY STANDARDS.....	94
15.2.2 INFECTION CONTROL.....	94
15.2.3 PRACTITIONER QUALITY ASSURANCE AND IMPROVEMENT PROGRAMS.....	95

15.3 QUALITY OVERSIGHT.....	95
15.3.1 QUALITY REVIEW.....	96
15.3.2 OPS' QUALITY ASSURANCE & IMPROVEMENT PROGRAMS.....	97
15.3.3 SENTINEL EVENTS/REPORTABLE OCCURRENCES FOR OPS.....	97
15.4 SENTINEL EVENT/REPORTABLE OCCURRENCES-HOME AND HOSPICE AGENCY PROVIDERS.....	97
15.4.1 NOTIFICATION TIMEFRAMES.....	97
15.4.2 REPORT WITHIN 24 HOURS.....	98
15.4.3 REPORT WITHIN 72 HOURS.....	98
15.5 DO NOT BILL EVENTS (DNBEs)/REPORTABLE OCCURRENCES FOR PROVIDERS.....	99
15.6 QA & REPORTING REQUIREMENTS FOR HOME HEALTH PROVIDERS.....	100
15.6.1 ANNUAL REPORTING.....	100
15.6.2 SITE VISIT AND/OR CHART REVIEW.....	100
15.7 QA & REPORTING REQUIREMENTS FOR SNFs.....	100
15.7.1 QUARTERLY REPORTING.....	100
15.7.2 MEDICAL RECORD DOCUMENTATION.....	101
15.8 QA & I AM REPORTING REQUIREMENTS FOR CHRONIC DIALYSIS PROVIDERS	
15.8.1 REPORTING REQUIREMENTS.....	101
15.8.2 CHRONIC DIALYSIS PATIENTS.....	102
15.9 MEDICAL RECORD REVIEW AND STANDARDS.....	103
<u>SECTION XVI: DISEASE MANAGEMENT RESOURCES</u>	<u>106</u>
<u>SECTION XVII: CULTURAL DIVERSITY</u>	<u>107</u>
17.1 NON-DISCRIMINATION.....	107
17.2 KP'S LANGUAGE ASSISTANCE PROGRAM.....	108

17.3 USING QUALIFIED BILINGUAL STAFF.....	109
17.4 WHEN QUALIFIED BILINGUAL STAFF IS NOT AVAILABLE.....	109
17.5 TELEPHONE INTERPRETATION.....	109
17.6 SIGN LANGUAGE SUPPORT.....	110
17.7 FAMILY MEMBERS AND FRIENDS AS INTERPRETERS.....	110
17.8 DOCUMENTATION.....	111
17.9 ONSITE SIGHT TRANSLATION SERVICES.....	111
17.10 STAFF TRAINING.....	111
17.11 COMPLIANCE WITH LANGUAGE ASSISTANCE.....	112
<u>SECTION XVIII: COMPLIANCES</u>	<u>113</u>
18.1 COMPLIANCE WITH THE LAW.....	113
18.2 KP PRINCIPLES OF RESPONSIBILITY AND COMPLIANCE HOTLINE.....	113
18.3 GIFTS AND BUSINESS COURTESIES.....	113
18.4 CONFLICTS OF INTEREST.....	114
18.5 FRAUD, WASTE, AND ABUSE.....	114
18.6 PROVIDERS INELIGIBLE FOR PARTICIPATION IN GOVERNMENT HEALTHCARE PROGRAMS.....	115
18.7 VISITATION POLICY.....	115
18.8 CONFIDENTIALITY OF PATIENT INFORMATION.....	115
18.9 HIPAA AND PRIVACY RULES.....	116
18.10 CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS	
18.11 PROVIDER RESOURCES.....	117
18.12 REGULATORY COMPLIANCE.....	117

Section 1: How this Provider Manual is Organized

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

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

1.1 PROVIDER RESPONSIBILITIES:

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

1.2 PROVIDER CHANGES THAT MUST BE REPORTED

Please remember to send written notification to Kaiser Permanente Network Development and Administration department when you have important changes to report. Please check your contract as it may contain provisions that limit your ability to add, delete or relocate Practice sites, service locations or practitioners. Email address:

ProviderDemographicsHawaii@kp.org.

1.2.1 RELOCATIONS: Notify Provider Relations at ProviderDemographicsHawaii@kp.org of relocation to allow for the transition of members to other providers, if necessary.

1.2.2 ADDING/DELETING NEW PRACTICE SITE OR LOCATION: Notify Provider Relations at ProviderDemographicsHawaii@kp.org when opening an additional practice site or closing an existing service location.

1.2.3 CHANGES IN TELEPHONE NUMBER: Notify Provider Relations at ProviderDemographicsHawaii@kp.org of a change in a telephone number. If the initial notification is given verbally, we ask that you send written confirmation of what was verbally conveyed.

1.2.4 FEDERAL TAX ID NUMBER AND NAME CHANGE: If your Federal Tax ID Number or name changes please notify Provider Relations at ProviderDemographicsHawaii@kp.org

1.2.5 MERGERS AND OTHER CHANGES IN LEGAL STRUCTURE: Please notify us in advance and as early as possible of any planned changes to your legal structure, including pending merger or acquisition in writing.

Notify Provider Relations department of the above-mentioned changes. Email address: Hawaii-ndanda-providerrelations@kp.org

Contract Termination (Voluntary):

Your Agreement requires you to give advance written notice if you plan to terminate your contractual relationship with KP. The written notice must be sent by the terms stated in your Agreement. Please refer to your Agreement for instructions.

If you have questions or concerns, please feel free to contact Provider Contracting Department at: Hawaii-ndanda-providerrelations@kp.org

Section II: Kaiser Permanente Medical Care Program

The KP Medical Care Program is a cooperative endeavor among representatives of medicine and management, sharing responsibilities for organizing, financing, and delivering high-quality healthcare services to its members and patients.

Three separate entities comprise the Kaiser Permanente Medical Care Program: Kaiser Foundation Health Plan, Inc. (KFHP); Kaiser Foundation Hospitals. (KFH); and Hawaii Permanente Medical Group (HPMG). For purposes of this Provider Manual, the terms Kaiser Permanente or KP mean KFHP, KFH, and HPMG, collectively.

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

Today, Kaiser Foundation Health Plan is one of the countries’ largest nonprofit, independent, and prepaid group practice health maintenance organizations. We are proud of our over 60-year history of providing quality healthcare services to our members and of the positive regard we’ve earned from our members, peers, and others within the healthcare industry.

2.2 ORGANIZATIONAL STRUCTURE: Like the Kaiser Permanente Enterprise, Kaiser Permanente’s Hawaii is comprised of three separate entities that share responsibility for providing medical, hospital, and business management services. These groups of entities are referred to in this Provider Manual as Kaiser Permanente.

The entities are:

Kaiser Foundation Health Plan, Inc. (KFHP) - contracts with Kaiser Foundation Hospitals and The Permanente Medical Group to provide or arrange for the provision of medical services.

Kaiser Foundation Hospitals (KFH). KFH provides and arranges for hospitals and other facility services.

Hawaii Permanente Medical Group (HPMG) is a professional corporation of physicians and advanced practice providers (with support from additional administrative specialists) that provides and arranges professional medical services in HPMG that provides and arranges professional medical services.

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

2.4 PREVENTIVE HEALTH CARE: Kaiser Permanente continues to influence the practice of medicine by focusing on keeping the member healthy and treating illnesses and injuries. We encourage members to seek care on a regular and preventive basis.

Section III: Contracting for Medical Services

The Hawaii Network Development and Administration Department (ND&A) is responsible for the contracts between Kaiser Foundation Hospitals and community hospitals, skilled nursing facilities, and other care facilities to provide services for our members. Hawaii ND&A handles the day-to-day operational maintenance of the contracts, including, but not limited to, relocations, additions/deletions of practice site/location, changes in telephone numbers, federal tax ID number and name changes, and mergers and other changes in legal structure. For more information regarding this section, please contact us at the number listed in the Key Contacts section of this Provider Manual.

Section IV: Key Contacts

At Kaiser Permanente, we believe in clear, open, and frequent communication with our contracted providers. The following are the key departments and individuals available to assist you with questions or clarification of any issues regarding your association with Kaiser Permanente. Please feel free to call them as the need may arise. For clarification, questions, or comments about your role as a contracted provider for Kaiser Permanente, please contact Network Development and Administration at [email: ProviderDemographicsHawaii@kp.org](mailto:ProviderDemographicsHawaii@kp.org)

4.1 KEY CONTACTS NUMBERS AND EMAILS:

Department	Contact Information	Hours
Appeals	Phone: 1-808-432-7535 Fax: 1-808-432-5260	Monday-Friday 8-5 PM KPHawaii.Appeals@kp.org
Medicare Member Standard Appeal	1-800-805-2739	
Non-Medicare/Commercial Member Standard Appeal	1-800-966-5955	
Expedited Appeal	Phone: 1-808-432-7503 or 1-866-233- 2851	
Authorization& Referrals/Outside Services Coordination	Phone: 1-808-432-5687 Fax: 1-808-432-5691	Monday-Friday 8-4:30 PM

Case Management	Phone: 1-808-432-7252	Daily 8-4:30 PM except holidays
Claims Customers Service	Phone: 1-877-875-3805	Monday-Friday 8-4:30 PM
Durable Medical Equipment (DME)	Phone: 1-808-432-5692 Fax: 1-808-432-5689	Monday-Friday 8-4:30 PM
	Email: HI-DME@kp.org	
Medical Doctor Call Center (MDCC)	Phone: 1-808-643-6363	24 hours, 7 days a week
Member Services KP Non-Medicare/Commercial Members Kaiser Permanente Medicare Members	Phone: 1-800-966-5955 Fax: 1-808-432-5260- Phone: 1-808-805-2739	Monday-Friday 8-5 PM Saturday 8-12 PM 7 days a week, 8am-8pm Except for major holidays
Hawaii Network Development and Administration Provider Relations		Hawaii-NDandA-Provider Relations@kp.org

4.2 PROVIDER CONTRACTING

Department	Area Of Interest	Contact Information
Provider Contracting	Inquiries regarding Facilities (i.e. Hospital, SNF, Hospice) Individual Practitioners (i.e. Behavioral Health Provider (PhD, PsyD, LCSW) Non-Physician Professional (i.e. AU, PT, OT, ST)	Email: providerdemographicshawaii@kp.org

4.3 MEMBER SERVICES INTERACTIVE VOICE RESPONSE SYSTEM (IVR): KP Member Services IVR can assist you with a variety of questions.

Call 1-800-464-4000 to use this service. Please have the following information available to provide authentication when you call into the system:

- Provider tax ID or national provider identifier (NPI)
- Medical record number
- Member's date of birth
- Date of service for the claim in question

4.4 HAWAII COMMUNITY PROVIDER PORTAL-

<https://healthy.kaiserpermanente.org/hawaii/community-providers/claims>

Welcome to the Community Provider Portal!

Hawaii



Important Updates

- [Cigna Providers Outside a Kaiser Permanente State \(Outside CA, CO, DC, GA, HI, MD, OR, VA, WA\)](#)
- [News](#)

Announcements

- For alternative EDI solution options, please see our [Claims page section](#), which includes the different EDI Clearinghouses Kaiser Permanente connects with and special solutions available from Office Ally for FREE bulk and individual claim submissions to KP.
- [Register](#) for Online Affiliate or [sign-on](#) to begin submitting online disputes, appeals, supplemental claim attachments or request for information (RFI). Learn more about our new [Claim submission tools and partnership](#).
- Medicaid Quest Integration Providers: [Provider Relief Fund Post Payment Reporting Requirements Toolkit](#) Kaiser Permanente appreciates your willingness to work with us in providing quality care to our Members.

Quick Links

- [Pediatric Occupational Therapy Services Authorization Requirements](#)
- [Hawaii HR 133 Form](#)
- [Formulary](#)
- [View member eligibility as a guest user](#)
- [View claim status as a guest user](#)
- [Provider Newsletters](#)
- [Added Choice](#)
- [Provider Onboarding Training Calendar](#)

Training Resources

- [Provider Training](#)
- [QUEST Training](#)
- [Video Overview of EOP Account Summary](#)
- [Video Overview Recoupment Detail Report](#)

Section V: Member Eligibility and Benefits

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

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

You are also responsible for confirming that services provided to a member are covered benefits. Both requirements and verification tools are described in more detail in this section. For specific questions regarding eligibility or a member's benefit plan and coverage for services, please call Member Services. The Member Services telephone number is in the "Key Contacts" section of this Provider Manual.

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

Member Services Contact Center

Non-Medicare/Commercial Members

Phone: 1-800-966-5955; Fax : 1-808-432-5300
Monday-Friday 8 a.m- 5 p.m., Saturday 8 a.m.-12 p.m.

Medicare Members

Phone: 1-800-805-2739
7 days a week, 8 a.m. – 8 p.m. except for major holidays

MEMBER ELIGIBILITY AND BENEFITS

5.1 VERIFICATION OF ELIGIBILITY: You must verify the member's eligibility each time a member presents for services. After receiving the health plan identification card, members may lose their eligibility or change health plans. Unless a referral and/or authorization have been received, you must verify the member's eligibility before rendering the service prior to the member presenting for services. Verification of eligibility may be done quickly and easily by contacting Member Services.

Member Services Contact Center

Non-Medicare/Commercial Members

Phone: 1-800-966-5955; Fax: 1-808-432-5300
Monday-Friday 8 a.m.- 5 p.m., Saturday 8 a.m.-12 p.m.

Medicare Members

Phone: 1-800-805-2739
7 days a week 8 a.m. – 8 p.m. except for major holidays

5.2 AFTER-HOURS REQUEST: A member who requests medical care after normal business hours must have his or her eligibility verified during the next business day. During the interim, requesting that the patient complete a financial responsibility form that places payment responsibility on the patient if he or she is found to be ineligible as a member of the care provided is not a covered benefit. A financial responsibility form is not required for the provision of emergency services; however, KP will not pay for emergency services or other unauthorized services provided if the person is not a member.

5.3 BENEFIT COVERAGE DETERMINATION: In addition to eligibility, Providers must confirm that the member has coverage for the services at issue prior to providing such services to a member, usually by requesting authorization or receiving a referral from KP. ("Referrals and Authorizations") of this Provider Manual provides further details on the process for obtaining referrals and authorizations, except in cases of emergency.

5.4 BENEFIT EXCLUSIONS AND LIMITATIONS: KP benefit plans may be subject to limitations and exclusions. It is important to contact KP Member Services to obtain information on and verify the availability of member benefits for services before rendering the service so the member can be informed of any potential payment responsibility.

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

5.5 DRUG BENEFITS: Drug benefits vary based on the benefit plan. To verify if a member has a drug benefit, please contact Member Services.

5.6 MEMBER IDENTIFICATION: The following information helps you to identify KP members and treat them accordingly.

5.7 MEDICAL RECORD NUMBER: A unique Medical Record Number (MRN) is assigned to each member and is listed on the front of the member's identification card. The MRN is used by Kaiser Permanente to identify the member's medical record, eligibility, and benefit level. If a member's enrollment terminates and the member re-enrolls later, the member retains the same MRN, although the employer or other information may change. The MRN enables medical records/history to be tracked for all periods of enrollment.

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

5.8 KAISER PERMANENTE MEMBERSHIP TYPE:

5.9 KAISER PERMANENTE ID CARD

Membership Type	Membership Defined	Covered Benefits Defined By
Commercial HMO Physical Card Front  Physical Card Back  Future ID Card Starting May 20, 2025 	- Members* who purchase Health Plan coverage on an individual basis (other than Medicare and Medicaid). - Members who are covered as part of an employer group and are not Medicare eligible - Kaiser Foundation Health Plan sends each member a permanent ID card. The card displays the member's medical record number, which is used for identification. * In each case, "Member" includes the subscriber and any eligible dependents, in accordance with the terms of the applicable membership agreement.	- Membership Agreement/ Evidence of Coverage - Membership Agreement

Medicare Advantage (formerly Medicare + Choice) Senior Advantage Physical Card Front Physical Card Back	- Individual Medicare beneficiaries who have assigned their Medicare benefits to Kaiser Permanente by enrolling in the Kaiser Permanente Senior Advantage Program. - Employer group retirees or otherwise Medicare-eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to Kaiser Permanente by enrolling in the Kaiser Permanente Senior Advantage Program	- Medicare with additional benefits provided by Kaiser Permanente as described in the EOC. - Medicare and Membership Agreement
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5.9.2 QUEST INTEGRATION ID CARD

QUEST (Medicaid)

Physical Card Front

 	
Medical Record Number 77 77 77 2	
QUEST,CANDY,B	
Effective Date 10/01/2013	Primary Clinic Kaiser Permanente
Third Party Liability https://hiweb.statemedicaid.us	Clinic Phone Number 1-833-833-3333

Physical Card Back

Call **911** or go to the nearest emergency room if you are experiencing a medical emergency.

If hospitalized outside of Hawaii call (toll free) **1-800-227-0482** within 48 hours.

Appointments and 24/7 Advice Line
1-833-833-3333
711 (toll free) TTY for the hearing/speech impaired

Kaiser Permanente QUEST Integration Member Services
808-432-5330 (Oahu) or **1-800-651-2237** (neighbor islands)
711 (toll free) TTY hearing/speech impaired

Possession of the Health Plan identification card confers no rights or services or other benefits unless the holder of the card is in fact a member complying with all provisions of a Medical and Hospital Service Agreement including provisions regarding payment of applicable charges.

03131 QI THIS CARD IS FOR IDENTIFICATION ONLY

Quest (Medicaid) Effective

12/2024

 	
Medical Record Number 97 08 65 1	
QUEST,CANDY,B	
Effective Date 10/01/2013	Primary Clinic Kaiser Permanente
Third Party Liability https://hiweb.statemedicaid.us	Clinic Phone Number 1-833-833-3333

Call **911** or go to the nearest emergency room if you are experiencing a medical emergency.

If hospitalized outside of Hawaii call (toll free) **1-800-227-0482** within 48 hours.

Appointments and 24/7 Advice Line
1-833-833-3333
711 (toll free) TTY for the hearing/speech impaired

Kaiser Permanente QUEST Member Services
808-432-5330 (Oahu) or **1-800-651-2237** (neighbor islands)
711 (toll free) TTY hearing/speech impaired

Possession of the Health Plan identification card confers no rights or services or other benefits unless the holder of the card is in fact a member complying with all provisions of a Medical and Hospital Service Agreement including provisions regarding payment of applicable charges.

03131 QI THIS CARD IS FOR IDENTIFICATION ONLY

- QUEST Integration (QI) is a statewide Medicaid program that provides medical, home, community-based services, and behavioral services through managed care delivery systems.
- Kaiser Permanente participates in this program as one of the managed care plans.
 - Kaiser Permanente medical record number
 - Member Name
 - Effective date of member's Kaiser QUEST coverage
 - Primary clinic name and telephone Number
 - Third Party Liability (TPL) information The QUEST ID card has additional information required by State of Hawaii DHS.
- Contact Member Services for detailed information specific to your geographic area.

5.9.3 ADDED CHOICE POS PLAN

Added Choice POS Plan

Physical Card Front

Added Choice POS Plan

Customer Service
1-800-238-5742
TTY 711

ADDEDCHOICE,MELISSA,A

MEDICAL RECORD NUMBER/ID:
22 22 26

For Providers and Pharmacies:
This member has an insurance plan, which lets them get care for covered services from any licensed provider or pharmacy they choose.
For questions about network participation, benefits, or precertification, please call Customer Service at the number above.

RXBIN: 003585 RXPCN: 70000

BIRTH DATE:
12/28/1957

In-Network	Participating Provider	Out-of-Network
Deductible \$0/\$0	\$100/\$300	\$100/\$300
Out-of-Pocket Max \$2000/\$6000	\$2000/\$6000	\$2000/\$6000

Physical Card Back

kp.org/addedchoice-hawaii

Emergency: Call 911 or go to the nearest emergency room.
If you are hospitalized outside of Hawaii, call toll free 1-800-227-0482 (TTY 711) within 48 hours.

