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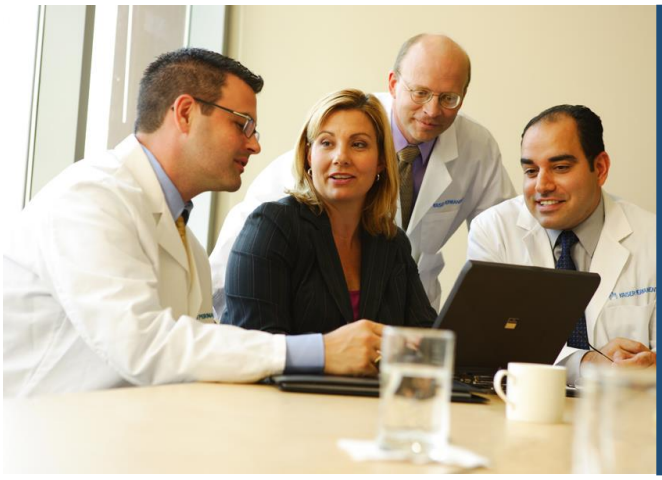
KAISER PERMANENTE®

Provider Manual

- **Billing and Payment**

KAISER PERMANENTE®



Billing and Payment

This section of the Manual was created to help guide you and your staff in working with Kaiser Permanente's billing and payment policies and procedures. It provides a quick and easy resource with contact phone numbers, detailed processes, and site lists for services.

If, at any time, you have a question or concern about the information in this Manual, you can reach our National Provider Contracting Department by calling (510) 268-5448.

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Introduction

At the heart of Kaiser Permanente‘s claim processing operation is the set of policies and procedures followed in determining the appropriate handling and reimbursement of claims received.

Section 5: Billing and Payment

Inquiries regarding referred services may be directed to KP by calling **(800) 390-3510.** Please contact EDISupport@kp.org for claims submission requirements.

Providers are invited and encouraged to request access to KP’s **Online Affiliate** tool. Many functions, including but not limited to obtaining information on benefits and eligibility, Member costshare and claim status are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please select your applicable region from the following list to learn more about gaining access to Online Affiliate Link and the guest access feature:

California – Northern*
California – Southern*
Colorado*
Georgia*
Hawaii*
Mid-Atlantic States*
Northwest*

*This link will open a new window. If you can't view this new page, please make sure that you've disabled any pop-up blockers on your computer.

It is the contracted Provider’s responsibility to ensure prompt payment through proper and timely submission of itemized bills using a CMS-1500 claim form (or 837P EDI transaction if appropriate) for all professional services and UB-04 (CMS-1450) (or 837I EDI transaction if appropriate) for all facility services in accordance with the terms of the Agreement with Kaiser Permanente. Bills for authorized services must include the authorization number and should be submitted to the address listed on the Authorization Form. ***PLEASE DO NOT BILL OUR MEMBERS*** other than for copay and deductibles.

Billed items that are incorrectly coded will be denied and the Provider will be required to re-bill with the correct codes. Incorrect coding is coding that does not comply with industry standard coding practices as adopted by Kaiser Permanente, or the use of codes which have been updated in the CPT Manual since the contract was signed. Final payment will be based on these reviews. Any bill submitted more than one hundred eighty (180) days after the date the Covered Services were provided, or the date of receipt of an EOB (from a payer other than

Kaiser Permanente), shall not be paid, except as otherwise required by law, or stated in your Agreement.

Provider shall submit claims and/or encounter data for services rendered. When submitting encounter data, the Provider certifies the information as complete and truthful to the best of its knowledge. A complete CMS-1500 (or 837P EDI transaction if appropriate) for all professional services or CMS-1450 (or 837I EDI transaction if appropriate) for all facility services is the best method for complying with the encounter data required.

It is Kaiser Permanente's goal to assure that the Provider is compensated in a timely and accurate manner in accordance with the terms of the Agreement and applicable law. Kaiser Permanente will pay for authorized covered services rendered to Members within the time period identified in the Agreement with Kaiser Permanente.

5.1. Whom to Contact with Questions

The following information is provided as a quick reference to the Kaiser Permanente system.

Member Service Department

To verify benefits or eligibility of a Kaiser Permanente Member, contact the Member Services department in the Member's health plan region. Providers can also find benefit information on the member's Kaiser Permanente ID card.