Kaiser Permanente providers:
Appointments, 24/7 medical advice, and pharmacy
1-833-833-3333 (TTY 711)

Appointments with all other providers:
Contact your provider directly. Some services may require precertification.
For use by your provider:
Out-of-network providers precertification 1-888-529-1553
Cigna PPO Network providers eligibility, benefits, and precertification 1-888-831-0761

Mail claims to:
Kaiser Permanente
Claims Administration
P.O. Box 378021
Denver, CO 80237
EDI Payer ID: 94123

For Cigna providers, mail claims to:
Cigna
P.O. Box 188061
Chattanooga, TN 37422-8061
EDI Payer ID: 62308

IMPORTANT NETWORK INFORMATION: The Cigna PPO Network only provides access to care outside Kaiser Permanente states of CA, CO, GA, HI, MD, OR, VA, WA, and DC. The Cigna PPO Network only provides access to care in non-Kaiser Permanente states and refers to providers (doctors, hospitals, specialists) contracted as part of the Cigna PPO Network for Shared Administration.

Cigna

IMPACT

KAISER PERMANENTE

3133 AddChoice (09/22)

Future ID Card Effective 10/01/2025

Added Choice Point-of-Service Plan

Customer Service
kp.org/addedchoice-hawaii
1-800-238-5742 (TTY 711)

MEMBERFIRSTNAME A MEMBERLASTNAME SUFFIX

Medical Record Number/ID: 12345678912

RxBIN: 003585 RXPCN: 70000

Group No.: 123456-A00

	Kaiser Permanente Provider	Contracted Provider	Non-Contracted Provider
Deductible	\$1111/1111	\$1111/1111	\$1111/1111
Out-of-Pocket Maximum	\$1111/1111	\$1111/1111	\$1111/1111

Kaiser Foundation Health Plan, Inc. (KFHP) underwrites the Kaiser Permanente in-network tier.
The contracted provider and non-contracted provider tiers of this plan are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP.
This card is for identification only. Use of this card is subject to the applicable agreement.

Emergency: Call 911 or go to the nearest emergency room

Kaiser Permanente Providers:
Appointments, 24/7 Medical Advice, Urgent Care & Pharmacy
1-833-833-3333 (TTY 711)

Appointments with all other Providers: Contact your provider directly. Some services may require precertification.
For use by your Provider:
PHCS and Non-Contracted Provider precertification 1-888-529-1553
Cigna Healthcare PPO Network providers eligibility, benefits, and precertification 1-888-831-0761
MedImpact Pharmacy (eligibility, claims, and prior-authorizations) 1-800-788-2949

Send claims to:
Claims Administration
P.O. Box 378021
Denver, CO 80237
EDI Payer ID: 94123

For Cigna Healthcare Providers:
Cigna Medical Claims
P.O. Box 188061
Chattanooga, TN 37422
EDI Payer ID: 62308

If you receive emergency care in a non-Plan hospital, please call us at 1-800-227-0482 (TTY 711) as soon as your condition is stabilized so that a Kaiser Permanente physician can access your medical information to discuss your care with the treating physician.

IMPORTANT NETWORK INFORMATION: The PHCS Network for the POS plan provides access to care in the Kaiser Permanente states of CA, CO, GA, HI, MD, OR, VA, WA, and DC. The Cigna Healthcare PPO Network only provides access to care in non-Kaiser Permanente states and refers to providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO Network for Shared Administration. This card does not guarantee services or benefits. Benefits are not insured by Cigna or Affiliates. For Cigna Healthcare provider prior authorization call 1-888-831-0761 (TTY 711).

Cigna

PHCS

IMPACT

KAISER PERMANENTE

- Added Choice plans are point-of-service options offered by either Kaiser Foundation Health Plan, Inc. or Kaiser Permanente Insurance Company (KPIC).
- These plans allow members and their enrolled dependents to choose services from Kaiser Permanente providers (in-network) or contracted community providers

26

Kaiser Permanente ND&A
Provider Contract Relations (PCR) (REV. 10-25)

 KAISER PERMANENTE.

Future ID Card Effective 09/21/2025


KAISER PERMANENTE
 Kaiser Foundation Health Plan of Hawaii

Member Services
1-808-432-5250
 (TTY 711)
kp.org/eutf

MEMBERFIRSTNAME A MEMBERLASTNAME SUFFIX

Medical Record Number/ID: **12345678912**

RxBIN: 003585 RxCN: 70000

Deductible \$1111/1111
 Out-of-Pocket Maximum \$1111/1111

This card is for identification only. Use of this card is subject to the applicable agreement.

Emergency: Call 911 or go to the nearest emergency room

Appointments, 24/7 Medical Advice, Urgent Care & Pharmacy:
1-833-833-3333 (TTY 711)

EUTF Member Services, Eligibility, Benefits, Claims:
 Oahu: **1-808-432-5250**
 Neighbor Islands or out of state: **1-844-276-6628**

Send claims to:
 Claims Administration
 P.O. Box 3718021
 Denver, CO 80237
EDI Payor ID: 94123

For Cigna Healthcare Providers:
 Cigna Medical Claims
 P.O. Box 188061
 Chattanooga, TN 37422
EDI Payor ID 62308

If you get emergency care in a non-Plan hospital, please call us at **1-800-227-0482 (TTY 711)** as soon as your condition is stabilized so that a KP physician can access your medical information to discuss your care with the treating physician.

For care options when traveling, visit kp.org/travel or call **1-951-268-3900 (TTY 711)**. Urgent or emergency care is available from any provider when traveling. If you get urgent or emergency care from a Cigna Healthcare™ PPO Network provider outside of CA, CO, GA, HI, MD, OR, VA, WA and DC, you will be billed your usual copay or coinsurance later.

Benefits are not insured by Cigna or Affiliates. For Cigna Healthcare provider prior authorization, call **1-888-831-0761 (TTY 711)**.




Regular Medicare (Medicare Unassigned)


MEDICARE HEALTH INSURANCE

Name/Nombre

Medicare Number/Número de Medicare

Entitled to/Con derecho a HOSPITAL (PART A) MEDICAL (PART B)	Coverage starts/ Cobertura empieza 10/01/2019 10/01/2019
--	--

Front of card

You may be asked to show this card when you get health care services. Only give your personal Medicare information to health care providers, your insurers, or people you trust who work with Medicare on your behalf. **WARNING:** Intentionally misusing this card may be considered fraud and/or other violation of federal law and is punishable by law.

Es posible que le pidan que muestre esta tarjeta cuando reciba servicios de cuidado médico. Solamente dé su información personal de Medicare a los proveedores de salud, sus aseguradores o personas de su confianza que trabajan con Medicare en su nombre. **ADVERTENCIA:** El mal uso intencional de esta tarjeta puede ser considerado como fraude y/u otra violación de la ley federal y es sancionada por la ley.

1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048)

Medicare.gov

Back of card

- Members (i) entitled to coverage under Part A or Part B only or Part A and Part B of Medicare but (a) are not enrolled under a Medicare Advantage contract between Health Plan (or another Kaiser Payor) and CMS and (b) for whom the Medicare covered services under Medicare reimbursement rules, or (ii) enrolled under a Medicare Advantage contact and hospice patients receiving care from Provider for services unrelated to the hospice patient's terminal condition.

- Dual Coverage: Some members have two types of coverage: - Primary coverage is Medicare, which defines Medicare benefits. - Secondary coverage is through the Health Plan, which provides benefits as described in the
- Membership Agreement (and the Employer Group agreement, if applicable).

5.9.5 CONGRESSIONAL ID CARD

Congressional Staffer ID Card

Physical Card Front



MEDICAL RECORD NUMBER
55 55 55 1

CONGRESSIONAL MADISON, T

RxBIN: 610127	Deductible \$1000/\$2000
RxPCN: MASF	Out of Pocket Max \$6750/\$13500
RxMRN: 005555551	MAS: 005555551

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.

Physical Card Back

kp.org

Call 911 if you think you are having a medical emergency.

Call 711 for TTY.

Appointments/Cancel Appointments
Toll-free: 1-800-833-3333 (TTY 711)
Washington D.C. Metro Area: (800) 777-7966

Member Services (Medical & Pharmacy) (877) 9-KAISER

Submit medical claims to:
Kaiser Permanente
PO Box 30947
Salt Lake City, UT 84130-0947
Payor ID# 96320

Underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and purchased through DC Health Link SHOP Exchange.

03131 CONG

Future ID Card Effective 09/21/2025



Member Services
1-877-852-4737
(TTY 711)
kp.org



MEMBERFIRSTNAME A MEMBERLASTNAME SUFFIX

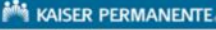
Medical Record Number/ID: **12345678912**

RxBIN: 610127 RxPCN: MASF RxMRN: 12345678

Deductible	\$1111/1111
Out-of-Pocket Maximum	\$1111/1111
MAS: 987654321	

Underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. And purchased through DC Health Link SHOP Exchange.

This card is for identification only. Use of this card is subject to the applicable agreement.

Emergency: Call 911 or go to the nearest emergency room Appointments, 24/7 Medical Advice, Urgent Care & Pharmacy: Hawaii: 1-833-833-3333 (TTY 711) Washington D.C. Metro Area: 1-800-777-7904 Member Services, Eligibility, Benefits, Claims, Pharmacy: (877) 8-KAISER Send claims to: Claims Administration P.O. Box 30547 Salt Lake City, UT 84150 EDI Payer ID: 94320		
Commercial Part D Only used by PHCS group #18482 Physical Card Front  Issuer: 80840 RxBin: 011214 RxPCN: HICMSD (HMO) RxGrp: HI CMS - 50262 0834 MEDICAL RECORD NUMBER/ID 45 63 94 Deductible \$6500/\$13000 Out of Pocket Max \$8550/\$17100 PARTD,HMO,G 03/09/1953 BIRTH DATE MedicareRx Prescription Drug Coverage kp.org Physical Card Back Emergency: Call 911 or go to the nearest emergency room. If you are hospitalized outside of Hawaii, call toll free 1-800-227-0482 (TTY 711) within 48 hours, or call our Away from Home Travel Line (951) 268-3900 (TTY 711) Appointments and 24/7 Advice: 1-833-833-3333 (TTY 711) For more information about your Kaiser Foundation Health Plan or claim, call Member Services: Oahu/Neighborhood Islands/Out of state: 1-800-966-5955 (TTY 711) Visit kp.org anytime. For care options when traveling, visit kp.org/travel or call (951) 268-3900 (TTY 711). Urgent or emergency care from a Cigna Healthcare PPO Network provider outside of CA, CO, GA, HI, MD, OR, VA, WA and DC, you will be billed your usual copay or coinsurance later. Benefits are not insured by Cigna Healthcare and Affiliates. For Cigna Healthcare provider preauthorization, call 1-800-835-0761 (TTY 711). Kaiser Permanente Kaiser Permanente Insurance Company cigna CIGNA Insurance Company Kaiser Permanente providers only: Claims Administration PO Box 378021 Denver, CO 80237 EDI Payer ID: 94123 For Cigna providers only: Cigna Medical Claims PO Box 188061 Chattanooga, TN 37422-8061 EDI Payer ID: 62308 This identification card is for Kaiser Permanente members only and should be presented with a photo identification card when seeking medical services. 03131 HMO PART D		

5.9.6 CVS ID CARD

CVS ID Card

Physical Card Front



Physical Card Back



Future ID Card Effective 09/21/2025



Dual Complete (D-SNP)

 **Kaiser Permanente®**

Issuer: 80840
RxBin: 011214 RxPCN: HICMS
RxGrp: HI

MEDICAL RECORD NUMBER
81 67 68 3

XEDCAX, OLIVER

Primary Clinic
Kaiser Permanente
Clinic Phone Number
1-833-833-3333 (TTY: 711)

HMO D-SNP
Kaiser Foundation Health Plan, Inc.
Hawaii Region

Dual Complete

CMS - H1230 0008

01/01/1955
BIRTH DATE

01/01/2024
EFFECTIVE DATE

MedicareRx
Prescription Drug Coverage
kp.org

Call **911** or go to the nearest emergency room if you are experiencing a medical emergency.

If you are hospitalized outside of Hawaii, call toll free **1-800-227-0482 (TTY: 711)** within 48 hours, or call our Away from Home Travel Line at **(951) 268-3900 (TTY: 711)**.

Appointments and 24/7 Advice: 1-833-833-3333 (TTY: 711)

For more information about your Kaiser Foundation Health Plan call Member Services toll free: **1-800-805-2739 (TTY: 711)**

Submit claims to: Hawaii Claims Administration
P.O. Box 378021, Denver, CO 80237
EID Payor ID: 94123

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.

03131 D-SNP - 01/2025

Section VI: Quest Integration

This provider manual has a section dedicated to QUEST Integration (Hawaii Medicaid) and information can be accessed by the link below to the Provider Manual for Kaiser Permanente QUEST Providers. If the Provider requests a printed copy, the QUEST Integration Provider Manual is available in electronic version and at no charge. [Kaiser Permanente QUEST Integration Provider Manual](#)

Section VII: Member Rights and Responsibilities

Kaiser Permanente recognizes that members have both rights and responsibilities in managing their health care.

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

At the same time, members are responsible for their own knowledge, attitudes, and behaviors related to the health care services they receive while enrolled in a Kaiser Permanente Health Plan.

This section outlines a member's rights and responsibilities and explains the options available if a member feels they have not received appropriate services, care, or treatment.

7.1 MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

Kaiser Permanente has developed a statement that addresses a member's right to participate in their medical care decisions. These decisions range from selecting a primary care provider to being provided with all the information needed to make decisions regarding recommended treatment plans.

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

Kaiser Permanente provides each member with the Member Rights and Responsibilities Statement upon enrollment in the Health Plan. A copy of the statement is included in the Kaiser Permanente Rights and

Responsibilities Handbook, the Disclosure Form

Evidence of Coverage booklet, and in new-member materials. Members may call Member Services to obtain additional copies of the above information.

Kaiser Permanente members have the right to:

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

This includes information about:

- Kaiser Permanente
- The services we provide, including behavioral health services
- The names and professional status of the individuals who provide you with service or treatment
- The diagnosis of a medical condition, its recommended treatment, and alternative treatments
- The risks and benefits of recommended treatments
- Preventive care guidelines
- Ethical issues
- Complaint, grievance, and appeal procedures

We will make this information as clear and understandable as possible. When needed, we will provide interpreter services at no cost to them.

7.2 Participate in a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage:

Members have the right to a candid discussion with their Plan Physician about appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage. Members should feel free to ask any questions they have, even if they seem minor. Every question is important when it comes to understanding their care.

- Kaiser Permanente does not discriminate based on age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status
- In some situations, such as medical emergencies, members may not be able to take part in treatment decisions. In most cases, however, no medical treatment will be given without the consent of the member or their authorized representative. Whenever appropriate, members and their families will be informed about the results of care, treatment, and services provided including any unexpected outcomes.

Participate with practitioners and providers in making decisions about their health care: Members have the right to choose an adult representative, known as an agent, to make medical decisions for them if they are unable to do so and to express their wishes about their future care. Instructions may be expressed in directive documents such as an advance health care directive.

For more information about these services and resources, please contact our Member Services Contact Center on Monday-Friday 8-5 PM and Saturday 8-12 PM at 1-800-966-5955.

7.3 Participate with practitioners and providers in making decisions about their health care: Members have the right to choose an adult representative, known as a Health Care Agent, to make medical decisions for them if they are unable to do so and to express their wishes about their future care. Instructions may be expressed in advanced directive documents such as an advance health care directive.

For more information about these services and resources, please contact:

[Member Services Contact Center](#)

[Non-Medicare/Commercial Members](#)

[Phone: 1-800-966-5955; Fax: 1-808-432-5300](#)
[Monday-Friday 8 a.m.- 5 p.m, Saturday 8 a.m.-12 p.m.](#)

[Medicare Members](#)

[Phone: 1-800-805-2739](#)

[7 days a week, 8 a.m. – 8 p.m. except for major holidays](#)

7.4 Have ethical issues considered: Members have the right to ask that any ethical concerns related to their health care be reviewed by their care team. To support this, Kaiser Permanente has a Bioethics/Ethics Committee at each medical center to help patients, families, and providers make important medical or ethical decisions.

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

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

Member Services Contact Center Non-Medicare/ Commercial Members

Phone: 1-800-966-5955; Fax: 1-808-432-5300

Monday-Friday 8 a.m.- 5 p.m., Saturday 8 a.m.-12 p.m.

Medicare Members

Phone: 1-800-805-2739

7 days a week, 8 a.m. – 8 p.m. except for major holidays

7.6 Receive care with respect and recognition of their dignity: Kaiser Permanente respects each member's cultural, psychosocial, spiritual, and personal values, as well as their beliefs and preferences.

We are committed to delivering high-quality, culturally competent care while supporting healthy, thriving communities. To better understand and serve our members, we may collect information such as race, ethnicity, language preferences (spoken and written), and religion. This information helps us improve care and services for our members and communities.

All information is kept private and confidential, and it is not used for underwriting, rate setting, or determining benefits.

We believe quality health care requires open and honest communication about all aspects of care, and our goal is for every member to feel respected, understood, and satisfied with the care they receive from Kaiser Permanente.

7.7 Use interpreter services: When members come in for an appointment or call for advice, Kaiser Permanente will speak to them in the language they are most comfortable using. For more about interpreter services, please refer to www.kp.org or call our Member Services Contact Center.

Non-Medicare/Commercial Members

Phone: 1-800-966-5955; Fax: 1-808-432-5300
Monday-Friday 8 a.m.- 5 p.m. Saturday 8 a.m.-12 p.m.

Medicare Members

Phone: 1-800-805-2739

7 days a week 8 a.m. – 8 p.m. except for major holidays

7.8 Be assured of privacy and confidentiality: All Kaiser Permanente employees and Physicians, as well as practitioners and providers with whom Kaiser Permanente contracts, are required to keep protected health information (PHI) confidential. PHI is information that includes members' names, Social Security Number, or other information that reveals who they are, such as race, ethnicity, and language data. For example, a member's medical record is PHI because it includes their name and other identifiers

Kaiser Permanente has strict policies and procedures regarding the collection, use, and disclosure of member PHI that include the following:

- Kaiser Permanente's routine uses and disclosures of PHI
- Use of authorizations
- Access to PHI
- Internal protection of oral, written, and electronic PHI across the organization
- Protection of information disclosed to Plan sponsors or employers

For more information about your rights regarding PHI as well as our privacy practices, please refer to our Notice of Privacy Practices on our website www.kp.org or call our member services call center.

Member Services Contact Center Non-Medicare/ Commercial Members

Phone: 1-800-966-5955; Fax: 1-808-432-5300

Monday-Friday 8 a.m.- 5 p.m., Saturday 8 a.m.-12 p.m.

Medicare Members

Phone: 1-800-805-2739

7 days a week 8 a.m. – 8 p.m. except for major holidays

7.9 Participate in physician selection without interference: Members have the right to select and change their physician within the Kaiser Permanente Medical Care Program without interference, subject to physician availability.

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

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

A description of the dispute-resolution process is contained in the Evidence of Coverage booklet, Certificate of Insurance, or the Federal Employees Health Benefits Program materials. If health coverage is provided through an employer, a member can also contact their employer for a current copy. When necessary, Kaiser Permanente will provide interpreter services, including Sign Language, at no cost.

7.12 Kaiser Permanente Members are responsible for:

7.12.1 Knowing the extent and limitations of their health care benefits: A detailed explanation of benefits is contained in the Evidence of Coverage booklet, Certificate of Insurance, or the Federal Employees Health Benefits Program materials. If health coverage is provided through an employer, the member can also contact their employer for a current copy of the Evidence of Coverage booklet or Certificate of Insurance.

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

7.12.3 Identifying themselves: Members are responsible for carrying their identification (ID) card and photo identification to use when appropriate, and for ensuring that no one else uses their ID card. If someone else used their card, Kaiser Permanente may keep the card and terminate the membership.

The Kaiser Permanente ID card is for identification only and does not give rights to services or other benefits unless a member is an eligible member of our Health Plan. Anyone who is not a member will be billed for any services we provide.

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

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

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

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

7.12.8 Recognizing the effect of their lifestyle on their health: A member's health depends not only on the care provided by Kaiser Permanente but also on the decisions they make in daily life poor choices such as smoking or choosing to ignore medical advice or positive choices such as exercising and eating healthy foods.

7.12.9 Being considerate of others: Members are responsible for treating physicians, healthcare professionals, and fellow Kaiser Permanente members with courtesy and consideration. Members are also responsible for showing respect for the property of others and Kaiser Permanente.

7.12.10 Fulfilling Financial Obligations: Members are responsible for paying on time any money owed to Kaiser Permanente.

7.12.11 Knowing about and using the member satisfaction resources available to them, including the dispute resolution process: Providers and their staff are expected to review and abide by the statement. If you have any questions regarding the contents, please contact us at the phone number included in the Key Contacts Section of this Provider Manual.

7.13 NON-COMPLIANCE WITH MEMBER RIGHTS AND RESPONSIBILITIES:

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

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

If the member is not comfortable discussing concerns or the member feels the provider cannot resolve the issue to the member's satisfaction, the member may contact Member Services Contact Center or via web at www.kp.org to file a complaint against the provider and/or staff.

Member Services Contact Center

Non-Medicare/Commercial Members

Phone: 1-800-966-5955; Fax: 1-808-432-5300

Monday-Friday 8 a.m.- 5 p.m., Saturday 8 a.m.-12 p.m.

Medicare Members

Phone: 1-800-805-2739

7 days a week 8 a.m. – 8 p.m. except for major holidays

7.13.1 Providers:

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

The provider should advise Member Services if a member:

- Displays disruptive behavior or cannot develop a provider/member relationship

- Unreasonably and persistently refuses to follow provider's instructions to the extent that the member's health is considered jeopardized
- Commits a belligerent act or threatens bodily harm to physicians and hospital personnel
- Purposely conceals or misrepresents their medical history or treatment subvert proper treatment planning
- Uses documents with the provider's signature without proper authorization or forges/falsifies a provider's name to documents
- Allows someone to misrepresent him/herself as a Kaiser Permanente member

7.13.2 Kaiser Permanente reserves the right to:

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

7.14 ACCESS TO CARE DECISIONS:

Kaiser Permanente and affiliated hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for members' medical needs. Kaiser Permanente does not compensate anyone for denying coverage or service, and Kaiser Permanente does not use financial incentives to encourage denials.

To maintain and improve the health of members, all providers should be especially vigilant in identifying any potential underutilization of care or service.

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

Kaiser Permanente members have the right to choose treatment or service options regardless of benefit coverage limitations. Providers are encouraged to communicate appropriate treatment options, even when the options are not covered by the member's benefit plan. If the provider and the member decide upon a course of treatment that is not covered under the member's Health Plan, the member should be advised to contact Member Services for an explanation of his/her benefits plan.

Kaiser Permanente's Utilization Management program and procedures are:

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

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

7.15 ADVANCE DIRECTIVES:

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

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

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

If a member requests to formulate or change an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss the decision with the member. The attending physician will write a progress note in the member's medical chart to reflect the formulation or change of an Advance Directive.

An Advance Directive may be revoked by the member at any time, orally or in writing, as long as the member can do so. An Advance Directive is automatically invalidated by divorce if the spouse was designated as the surrogate decision-maker.

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

7.16 MEMBER COMPLAINT AND GRIEVANCE PROCESS

Kaiser Permanente members are assured of a fair and equitable process for addressing their complaints and grievances against contracted providers, provider staff, and Kaiser Permanente employees. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the member, the provider, and Kaiser Permanente. Members are notified of the processes available for resolving complaints and grievances in the Evidence of Coverage.

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

Valid member complaints and grievances against a provider are included in the provider's quality file at Kaiser Permanente and reviewed as part of the re-credentialing process. Complaints and grievances are tracked and trended on an ongoing basis to identify potential problems with a provider or Kaiser Permanente policies and procedures.

Quality of Care Complaint: A complaint received by the health plan concerning the quality of care a member received is a complaint or grievance. A members' complaint or grievance that contains a potential quality of care concern(s) is forwarded by Member Relations to the Member Relations Clinical Consultants for case review. Clinical Consultants will forward cases to the responsible quality department physician or leader as appropriate.

Specific to Medicare members, the written response to a quality-of-care grievance will inform the Member of the right to file the quality-of-care grievance with the Quality Improvement Organization (QIO). The QIO is an organization comprised of practicing doctors and other health care experts under contract with the federal government to monitor and improve the care given to Medicare members.

7.17 PROVIDER PARTICIPATION IN MEMBER COMPLAINT RESOLUTION:

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

7.18 MEMBER COMPLAINT AND GRIEVANCE RESOLUTION PROCEDURE:

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

Member Services Contact Center Non-Medicare/ Commercial Members

Phone: 800-966-5955; Fax: 1-808-432-5300

Monday-Friday 8 a.m.- 5 p.m, Saturday 8 a.m.-12 p.m.

Medicare Members

Phone: 1-800-805-2739

7 days a week 8 a.m. – 8 p.m. except for major holidays

7.19 COMPLAINT PROCEDURES: If the problem/issue is not amenable to immediate resolution at the point of service, the member may submit a written complaint or grievance via mail or at kp.org or by calling the Member Services Contact Center.

7.20 GRIEVANCE PROCEDURES: If a member is requesting care or service that is not amenable to immediate resolution at the point of service or the request is monetary in nature, he/she should be advised to contact the Member Service Contact Center to file a formal grievance. This may be done verbally or by writing via mail or at kp.org.

72-HOUR EXPEDITED REVIEW:

Members and providers who believe that the Member's health status would be seriously jeopardized by submitting an issue through the standard process may request an expedited review. If the issue is accepted for processing through this procedure, upon receipt of all necessary information, Kaiser Permanente must decide as expeditiously as required by the Member's medical condition, not to exceed 72 hours. If the request is denied, the Member will be informed of any applicable appeal rights. If it is determined that there is no serious threat to life or limb, the request will be processed under the standard timeframes, fourteen (14) to thirty (30) days depending on the type of request and membership. Members may request an expedited review by calling Member Services at 800-966-5955 or 800-805-2739 for Medicare members.

7.21 DEMAND FOR ARBITRATION: A member may file a demand for arbitration after he/she has received the appeal decision or at any earlier step in the process. For more information on arbitration procedures, advise the member to contact the Member Services Contact Center.

Member Appeals: Members have the right to request a standard or expedited appeal. An appeal is a request for reconsideration of a denied initial determination decision (adverse decision). Members must notify Member Relations in writing if they wish to file a standard appeal via mail, fax, or kp.org. A member may file an expedited appeal either verbally or in writing. Details pertaining to the appeal process are outlined in the members' Evidence of Coverage booklet, Certificate of Insurance, or the Federal Employees Health Benefits Program materials. The member may contact the Member Services Contact Center with questions.

Section VIII: Provider Rights and Responsibilities

As a Provider, you are responsible for understanding and complying with terms of your Agreement and this section. If you have any questions regarding your rights and responsibilities under the Agreement and as described in this section of the Provider Manual, we encourage you to email the Provider Contracting Department at ProviderDemographicsHawaii@kp.org

8.1 Providers are responsible for the following:

- Provide health care services without discriminating based on health status or any other unlawful category.
- Uphold all applicable responsibilities outlined in the Kaiser Permanente Member Rights & Responsibilities Statement.
- Maintain open communication with a member to discuss treatment needs and recommended alternatives, without regard to any covered benefit limitations or Kaiser Permanente administrative policies and procedures. Kaiser Permanente encourages open provider-member communication regarding appropriate treatment alternatives and does not restrict providers from discussing all medically necessary or appropriate care with members.
- Provide all services in a culturally competent manner.
- Provide for the timely transfer of member medical records when care is to be transitioned to a new provider, or if your Agreement terminates.
- Participate in Kaiser Permanente Utilization Management and Quality Improvement Programs. Kaiser Permanente Quality Improvement and Utilization Management Programs are designed to identify opportunities for improving health the care provided to members. These programs may interact with various functions, including, but not limited to, the complaint or grievance process, disease management, preventive health, or clinical studies. Kaiser Permanente will communicate information about the programs and the extent of provider participation through special mailings and updates.
- Securing authorization or referral from KP prior to providing any non-emergency services
- Collect applicable co-payments, deductibles, and coinsurance from members as required by your Agreement.
- Complying with this Provider Manual and the terms of your Agreement
- Verify the eligibility of members prior to providing covered services.
- Cooperate with and participate in the member complaint and grievance process, as necessary.
- Encourage all practitioners and provider staff to include members as part of the member safety team by requesting members to speak up when they have questions or concerns about the safety of their care.
- Discuss adverse outcomes related to errors with the member and/or family.
- Ensure members' continuity of care including coordination with systems and personnel throughout the care delivery system⁴⁴

- Foster an environment that encourages all practitioners and provider staff to report errors and near misses.
- Pursue improvements in member safety including incorporating member safety initiatives into daily activities.
- Ensure compliance with member safety accreditation standards, legislation, and regulations.
- Providing orientation of this Provider Manual to all subcontractors and participating practitioners and ensuring that downstream providers adhere to all applicable provisions of the Provider Manual and the Agreement.
- Reporting to the appropriate state agency any abuse, negligence, or imminent threat to which the member might be subject. You may request guidance and assistance from the local KP's Social Services Department to help provide you with the required information that must be imparted to these agencies.
- Contact your local county Public Health Department if you treat a patient for a reportable infectious disease.

Providers also have the following rights:

- Receive payment in accordance with applicable laws and applicable provisions of your Agreement.
- File a provider dispute.
- Participate in the dispute resolution processes established by Kaiser Permanente in accordance with your Agreement and applicable law.

8.2 COMPLAINT AND MEMBER CARE PROBLEMS

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

For Referral Related Issues: For assistance with referral or authorization issues, please contact the appropriate Kaiser Hawaii Authorization and Referrals department. The telephone number is listed in the "Key Contacts" section of this Provider Manual.

For Contractual Concerns: For assistance in resolving contractual issues, please contact your Contract Manager via the Network Development and Administration email ProviderDemographicsHawaii@kp.org

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

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

For All Other Issues: If any issue remains unresolved, please contact Provider Relations via email: Hawaii-ndanda-providerrelations@kp.org.

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

Section IX: Claim Billing and Payment Policies and Procedures

9.0 Introduction

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

[Provider Manual | Kaiser Permanente Washington](#)

9.1 Provider Responsibilities to Ensure Prompt Billing and Payment

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

9.2 Claim Payment Policy

You will be compensated for Covered Services provided to eligible Members based on the compensation arrangement and subject to the terms of your Agreement, this Provider Manual and applicable law. To ensure prompt adjudication and payment of your claims, do the following:

- Verify the Member's eligibility and benefits coverage before providing non-emergency services, as required by your Agreement and applicable law. Claims should be submitted to the Member's home KP Region.
- For those Covered Services that require prior authorization, obtain authorization for non-emergency services, including post-stabilization services, and include the authorization number in your submitted claim. Claims for non-emergency services that require an authorization and are submitted without authorization will be denied, unless required by law.

9.3 Electronic Claim Submission

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

Providers must submit their EDI claim through a clearinghouse. Each clearinghouse assigns a unique payor identifier for Kaiser Permanente. The table below lists Payer IDs for Kaiser Permanente's affiliated direct clearinghouses.

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

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

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

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

9.3.1 EDI Claims Acknowledgement

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

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

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

9.4 Supporting Documentation for Electronic Claims

When submitting claims electronically, the 837 transaction contains data fields for supporting documentation through free-text format (the exact system data field may vary).

When additional information is required, it will be requested.

Examples of additional information include but are not limited to:

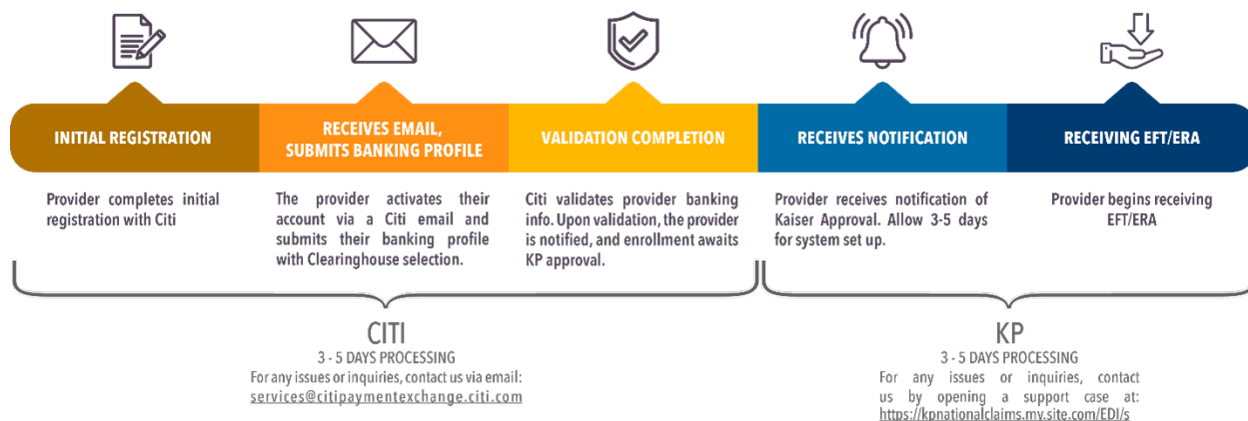
- Discharge summary and/or progress notes
- Operative report(s)
- Emergency room records with respect to all emergency services

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

9.5 Electronic Payment and Remittance Advice Online Enrollment

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

EFT/ERA SET UP PROCESS



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

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

Enrollment URL	Activation Code
Colorado https://b2bportal.citipaymentexchange.citi.com/enroll/CO-KFHP-ACH	YJRW6
Georgia https://b2bportal.citipaymentexchange.citi.com/enroll/GA-KFHP-ACH	KYP6BZ
Northwest https://b2bportal.citipaymentexchange.citi.com/enroll/NW-KFHP-ACH	R3ML96
Mid-Atlantic States https://b2bportal.citipaymentexchange.citi.com/enroll/MAS-KFHP-ACH	R4GWM4
Hawaii https://b2bportal.citipaymentexchange.citi.com/enroll/HI-KFHP-ACH	3PZFK2
Northern California https://b2bportal.citipaymentexchange.citi.com/enroll/NCAL-KFHP-ACH	6WLKT7
Southern California https://b2bportal.citipaymentexchange.citi.com/enroll/SCAL-KFHP-ACH	MN4WX2
Washington – Not Supported	N/A

NOTE: To receive electronic payments or Electronic Remittance Advices, Providers MUST be contracted with Kaiser or MUST have successfully submitted a claim to Kaiser.

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

For questions regarding enrollment status or failure to receive EFT payments and ERAs, after allowing 7-10 days for initial enrollment, please contact Kaiser Permanente EDI Support team by clicking on the following link: <https://kpnationalclaims.my.site.com/EDI/s/>.

9.6 Self-Service Provider Portal (Kaiser Permanente Online Affiliate) Enrollment

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

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

kp.org/providers

Provider resources



This portal includes several **time-saving features**, such as:

- Accessing patient eligibility, benefits, and demographics.
- Viewing referrals and authorizations (access varies by region, contract status and job role).
- Viewing and downloading Explanation of Payments (EOP).
- Checking the status of submitted claims and viewing claim details including service date, billed amount, allowed amount, and claim codes.
- Confirming payment information such as check number, payment date, and total amount.

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

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

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

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

9.7 Paper Claim Submission

9.7.1 Methods of Paper Claim Submission

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

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

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

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

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

9.8 Claim Submission Requirements

9.8.1 Subscriber Information

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

9.8.2 Record Authorization Number

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

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

9.8.3 One Member and One Provider per Claim Form

Complete separate claim forms for each Member and each Provider.

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

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

9.8.5 Billing Inpatient Claims That Span Different Years

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

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

9.8.6 Billing Outpatient Claims That Span Different Years

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

9.8.7 Interim Inpatient Bills

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

- Follow CMS billing requirements for interim inpatient facility claims.
 - Use the same patient control number/account number for interim facility claims as on the initial claim.
 - KP accepts the initial interim claim with Bill Type 112.
 - Subsequent interim claims must be billed as adjusted claims with Bill Type 117, including cumulative charges up to each “through” date.
 - Original claim must be finalized before submitting additional replacement/adjusted interim claims
- **Northern CA and Southern CA Only** - for inpatient services, submit separate claims weekly as required by California Law (28 CCR 1300.71 (a)(7)(B)).

9.8.8 Telehealth

Telehealth is the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member’s health care. Telehealth interactions between Providers and Members are subject to all applicable laws regarding telehealth, including the confidentiality of health care information and a Member’s rights to the Member’s medical information. Telehealth includes synchronous interactions, and asynchronous store-and-forward transfers. Telehealth may be conducted using audio and video or audio only.

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

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

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

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

9.9 Corrected Claims Processing Guidelines

9.9.1 Claim Corrections

When a claim is received within the contractual timely filing period but is received with missing information, the Provider will be required to submit a corrected claim to KP within 90 calendar days (Colorado), 365 calendar days (Georgia, Hawaii, Mid-Atlantic States, Northwest), or same limits as original claim (California) from the date of the original Remittance Advice, unless a different timeline is specified in your Agreement or required by state or federal rule.

9.9.2 Correcting a Previously Submitted Claim

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

9.9.3 Justifications for Claim Corrections

Providers can submit a claim correction for the following reasons:

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

9.9.4 Electronic Replacement/Corrected Claim Submissions

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

9.9.5 Paper Replacement/Corrected Claim Submissions

- Corrected claims should be submitted using the appropriate frequency code (7 or 8) and providing the original Kaiser Permanente Claim number that you want corrected.
- Frequency Code
 - o UB Claim – Field 4-Bill Type (xx7/xx8)
 - o CMS Claim – Field 22 (RESUB CODE)
- Original Claim Number/DCN should be included in the following field:
 - o UB Claim - Field 64 (Document Control Number)
 - o CMS Claim – Field 22 (Original REF No.)

9.10 Claims Review and Adjustments

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

9.11 Compensation Methodologies

- The term of your Agreement has information on the payment amounts for services. Refer to your Agreement for detailed information on applicable compensation methodologies.

9.12 Code Review and Editing

The standards for determining payable items or services are outlined in POL-020, Clinical Review Payment Determination Policies.

9.13 Clinical Review

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

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

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

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

- History reportsPhysical reports
- Consultant reports
- Discharge summaries
- Emergency department reports
- Diagnostic reports
- Progress reports

CDI coding queries to physicians and physician responses

9.14 Prohibited Member Billing Practices

Providers cannot bill, charge, collect deposits, impose surcharges, or seek recourse against Members or their representatives for covered services under the Agreement. Balance billing for services covered by KFHP is prohibited.

Health Plan members may be billed only for copayments, coinsurance and deductibles where applicable according to Member benefit coverage and your Agreement, which payments may be subject to an out-of-pocket maximum. These are the only situations in which a Health Plan Member can be billed for covered services.

Except for member cost share and as expressly permitted by the Agreement and applicable law, Providers must seek compensation for covered services from KP or other responsible payors (e.g., Medicare).

Fees for missed appointments, "no-show" fees, and late cancellation fees cannot be charged to or paid by Kaiser Permanente. These fees also cannot be charged to Medicare or QUEST members. For commercial members, these fees may be collected only if the Provider has a written policy detailing the circumstances under which such fees may be imposed, and the Commercial Member has agreed in writing to be financially responsible for these fees before receiving services.

9.14.1 Member Cost Share

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

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

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

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

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

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

9.15 Do Not Bill Events (DNBE)

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

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

CMS-defined HCACs are updated annually and include:

- Wrong surgery or invasive procedure on a patient
- Surgery or invasive procedure on the wrong patient
- Surgery or invasive procedure on the wrong body part
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility

- Stage III and IV pressure ulcers
- Falls and trauma (e.g., fractures, dislocations, intracranial injuries, crushing injuries, burns)
- Manifestations of poor glycemic control (e.g., diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis or hyperosmolarity)
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infections (e.g., mediastinitis following coronary artery bypass graft, infections following bariatric surgery, orthopedic procedures, cardiac implantable electronic devices)
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures (e.g., total knee replacement, hip replacement)
- Iatrogenic pneumothorax with venous catheterization

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

9.16 Claims Submission for HAC (Hospital Acquired Conditions), DNBE, or Never Event:

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

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

9.16.1 Additional Requirements

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

HCCS Modifiers: Use applicable modifiers with associated charges on all lines.

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

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

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

9.17 Coordination of Benefits (COB)

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

With the exception of California, COB information must be submitted within 12 months of the request for Commercial Member's claims and 24 months for Medicare/Medicaid Member's claims, unless otherwise stated in your agreement. If the request is made in the last three months of the year, Medicare/Medicaid Members have 27 months. COB information for California should be submitted within 90 calendar days from date of the primary carrier's EOB, unless otherwise stated in your agreement. Delays in processing may occur if COB information is not received within these timeframes.