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Please Call:	If you have questions about:	Instructions
Member Services	• Benefits/Co-Pay Information • Member Eligibility • Claim Payment Inquiries • Claim Status • Claim Submission • Explanation of Payment (EOP) • Provider Appeals	**California - Northern** Kaiser Referral Invoice Service Center (RISC) 2829 Watt Avenue, Suite #130 Sacramento, CA, 95821 For claims inquires and issues, please call 800-390-3510. Claims for DME, SNF, Home Health, and Hospice services should be sent to: DME Claims Continuum Processing Center 320 Lennon Lane Walnut Creek, CA 94598 For inquiries for DME claims and billing information, call 800-337-0115 (toll-free). **Claims as part of a transplant case should be sent to**: Kaiser Permanente Transplant Claims Processing Unit 1950 Franklin St, 7th Floor Oakland, CA 94612 **California - Southern** Contact 866-285-0361 (toll free) for instructions on submitting electronic claims. Kaiser Foundation Health Plan, Inc. Claims Administration Department P.O. Box 7004 Downey, California 90242-7004 For inquiries on DME claims and billing information, call 800-390-3507 (toll-free). For claims inquires and issues, please call 800-390-3510 **Colorado** Kaiser Permanente of Colorado Claims Administration P.O. Box 373150 Denver, CO 80237 For claims inquiry and issues, please call 303-338-3600. **Georgia** National Claims Administration - Georgia P.O. Box 370010 Denver, CO 80237-9998 For claims for inquiry and issues, please call 404-261-2825 or 888-895-5813 (toll-free) **Hawaii** Hawaii Claims Administration P.O. Box 378021 Denver, CO 80237 For claims inquires and issues, please call 877-875-3805. **Mid-Atlantic States** Mid-Atlantic Claims Administration P.O. Box 371860 Denver, CO 80237-9998 For claims inquires and issues, please call 800-777-7902. **Northwest** National Claims Administration - Northwest P.O. Box 370050 Denver, CO 80237-9998 For claims inquires and issues, please call 503-735-2727. **Washington** Kaiser Permanente Claims Administration P.O. Box 34585 Seattle, WA 98124-1585 For claims inquires and issues, please call 509-241-7206 or 1-888-767-4670.

Topic	Instructions
5.2 Methods of Claims Filing	Kaiser Permanente accepts all transplant claims submitted by mail or electronically.
5.3 Paper Claim Forms	CMS-1450 must be used by all facilities (e.g., hospitals, UB-04 form). All applicable fields on the CMS-1450 must be completed by the hospitals billing office for services rendered. To avoid payment delays and for correct reporting of encounter data, the CMS-1450 fields listed on the following table must be completed. Additionally, standard codes must be used on bills: • REVENUE CODE: Code used to identify specific accommodation, ancillary service or billing calculation • CPT-4: Physicians Current Procedural Terminology • HCPCS: Health Care Procedure Coding System • ICD-10-CM: Medical Index, for medical diagnostic coding • DSM-IV-R: Diagnostic coding for mental disorders If appropriate, attach surgical reports, consultation reports, or progress notes to the claim form. Professional charges must be submitted on a CMS -1500 form (or successor form) with current ICD-10 diagnostic and CPT-4 procedure coding (or successor coding accepted commonly in the industry). Kaiser Permanente often receives CMS 1500 and UB-04/CMS 1450 claim forms that have been reproduced. Most often, they come to us in a black and white standard claim form. In our claims department, we use an Optical Character Recognition (OCR) process to expedite claims adjudication. When we receive reproduced claim forms, it is not possible for them to be processed without extensive manual intervention, due to the inability of the OCR to read any reproduced forms. In our pursuit of continuous improvement and the elimination of waste, **we will no longer be accepting reproduced standard claim forms**. CMS-1500 must be used for all professional services and suppliers. • Any professional services (for example, services rendered by radiologists, ER physicians, etc.) should be billed on CMS-1500 claim forms, unless you are contracted under a GLOBAL rate, in which case “professional services” should not be billed separately.