9.17.1 Provider Responsibilities

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

9.17.2 Payment Determination

- **Secondary Payor:** When KP is secondary to another payor, KP will coordinate benefits and determine the amount payable to the Provider, where the standard payment determination methodology is to pay up to the primary payor's allowable, not to exceed what KP would have paid as a primary payor.

9.17.3 Cooperation Requirements

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

9.17.4 Determining the Primary Payor

Primary coverage is determined by applicable law and the member's benefit plan. Below are common scenarios.

- **Adults**

The plan covering the person as an employee, Member, subscriber, policyholder, or retiree is primary. The plan covering the person as a dependent is secondary. For Adult Medicare beneficiaries, CMS guidelines apply and can be found at:

<https://www.cms.gov/medicare/coordination-benefits-recovery/overview>

Dependent Children

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

Joint Custody: The birthday rule above still applies.

Separated or Divorced Parents: Court Agreement: Follow the court agreement or decree stipulating parental healthcare responsibilities for a dependent child.

No Court Order: Apply benefits in this order:

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

- **Medicare Members**

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

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

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

9.17.5 Workers' Compensation/Third Party Liability (TPL)

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

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

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

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

Virginia Medicaid and FAMIS Only - Commercial plans will always be primary for those members enrolled in Medicaid and FAMIS programs. For members who have dual entitlement, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their state Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the state's payment limit.

9.18 COB Claims Submission Requirements and Procedures

If a claim is submitted to KP without the necessary primary payment information and member responsibility details, or without the primary payor's Explanation of Payment (EOP), KP will deny the claim. Providers must first submit the claim to the primary payor. Within 90 days (or longer if required by law or your Agreement) after the primary payor has paid, resubmit the claim to KP with the primary payor payment information. KP will then review the claim and determine the payment amount based on your Agreement.

9.18.1 Members Enrolled in Two Kaiser Permanente Plans: (Dual Coverage)

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

9.18.2 Secondary Claims Submission via EDI

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

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

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

Contact your clearing house for assistance with electronic COB claims.

9.19 Third Party Liability (TPL)

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

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

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

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

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

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

Guidelines (Information Required)

Providers must enter the following on the billing form:

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

9.20 Workers' Compensation

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

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

If authorized by Kaiser Permanente

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

9.21 Copayments, Coinsurance and Deductibles

Copay Collection Responsibilities

Contracted providers must collect copayments, coinsurance, and deductibles ("Copays") according to member benefits, unless stated otherwise in your Agreement.

Claims Submission

- **Payment:** Claims will be paid at the applicable rate under your Agreement, minus the Copay amount due from the member.
- **Waiving Member Cost Share:** Do not waive Copays unless expressly permitted by law and your Agreement.

Verification:

- **Verify Member Cost Share:** Contact Kaiser Permanente Member Services for the appropriate region as listed in section 5.24.1 of the Appendix to verify applicable Copays at the time of service.

9.22 Overpayment Policy

Notification and Return

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

Overpayment Identified by KP

- **Return Within 30 Days:** Return any overpayment identified by Kaiser Permanente within 30 working days of receiving the notice, unless contested.

Contesting Overpayment

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

Information Required for Returning Uncontested Overpayments

- Member Name: Name of each Health Plan member who received care.
- Remittance Advice: Copy of each applicable remittance advice.
- Primary Carrier Information: If applicable.
- Explanation of Payment (EOP): Copy of EOP with an explanation of the erroneous payment.
- Medical Record Number (MRN): Each applicable member's Kaiser Permanente MRN.
- Authorization Numbers: For all applicable non-emergency services.
- Claim Numbers: Relevant claim numbers.
- Dates of Service: Dates when the services were provided.

9.23 Overpayment Recoupment

- Kaiser Permanente will recoup an uncontested overpayment from a provider's current claim submissions only if:
 - The Provider fails to reimburse KP within the specified timeframe.
 - The Agreement authorizes recoupment from current claims or KP has obtained other written offset authorization from the Provider.

Evidence of Payment (EOP)

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

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

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

You are responsible for identifying the primary payer, seeking authorization from the primary payer (if authorization is required), and billing the appropriate party. See Section VI, "Member Eligibility and Benefits".

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

- To determine whether a Medi-Cal Member may have OHC prior to delivering services, please access the DHCS Automated Eligibility Verification System at

800-427-1295 or the Medi-Cal Online Eligibility Portal available at: <https://www.medi-cal.ca.gov/Eligibility/Login.aspx>

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

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

9.24 Appendix

9.24.1 KP Contact Information

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

9.24.2 Community Provider Portal (CPP)

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

Section X: Provider Appeals

INTRODUCTION

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

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

IMPORTANT INFORMATION ABOUT YOUR RIGHTS TO DISPUTE OUR DETERMINATION ON THIS CLAIM: If you wish to dispute our action or decision, you must submit your dispute online or in writing **within 60 days** of the date the claim was originally processed on the Explanation of Payment (EOP).

10.1 REQUIRED INFORMATION FOR PROVIDER DISPUTE NOTICES:

Your Provider Dispute Notice must contain your Provider Contact Information, and the required information listed below for us to acknowledge your dispute:

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

A payment dispute request may also be submitted in writing and sent to:

Kaiser Permanente Hawaii
Provider Appeals
Claims Administration Department

ATTN:
Provider Disputes
PO BOX 378021
Denver CO, 802387-9998

10.2 INSTRUCTIONS FOR RESOLVING SUBSTANTIALLY SIMILAR PAYMENT

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

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

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

Resources are available at the following link:

<https://healthy.kaiserpermanente.org/hawaii/community-providers>

Section XI: Credentialing and Re-Credentialing Process

11.1 PROVIDER CREDENTIALING AND RE-CREDENTIALING: As an important part of KP's Quality Management Program, all credentialing and re-credentialing activities are structured to assure applicable Providers are qualified to meet KP, NCQA, TJC, AAAHC and other regulatory standards for the delivery of quality health care and service to members.

The credentialing and re-credentialing policies and procedures approved are intended to meet or exceed the managed care organization standards outlined by the NCQA, TJC, and the AAAHC.

Kaiser Permanente has developed and implemented credentialing and re-credentialing policies and procedures for Providers. Practitioners include, but are not limited to, MDs, DOs, oral surgeons, podiatrists, advanced practice nurses, behavioral health practitioners, and optometrists. Organizational Providers (OPs) include, but are not limited to, hospitals, SNFs, home health agencies, hospice agencies, dialysis centers, congregate living facilities, behavioral health facilities, ambulatory surgical centers, clinical laboratories, comprehensive outpatient rehabilitation facilities, portable x-ray suppliers, federally qualified health centers, and community-based adult services centers. Services to members may be provided only when the Provider meets KP's applicable credentialing standards and has been approved by the appropriate Credentials and Privileges Committee.

Providers must also submit, upon renewal, ongoing evidence of current licensure, insurance, and accreditation/certification as applicable, along with other credentialing documents subject to expiration.

11.2 PRACTITIONERS: KP requires that all practitioners within the scope of KP's credentialing program be credentialed prior to treating members and must always maintain credentialing. Re-credentialing will occur at least every 24 months in a hospital setting, at least every 36 months in an ambulatory (medical office) setting, and may occur more frequently. Requirements for initial credentialing and re-credentialing for practitioners include, but are not limited to:

- Complete, current, and accurate credentialing/re-credentialing application.
- Current licensures, certifications, and/or permits as required by law.
- Evidence of appropriate education, clinical training, and current competence in practicing specialty.
- No history of state or federal sanctions/limitations/exclusions.
- Evidence of current insurance, in amounts as required by KP.
- Complete clinical work history.
- Complete malpractice claim history.
- Evidence practitioners are not currently opted out of Medicare.
- No significant events as identified through Kaiser Permanente performance data (at re-credentialing only).

KP adheres to the NCQA and TJC standards for credentialing and re-credentialing of hospitalists. Hospitalists who provide services exclusively in the inpatient setting and provide care for members only because of members being directed to the hospital setting are deemed appropriately credentialed and privileged in accordance with state, federal, regulatory, and accreditation standards when credentialed and privileged by the hospital in which they treat members.

The appropriate Permanente Regional Credentials and Privileges Committee will communicate credentialing determinations in writing to practitioners. In the event the committee decides to deny initial credentialing, terminate existing credentialing, or make any other adverse decision regarding the practitioner's ability to treat members, appeal rights will be granted in accordance with applicable legal requirements and policies and procedures. The practitioner will be notified of those rights when notified of the committee's determination.

All information obtained by KP during the practitioner credentialing and the re-credentialing process is considered confidential as required by law. For additional information regarding credentialing and re-credentialing requirements and policies, please email: hi-credentials-department@kp.org

11.3 PRACTITIONER RIGHT TO CORRECT ERRONEOUS OR DISCREPANT INFORMATION: The credentials staff will notify the practitioner, orally or in writing, of information received that varies substantially from the information provided during the credentialing process. The practitioner must correct the erroneous or discrepant information in the timeframe set forth by the credentialing staff. The notice will state to whom, and in what format, to submit corrections.

11.4 PRACTITIONER RIGHT TO REVIEW INFORMATION: Upon written request, and to the extent allowed by law, a practitioner may review the information submitted in support of their credentialing application and verifications obtained by that are a matter of public record. The credentials file must be reviewed in the presence of Kaiser Permanente credentialing staff. Upon receipt of a written request, an appointment time will be established during which practitioners may review the file.

11.5 PRACTITIONER RIGHT TO BE INFORMED OF THE STATUS OF THE CREDENTIALING APPLICATION: The credentialing staff will inform the practitioner of their credentialing or re-credentialing application status upon request. Requests and responses may be written or oral. Status information is limited to:

- Information specific to the practitioner's credentials file.
- Current credential status.

- Estimated committee review date, if applicable and available.
- Outstanding information needed to complete the credentials file.

11.6 PRACTITIONER RIGHT TO CREDENTIALING AND PRIVILEGING POLICIES: Upon written request, a practitioner may receive a complete and current copy of KFHP Hawaii Region Credentialing and Privileging Policies and Procedures. For those hospitals where the practitioner maintains active privileges, the practitioner may also request and receive complete and current copies of the Professional Staff Bylaws and the Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital.

11.7 ORGANIZATIONAL PROVIDERS (OPs): KP requires that all OPs within the scope of its credentialing program be credentialed prior to treating members and always maintain credentialing. Re-credentialing will occur at least every 36 months and may occur more frequently. Requirements for both initial and re-credentialing for OPs include, but are not limited to:

- Completed credentialing/re-credentialing application
- Hawaii license in good standing, as applicable
- Medicare and Medicaid certification, if applicable. Accreditation by a KP recognized accreditation body and/or site visit by Kaiser Permanente.
- Evidence of current professional and general liability insurance, in amounts as required by KP. Other criteria specific to organizational specialty

11.8 CORRECTIVE ACTION PLAN OR INCREASES MONITORING STATUS FOR (Ops): Credentialing and re-credentialing determinations are made by the KP Regional Credentialing and Privileges Committee. At the time of initial credentialing, newly operational OPs may be required to undergo monitoring.

Newly operational OPs are typically monitored for at least six months. These Providers may be required to furnish monthly reports of applicable quality and/or clinical indicators for a minimum of the first three months of the initial credentialing period. This monitoring may include on-site visits.

If deficiencies are identified through KP physicians, staff, or members, the OP may be placed on a corrective action plan (CAP), or performance improvement plan (PIP) related to those deficiencies.

The OP will be notified in writing if deficiencies are identified. The notice will include the reason(s) for which the CAP or PIP is required, the monitoring time frames, and any other specific requirements that may apply regarding the monitoring process. Within two weeks of such notice, the OP must create, for

KP review, is a time-phased plan that addresses the reason for the deficiency and their proposed actions toward correcting the deficiency. KP will review the draft CAP or PIP and determine whether it adequately addresses identified issues.

If the plan is not acceptable, KP representatives will work with the OP to make necessary revisions to the plan. OPs subject to a CAP or PIP will be monitored for six months or longer. For additional information regarding credentialing and re-credentialing requirements and policies, please contact the Credentialing and Privileging Department: hi-credentials-department@kp.org

11.9 LICENSURE, CERTIFICATION, AND CREDENTIALING:

Subcontractors and participating practitioners are subject to the same credentialing and re-credentialing requirements as the Provider. The Provider is responsible to ensure that all subcontractors and participating practitioners are properly licensed by the State of Hawaii or the state(s) in which services are provided and that the licensure and/or certification is in good standing in accordance with all applicable local, state, and federal laws.

Further, the Provider is responsible to ensure that its subcontractors and participating practitioners participate in KP's credentialing and re-credentialing processes and that any site where members may be seen is properly licensed. For additional information on credentialing requirements.

Section XII: Utilization Management

INTRODUCTION

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

12.1 UTILIZATION MANAGEMENT PROGRAM: We expect our contracted providers to make medical decisions based on the appropriateness of care for a member's medical needs and clinical condition. 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.

Kaiser Permanente expects our contracted providers to allow open provider-patient communication regarding appropriate treatment alternatives without regard for a member's benefit plan. We do not penalize providers for discussing available care options with 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, and to coordinate the evaluation of resource management.

Kaiser Permanente monitors member and provider experience annually. Results are used in the Utilization Management (UM) program.

Through standardized Utilization Management (UM) processes, objective information regarding medical necessity and medical appropriateness of health care services is obtained. Appropriate licensed healthcare professionals supervise all Utilization Management (UM) decisions. A licensed physician reviews all full and partial denials of a health care service when the determination is based on medical appropriateness or medical necessity.

The criteria used in the Utilization Management (UM) review process are available to all practitioners upon request at no cost, Utilization Management (UM), oversight is invoked in a small minority of medical decisions and is based on objective criteria (e.g., InterQual criteria) or guidelines used in conjunction with clinical judgment.

12.2 REQUEST FOR AUTHORIZATION FOR CONTRACTED PROVIDER SERVICES: For health care services provided to a member by a contracted provider, a referral and authorization is required. The contracted provider must contact Kaiser Permanente to arrange for and to coordinate the necessary medical care

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

You are also responsible for confirming that services provided to a member are covered benefits. For specific questions regarding eligibility or a member's benefit plan and coverage for services, please call the Authorizations & Referrals Management department at 1-808432-5687.

12.2.2 INPATIENT SERVICES IN THE STATE OF HAWAII: To receive authorization for inpatient services in the state of Hawaii, affiliated and non-affiliated Providers must contact MDCC Hotline at 1-808-643-6363 prior to admission. To receive authorization for services outside the state of Hawaii, Providers must contact the Authorization and Referrals Management department at 1-808-432-5687.

12.2.3 OUT-OF-PLAN REFERRAL PROCESS: All out-of-plan requests require a referral and authorization, please call the Authorizations & Referrals Management department at 1-808432-5687 or fax 1-808-432-5691.

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

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

12.4 HOSPITAL ADMISSIONS OTHER THAN EMERGENCY SERVICES:

Emergency care needed to stabilize an emergency medical condition does not require prior authorization. However, the Health Plan requires prior authorization for out-of-plan post-stabilization care, according to standards outlined in applicable statutes and regulations. Such authorization can be requested as described above by contacting the Case Manager.

12.5 ADMISSION TO SKILLED NURSING FACILITY (SNF): A SNF stay may be authorized when a KP plan physician or KP-designated specialist refers to a member for the skilled level of care at an SNF. Such authorization will include a description of specific, approved therapies and other medically necessary skilled nursing services per Medicare guidelines.

The initial skilled care authorizations or denials are based on the member's medical needs at the time of admission, and the member's benefits and eligibility status. The member is informed by the KP care coordinator what his or her authorized anticipated length of stay will be.

The KP care coordinator conducts telephonic or on-site reviews at least weekly to evaluate the member's clinical status and level of care needs and to determine if continuation of the authorization is appropriate. The SNF may request an extension of authorization for a continued stay from the patient care coordinator. Based on the member's skilled care needs and benefit eligibility, more SNF days may be approved. If additional days are authorized, then the SNF will receive verbal or written notice of authorization from KP.

Other services in connection with an SNF stay are authorized when either the member's plan physician or other KP designated specialists expressly order such services. These services may include, but are not limited to, the following items:

- Laboratory and radiology services
- Special supplies or DME
- Ambulance transport (when the patient meets medical necessity)

12.6 HOSPICE AND SKILLED NURSING FACILITY (SNF) SERVICES:

These services are to be prescribed and directed by a Kaiser Permanente physician or an affiliated network physician and provided by a licensed and contracted SNF facility or hospice agency. To be eligible for the SNF benefit, a member must meet Medicare guidelines, except that a prior three-day stay in an acute hospital is not required. These services can also be coordinated by our Continuing Care/Home Health Department. Medications; medical supplies; and durable medical equipment ordinarily furnished by the skilled nursing facility. Services not covered are personal comfort items such as a telephone, television, and take-home medical supplies.

12.7 HOME HEALTH AND HOSPICE SERVICES: As described below, all home health and hospice services must be authorized by KP Care at Home prior to providing services. Home health or hospice services are provided subject to the following criteria, as applicable to the specific situation:

- A KP plan physician must order and direct the requests for home health and hospice services.
- The patient is an eligible member.
- Services are provided in accordance with benefit guidelines.
- The patient requires care in his or her place of residence. Any place that the patient is using as a home is considered the patient's residence.
- The home environment is a safe and appropriate setting to meet the patient's needs and provide home health or hospice services.
- There is a reasonable expectation that the patient's clinical needs can be met by the Provider.

Home health services do not include:

- 1) Custodial care
- 2) Homemaker care
- 3) Domiciliary care
- 4) Care that a Medical Group Home Health Committee determines may be appropriately provided in a medical office, hospital, or skilled nursing facility.
- 5) Such care is provided or offered in such a setting in accordance with the Member's Service Agreement.

12.8 HOME HEALTH ONLY: KP Care at Home evaluates authorization requests for home health services based on, but not limited to, the following criteria:

- The services are medically necessary for the member's clinical condition.
- The patient is homebound, which is characterized by an inability to leave home without the aid of supportive devices, special transportation, or the assistance of another person. A patient may be considered homebound if absences from the home are infrequent and short distances. A patient is not considered homebound if lack of transportation or inability to drive is the reason for being confined to the home.
- The patient and/or caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals.

12.9 Referral to Community Hospice Agencies

When KP Care at Home (KPCAH) refers a patient to a community hospice agency, the agency must:

- Receive and review the referral from KPCAH
- Conduct its own evaluation and assessment to determine whether the patient meets the eligibility criteria for hospice services.
- Certify that the patient is terminally ill, in accordance with Medicare or applicable program guidelines, before accepting the patient into care.

Once the patient is accepted and admitted by the community hospice agency, that agency assumes full responsibility for coordinating all hospice-related care, including:

- The community hospice agency and its own physicians assume full responsibility for the ongoing management of the patient's care.
- The agency's interdisciplinary group (IDG) determines the appropriate level of hospice care (e.g., Routine Home Care, Inpatient Respite, General Inpatient, or Continuous Home Care).
- The community hospice agency is responsible for transitioning the patient to the next appropriate level of care as needed, based on clinical assessments and care needs.

Although hospice services must be prescribed and directed by a physician, once the patient is under the care of a community hospice agency, it is that agency's physicians—not Kaiser Permanente physicians—who direct and manage the patient's hospice care.

Authorization Process for Hospice Services and Room & Board

Initial Authorization

- KPCAH will send the hospice referral and initial service authorization via **Affiliate Link** and/or email/fax.

Reauthorization Process

To request reauthorization of hospice services and Room & Board:

1. **Complete the reauthorization request form** at least **1 week before** the benefit period ends: [Reauthorization Form](#)
2. **Email the following documentation to:**
kpcah-hospice-reauthorization-hi@kp.org
 - Current Care Plan
 - Current or most recent Certificate of Terminal Illness (CTI)
 - Most recent MD Face-to-Face (F2F) notes
 - Admission nursing notes and all nursing notes from the last 30 days before the end of the current authorization
3. The **KPCAH Hospice team** will review the request and send an **automated fax notice** with the approval letter.

4. Authorizations are issued for **each certification period**.

Communication of Member Death or Discharge

If a KP member under community hospice care passes away or is discharged:

1. **Complete the communication form** within **3 business days**:
[Death/Discharge Notification Form](#)
2. Continue your current process of notifying the **primary care physician** regarding the member's death or discharge.

For questions or further guidance, please contact the **KPCAH Hospice Agency** at **(808) 432-7660** or email kpcah-hospice-reauthorization-hi@kp.org.

12.10 DURABLE MEDICAL EQUIPMENT (DME): The Health Plan evaluates *r e f e r r a l* *o r d e r* requests for durable medical equipment for appropriateness based on, but not limited to, the following information:

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

Health Plan DME Formulary information may be available upon request by calling the Regional HI DME Office at:

DURABLE MEDICAL EQUIPMENT (DME)

Phone: 1-808-432-5692

Fax: 1-808-432-5689

Email: HI-DME@kp.org

Hours: Monday-Friday 8-4:30P.M

12.11 PSYCHIATRIC HOSPITAL SERVICES: Initial verbal authorizations will be made to the psychiatric facility by a KP Psychiatry Department/Call Center referral coordinator at the direction of a KP plan physician or clinician. When a member is admitted to your facility for psychiatric service. For the initial authorization to be activated you must notify KPat the appropriate facility number. You may be asked to complete supplemental documentation such as an Insurance Admission Information form.

12.12 NON-EMERGENCY TRANSPORTATION

12.12.1 Non-Emergency Medical Transport (Gurney Van/Wheelchair Van):

Providers may call KP to arrange for KP physician-authorized non-emergency medical transportation. Non-emergency medical transportation may or may not be a covered benefit for the member.

12.12.2 Non-Emergency Ambulance Transportation: If a member requires non-emergency ambulance transportation to a Kaiser Medical Center or any other location designated by KP, Providers may contact KP Hospital Operations Center (HOC) to arrange the transportation of the member. The provider should never contact any ambulance company directly to arrange authorized non-emergency ambulance transportation for a member.

Non-emergency ambulance transportation may or may not be a covered benefit for the member. Payment may be denied for ambulance transport of a member that is not coordinated by KP and not properly documented as an authorized referral.

12.13 CONCURRENT REVIEW PROGRAM: Kaiser Permanente is committed to providing care of the very highest quality to our members in the most efficient, cost-effective manner possible. The goal of our Concurrent Review Program is to coordinate the effective management of care and facilitate improved resource management strategies that result in better utilization of resources, while striving to provide a positive member experience. It includes issuing and reviewing expedited, pre-service, and post-service denials.

The Outside Services Coordination department case manager is responsible for a wide variety of functions for members in out-of-plan facilities. This includes coordinating all case management activities; performing inpatient concurrent reviews; retrospective reviews; collecting, analyzing, and reporting inpatient data; and overseeing the use of continuing care services such as home, sub-acute, and hospice care, and transfer to in-plan facilities when appropriate.

Criteria used for inpatient concurrent and retrospective reviews are reviewed by the medical staff and updated annually. The criteria are available to medical staff by request from the Continuing Care department.

A physician reviewer is available to discuss by telephone determinations based on medical appropriateness. Contact the Outside Services Coordination department at 1-808-432-7252 7100 to be directed to the appropriate UM physician advisor. Behavioral Health, contact the Integrated Behavioral Health department at 1-808-432-7600.

12.14 DISCHARGE PLANNING: Providers such as hospitals, SNFs, psychiatric facilities, home health and hospice agencies are expected to provide discharge planning services for members, and to cooperate with KP to ensure timely and appropriate discharge. Providers should designate staff to provide proactive, ongoing discharge planning. Discharge planning services should begin upon the member's admission and be completed

by the medically appropriate discharge date. The Provider's discharge planner will identify barriers to discharge and determine an estimated date of discharge. Upon request by KP, Provider will submit documentation of the discharge planning process.

The Provider's discharge planner, in consultation with the KP care coordinator, will arrange and coordinate transportation, DME, follow-up appointments, appropriate referrals to community services and any other services requested by KP. Unless the Provider has received prior authorization to furnish follow-up care, the Provider must contact KP to arrange for and to coordinate covered medically necessary care after discharge.

12.15 CASE MANAGEMENT: KP care coordinators work with treating Providers to develop and implement plans of care for acutely ill, chronically ill, or injured members. KP case management staff may include nurses and social workers who assist in arranging care in the most appropriate setting and help coordinate other resources and services.

While any Provider may request authorization for services or may seek a member's inclusion in a particular KP UM program (for example, case management), the personal physician continues to be responsible for managing the member's overall care. It is the Provider's responsibility to send a report to the referring physician of any consultation with, or treatment rendered to, the member, regardless of whether the referring physician is the member's physician. Contact Case Management at 1-808-432-7252 daily 8-4:30 P.M. except for holidays.

Section XIII: Pharmacy Services / Drug Formulary

INTRODUCTION

Kaiser Permanente uses a drug formulary to ensure that the most appropriate and effective prescription drugs are available to members. The drug formulary is a list of drugs that have been approved by the Pharmacy and Therapeutics (P&T) Committee comprised of physicians, pharmacists, nurses, and other allied healthcare professionals. The drug formulary is reviewed regularly to add new drugs and remove drugs as deemed appropriate. The drug formulary also helps to restrict drugs that can be toxic or otherwise dangerous if misused.

The drug formulary is considered a closed drug formulary, in which listed medications are usually covered under plan benefits. However, a listing of medication in the drug formulary does not necessarily mean it is covered under your patient's prescription drug benefit plan since prescription benefit coverage varies depending on your patient's plan.

Affiliated Providers who have questions regarding Kaiser Permanente's pharmaceutical management procedures may call the Pharmacy Administration department at 1-808- 752-5598.

13.1 PRESCRIBING NON-FORMULARY DRUG: Non-Formulary drugs are those that have not yet been reviewed, and those drugs that have been reviewed but given non-Formulary status by the P&T Committee. However, the situations outlined below may allow a non-Formulary drug to be covered by the member's drug benefit.

- New members If needed and the member's benefit plan provides, new members may be covered for an initial supply (up to 90 days for Commercial members and 30 days' supply of medication for Medicare Members) of any previously prescribed "non-formulary" medication to allow the member time to make an appointment to see a KP provider. If the member does not see a KP provider within the first 90 days of enrollment, they must pay the full price for any refills of non-formulary medications.
- Existing members A Non-formulary drug may be prescribed for a member if they have an allergy, intolerance to, or treatment failure with all formulary alternatives or has a special need that requires the member to receive a non-Formulary drug. For the member to continue to receive the non-Formulary medication covered under their drug benefit, the exception reason must be provided on the prescription.

NOTE: Generally, non-formulary drugs are not stocked at KP pharmacies. Therefore, before prescribing a non-Formulary drug, call the pharmacy to verify the drug is available at that site.

The KP Formulary may be found at: [Formulary \(covered drugs\), Hawaii | Kaiser Permanente](#)

NOTE: Generally, non-formulary drugs are not stocked at Kaiser Permanente pharmacies. Therefore, before prescribing a non-formulary drug, call the pharmacy to verify if the drug is available at that site.

The Kaiser Permanente formulary may be found at: [Formulary \(covered drugs\), Hawaii | Kaiser Permanente](#)

13.2 PHARMACIES: KP pharmacies provide a variety of services including the filling of new prescriptions, transferring prescriptions from another pharmacy, providing refills, and consulting about new medications.

13.3 TELEPHONE AND INTERNET REFILLS: Members may request refills on their prescriptions, with or without refills remaining, by calling the pharmacy refill number on their prescription label. All telephone requests should be accompanied by the member's name, MRN, daytime phone number at 1-808-643-7979, prescription number, and credit or debit card information. Members may also refill their prescriptions online by accessing the KP Member website [at www.kp.org/refill](http://www.kp.org/refill)

ORDERING REFILLS: Members may request refills on their prescriptions, with or without refills remaining, by using the Kaiser Permanente app, or online at www.kp.org/refill. Members can also call 1-808-643-7979

13.4 MAIL ORDER: Members with a prescription drug benefit are eligible to use the KP “Prescription by Mail” service. For more information regarding mail-order prescriptions please contact the Mail Order Pharmacy at 1-808-643-7979.

13.5 RESTRICTED USE OF DRUGS: Some drugs (i.e., chemotherapy) are restricted to prescribing only by approved KP specialists. Restricted drugs are noted in the Formulary. If you have any questions regarding prescribing restricted drugs, please call the main pharmacy at the local KP facility.

13.6 EMERGENCY SITUATIONS: If emergency medication is needed when KP pharmacies are not open, members may use pharmacies outside of Kaiser Permanente. Since the member will have to pay the full retail price in this situation, they should be instructed to download a claim form on [Custom Care & Coverage Just For You | Kaiser Permanente](#) or to call Member Services to obtain a claim form reimbursed for the cost of the prescription less any copayments, co-insurance and/or deductibles (sometimes called Member Cost Share) which may apply.

Section XIV: Emergency and Urgent Care Services

This section defines emergency services and urgent care so that affiliated practitioners can appropriately direct Kaiser Permanente Members to receive these services.

14.1 EMERGENCY ADMISSIONS AND SERVICES HOSPITAL REPATRIATION POLICY:

Consistent with applicable law, Kaiser Permanente Members are covered for emergency care needed to clinically stabilize their situation. An emergency medical condition means any of the following:

- A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the member's health, or in the case of a pregnant woman, the health of the woman or her unborn child, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.
- A mental disorder that manifests itself by acute symptoms of sufficient severity that either the member is an immediate danger to themselves or others, or the member is not immediately able to provide for or use food, shelter, or clothing, due to the mental disorder.
- Concerning a pregnant woman who is having contractions, (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or her unborn child.
- As otherwise defined by applicable law (including California law or EMTALA), or as otherwise required by law.

Services provided to members to screen and stabilize a patient suffering from an emergency medical condition as defined above **do not** require prior authorization.

14.2 EMERGENCY SERVICES: A medical emergency is a sudden, unforeseen, and potentially life-threatening situation that requires immediate attention. A member with a medical emergency should be directed to the nearest emergency facility. Coverage for emergency care is based on the member's health plan eligibility and benefit coverage at the time of service.

Emergency services from non-Kaiser Permanente practitioners are covered **ONLY** if the services meet the prudent layperson standard and the services were immediately required because it was an unforeseen illness or injury and the delay caused by coming to a Kaiser Permanente facility would have resulted in death, serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or placed the health of the individual in serious jeopardy. Continuing or follow-up care from non-Kaiser Permanente providers is not covered.

Coverage for emergency services is slightly different for Senior Advantage and Medicare Cost Members, so please see your Evidence of Coverage for details.

If emergency services are provided to screen and stabilize a patient, they are covered in situations when a prudent layperson would have believed that an emergency condition existed. Once a patient is stabilized, the treating physician is required to communicate with Kaiser Permanente for the approval to provide further care; to effect a transfer.

14.3 AUTHORIZATION FOR KP EMERGENCY DEPARTMENT VISITS:

If due to a change in a member's condition, the member requires a more intensive level of care than your facility can provide, you can request a transfer of the member to a Kaiser Permanente medical center. HOC or designee will arrange the appropriate transportation. Transfers to a Kaiser Permanente medical center should be made by the facility after verbal communication with the appropriate Kaiser Permanente staff, such as an HPMG SNF physician or the emergency department physician.

If a member is sent to the emergency department via a 911 ambulance and it is later determined by Kaiser Permanente P that the ambulance transport or emergency department visit was not medically necessary, Kaiser Permanente may not be obligated to pay for the ambulance transport.

14.4 EMERGENCY TRANSFERS TO: Kaiser Foundation Hospital Moanalua Medical Center: If a member needs to be transferred to Kaiser Foundation Hospital Moanalua Medical Center and it is an emergency, the treating affiliated network practitioner needs to follow the procedure as outlined below:

When you encounter a Kaiser Permanente member at your emergency department who may need to be admitted, we request that you call the **Kaiser Permanente Hawaii Medical Doctor Call Center (MDCC)** at 1-808-643-6363. Our support staff at the MDCC call center will be able to assist you in providing care to our members, including transfers and follow-up care.

- Patient name & DOB
- Patient's medical record number (if known)
- Treating physician
- Phone/pager number where the physician can be reached
- Patient diagnosis
- Patient condition Services needed
- Vital Signs and events of current ED visit including any diagnostic tests and treatments.
- Most current provider notes if available.
- Transmit radiologic images
- Fax EKGs (Fax to 1-808-432-7251)

14.5 POST-STABILIZATION CARE: If the member is admitted to the facility as part of the stabilizing process and the facility has not yet been in contact with Kaiser Permanente, the facility must contact the local Outside Services Coordination department case manager at

the appropriate number to discuss authorization for continued stay as well as any additional appropriate post-stabilization care.

A Kaiser Permanente emergency physician will then accept the transfer of the patient, and the transfer process can be initiated. The Kaiser Permanente hospital team will take all necessary steps to ensure the patient's needs can be met at the Kaiser Foundation Hospital Moanalua Medical Center. If the patient cannot be accommodated at either the original hospital or Kaiser Foundation Hospital Moanalua Medical Center, the rendering hospital will coordinate care at a facility that can provide the level of care or specialty that is required.

14.6 URGENT CARE: Urgent care is care requiring prompt medical attention, usually within 24 or 48 hours, but not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, frequent urination, or a burning sensation when urinating.

When members need urgent care, please contact the nearest Kaiser Permanente facility. After hours, call the Kaiser Permanente After-Hours Advice Nurse on Oahu at 1-808-432-7700 or neighbor islands at 1-800-467-3011.

Section XV: Quality Management

INTRODUCTION

The KP Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation and licensing, and other elements. The KP quality improvement program assures that quality improvement is an ongoing priority for the organization. Information about our quality program is available in the “Quality Program at KP” document, including:

- Awards and recognition for our quality program
- Programs and systems within KP that promote quality improvement
- Quality improvement structure
- Areas targeted by our quality goals

To obtain a copy of this document, call Member Services at **1-800-966-5955** or **TTY 711**. Alternatively, you can view and print the document by visiting kp.org/quality. Click on “Measuring quality” then click on “Hawaii’s Quality Program at KP”

Additionally, we send an annual Quality Summary to provide you with the best quality support and communication. Topics covered in the summary include:

- Utilization Management
- Pharmaceutical Management
- Member Rights and Responsibilities
- Cultural Competency Plan
- Quality Program and quality-related efforts
- Clinical Practice Guidelines
- Medical Record Documentation Standards

Patient safety is a central component of KP's care delivery model. We believe our distinctive structure as a fully integrated healthcare delivery system provides us with 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.

If you would like independent information about KP's healthcare quality and safety, the following external organizations offer information online:

The National Committee for Quality Assurance (NCQA) works with consumers, purchasers of health care benefits, state regulators, and health plans to develop standards that evaluate health plan quality. KP is responsible for managing, measuring, and assessing patient care to achieve NCQA accreditation, which includes ensuring that all members are entitled to the same high level of care regardless of the site or provider of care. The focus of NCQA is on care provided in the ambulatory setting.

KP received accreditation from NCQA, and we periodically undergo re-accreditation. KP Hawaii Region provides the appropriate information related to quality and utilization upon request, so that KP may meet NCQA standards and requirements and maintain successful NCQA accreditation. You can review the report card for KFHP Hawaii at

<https://reportcards.ncqa.org/health-plans?q=kaiser&dropdown-state=Hawaii&filter-state>

The Leapfrog Group is a group of Fortune 500 companies, including nonprofit and large private companies, that encourages purchasers and consumers to use their healthcare buying power as leverage to create quality and safety standards in the U.S. The group gathers information about aspects of medical care and patient safety relevant to urban hospitals via an annual Leapfrog Survey. All KP hospitals in Hawaii, as well as most contracted hospitals, participated in the most recent survey. To review survey results, visit www.leapfroggroup.org/cp.

The Joint Commission is a healthcare accreditation organization recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain its accreditations, KP must conduct an on-site survey by The Joint Commission survey team at least every three years. KP has adopted a set of Joint Commission compliance expectations for contracted practitioners coming into our facilities. Learn more at www.jointcommission.org.

15.1 QUALITY ASSURANCE AND IMPROVEMENT PROGRAM OVERVIEW: KP's Quality Assurance and Improvement Program use a multidisciplinary and integrated approach that focuses on opportunities for improving operational processes, health outcomes, and member and Provider satisfaction.

The quality-of-care members receive is monitored by KP's oversight of Providers. You may be monitored for various indicators and required to participate in some KP processes. For example, we monitor and track the following:

- Patient access to care
- Patient complaint and satisfaction survey data for administrative and quality of care issues.
- Compliance with KP policies and procedures.
- Utilization Management statistics
- Quality of care indicators and provision of performance data as necessary for KP to comply with requirements of NCQA, Medicare, Joint Commission, and other regulatory and accreditation bodies.
- Performance standards in accordance with your Agreement.
- Credentialing and re-credentialing of Providers.

In any of the above situations, when KP reasonably determines that the Provider's performance may adversely affect the care provided to members, KP may take corrective actions in accordance with your Agreement. As a Provider, you are expected to investigate and respond promptly to all quality issues and work with KP to resolve any quality and

accessibility issues related to services for members. Each Provider is expected to remedy, as soon as reasonably possible, any condition related to patient care involving a member that has been determined by KP or any governmental or **accrediting agencies to be unsatisfactory**.

15.1.1 PRACTITIONER OFFICE SITE QUALITY: KP adheres to the NCQA standards for practitioner office site quality. Practitioner office site visits will be conducted when member complaints exceed established thresholds for accessibility, physical appearance, adequacy of the waiting room, and adequacy of examining room space. Actions will be instituted to improve offices that do not meet established thresholds.

15.2 MONITORING QUALITY:

15.2.1 Compliance with Legal, Regulatory, and Accrediting Body Standards: KP expects all applicable Providers to comply with all legal, regulatory, and accrediting requirements, to have and maintain accreditation as appropriate, to maintain a current certificate of insurance, and to maintain current licensure. If any entity takes any adverse action concerning licensure or accreditation, this must be reported to KP's Credentialing Department, along with a copy of the report and the action plan to resolve the identified issue or concern, within 90 days of the receipt of the report.

15.2.2 Infection Control: KP requests the cooperation of Providers in monitoring their practice for reporting communicable diseases including COVID-19 during the pandemic, aimed at the prevention of hospital associated infection (HAI) including, but not limited to, multi-drug resistant organisms such as MRSA, VRE, and difficult (C.diff), postoperative surgical site infections, central line-associated bloodstream infections, and catheter-associated urinary tract infection. When a potential infection is identified, notify the local Infection Preventionist. Confirmed HAI cases in the facility are tracked and entered the Centers for Diseases and Control (CDC) database called National Health and Safety Network (NHSN) as required per mandated public reporting.

When a trend is identified by the affiliated practitioner or Provider, this should be shared with the local Infection Control Committee (ICC) and a collaborative approach should be undertaken to improve practices related to infection prevention and control. All HAI summary reports, and analyses should be submitted for review on an ongoing basis to the KP ICC and Quality Management (QM) Departments. The results of this review should then be shared with the affiliated practitioner or Provider. The IP and QM Departments will request certain actions and interventions be taken to maximize patient safety, as appropriate.

15.2.3 Practitioner Quality Assurance and Improvement Programs: KP ensures that mechanisms are in place to continually assess and improve the quality of care provided to members to promote their health and safety through a comprehensive and effective program for practitioner peer review and evaluation of practitioner performance. This policy supports a process to conduct a peer review investigation of a healthcare practitioner's performance or conduct that has adversely affected or could affect the health or welfare of a member.

15.3 QUALITY OVERSIGHT: The peer review process is a mechanism to identify and evaluate the potential quality of care concerns or trends to determine whether standards of care are met and to identify opportunities for improvement. The process is used to monitor and facilitate improvement at the individual practitioner and system levels to assure safe and effective care. Peer review provides a fair, impartial, and standardized method for review whereby appropriate actions can be implemented and evaluated. The peer review process includes the following:

- Practitioner performance review and oversight – Practitioner profiling for individual re-credentialing as well as oversight and evaluation of the quality of care provided by practitioners in a department.
- Practitioner peer and system review – Quality of care concern.
- Focused practitioner review and practice improvement plan – Provides an objective evaluation of all or part of a practitioner's practice when issues are identified around the performance of that practitioner.

The primary use of the information generated from these activities is for peer review and quality assurance purposes. Such information is subject to protection from discovery under applicable state and federal law. All such information and documentation will be labeled "Confidential and Privileged," and stored in a separate, secured, and appropriately marked manner. No copies of peer review documents will be disclosed to third parties unless consistent with applicable KP policy and/or upon the advice of legal counsel. Information, records, and documentation of completed peer review activity (along with other information on practitioner performance) shall be stored in the affected individual practitioner's confidential quality file.