5.4 Record Authorization Number

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

Authorized services must be rendered before the expiration date stated on the Transplant Authorization Form. Each authorization identifies a specific number of approved visits, as well as, specific services. Additional authorization must be obtained by contacting the Transplant Coordinator for care beyond the expiration date. Transplant authorizations are issued for three stages of a transplant case:

1. **Pre-transplant Evaluation and Care:** This stage usually begins when a patient is listed for transplantation.
2. **Transplant Period:** This stage begins the day of the transplant and concludes at the end of the follow up period as defined in the Agreement. This authorization will cover both inpatient and outpatient services.
3. **Post-Transplant:** This stage covers outpatient follow-up services following the transplant period.

5.5 One Member/ Provider per Claim Form

One Member per Claim Form/One Provider per claim

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

5.6 Submission of Multiple Page Claim

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

5.7 Entering Dates

An example of how to enter dates on the CMS-1500 (HCFA-1500) Claim Form is provided below.

TOPIC	INSTRUCTIONS
ENTERING DATES	• All dates (dates of birth, dates of service, etc.) must be reported in the following format: month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2003 • CONSECUTIVE DATES OF SERVICE Consecutive dates of service can be billed on one claim line as long as the units entered in Field 24g equal the total number of days billed. Example: Correct Way to Bill →

CPT/HCPCS	DATE OF SERVICE	UNITS
97110	01/05/2004-01/07/2004	3
97110	01/09/2004-01/13/2004	5

This is the correct way to bill for consecutive dates of service. The Units field should equal the total number of days billed on each claim line.

Incorrect Way to Bill →

CPT/HCPCS	DATE OF SERVICE	UNITS
97110	01/05/2004-01/13/2004	5

Practitioners/Providers should not enter a date span on the claim line if the services are not performed on consecutive dates. Claims will be denied for the exact dates of service.

<table>
<tr><td><u>5.8 Multiple Dates of Services and Place of Services</u></td><td>

Multiple dates of services at the same location can be filed on the same claim form but must be entered on a separate line.
Multiple dates of service at different locations must be filed on a separate claim form.
Same date of the service at the same location can be filed on a separate claim form.
Same date of service at different locations must be filed on a separate claim form.

</td></tr>
<tr><td><u>5.9 Billing Inpatient Claims That Span Different Years</u></td><td>When an inpatient claim spans different year (for example, the patient was admitted in December and was discharged in January of the following year), it is NOT necessary to submit two claims for these services. Bill all services for this inpatient stay on one claim form (if possible), reflecting the correct date of admission and the correct date of discharge. Kaiser Permanente will apply the appropriate/applicable payment methodologies when processing these claims.</td></tr>
<tr><td><u>5.10 Supporting Documentation for Paper Claims</u></td><td>Providers may be required to include supporting documentation with any invoice submitted to Kaiser Permanente for payment. If documentation is required, Providers will be notified in writing.

When billing with an unlisted CPT code, to expedite claims processing and adjudication, Providers should submit supporting written documentation.
To expedite claims processing and adjudication, a Practitioner/Provider should submit supporting written documentation with certain types of claims outlined in the table below.

For <u>electronic claim submissions</u>, complete a Supporting Documentation Cover Sheet (see pages 5 and 92 for additional information and complete instructions) to submit supporting written documentation. <u>Exception</u>: Coordination of Benefits

<table>
<tr><th>ATTACHMENT</th><th>CIRCUMSTANCE</th></tr>
<tr><td>ADMITTING NOTES</td><td>Except in the case of emergency services rendered in accordance with Prudent Layperson guidelines, if the claim is for inpatient services provided outside of the time or scope of the authorization.</td></tr>
<tr><td>CONTRACTUAL REQUIREMENTS IN THE GLOBAL CONTRACT</td><td>Documents referenced in global contract between Kaiser Permanente and a health care Practitioner, hospital, or person entitled to reimbursement.</td></tr>
<tr><td>EXPLANATION OF BENEFITS/ MEDICARE SUMMARY NOTICE</td><td>To determine Kaiser Permanente liability when another health plan and/or Medicare is primary for medical coverage.</td></tr>
<tr><td>ITEMIZED BILL</td><td>Except in the case of emergency services rendered in accordance with Prudent Layperson guidelines, if the claim is for services rendered in a hospital and the hospital claim has no prior authorization for an admission or the admission is inconsistent with a Kaiser Permanente concurrent review determination rendered prior to the delivery of services, regarding the medical necessity of the service.</td></tr>
<tr><td>OFFICE/PHYSICIAN NOTES</td><td>Except in the case of emergency services rendered in accordance with Prudent Layperson guidelines, if the claim for services provided is outside of the time or scope of the authorization, or when there is an authorization in dispute.</td></tr>
<tr><td>OFFICE VISIT NOTES/ ANESTHESIA RECORDS</td><td>If the claim includes modifier 21 or 22.