Individuals involved in the peer review process shall be subject to the policies, principles, and procedures governing the confidentiality of peer review and quality assurance information.

When a peer review investigation results in any adverse action reducing, restricting, suspending, revoking or denying the current or requested authorization to provide health care services to members based upon professional competence or professional conduct, such adverse actions will be reported by the designated leaders of the entities responsible to make the required report (e.g., the chief of staff or hospital administrator) to the National Practitioner Data Bank, and/or regulatory agencies, as appropriate.

15.3.1 Quality Review: Criteria that trigger a referral for Quality Review are identified through multiple mechanisms. Some sources include, but are not limited to:

Allegations of professional negligence (formal or informal)

Member complaints/grievances related to the quality of care

Risk management (significant events, potentially compensable events)

Medical legal referrals

Cases referred to as quality review are screened for issues related to the professional competence of a practitioner, which may be subject to peer review. These may include, but are not limited to:

- Inter- or intra-departmental or facility referrals
- Issues identified by another practitioner UM
- Member complaints to external organizations
- Nationally recognized practice standards, preferably evidence based.
- Professional practice requirements.
- KP and other CPG.
- KP policies and procedures, including policies related to patient safety.
- Regulatory and accreditation requirements.
- Community standard of care.
- Concerns regarding the possibility of any breach of professional judgment or conduct towards patients.
- Concerns regarding the possibility of failure to appropriately diagnose or treat a member/patient.
- Adverse patterns of care identified through aggregate review of performance measures (e.g., automatic triggers).
- To assist in the review, the reviewer will use appropriate information from sources that include, but are not limited to:
 - Nationally recognized practice standards, preferably evidence based.
 - Professional practice requirements.
 - KP and other CPG.
 - KP policies and procedures, including policies related to patient safety.
 - Regulatory and accreditation requirements.
 - Community standard of care.

15.3.2 OPs' Quality Assurance & Improvement Programs: Each OP must maintain a QA & I program, described in a written plan approved by its governing body that meets all applicable state and federal licensure, accreditation, and certification requirements. When quality problems are identified, the OP must show evidence of corrective action, ongoing monitoring, revisions of policies and procedures, and changes in the provision of services. Each OP is expected to provide KP with its QA & I plan and a copy of all updates and revisions.

15.3.3 Sentinel Events/Reportable Occurrences for Ops: All Providers must report sentinel events and reportable occurrences as defined below. OPs must report events and occurrences at the facilities covered by its Agreement.

Reportable occurrences include, but are not limited to, all of the following:

- Patient fall results in serious injury, which requires subsequent medical intervention.
- A cluster of nosocomial infections (cohort of three or more).
- Outbreaks of infectious diseases are reportable to the County Health Department.
- Official notice concerning revocation (requested or actual) of Medicare/Medicaid Certification or suspension of Medicare/Medicaid admissions.

15.4 SENTINAL EVENT/REPORTABLE OCCURRENCES-HOME AND HOSPICE AGENCY PROVIDERS

15.4.1 Notification Timeframes: Practitioners and OPs will report sentinel events and reportable occurrences within 24 hours of becoming aware of the event or occurrence. The report will be made to Kaiser Permanente as follows:

Provider	KP Contact	Timeframe
Practitioner	Case Manager	Within 24 hours
Acute Hospital	Case Manager	Within 24 hours
Chronic Dialysis Center	Case Manager	Within 24 hours
Ambulatory Surgery Center	Case Manager	Within 24 hours
Psychiatric Hospital	Case Manager	Within 24 hours
SNF	Case Manager	Within 24 hours

15.4.2 Report Within 24 Hours: Immediately upon discovery, verbally report the following sentinel/significant events to the referring KP home health agency, hospice agency, or facility. The verbal report must be followed by a written notification sent within 24 hours or by the end of the next business day by certified mail and return receipt.

- The event is not related to the natural course of the patient's illness or underlying conditions and results in an unanticipated death or major permanent loss of function (sensory, motor, physiologic), or intellectual impairment does not present at the initiation of the care episode that requires continued treatment or lifestyle change.
- The event is a significant adverse deviation from the usual process(es) for providing health care service or managing health care operations.
- The event or related circumstances have the potential for significant adverse media (press) involvement.
- Any process variation from which a recurrence would carry a significant chance of a serious adverse outcome.
- Significant drug reactions.
- Medication errors result in actual or potential harm to the patient.
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibility.
- Member/patient is either a perpetrator or victim of a crime or reportable abuse while under home health or hospice care.
- Loss of license, certification, or accreditation status.
- Release of any toxic or hazardous substance that requires reporting to a local, state, or federal agency.

15.4.3 Report Within 72 Hours: You must report the following events involving members that may impact the quality of care and/or have the potential for a negative outcome to the referring KP home health agency, hospice agency, or facility during KP business hours. Such reports should be made within 72 hours of the occurrence. These include but are not limited to the categories below.

- Reportable, communicable diseases, outbreaks of scabies or lice, and breaks in infection control practices.
- Falls resulting in injury.
- Re-admission to a hospital.
- Medication errors (wrong patient, wrong drug, wrong dose, wrong route, wrong time, wrong day, or an extra dose, or an omission of an ordered drug).
- Disciplinary action taken against a practitioner caring for a KP Member that requires a report to the applicable state board or the National Practitioner Data Bank.

Noncompliance with regulatory and/or accreditation standards requiring CAP

15.5 DO NOT BILL EVENTS (DNBEs)/REPORTABLE OCCURRENCES FOR

PROVIDERS: As part of its required participation in KP's QI Program and in addition to the claim's submission requirements in this Provider Manual, and to the extent permitted by law, the Provider must promptly notify KP and, upon request, provide information about any DNBE that occurs at its location or locations covered by its Agreement in connection with services provided to a member. Notices and information provided pursuant to this section shall not be deemed admissions of liability for acts or omissions, waivers of rights or remedies in litigation, or a waiver of evidentiary protections, privileges, or objections in litigation or otherwise.

Notices and information related to DNBEs should be sent to:

Risk Management
3288 Moanalua Rd.
Honolulu, HI 96819

Phone: 1- 808-432-7826

At a minimum, Providers should include the following elements in any DNBE notice sent to KP:

- KP medical record number
- Service Date(s)
- Place of service
- Referral number or emergency claim number
- General category description of DNBE(s) experienced by the member

15.6 QA & REPORTING REQUIREMENTS FOR HOME HEALTH PROVIDERS: Quality monitoring activities will be conducted at each individual home health agency.

15.6.1 Annual Reporting: On an annual basis, Providers of home health and hospice services, and licensed/certified Providers who manage members' plan of care on referral, must submit to KP:

- Copies of current license and insurance.
- Reports of any accreditation and/or regulatory site visits occurring within the last 12 calendar months.
- Results of the recent patient satisfaction survey.
- Action plans for all active citations, conditions, deficiencies and/or recommendations

15.6.2 Site Visits and/or Chart Review: A site visit and/or chart review may be requested by KP at any time to monitor quality and compliance with regulations. When on-site reviews are requested by the referring KP home health agency, your agency will make the following available:

- Documentation for member complaints and follow-up.
- Member medical records.
- Other relevant quality and compliance data.

15.7 QA & REPORTING REQUIREMENTS FOR SNFs: The KP QA & I plan includes quality indicators that are collected routinely. KP will collect some of these indicators, while others will be collected by the SNF Providers. These indicators will be objective, measurable, and based on current knowledge and clinical experience. They reflect structures, processes, or outcomes of care. KP promotes an outcome-oriented quality assessment and improvement system and will coordinate with SNF Providers to develop reportable outcomes.

15.7.1 Quarterly Reporting: Quarterly SNF quality assessment indicator trend reports will include, at a minimum, the following:

- Patient falls
- Pressure sores
- Medication errors
- Any CMS deficiency with a CAP or Hawaii Department of Public Health (HDPH) deficiency or citation with a CAP
- Reports to HDPH of unusual occurrences involving KP Members

15.7.2 Medical Record Documentation: KP procedures regarding medical record documentation for SNF Providers are detailed below. Any contradiction with an SNF Provider's policies and procedures should be declared by the SNF, so that steps can be taken to satisfy both the SNF Provider and KP.

All patient record entries shall be written (preferably printed), made in a timely manner, dated, signed, and authenticated with professional designations by individuals making record entries.

Medical record documentation shall include at least the following:

- Member information, including emergency contact and valid telephone number
- Diagnoses and clinical impressions
- Plan of care
- Applicable history and physical examination
- Immunization and screening status when relevant
- Allergic and adverse drug reactions when relevant
- Documentation of nursing care, treatments, frequency, and duration of therapies for Members, procedures, tests, and results
- Information/communication to and from other Providers
- Referrals or transfers to other Providers
- Recommendations and instructions to patients and family members
- Date, purpose, and updated information for each visit
- Advance directive

15.8 QA & I AM REPORTING REQUIREMENTS FOR CHRONIC DIALYSIS PROVIDERS:

15.8.1 Reporting Requirements: Providers who deliver chronic dialysis services are expected to send, on a monthly basis via hard copy or electronic file, a Patient Activity Report form containing the following information for patients who are:

- Dialyzing for the first time
- Transferring into the contracted dialysis center from another dialysis center
- Returning after transplant
- Recovering renal function
- Receiving a transplant
- Transferring to another dialysis center
- Deceased
- Changing treatment modality

Providers must also submit the above information for patients who were on dialysis prior to joining Kaiser Permanente.

15.8.2 Chronic Dialysis Patients: The following performance targets are the clinical indicators for KP Members on hemodialysis and peritoneal dialysis and shall be reported by the Provider to KP within 15 calendar days from the end of the calendar quarter. The submission of the indicators shall be in a format acceptable to KP via an electronic file or other method designated by KP. Each contracted dialysis company must report the indicators every quarter for each of its participating dialysis centers in their Agreement:

REGIONAL RENAL ESRD QUALITY IMPROVEMENT PROGRAM DIALYSIS FACILITY-SPECIFIC TARGETS			
MODALITY	MEASUREMENT	DESCRIPTION	TARGET
In-Center HD	Vascular Access	Percentage of patients in a given reporting period with a central venous catheter in place. If fistula or graft in use, but CVC in place, CVC will count.	Monitoring only
	Adequacy of Dialysis	Percent of all patients at the clinic whose last valid Kt/V of the month ≥ 1.2	95%
	Positive Blood Cultures	Report all positive blood cultures according to NHSN guidelines.	100% of known positive blood cultures are reported.
	Patients with Flu Vaccination	Includes vaccines administered at the unit and if the patient reports that they received a vaccine elsewhere from September through March. Patients who are contraindicated, refused, or who are allergic are counted as "No." Data not included on reports from April through August.	N/A (Data provided if available)
	Patients with Pneumonia Vaccination	Includes patients who received one dose within the last five years or two doses, five years apart within a lifetime. Either administered at the unit or reported by the patient. Patients who are contraindicated, refused, or who are allergic are counted as "No."	N/A (Data provided if available)

REGIONAL RENAL ESRD QUALITY IMPROVEMENT PROGRAM DIALYSIS FACILITY-SPECIFIC TARGETS			
MODALITY	MODALITY	MODALITY	TARGET
MODALITY In-Center HD	In-Center HD	In-Center HD	Monitoring only
		graft in use, but CVC in place, CVC will count.	
	Adequacy of Dialysis	Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.2	$\geq 95\%$
	Positive Blood Cultures	Report all positive blood cultures according to NHSN guidelines.	100% of known positive blood cultures are reported.

Patients with Flu Vaccination	Includes vaccines administered at the unit and if patient reports that they received a vaccine elsewhere September through March. Patients who are contraindicated, refused or who are allergic are counted as "No." Data not included on reports April through August.	N/A (Data provided if
Patients with Pneumonia Vaccination	Includes patients who received one dose within the last five years or two doses, five years apart within a lifetime. Either administered at the unit or reported by the patient. Patients who are contraindicated, refused or who are allergic are counted as "No."	N/A (Data provided if

15.9 MEDICAL RECORD REVIEW AND STANDARDS: KP recommends that all Providers maintain their medical records following standards applicable to their specialty to comply with various regulatory and accreditation organizations regarding clinical documentation and to assure the consistency and completeness of patient medical records. KP may review medical records for conformance to the standards:

KP MEDICAL RECORD DOCUMENTATION STANDARDS

I. General Guidelines

- A. Entries must be completed at the time of the visit or by the end of the day.
- B. Entries must be charted using SOAP (Subjective, Objective, Assessment, Plan) guidelines which provide a standard format
- C. Entries must be documented in the electronic health record. During downtime, handwritten notes are acceptable. All handwritten entries must be accurate, timely, and documented on valid medical record forms
- D. All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice
 - . All medical records are maintained in a manner that permits effective professional medical review and medical audit processes
- A. All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment
- B. All medical records shall be legible, signed and dated

II. Demographics

- A. Each page of the paper or electronic record includes the patient's name or ID number
- B. All medical records contain patient demographic information, including age, sex, address, home, and work telephone numbers, marital status, and employment, if applicable

III. Content

- A. Contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record
- B. All forms or notes have a notation regarding follow-up care, calls or visits, when indicated
- C. Contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations, and illnesses. For children, past medical history including prenatal care and birth
- D. All pediatric medical records include a completed immunization record or documentation that immunizations are up to date
- E. Include the provisional and confirmed diagnosis(es)
- F. Contain medication information
- G. Contain information on the identification of current problems (i.e., significant illnesses, medical conditions, and health maintenance concerns)
- H. Contain information about consultations, referrals, and specialist reports
- I. Contain information about emergency care rendered with a discussion of requirements for physician follow-up
- J. Contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate
- K. All medical records for members eighteen (18) years of age or older include documentation indicating whether the member has or has not executed an advanced directive, including an advance mental health care directive
- L. All medical records shall contain written documentation of a rendered, ordered, or prescribed service, including documentation of the medical necessity
- M. All medical records shall contain documented patient visits, which include, but are not limited to:
 - A history and physical exam
 - Treatment plan, progress, and changes in the treatment plan
 - Laboratory and other studies ordered, as appropriate
 - Working diagnosis(es) consistent with findings
 - Documentation concerning follow-up care, telephone calls, emails, other electronic communication, or visits, when indicated
 - Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits
 - Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans
 - Hospitalizations and/or emergency department visits, if applicable
 - All other aspects of patient care, including ancillary services.

IV. Dictated / Transcribed Documentation

- A. Data to be dictated on the day of the encounter
- B. Stat dictation to be transcribed within 24 hours
- C. Hospital operative reports, history & physical, consults, and discharge summaries are to be transcribed within 24 hours
- D. Clinic consults and progress notes are to be transcribed within 7 days

V. Ancillary Service Results

- A. Laboratory, Diagnostic Imaging, and Pathology results are available in the electronic medical record
- B. Non-electronic reports/interpretations of other ancillary services are scanned into the electronic health record

VI. Advice / Messages Related to Patient Care

A. An entry is to be made in the health record of all communication relating to patient care including, but not limited to:

- Medication refills
- Any new illness or change in health status
- All messages (communications) to and from the patient, except for the patient's request for an appointment which is honored
- Any medical or professional advice which is given
- Abnormal laboratory results or requests to return for additional testing procedures

VII. "No Show" Appointments

- A. When a patient fails to appear for the appointment (no show), it must be clearly indicated in the electronic health record and efforts to contact the patient with subsequent actions documented

VIII. Late Entries

- A. Documentation of late entries written out of chronological order must begin with "LATE ENTRY FOR (date/time)"

VIII. Correcting Entries

- A. Federal and State statutes require that when correcting the inaccuracy of a medical record entry, information must not be eradicated (whiteout) or removed

X. Forms

A. The Regional Forms Committee, Medical Records Administration, and Health Information Management Committee must approve all forms to be used in the medical record

XI. Copy and Paste

- A. Clinicians documenting in the electronic medical record must avoid indiscriminately copying and pasting another clinician's progress note, discharge summary, electronic mail communication, and redundant information provided in other parts of the health record.

Section XVI: Disease Management Resources

Kaiser Permanente Hawaii has several disease management resources in place to assist you with managing your patients.

The Patient Support Service (PSS) is a model for population care that utilizes the special skills of clinical pharmacists, pharmacy technicians, advanced practice RNs, and registered nurses. To reach defined quality goals and assist with regional priorities through an evidence-based, whole-member care approach to improve the health status of patients with chronic conditions and to support the primary care physician.

The PSS team currently helps manage patients with chronic conditions including diabetes, hypertension and cardiovascular disease, gout, depression, and osteoporosis, among others. The team utilizes tools to provide real-time data on targeted populations for feedback, monitoring, and management of the quality outcomes as measured against regional clinical standards. Members do not have to enroll in the PSS, as they are automatically enrolled when they engage with the care delivery system for chronic disease condition(s). Members are informed that the program is voluntary and that they may “opt out” at any time. Member feedback and clinical processes are also analyzed for continuous improvement in meeting member needs.

The approach to providing service to members with complex health needs involves an assessment of the member’s condition, determining available benefits and resources, and developing a care management plan for monitoring and follow-up. Conditions require treatment and services across a variety of domains of care to ensure the best possible outcome.

At a minimum on an annual basis, Kaiser Permanente Hawaii reviews its disease management programs and revises as necessary based on new treatments and innovations in the standard of care and notifies HPMG and affiliate practitioners of program information in the annual Quality Summary document.

For any questions or concerns regarding any clinical practice guidelines please email: HI.ClinicalLibrary@kp.org

Section XVII: Cultural Diversity

At Kaiser Permanente (KP), we are committed to improving the quality of care provided to our increasingly diverse membership. Member's cultural needs are considered and respected at every point of contact. This is integral for providing a culturally competent system of care. A person's culture is composed of many factors. Examples include:

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

At Kaiser Permanente, we

- Value differences in culture, experience, and perspective
- Seek out and consider different 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

17.1 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”) and Section 504 of the Rehabilitation Act of 1973 (“Section 504”) and other applicable federal and state laws and regulations that prohibit discrimination based on disability. Kaiser Permanente is committed to providing equal access for members with disabilities.

As a provider of HMO 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 based on disability

17.2 KP’S LANGUAGE ASSISTANCE PROGRAM: All Providers must cooperate and comply with KP’s Language Assistance Program by assisting any limited English proficient (LEP) KP member with access to KP’s Language Assistance Program services.

Providers must ensure that KP members or, if applicable, their family, caregivers, or legal guardian(s) receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language. Providers should offer language assistance, auxiliary aids, and services, including sign language interpreters to KP members who appear to need it even if they do not ask for it or if their language preference was not indicated on the referral form. If the facility or place of business is open 24 hours/day, 7 days/week, then language assistance is to be made available 24 hours/day, 7 days/week.

The proactive offer and/or use of language assistance services must be documented in the KP member’s medical record, even if the communication occurred directly with the Provider or Provider’s Qualified Bilingual Staff (QBS). If language assistance was utilized the type of service provided must be documented, along with the type/name of the service and the interpreter’s name and ID, either of the Provider, the Provider’s QBS, or the contracted KP language assistance vendor. Should an LEP KP member refuse to accept language interpreter services, the Provider must document this refusal in the KP member’s medical record and the reason for such refusal. In addition, if language assistance was requested by the KP member and not provided, the reason for not providing such services must be documented in the patient’s medical record. Please see the subsection titled “Documentation” below.

You can review Kaiser Permanente’s Interpreter Services for Limited English Proficient Persons policy on the kp.org website or you may contact the Interpreter Services Management Team at 1-808-432-2250 for questions regarding language services.

17.3 USING QUALIFIED BILINGUAL STAFF: We expect that you will provide interpreter services in-person using your qualified bilingual staff if you have them.

Your qualified bilingual staff should meet the regulatory standards set out in KP's minimum quality standards for interpreters:

- Documented and demonstrated proficiency in both English and the other (target) language.
- Fundamental knowledge in both languages of health care, clinical, and medical terminology, and concepts; and Education and training in interpreting ethics, conduct, and confidentiality.
- The 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.

17.4 WHEN QUALIFIED BILINGUAL STAFF IS NOT AVAILABLE: If you do not have qualified bilingual staff at the time services are needed, KP has made the following arrangements available to Providers when providing services to 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.

17.5 TELEPHONE INTERPRETATION: United Language Group 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 1-855-346-4810. This phone number is dedicated to the interpreter's needs of members. While no lead time is needed to engage an interpreter through this service, Providers must have the following data elements available before placing the call:

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

United Language Group customer service can be reached at 1-877-526-8438. In addition, United 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. United Language Group/Propio Language Services (ULG/PLS) customer service can be reached at 1-888-528-6692. In addition, ULG/PLS offers an email address if you wish to submit an issue through email (clientservices@propio.com). You will receive a follow-up response within 48 hours.