If the claim for anesthesia services rendered includes modifier P4 or P5.</td></tr>
<tr><td>OPERATIVE NOTES</td><td>If the claim is for multiple surgeries, or includes modifier 22, 58, 62, 66 or 78.</td></tr>
</table>
</td></tr>
</table>

	Supporting Documentation for Electronic Claims: If submitting claims electronically, the 837 transaction contains data fields to house supporting documentation through free-text format (exact system data field within your billing application varies). If supporting documentation is required, KP will request the supporting documentation and let you know where to send the information.
5.11 Where to Mail/Fax Paper Claims	**California – Northern** We encourage you to submit your claims electronically. Kaiser Permanente's payer ID number is 94135. Clean claims will be paid or denied within the time frames required by applicable federal or state law. The mailing address for paper claims and correspondence is: Unless otherwise indicated on the written Authorization for Medical Care or Patient Transfer Referral form, claims for referred services should be sent to: Kaiser Referral Invoice Service Center (RISC) 2829 Watt Avenue, Suite #130 Sacramento, CA, 95821 For claims inquires and issues, please call 800-390-3510. Claims as part of a transplant case should be sent to: Kaiser Permanente Transplant Claims Processing Unit 1950 Franklin St, 7th Floor Oakland, CA 94612 **California - Southern** Please mail paper claims (and any necessary supporting documentation) to: HMO/DHMO/Senior Advantage members For HMO/DHMO/Senior Advantage members, claims for services must be sent to the following: We encourage you to submit your claims electronically. Kaiser Permanente's payer ID number is 94134. By electronic delivery: Contact 866-285-0361 (toll free) for instructions on submitting electronic claims. By U.S mail: National Claims Administration - SCAL P.O. Box 7004 Downey, California 90242-7004 For claims inquires and issues, please call 800-390-3510 **Colorado** We encourage you to submit your claims electronically. Kaiser Permanente's payor ID number is 91617. Complete claims will be paid or denied within the time frames required by applicable federal or state law. Please mail paper claims (and any necessary supporting documentation) to: National Claims Administration - Colorado P.O. Box 373150 Denver, CO 80237 For claims inquiry and issues, please call 303-338-3600.

Georgia
We encourage you to submit your claims electronically.
Kaiser Permanente's payer ID number is 21313. Clean claims will be paid or denied within the time frames required by applicable federal or state law.
Please mail paper claims (and any necessary supporting documentation) to:

National Claims Administration - Georgia
P.O. Box 370010
Denver, CO 80237-9998
For claims for inquiry and issues, please call 404-261-2825 or 888-895-5813 (toll-free)

Hawaii
We encourage you to submit your claims electronically.
Kaiser Permanente's payor ID number is 94123. Complete claims will be paid or denied within the time frames required by applicable federal or state law.
Please mail paper claims (and any necessary supporting documentation) to:

Hawaii Claims Administration - Hawaii
P.O. Box 378021
Denver, CO 80237
For claims inquires and issues, please call 877-875-3805.

Mid-Atlantic States
We encourage you to submit your claims electronically.
Kaiser Permanente's payor ID number is 52095. Complete claims will be paid or denied within the time frames required by applicable federal or state law.
Please mail paper claims (and any necessary supporting documentation) to:

National Claims Administration – Mid-Atlantic States
P.O. Box 371860
Denver, CO 80237-9998
For claims inquires and issues, please call 800-777-7902.

Northwest
We encourage you to submit your claims electronically.
Kaiser Permanente's payor ID number is 93079. Complete claims will be paid or denied within the time frames required by applicable federal or state law.
Please mail paper claims (and any necessary supporting documentation) to:

National Claims Administration - Northwest
P.O. Box 370050
Denver, CO 80237-9998
For claims inquires and issues, please call 503-735-2727.

Washington
Mail paper claims (and any necessary supporting documentation) to:

Kaiser Permanente Claims Administration
P.O. Box 30766
Salt Lake City, UT 84130-0766
For claims inquires and issues, please call 509-241-7206 or 1-888-767-4670.