17.6 SIGN LANGUAGE SUPPORT: Hawaii Interpreting Services 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 two weeks' advance notice of the need for an ASL interpreter is recommended to help ensure an interpreter is available. Please provide as much advance notice as possible when requesting a Sign Language interpreter. Hawaii Interpreting Services can be reached by calling: 1-808-394-7706 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:

- KP Client ID number. This number will be provided to you, in writing, together with your authorization.
- KP referral or authorization number
- Member's Medical Record Number (MRN)
- Date(s) of member's appointment(s)
- Time and duration of each appointment
- Specific address and location of appointment(s)
- Any access or security measures the interpreter will need to know and plan for to gain entry to the place of service
- Any cancellation should be made at least twenty-four (24) hours in advance of the scheduled appointment
- Key Contact Name and Number for KP inquiries regarding the request for interpreter services

Please inform KP of any complaints, concerns, or questions that you have with the KP-provided language assistance service vendors by calling 1-808-432-2250.

17.7 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.

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

- Language assistance was either offered (or requested) to (by) a limited English proficient (LEP) KP member.
- If language assistance was refused by the KP member; the reason why must be noted, e.g., used family member.
- What type of service was utilized (telephonic, in-person interpreter services, or bilingual staff), for those members who accept/use language assistance.
- Name, ID, and 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.

17.9 ONSITE SIGHT TRANSLATION SERVICES: The requirements set forth above also apply

to KP member requests for the onsite verbal translation of documents related to such members' care (i.e., verbal translation of a written document provided to the KP member and related to services provided to such members). To the extent a KP member requests a written translation of one or more documents, the member should be referred to the KP Member Services Department.

17.10 STAFF TRAINING: Providers shall provide adequate training regarding the KP's language assistance program requirements to Provider staff who have contact with KP's limited English proficient (LEP) members. The training shall include instruction on:

- Understanding and complying with KP 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.
- How to access the KP language vendors and how to report any problems.
- How to document the use and refusal of language services.
- Understanding the cultural diversity of KP's member population and sensitivity to cultural differences relevant to the 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.

17.11 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 XVIII: Compliances

INTRODUCTION

Kaiser Permanente strives to demonstrate high ethical standards in our business practices. The Agreement details specific laws and contractual provisions with which you are expected to comply.

18.1 COMPLIANCE WITH LAW: Providers are expected to conduct their business activities in full compliance with all applicable policies, codes of conduct, state, and federal laws regulations and demonstrate high ethical standards. civil or criminal charges.

18.2 KP PRINCIPLES OF RESPONSIBILITY AND COMPLIANCE HOTLINE: The KP Principles of Responsibility (POR) is the code of conduct for KP physicians, employees, and contractors working in KP facilities (KP personnel) in their daily work environment. The POR is available for you to reference on the MyKP intranet and is reviewed annually within the Annual Ethics and Compliance Training.

You should report to KP any suspected wrongdoing or compliance violations by KP personnel under the POR. The KP Compliance Hotline is a convenient and anonymous way to report suspected wrongdoing without fear of retaliation.

CODE OF ETHICAL CONDUCT, KAISER PERMANENTE'S PRINCIPLES OF RESPONSIBILITY AND COMPLIANCE HOTLINE: The Code of Ethical Conduct, Kaiser Permanente's Principles of Responsibility is the code of conduct for KP physicians, employees, and contractors working in KP facilities (KP personnel) in their daily work environment. The Code of Ethical Conduct is available for you to reference on the MyKP intranet and is reviewed annually within the Annual Ethics and Compliance Training.

You should report to KP any suspected wrongdoing or compliance violations by KP personnel under the Code of Ethical Conduct. The KP Compliance Hotline is a convenient and anonymous way to report suspected wrongdoing without fear of retaliation.

It is available 24 hours a day, 365 days a year. The toll-free Compliance Hotline number is 1-888-774-9100. **For more information on what happens when you report a concern [click here.](#)**

KP also provides an online resource to report suspected wrongdoing online, at: <http://www.kp.org/compliance>

Additionally, Providers may review the KP POR and Provider Code of Conduct at: <http://providers.kaiserpermanente.org/html/cpp> and are encouraged to do so. The KP POR and Code of Conduct apply to interactions between you and KP. Failure to comply with the provisions of these standards may result in a breach of your Agreement with KP.

Providers should use the Principles of Responsibility whenever you need guidance on appropriate actions in your work and whenever your instincts tell you that something doesn't feel quite right.

Additionally, Providers may review the Code of Ethical Conduct and Provider Code of Conduct at: <http://providers.kaiserpermanente.org/html/cpp> and are encouraged to do so. The Code of Ethical Conduct apply to interactions between you and KP. Failure to comply with the provisions of these standards may result in a breach of your Agreement with KP.

Providers should use the Principles of Responsibility whenever you need guidance on appropriate actions in your work and whenever your instincts tell you that something doesn't feel quite right.

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

- Gifts or entertainment of any value
- Gifts, meals, or entertainment that are provided regularly
 - Meals:
 - o Valued at more than \$25,
 - o Has not been previously approved by employee's supervisor, AND
 - o Accepted without business justification
-
- 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 an advantage
- Gifts or entertainment given to KP Personnel involved in KP purchasing and contracting decisions

18.4 CONFLICTS OF INTEREST: Conflicts of interest between a Provider and KP Personnel or the appearance of it, should be avoided. There may be some circumstances in which members of the same family or household may work for KP and for a Provider. However, if this creates an actual or potential conflict of interest, you must disclose the conflict at the earliest opportunity, in writing, to a person in authority at KP (other than the person who has the relationship with the Provider). You may call the toll-free Compliance Hotline number at 1-888-774-9100.

18.5 FRAUD, WASTE, AND ABUSE: Providers must be aware that funds received from KP are in whole or in part derived from federal funds. You are expected to comply with all applicable state and federal laws governing remuneration for health care services, including anti-kickback and physician self-referral laws. KP will investigate allegations of Provider fraud,

waste, or abuse related to services provided to members, and where appropriate, will take corrective action, including but not limited to civil or criminal action.

The Federal False Claims Act and similar state laws are designed to reduce fraud, waste, and abuse by allowing citizens to bring suit on behalf of the government to recover fraudulently obtained funds (i.e., “whistleblower” or “qui tam” actions). No individual may be threatened, harassed, or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws. Kaiser Permanente’s fraud control program protects our members and patients and preserves our resources to reduce costs and helps us provide affordable health care. This is part of our mission and values and requires that every physician, dentist, and employee be involved, committed, and participate. Many of our activities at work are monitored to prevent and detect fraud, waste, and abuse.

18.6 PROVIDERS INELIGIBLE FOR PARTICIPATION IN GOVERNMENT HEALTH CARE PROGRAMS: KP requires the Provider to (a) disclose whether any of its officers, directors, employees or subcontractors are or become sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program, or is convicted of a criminal offense related to the provision of health care, and (b) assume full responsibility for taking all necessary steps to assure that the Provider’s employees, subcontractors, and agents directly or indirectly involved in KP business have not been and are not currently excluded from participation in any federal program.

This shall include, but not be limited to, routinely screening all such names against all applicable lists of individuals or entities sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program published by government agencies (including the U.S. Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities at http://oig.hhs.gov/exclusions/exclusions_list.asp, and U.S. General Services Administration, Excluded Parties List System at <https://www.epls.gov/>) as and when those lists are updated from time to time, but no less often than upon initial hiring or contracting and annually thereafter.

Providers are required to document their actions to screen such lists and certify compliance with this requirement to KP upon request. KP will not do business with a health care practitioner who is or becomes excluded by, 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.

18.7 VISITATION POLICY: When visiting KP facilities (if applicable), you are expected to comply with the applicable visitation policy, which is available at KP facilities upon request. “Visitor” badges provided by the visited KP facility must be always worn during the visit.

18.8 CONFIDENTIALITY OF PATIENT INFORMATION: Healthcare providers, including KP and you or your facility, are legally and ethically obligated to protect the privacy of patients and members. KP requires that Providers keep members’ medical information confidential and secure. These requirements are based on state and federal laws both applicable to Providers and KP, as well as policies and procedures created by KP.

Providers may not use or disclose the personal health information of a member, except as permitted or required by law. Personal health information refers to medical information, as well as information that can identify a member (for example, a member's address or telephone number).

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

18.9 HIPAA AND PRIVACY RULES: As a Provider, you may have signed a document that creates a "business associate" relationship with KP as defined by federal regulations commonly known as HIPAA. If you are providing standard patient care services that do not require a business associate agreement, you still must preserve the confidentiality, privacy, and security of our common patients' medical information.

If you did not sign a business associate agreement, you are likely a "covered entity" as that term is defined under HIPAA and the Privacy Rules issued by the Department of Health and Human Services. As a covered entity, you have specific responsibilities to limit the uses and disclosures of protected health information (PHI), and to ensure the security of PHI as that term is defined by the Privacy Rule (45 CFR Section 160.103). Certain data which may be exchanged as a consequence of your relationship with KP is subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and its regulations or as updated and amended by Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and the Health Information Technology and Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as each are codified in the United States Code, and all regulations issued under any of the foregoing statutes, as and when any of them may be amended from time to time (collectively "HIPAA"). To the full extent applicable by the provisions of HIPAA, you must comply with HIPAA, including but not limited to the HIPAA standards for (i) privacy, (ii) code set, (iii) data transmission standards, and (iv) security regarding physical storage, maintenance, transmission of, and access to individual health information.

Providers must use and disclose PHI only as permitted or required by law, subject to any additional limitations, if any, on the use and disclosure of that information as imposed by your Agreement or any Business Associate Agreement you may have signed with KP. You must maintain and distribute your Notice of Privacy Practices (45 CFR Section 164.520) to and obtain acknowledgements from members receiving services from you, in a manner consistent with your practices for other patients. You must give KP a copy of your Notice of Privacy Practices upon request and give KP a copy of each subsequent version of your Notice of Privacy Practices whenever a material change has been made to the original Notice.

Providers are required by HIPAA to provide a patient with access to his or her PHI, to allow that patient to amend his or her PHI, and to provide an accounting of those disclosures

identified under the Privacy Rule as reportable disclosures. You must extend these same rights to members who are patients.

18.10 CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: In receiving, storing, processing, or otherwise dealing with any patient records, Provider is fully bound by the federal substance abuse confidentiality rules set forth at 42 CFR Part 2 and if necessary, must resist in judicial proceedings any efforts to obtain access to patient records, except as permitted by these regulations.

18.11 PROVIDER RESOURCES:

KP's National Compliance Office: **1-510-271-4699**

KP's Compliance Hotline: **1-888-774-9100**

18.12 REGULATORY COMPLIANCE: CMS, DOH, DCCA, DHS, NCQA, and other state and federal agencies and accrediting organizations conduct surveys of KP to measure compliance with legal, regulatory, and accreditation requirements and standards. Regulatory requirements related to the use of subcontractors obligate KP to validate that subcontracts are in a place where applicable, and they meet all regulatory and contractual requirements. Upon request, the Provider must provide KP a copy of its subcontract template along with executed signature pages for each subcontractor. When a subcontract is amended or altered, the Provider should notify KP within 30 Calendar Days

The Provider must furnish copies of executed subcontracts, and other documents related to subcontractors, upon the request of governmental, regulatory, or accreditation agency personnel and/or when KP is preparing for internal and/or regulatory or accreditation agency audits. Additionally, upon request, the Provider is responsible to furnish copies of its policies and procedures related to any economic profiling information that is used to evaluate participating practitioner or subcontractor performance. Further, the Provider is responsible to provide a copy of the information, upon request, to the subcontractor or participating practitioner. Economic profiling is defined as an evaluation based in whole or in part on the economic costs or utilization of services associated with providing medical care.

APPENDIX 1

Please refer to this link for 'POL – 020 Clinical Review Payment Determination Policy' as referenced on page 46 of this HMO Provider Manual.

POL-020.3 Clinical Review Coding Payment Determination Policy



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

1.0 Business Policy

1.1 Payment Policy Statement

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

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

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

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

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

1.2 Scope

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

2.0 Rules

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

- 2.1.1** CPT codes 5-digit numeric codes maintained by the American Medical Association (AMA). These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.
- 2.1.2** HCPCS Level II codes Alpha-numeric (1 letter followed by 4 numbers) codes, which are used to identify products, supplies and services not included in Level I CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.
- 2.1.3** International Classification of Diseases, ICD-10-CM codes Used to indicate diagnosis or condition. ICD-10 codes are required on all claims. KFHP follows ICD-10-CM Official Guidelines for Coding and Reporting and may deny claims when billed inappropriately.
- 2.1.4** NDC (National Drug Code) codes A universal number that identified a drug. The NDC number consists of 11 digits in a 5-4-2 format (Do not bill with hyphens, only the 11-digit NDC).
- 2.1.5** Revenue codes 4-digit numeric codes used by institutional providers. HCPCS or CPT codes may be required in addition to specific revenue codes to describe the services rendered.

- 2.2.1** Supportive documentation may be requested to validate the accuracy of billed services before finalizing reimbursement. These practices apply to both contracted and non-contracted providers, hospitals, and suppliers eligible to bill for services.
- 2.2.2** Guidelines are based on nationally recognized standards, including but not limited to, CMS, AMA CPT coding guidelines, CMS's National Correct Coding Initiative (NCCI), provider manuals, associated medical societies, and billing and coding sources. As required by the Centers of Medicare and Medicaid Services (CMS) and Health Insurance Portability and Accountability Act (HIPAA), Providers must select CPT/ICD-10/HCPCS/Revenue codes that provide the highest degree of accuracy and completeness.

2.3 Medically Unlikely Edits (MUE)

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

2.4 Bundled Procedures

- 2.4.1** Facility Claims – OPPS Status Codes KFHP follows the Centers for Medicare and Medicaid services (CMS) Hospital Outpatient Prospective Payment System (OPPS). Reimbursable codes are determined based upon the assigned OPPS Status Indicator(s). CMS assigns Payment Status Indicators, and their definition can be found by accessing Addendum D1.
- 2.4.2** Professional Claims - Bundled/Unbundled when two or more procedure codes are submitted on a claim, the two codes are reviewed to determine if they are compatible or appropriate when performed together. The review identifies potential instances of unbundling or inappropriate billing, where separate procedures that should be billed together are instead billed separately.

2.5 Modifiers

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

2.6 Documentation Required:

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

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

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

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

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

2.7 Multiple Modifiers:

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

2.8 Site of Service Modifier:

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

2.9 TC Technical Component:

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

2.10 Modifier 24:

2.10.1 When using Modifier 24 the following shall apply:

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

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

2.11 Modifier 25:

- 2.11.1** Modifier 25 is used to indicate that on the same date as a procedure or other service, a significant and separately identifiable evaluation and management (E/M) service was performed by the same provider.
- 2.11.2** Modifier 25 is appropriate only when the documentation clearly supports the distinct nature of the E/M service. KFHP reviews for proper use of Modifier 25 to ensure that the E/M was medically necessary, clearly documented, and not part of the routine care bundled into the procedure. Claims submitted with Modifier 25 that lack sufficient documentation or are appended inappropriately may be denied.

2.12 Modifier 26 Professional Component:

- 2.12.1** Modifier 26 is used to indicate the professional service associated with a procedure that consists of a combination of both technical and professional services. KFHP follows the CMS guidelines for correct usage of modifier 26.
- 2.12.2** This modifier should be appended to health service codes that have a 1 in the PC/TC field on the National Relative Value Field file. KFHP will automatically append modifier 26 to services performed in place of service 21, 22, or 23.

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

- 2.13.1** These modifiers are used to indicate services provided during a global surgical period and are required to ensure accurate reimbursement across providers. For more information, please refer to the Modifier Reimbursement Policy:
 - 2.13.1.1 Modifier 54:** Used when the same provider completes both the surgery and the preoperative care.
 - 2.13.1.2 Modifier 55:** Appended when a different provider performs postoperative management.
 - 2.13.1.3 Modifier 56:** Leveraged when a different provider performs preoperative care.

2.14 Bilateral Surgery (LT/RT/50)

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

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

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

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

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

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

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

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

2.16 Co-Surgeons (Modifier 62):

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

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

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

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

2.17 Team Surgery (Modifier 66)

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

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

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

2.17.1.3 Payment Indicator 2: Team surgeons are permitted.

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

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

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

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

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

2.18.2.2 Payment Indicator 1: Assistant surgeon not permitted.

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

2.18.2.4 Payment Indicator 9: Assistant surgeon concept does not apply. **2.19 Global**

Period

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

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

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

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

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

2.19.6 XXX Global concept does not apply.

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

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

2.20 Multiple Procedure Payment Rules

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

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

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

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

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

2.21 MPFS Status Indicator Codes:

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

2.22 Anesthesia

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

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

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

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

2.23.3 To learn more about the EDC Analyzer TM tool, see [EDC Analyzer.com](https://www.edc-analyzer.com).

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

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

2.25 Robotic Assisted Surgery

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

2.26 Unlisted Codes

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

2.27 Outpatient Observation Services

- 2.27.1** Observation services are provided in place of inpatient admission. Observation services allow the necessary time to evaluate and provide needed services to a member whose diagnosis and treatment are not expected to be longer than forty-eight (48) hours without discharge or admission. Observation care can, for example, be delivered in a hospital emergency room, an area designated as "observation," a bed within a unit, or an entire unit designated as an observation area.
- 2.27.1.1** Admission to observation begins at the clock time documented in the medical record when the patient clearly transitions to observation level of care (i.e. Is placed in an observation bed), as confirmed by the initiation of services rendered and documented in accordance with the directions on the physician order.
- 2.27.1.2** Observation services should not be billed along with diagnostic or therapeutic services for which active monitoring is a part of the procedure. Documented observation time should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., CT scans, MRI, colonoscopy, chemotherapy).
- 2.27.1.3** Observation time does not include the time patients remain in the hospital after treatment is finished, for reasons such as waiting for transportation home or while awaiting placement to another health care facility.
- 2.27.1.4** Routine preoperative preparation, monitoring and postoperative recovery is included in the allowance for the procedure. Prolonged services that require placing the patient in observation status are not eligible for payment unless a 6-hour threshold of post-operative monitoring is exceeded, regardless of the location of the postoperative monitoring.

2.28 Diagnosis Related Group (DRG) Payment

- 2.28.1** DRG validation is to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the facility on the submitted claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. KFHP Clinical Review performs DRG reviews on claims with payment based on DRG reimbursement to determine the diagnosis and procedural information leading to the DRG assignment is supported by the medical record.
- 2.28.1.1** Validation must ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the facility on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.
- 2.28.1.2** Reviewers will validate principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.
- 2.28.1.3** Comprehensive review of the patient's medical records will be conducted to validate:
- 2.28.1.3.1** Physician ordered inpatient status.
 - 2.28.1.3.2** Accuracy of diagnostic code assignment. **2.28.1.3.3** Accuracy of the procedural code assignments.
 - 2.28.1.3.4** Accuracy of the sequencing of the principal diagnosis and procedure codes.
 - 2.28.1.3.5** Accuracy of the present on admission (POA) indicator assignment.
 - 2.28.1.3.6** Accuracy of the DRG grouping assignment and associated payment.
 - 2.28.1.3.7** Accuracy of the Discharge Disposition Status Code assignment.
 - 2.28.1.3.8** Other factors that may impact DRG assignment and/or claim payment.
 - 2.28.1.3.9** Compliance with KP's payment policies including but not limited to those policies that address DRG inpatient facility, never events, hospital-acquired conditions, and readmissions or transfers to another acute care hospital.