5.12 Electronic Data Interchange (EDI)	Kaiser Permanente encourages (and your Agreement may require) electronic submission of claims and encounter data. If you have questions about electronic submission of bills and encounter data, please contact the Kaiser Permanente National EDI Helpline at 866.285.0361, Option 2 or email EDISupport@kp.org. EDI is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI transactions replace the submission of paper claims. Required data elements (for example: claims data elements) are entered into the computer only ONCE—typically at the Provider's office, or at another location where services were rendered or billed. Benefits of EDI Submission 1. Reduced Overhead Expenses: Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated. 2. Improved Data Accuracy: Because the claims data submitted by the Provider is sent electronically, data accuracy is improved, as there is no need for re-keying or re-entry of data. 3. Low Error Rate: Additionally, "up-front" edits applied to the claims data while information is being entered at the Provider's office, and additional payor-specific edits applied to the data by the clearinghouse before the data is transmitted to the appropriate payor for processing, increase the percentage of clean claim submissions. 4. Bypass U.S. Mail Delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system. 5. Standardized Transaction Formats: Industry-accepted standardized medical claim formats may reduce the number of "exceptions".
5.13 Electronic Claims Forms	Professional and facility claims can be submitted electronically via the current version of: • 837P must be used for all professional services and suppliers. • 837I must be used by all facilities (e.g., hospitals)
5.14 Supporting Documentation on for EDI Claims	Kaiser Permanente is now permitting providers that use Online Affiliate Link to submit claim appeals/disputes, upload claim-related documents/attachments, and respond to requests for information (RFI). Please select your applicable region from the following list to learn more about gaining access to Online Affiliate Link and the guest access feature: California – Northern, California – Southern, Colorado, Georgia, Hawaii, Mid-Atlantic States, Northwest*
5.15 To Initiate Electronic Claims Submissions	For information or questions regarding EDI with KP, send an email to EDISupport@kp.org, or call **(866) 285-0361,** and select **Option 2**

5.16 Electronic Submission Process

1. Providers' EDI Responsibilities: Once a Provider has entered all of the required data elements (e.g., all of the required data for a particular claim) into its claims processing system, the Provider then electronically "sends" all of this information to a Clearinghouse for further data sorting and distribution.

2. Clearinghouse's EDI Responsibilities: The Clearinghouse receives information electronically from a variety of Providers, which have chosen that particular Clearinghouse as their data sorter and distributor.

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

   In addition, Clearinghouses:
   - Frequently supply the required PC software to enable direct data entry in the Provider's office.
   - Edit the data which is electronically submitted to the Clearinghouse by the Provider's office, so that the data submission will be accepted by the appropriate payer for processing.
   - Transmit the data to the correct payer in a format easily understood by the payer's computer system.
   - Transmit electronic claim status reports from payers to Providers.

3. Kaiser Permanente's EDI Responsibilities: Kaiser Permanente receives EDI information after the Provider sends it to the Clearinghouse for distribution. The data is loaded into Kaiser Permanente's claims systems electronically and it is prepared for further processing. On the same day that Kaiser Permanente receives the EDI claims, Kaiser Permanente prepares an electronic acknowledgement which is transmitted back to the Clearinghouse.

   NOTE: If a Provider is not receiving Kaiser Permanente's electronic claim acknowledgement from the Clearinghouse, contact your billing service or the Clearinghouse and request that this be routinely forwarded to you.

   Additionally, Kaiser Permanente provides a KP EDITS Reject

	Detail Report for those claims which were rejected by Kaiser Permanente because of "fatal" front-end errors. Any rejected claims may be re-submitted electronically once the claims have been corrected by the Provider. NOTE: See the Claims Status Category and Reason Codes at http://www.wpc-edi.com for a list of common "Fatal Errors".
5.17 HIPAA Requirements	All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and electronic loops and segments. If a Provider does not have internet access, HIPAA Implementation Guides can be ordered by calling Washington Publishing Company (WPC) at (301) 949-9740. • www.dhhs.gov • www.wedi.org • www.wpc-edi.com
5.18 Clean Claims	You are required to submit "complete claims" as defined in 28 CCR 1300.71(a)(2) for the services provided. A "complete claim" must include the following information, as applicable: • Correct Form: All professional claims should be submitted using the CMS-1500 or the EDI 837P file, and all facility claims (or appropriate ancillary services) should be submitted using the UB-04 or EDI 837I file based on CMS guidelines. • Standard Coding: All fields should be completed using industry standard coding, including the use of ICD-10 code sets for outpatient dates of service and inpatient discharge dates on/after October 1, 2015. • Applicable Attachments: Attachments should be included in the submission when circumstances require additional information. • Completed Field Elements for CMS-1500 or UB-04: All applicable data elements of CMS forms, including correct loops and segments on electronic submission, should be completed. In addition, depending on the claim, additional information may be necessary if it is "reasonably relevant information" and "information necessary to determine payer liability" (as each such term is defined in 28 CCR 1300.71(a)(10) and (11)). A claim is not considered to be complete or payable if one or more of the following exists: • The format used in the completion or submission of the claim is missing required

	• fields or codes are not active • The eligibility of a Member cannot be verified • The service from and to dates are missing • The rendering Provider information is missing, and/or the applicable NPI is missing • The billing Provider is missing, and/or the applicable NPI is missing • The diagnosis is missing or invalid • The place of service is missing or invalid, and/or the applicable NPI is missing • The procedures/services are missing or invalid • The amount billed is missing or invalid • The number of units/quantity is missing or invalid • The type of bill, when applicable, is missing or invalid • The responsibility of another payor for all or part of the claim is not included or sent with the claim • Other coverage has not been verified • Additional information is required for processing such as COB information, operative report or medical notes (these will be requested upon denial or pending of claim) • The claim was submitted fraudulently **NOTE:** Failure to include all information will result in a delay in claim processing and payment and will be returned for any missing information. A claim missing any of the required information will not be considered a complete claim. For further information and instruction on completing claims forms, please refer to the CMS website (www.cms.hhs.gov), where manuals for completing both the CMS-1500 and UB-04 can be found in the "Regulations and Guidance/Manuals" section.

5.19 Claims Submission Timeframes	Timeframes for filing a claim: • All claims for services provided to Kaiser Permanente members must be submitted within the timeframe outlined in section 6.1.7 of the Provider Rights & Responsibilities section of this Provider Manual (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge if applicable. • To the extent required by law, claims that are denied because they are filed beyond the applicable claims filing deadline shall, upon a provider's submission of a provider dispute notice as described in of the Provider Rights & Responsibilities section 6.2.5 of this Provider Manual and the demonstration of good cause for the delay, be accepted and adjudicated in accordance with the applicable claims adjudication process.
5.20 Appeal of Timely Claims Submission	Resubmitted claims along with proof of initial timely filing received within the timeframes outlined below from the original date of denial or explanation of payment will be allowed for reconsideration of claim processing and payment. Any claim resubmissions received for timely filing reconsideration beyond timeframes outlined below of the original date of denial or explanation of payment will be denied as untimely filing. **(California)** 365 calendar days or one calendar year (if leap year) from the date of the last action on the claim being disputed. **(Colorado)** 45 calendar days from the date of the receipt of the denial/adverse benefit determination. **(Georgia)** 365 calendar days from the date of the receipt of the denial/adverse benefit determination. **(Hawaii)** 180 calendar days from the date of the receipt of the denial/adverse benefit determination. **(Mid-Atlantic States - Maryland)** 90 calendar days from the date of the receipt of the denial/adverse benefit determination. **(Mid-Atlantic States - Virginia)** 180 calendar days from the date of the receipt of the denial/adverse benefit determination. **(Mid-Atlantic States - Washington DC)** 180 calendar days from the date of the receipt of the denial/adverse benefit determination. **(Northwest - Oregon)** 2 years from the date of the receipt of the denial/adverse benefit determination. **(Northwest - Washington)** 2 years from the date of action giving rise to the dispute. For example, date of claim denial.