3.0 Guidelines

N/A

4.0 Definitions

- 4.1 Centers for Medicare and Medicaid Services (CMS)** Part of the Department of Health and Human Services (HHS) that administers programs such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.
- 4.2 Current Procedural Terminology (CPT)** A set of five-digit numeric or alphanumeric codes used to describe medical, surgical, and diagnostic services. These codes provide a uniform language that accurately describes medical services and procedures, facilitating efficient reporting, billing, and data analysis.
- 4.3 Healthcare Common Procedure Coding System (HCPCS) Level II** A standardized alphanumeric coding system used primarily to identify products, supplies, and services not included in the CPT® codes—such as ambulance services and durable medical equipment—for billing purposes. Each code consists of a single alphabetical letter followed by four numeric digits.
- 4.4 Integrated Outpatient Code Editor (I/OCE)** A tool developed by the Centers for Medicare & Medicaid Services (CMS) to validate and edit outpatient claims before they are submitted to Medicare.
- 4.5 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)** A standardized coding system used in the United States to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care. It is used by healthcare providers to document and report diseases and medical conditions (morbidity) for billing, statistical, and administrative purposes.
- 4.6 International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)** A procedure classification system developed by the Centers for Medicare & Medicaid Services (CMS) for use in the United States. It is used to code procedures performed in hospital inpatient settings and is designed to support accurate and consistent reporting of inpatient procedures for billing and statistical purposes.
- 4.7 Local Coverage Determinations (LCDs)** Policies created by Medicare Administrative Contractors (MACs) to decide which services are considered reasonable and necessary for Medicare coverage within their specific jurisdictions.
- 4.8 Medicare Physician Fee Schedule (MPFS)** Medicare uses the MPFS when paying for professional services of physicians and other healthcare providers in private practice, services covered incident to physicians' services, diagnostic tests (other than clinical laboratory tests), and radiology services.
- 4.9 National Correct Coding Initiative (NCCI)/Correct Coding Initiative (CCI)** The Medicare National Correct Coding Initiative (NCCI), also known as CCI, was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. CMS developed the NCCI program to promote national correct coding of Medicare Part B claims.
- 4.10 National Coverage Determinations (NCD)** Policy decisions by the Centers for Medicare & Medicaid Services (CMS) that specify whether a particular item or service is considered reasonable and necessary for Medicare coverage on a nationwide basis.

- 4.11 National Uniform Billing Committee (NUBC)** An organization established to develop and maintain a standardized billing form and data set—specifically the UB-04—for use by institutional healthcare providers and payers across the United States. Its goal is to ensure uniformity in the data reported on healthcare claims, facilitating efficient processing and accurate reimbursement.
- 4.12 Outpatient Prospective Payment System (OPPS)** CMS generally makes payment for hospital outpatient department services through the Hospital Outpatient Prospective Payment System (OPPS).
- 4.13 Relative Value Units (RVUs)** Relative value units (RVUs) are the basic component of the Resource-Based Relative Value Scale (RBRVS), which is a methodology used by the Centers for Medicare & Medicaid Services (CMS) and private payers to determine physician payment.
- 4.14 Revenue Codes** Four-digit numeric codes used on institutional (facility) claims to indicate the specific department or type of service provided during a patient's visit. These codes help identify where the patient received care (e.g., emergency room, radiology) or what type of item or service was provided (e.g., medical supplies, room and board), and are essential for billing and reimbursement purposes.
- 4.15 The Health Insurance Portability and Accountability Act of 1996 (HIPAA)** Establishes federal standards for protecting patients' health information from disclosure without their consent.

5.0 References

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>

<https://www.cms.gov/medicare/coding-billing/ncci-medicare>

<https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files>

https://www.aapc.com/resources/what-are-relative-value-units-rvus?srltid=AfmBOooizLh65MIIBqpJ0rYEhtEamQBpt7Lc6_sfJ2hTxMR0bCqsOj0x

<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00097341>

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

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

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

Medicare Claims Processing Manual: Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPOS), Section 290 Outpatient Observation Services. Accessed

03/16/2010 at <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf> 2

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

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

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy POL-020.2 Clinical Review Medical Record Review Payment Determination Policy POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)



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

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.
- 1.1.3** Kaiser recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
- . American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

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

1.2 Scope

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

2.0 Rules

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

1.2 Scope

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

2.0 Rules

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

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

2.2 Reimbursement Guidelines

2.2.1 Humanitarian Use Device (HUD)

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

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

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

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

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

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

2.2.2 Non-Covered Examples

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.0 Guidelines

N/A

4.0 Definitions

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

- 4.2 Centers for Medicare & Medicaid Services (CMS)** A federal agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare, Medicaid, and other health programs. CMS establishes national coverage policies and reimbursement methodologies, including those related to implantable devices.
- 4.3 Disposable Medical Supplies** Single-use items utilized during a procedure that are not retained in the body after discharge. These are not considered implants and are typically not reimbursed separately.
- 4.4 HCPCS Code** The Healthcare Common Procedure Coding System (HCPCS) is used to report medical procedures, services, and devices. A valid HCPCS code must be submitted for any implant billed on a claim.
- 4.5 Humanitarian Use Device (HUD)** A medical device intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 8,000 individuals in the U.S. per year. HUDs must have FDA approval for the specific indication to be eligible for reimbursement.
- 4.6 Implant** A device placed into a surgically or naturally formed cavity of the human body and intended to remain continuously for 30 days or more, as defined by the FDA.
- 4.7 Skin Substitutes** Products used to temporarily or permanently replace the skin's structure and function. Only those intended for permanent implantation may be considered for reimbursement; temporary wound coverings or dressings are not reimbursed as implants.

5.0 References

- 5.1** Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)
- 5.2** U.S. Food and Drug Administration (FDA). Implants and Prosthetics Guidance <https://www.fda.gov>
- 5.3** U.S. Food and Drug Administration (FDA). IDE Definitions and Acronyms [IDE Definitions and Acronyms | FDA](#)
- 5.4** CPT® Manual and CPT® Assistant, published by the American Medical Association (AMA)
- 5.5** HCPCS Level II Manual, published by CMS
- 5.6** ICD-10-CM Official Guidelines for Coding and Reporting

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)



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

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all payment policies are routinely updated.
- 1.1.3** KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
- . American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
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- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

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

2.0 Rules

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

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

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

2.3 Reimbursement Guidelines

2.3.1 Clinical Review will review the medical records to assess:

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

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

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

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

2.3.1.5 Whether the coding and billing is accurate and appropriate. **2.3.1.6** Whether the authorization reflects what is billed.

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

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

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

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

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

2.4 Trauma Activation

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

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

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

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

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

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

2.5 Level of Care (LOC) Review

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

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

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

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

2.6 Neonatal Intensive Care Level of Care (NICU)

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

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

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

2.7 Post Stabilization

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

2.8 Short Stay/2 Midnight Rule

- 2.8.1** KFHP follows Medicare reimbursement guidelines to determine whether inpatient services are reimbursable. If a doctor anticipates a patient will need medically necessary/appropriate hospital care for at least two nights (spanning two midnights), the stay can be billed as inpatient admission and will be reimbursed accordingly. Medical records must support inpatient admission and must be clearly documented. If the anticipated stay is less than two midnights, the care is typically considered outpatient and should be billed accordingly. There are some exceptions to the two-midnight rule, such as:
- 2.8.2** The patient is discharged against medical advice (AMA).
- 2.8.3** The patient dies during the stay.
- 2.8.4** In these cases, the patient may still be classified as an inpatient, even if their stay did not span two midnights if the initial expectation of a longer stay was reasonable and documented in the medical records.

2.9 Present on Admission (POA):

- 2.9.1** Consistent with Medicare requirements, KFHP requires POA indicator reporting for all claims involving inpatient admissions to general acute care hospitals or other facilities. General requirements to follow are:
- 2.9.2** Refer to UB-04, also known as the CMS-1450 Data Specifications Manual and the ICD-10-CM guidelines for Coding and Reporting to facilitate the assignment of the
- 2.9.3** POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claims forms UB-04.
- 2.9.4** Providers shall ensure any resequencing of diagnosis codes prior to claims submission include a resequencing of POA indicators.
- 2.9.5** Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.

2.10 Provider Preventable Conditions (PPC)

- 2.10.1** Clinical Review determines if the service provided meets the clinical guidelines set forth by CMS to ensure PPC services are not reimbursed. PPCs are defined into 2 types – Hospital Acquired Conditions (HACs) and Never Events/Serious Reportable Events (SREs).
- 2.10.2** Hospital Acquired Conditions (HACs) – These are conditions that could reasonably have been prevented through the application of evidence based clinical guidelines.
- 2.10.3** Inpatient Acute Care Hospitals are required to document these in the medical records and are reportable as Medicare requirements.
- 2.10.4** Never Events/SREs – These events are defined by CMS to include:
 - 2.10.4.1** Wrong surgery/invasive procedure.
 - 2.10.4.2** Surgery/invasive procedure performed on the wrong patient.
 - 2.10.4.3** Surgery/invasive procedure performed on the wrong body part.
- 2.10.5** Providers will not be reimbursed for these services, as these are errors in medical care that are of concern to both the public and health care. Providers must report these when these occur in any health care setting.

2.11 Thirty Day Readmissions

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

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

- 2.12.1** KFHP follows CMS guidelines for CAR-T reimbursement.

3.0 Guidelines

N/A

4.0 Definitions

- 4.1 Centers for Medicare & Medicare Services (CMS)** Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.
- 4.2 Post Stabilization Care** Following stabilization of the member's emergency

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

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

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

5.0 References

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

[Eliminating Serious, Preventable, and Costly Medical Errors - Never Events | CMS](#)

[Hospital Acquired Conditions | CMS Hosp. Readmission Reduction | CMS](#)

[Medicare.gov: https://www.medicare.org/articles/what-does-medically-necessary-mean/](#)

Frequently Asked Questions CR 7502

National Uniform Billing Committee | NUBC

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

[POL-020.4 Clinical Review Implant Payment Determination Policy](#)

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy



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

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.
- 1.1.3** KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
- . American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

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

1.2 Scope

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

2.0 Rules

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

- 2.1.1** The review is conducted on a pre-adjudication basis.
- 2.1.2** Reimbursement is made in accordance with industry standard billing guidelines, regulatory guidance, and applicable provider contract and/or provider manual requirements.
- 2.1.3** Clinical Review staff will submit a request for information (RFI) to the provider, requesting an itemized bill and/or medical records.
- 2.1.4** The IBR review will be completed upon receipt of the itemized bill and, or medical records. If the itemized bill and/ or medical records are not received timely a denial will be rendered.
- 2.1.5** For Inpatient facility services that are reimbursed under a prospective payment system, the payment amount for a particular service is based on the classification system of that service. In addition to the basic prospective payment, an outlier payment is made for certain claims that incur costs above the facility-specific threshold. DRG cost outlier claims are repriced based upon the IBR results.
- 2.1.6** KFHP will apply commonly accepted standards to determine which of the billed items or services are eligible for appropriate reimbursement. Commonly accepted standards include, without limitations, CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (NCCI) standards, and various professional and academic journals and publications as outlined above. KFHP clinicians will interpret these standards and apply them to claims using clinical discretion and judgment.

2.2 Reimbursement Guidelines

- 2.2.1** Clinical Review will not reimburse providers for items or services that are considered inclusive of, or an integral part of another procedure or service. Such services will be paid as part of the larger related service and are not eligible for separate reimbursement. Services to be considered for separate reimbursement should be clearly documented on the itemized bill and medical record. The Clinical reviewer will review the itemized bill and/or medical records for these charges.
 - 2.2.1.1** The following types of charges are examples of charges that a KFHP clinician may determine to be inclusive of, or an integral part of another procedure or service and therefore not separately payable. KFHP will use clinical discretion and judgment and will consider commonly accepted standards as applicable to the facts and circumstances of each case.

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2.8.1

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

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

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

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

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

- 2.2.11** Allow one daily ventilator management charge or BiPAP while the patient is in the specialty care unit.
- 2.2.12** Allow Continuous Positive Airway Pressure (CPAP) while the patient/neonate is in the neonatal intensive care unit (NICU).
- 2.2.13** CPAP for routine use, including use for obstructive sleep apnea is not separately payable.
- 2.2.14** Charges for respiratory services provided in the inpatient setting other than at a specialty care unit are limited to one unit/charge per date of service regardless of the number of respiratory treatments and/or procedures provided. Examples include, without limitation, the following:
- Chest percussions if done by a respiratory therapist
 - Demonstration of Metered Dose Inhaler (MDI) use or respiratory equipment by a respiratory therapist
 - Heated aerosol and oxygen
 - Nebulizers
- 2.2.15** Charges for Routine Floor Stock items and supplies necessary or otherwise integral to the provision of a specific service or delivery of service in a specific location are considered routine and are not separately reimbursable. The use of these services is part of the administration of care at a hospital or skilled nursing facility and are used during the normal course of treatment, which may be related to and/or part of a separately reimbursable treatment.
- 2.2.16** Charges for Point of Care (POC) tests are generally not separately reimbursed. These tests are performed by facility nursing staff, at the site where patient care is provided as part of the room and board services.
- 2.2.17** KFHP follows commonly accepted standards to not reimburse for duplicative charges and claims. Such duplicative charges and claims are not reimbursable. According to Medicare guidelines, the hospital must install adequate billing procedures to avoid submission of duplicate charges or claims.
- 2.2.18** Over the counter drugs (OTC) or, drugs which can be self-administered by the patient, are often not separately reimbursed in an inpatient setting. OTC drugs are typically included in the overall inpatient reimbursement.
- 2.2.19** Routine administrative services are included in the room and board or outpatient facility reimbursement. Routine services in a hospital are those services included by the provider in a daily service charge, commonly referred to as "room and board" charge. Examples include, without limitation, the following:

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

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

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

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

3.0 Guidelines

N/A

4.0 Definitions

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

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

4.3 Routine services Inpatient routine services in a hospital or skilled nursing facility are those services included in the providers daily service charge sometimes referred to as the "room and board" charge. Routine services are composed of two room and board components: (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care units (ICU's).

- 4.4 Diagnosis Related Group (DRG)** A system of classifying or categorizing inpatient stay into relatively homogenous groups for the purpose of payment by CMS.
- 4.5 Personal care items** Items used by the patient for non-medical use such as hygiene and comfort.
- 4.6 Point of Care (POC) tests** Tests that are performed at site where patient care is provided. Point of care (POC) tests do not require the equipment or supplies of a CLIA lab nor the skills of licensed or certified technicians or technologists. Under the Clinical Laboratory Amendments of 1988 (CLIA), a POC must have a Certificate of Waiver license in order for the site to allow CLIA- waived POC testing.
- 4.7 Routine floor stock** Supplies that are available to all patients in the floor or area of a hospital or skilled nursing facility. These are supplies provided to a patient during the normal course of treatment. Personal care items are non-chargeable because they do not contribute to the meaningful treatment of the patient's condition.
- 4.8 Specialty care unit** A specialized unit located within a hospital that must be physically identified as separate from general care areas; the unit's nursing personnel must not be integrated with general care nursing personnel. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive lifesaving nursing services of the type associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. Special life-saving equipment should be routinely available in the unit.
- 4.9 Room charge** A room and board or room care charge for a semi-private, private, or 3+ bedroom shall include the room, dietary services, all nursing care, personnel, and routine disposable or reusable equipment, supplies and items appropriate for that setting.
- 4.10 Inpatient** Patient whose condition requires treatment in a hospital or other health care facility, and when the patient is formally admitted to the facility by a doctor. It involves an overnight stay or prolongs the stay of a patient in a licensed healthcare facility.
- 4.11 Outpatient** Patient who receives medically necessary services at a hospital, clinic, or associated facility for diagnosis or treatment but has not formally been admitted on an inpatient basis.

5.0 References

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

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

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

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

National Uniform Billing Committee | NUBC

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

Implants and Prosthetics | FDA (implants section)

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

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

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

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

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

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

6.0 Related Topics

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/25)

[Revision History](#)

[Approvals](#)

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



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

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim, or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup payment for claim processed in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.
- 1.1.3** Kaiser recognizes commonly accepted standards to determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
- . American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
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- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

- 1.2.1** This policy outlines Kaiser's requirements for the review and reimbursement of Intraoperative Neuromonitoring (IONM) services. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified.
- 1.2.2** Clinical Review will evaluate submitted documentation to determine the medical appropriateness and/or medical necessity of IONM services in accordance with Kaiser medical policy for Intraoperative Neuromonitoring. The review process ensures that claims are submitted in compliance with federal and state regulations, industry-standard coding practices, and evidence-based literature.

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

2.0 Rules

2.1 Criteria

- ~~**2.1.1** This payment policy aligns with Kaiser's internal IONM Medical Policy. The criteria was established using evidence-based guidelines and nationally recognized standards to determine the medical necessity of services. Medical necessity and appropriateness requirements apply.~~
- 2.1.2** IONM is considered medically necessary only when performed for high-risk surgical procedures with a demonstrated benefit in reducing neurological complications. Standards are reviewed and updated regularly to reflect current clinical evidence and regulatory requirements.
- Charges related to intraoperative monitoring are billed on a HCFA 1500 claim form for professional charges. Any charges related to IONM billed on a UB form are not reimbursable.
 - Codes for automated monitoring devices that do not require continuous attendance by someone who is qualified to interpret the information should not be reported separately.
 - Kaiser will consider IONM for reimbursement when performed in place of service (POS) 19, 21, 22, or 24.
 - Recording and testing are performed either personally by the surgeon or anesthesiologist, or by a technologist who is physically present with the patient during the service.
 - Remote monitoring can be performed by a qualified professional using a real-time audio and visual connection.
- 2.1.3** Kaiser will not consider additional reimbursement when IONM is performed by the surgeon or anesthesiologist. In this case, the professional services are included in the primary service code(s) for the procedure and should not be reported separately.
- 2.1.4** Accurate coding is essential for appropriate reimbursement of IONM services. Standard coding guidelines should be followed, with all claim information supported by the medical record:
- IONM codes should be reported based upon the time spent monitoring only, and not the number of baseline tests performed, or parameters monitored.

- The monitoring professional should be solely dedicated to the intraoperative neurophysiologic monitoring service, and available to intervene immediately, if necessary, throughout the duration of the procedure.
- Time reported should not include items such as time to set up, record, and interpret baseline studies, time to remove electrodes at the end of the procedure, or standby time.

3.0 Guidelines

N/A

4.0 Definitions

- 4.1 Intraoperative Neuromonitoring (IONM)** The use of electrophysiological techniques to monitor the functional integrity of neural structures (e.g., spinal cord, brain, cranial nerves) during surgical procedures that pose a risk of neurological injury.
- 4.2 Real-Time Supervision** Continuous monitoring and interpretation of IONM data by a qualified physician who is immediately available via telecommunication and in direct communication with the surgical team throughout the procedure.
- 4.3 Technologist** A trained and credentialed individual who performs IONM in the operating room under the supervision of a qualified physician. The technologist must be present for the entire procedure and may not perform other clinical duties.
- 4.4 Supervising Physician** A licensed physician with expertise in neurophysiology who provides real-time interpretation of IONM data. The supervising physician must not be the operating surgeon or anesthesiologist.
- 4.5 CPT/HCPCS Codes** Standardized codes used to report medical procedures and services. For IONM, these include CPT codes 95940, 95941, and HCPCS code G0453.

5.0 References

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

CMS Article A56722. Billing and Coding: Intraoperative Neurophysiological Testing

Healthcare Common Procedure Coding System (HCPCS) Manual

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

National Correct Coding Initiative (NCCI) Policy Manual

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

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Payment Implant Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy



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

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.
- 1.1.3** KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
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- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
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- Medically Unlikely Edits
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- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

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

2.0 Rules

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

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

2.3 Reimbursement Guidelines

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

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

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

2.4 Preventable/Inappropriate Readmissions

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

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

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

3.0 Guidelines

3.1 Exclusions

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

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

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

4.0 Definitions

- 1.1 Centers for Medicare & Medicaid Services (CMS)** Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and ~~Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.~~
- 1.2 Readmission** A subsequent inpatient admission to any acute care hospital which occurs within 30 days of the discharge date; excluding any exceptions or planned readmissions.
- 1.3 Planned Readmissions** A non-acute admission for a scheduled procedure for limited types of care that may include, obstetrical delivery, transplant surgery, maintenance of chemotherapy/radiotherapy/immunotherapy.
- 1.4 Preventable Readmissions** A readmission within a specific time frame that is clinically related and may have been prevented had appropriate care been provided during the initial hospital stay and discharge process.

5.0 References

- 1.5** Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at: <http://www.cms.gov/manuals/downloads/clm104c03.pdf>. Accessed ~~September 29, 2011.~~
- 1.6** Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available

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

1.7 [Hospital-Acquired Condition Reduction Program | CMS](#)

1.8 [Medicare Claims Processing Manual \(CMS-Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing\)](#)

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy POL-020.2

Clinical Review Medical Record Review Payment Determination Policy POL-020.3 Clinical

Review Coding Payment Determination Policy POL-020.4 Clinical Review Implant Payment

Determination Policy

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

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)