5.21 Proof of Timely Claims Submission	Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frames. KP will consider system generated reports that indicate the original date of claim submission. Please note that handwritten or typed documentation is not acceptable proof of timely filing.
5.22 Claim Adjustments/ Corrections	Claim Adjustment: Kaiser Permanente reserves the right to audit claims for adjustments and corrections to ensure services rendered are medically necessary, coding requirements are met as stated in this Manual, and payment is according to your Agreement. Necessary adjustments may be made by offsetting against future claims to any and all claims prior to or after payment. Periodically, Kaiser Permanente will perform audits on claims to determine if payments have been made appropriately. If our audit determines that an overpayment was made, you will be notified in writing of the amount of the overpayment and given instructions on the process and time frame for reimbursing Kaiser Permanente for the amount overpaid. If you do not send a check for the amount of the overpayment within the timeframe specified in your notice, future claims will be offset. Remit notices for claims that have been offset will reflect the amount deducted from the expected payment. Multiple claims may be affected until the entire balance of the overpayment is recovered. Correcting a previously submitted claim: If your claim requires correction, you will receive a notice on the remit accompanying your rejected claim detailing the error. If corrections can be made, you should submit a corrected claim. The timeframe for submitting a corrected claim is either detailed in the notice you receive requesting corrections or will default to the timely filing limit if not specified. Contracted Providers can submit a claim correction if he/she has the following justifications: • Original claim submitted with incorrect diagnosis • Original claim submitted with incorrect procedure(s) • Original claim submitted with incorrect Member • Original claim submitted with incorrect date of service • Original claim submitted with incorrect contract rates applied • Authorization has been obtained • Any other information that has been added/corrected on the original claim.

	Procedures for submitting a paper claim correction to Kaiser Permanente for processing: • Paper Claims - Corrected claims should be submitted using CMS standards that include the use of Frequency Code 7 in field 22 on the CMS form along with the original claim number. • Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address for the Member's health plan region. Kaiser Permanente prefers corrections to professional claims be submitted via EDI using the ANSI standards. To submit a CMS-1450 (UB-04 based on CMS guidelines) claim correction to Kaiser Permanente for processing: • Electronic: The KP claims system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows providers to submit changes to claims which were not included on the original claim adjudication. Please include the appropriate Type of Bill code when electronically submitting a corrected CMS-1450 (UB-04 based on CMS guidelines) claim to Kaiser Permanente for processing. IMPORTANT: Claims submitted without the appropriate 3rd digit (xxx) in the "Type of Bill" code will be denied. • Paper (KP prefers corrected institutional claims be submitted via EDI): Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address for the Member's health plan region.
5.24 Rejected Claims Due to EDI Claims Error	Electronic Claim Acknowledgement: When Kaiser Permanente receives an EDI claim we transmit an electronic acknowledgement (277P transaction) back to the clearinghouse. This acknowledgement includes information about whether claim was accepted or rejected. The Provider's clearinghouse should forward this confirmation for all claims received or rejected by KP. Electronic claim acknowledgements also identify specific errors on rejected claims. Once the claims listed on the reject report are corrected, the Provider may resubmit these claims electronically. Providers are responsible for reviewing clearinghouse acknowledgment reports. If the Provider is unable to resolve EDI claim errors, please contact EDISupport@kp.org. Detailed Error Report: After receipt of your EDI claims from the Clearinghouse, Kaiser Permanente produces the EDI CLAIMS. KP EDIT

	Software then produces the Reject Report, which identifies specific Fatal Errors on non-accepted claims. Once the claims listed on the Reject Report are corrected, you may re-submit these claims electronically through the Clearinghouse. Providers are responsible for reviewing clearinghouse acknowledgment reports. If the Provider is unable to resolve EDI claim errors, please contact EDISupport@kp.org NOTE: If you are not receiving electronic claim receipts from the Clearinghouse, contact your Clearinghouse to request them.
5.25 Federal Tax ID Number	The Federal Tax ID Number as reported on any and all claim form(s) must match the information filed with the Internal Revenue Service (IRS). 1 When completing IRS Form W-9, please note the following: • Name: This should be the equivalent of your "entity name," which you use to file your tax forms with the IRS. • Sole Provider/Proprietor: List your name, as registered with the IRS. • Group Practice/Facility: List your "group" or "facility" name, as registered with the IRS. 2. Business Name: Leave this field blank, unless you have registered with the IRS as a "Doing Business As" (DBA) entity. If you are doing business under a different name, enter that name on the IRS Form W-9. 3. Address/City, State, Zip Code: Enter the address where Kaiser Permanente should mail your IRS Form 1099. 4. Taxpayer Identification Number (TIN): The number reported in this field (either the social security number or the employer identification number) MUST be used on all claims submitted to Kaiser Permanente. • Sole Provider/Proprietor: Enter your taxpayer identification number, which will usually be your social security number (SSN), unless you have been assigned a unique employer identification number (because you are "doing business as" an entity under a different name). • Group Practice/Facility: Enter your taxpayer identification number, which will usually be your unique employer identification number (EIN). If you have any questions regarding the proper completion of IRS Form W-9, or the correct reporting of your Federal Taxpayer ID Number on your claim forms, please contact the IRS help line in your area or refer to

	the following website: http://www.irs.gov/formspubs/ Completed IRS Form W-9 should be mailed to the following address: Kaiser Permanente Attn: National Provider Contracting and Network Management 300 Lakeside Drive, 13th Floor Oakland, CA 94612 IMPORTANT: If your Federal Tax ID Number should change, please notify us immediately, so that appropriate corrections can be made to Kaiser Permanente's files.
5.26 Changes in Federal Tax ID Number	If your office/facility changes any pertinent information (i.e. tax identification number, phone or fax number, billing address, practice address, etc.) please mail or fax written notice, including the effective date of the change, as soon as possible, or if it at all possible, with 90 days advance notice. For changes in the Federal Tax-ID numbers, please include a W-9 form with the correct information. Kaiser Permanente Attn: National Provider Contracting and Network Management 300 Lakeside Drive, 13th Floor Oakland, CA 94612
5.27 National Provider Identification (NPI)	As of May 23, 2008, Kaiser Permanente will not be able to process electronic claims unless they contain NPI. If you have already obtained your NPI numbers (both Individual Type 1 and/or Organization/Group Type 2), please notify Kaiser Permanente Provider Contracting & Network Management department. Individual (Type 1) and Organization/Group (Type 2) NPI applications and instructions can be accessed at https://nppes.cms.hhs.gov.
5.28 Coding for Claims	It is the Provider's responsibility to ensure that billing codes used on claim forms are current and accurate, that codes reflect the services provided and that coding complies with commonly accepted standards adopted by KP, including those specified in Section 5.15 below. Incorrect and invalid coding, and coding that does not comply with commonly accepted standards adopted by KP, may result in delays in payment or denial of payment. If you would like copies of KP's National Pay Policies, which contain additional detail regarding commonly accepted standards adopted by KP, please contact KP Claims and Referral Member Services at the above numbers listed above in the Whom to Contact section. Claims that use nonstandard, outdated or deleted CPT, HCPCS, ICD-10, or Revenue codes or are otherwise outside the coding standard adopted by KP will be subject to processing delay and/or rejection.

5.29 Coding Standards	Coding – All fields should be completed using industry standard coding as outlined below, as applicable. ICD-10 To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 10th Revision-Clinical Modification (ICD-10-CM) and International Classification of Diseases – 10th Revision – Procedure Coding System (ICD10- PCS) maintained by the ICD-10-CM and ICD-10-PCS Coordination and Maintenance Committee which includes the 4 cooperating parties: the American Hospital Association (AHA), the CMS, the National Center for Health Statistics (NCHS) and the American Health Information Management Association (AHIMA), ICD-10-CM codes in three, four-, five-, six-, or seven-digit codes, depending on the specific disease or injury being described. ICD-10-PCS hospital inpatient procedure codes in seven-digit codes. CPT-4 The Physicians' Current Procedural Terminology (CPT), Fourth Edition code set is a systematic listing and coding of procedures and services performed by Providers. CPT codes are developed by the American Medical Association (AMA). Each procedure code or service is identified with a five-digit code. If you would like to request a new code or suggest deleting or revising an existing code, obtain and complete a form from the AMA's Web site at https://www.ama-assn.org/practice-management/cpt/cpt-code-change-applications HCPCS The Health Care Common Procedure Coding System (HCPCS) Level 2 identifies services and supplies. HCPCS Level 2 begin with letters A–V and are used to bill services such as home medical equipment, ambulance, orthotics and prosthetics, drug codes and injections. Revenue Codes & Condition Codes Consult your NUBC UB-04 Data Specifications Manual for a complete listing. NDC (National Drug Codes) Codes for prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services. ASA (American Society of Anesthesiologists) Anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists.

	DSM-IV (American Psychiatric Services) For psychiatric services, codes distributed by the American Psychiatric Association.
5.30 Modifiers in CPT and HCPCS	Modifiers submitted with an appropriate procedure code further define and/or explain a service provided. Valid modifiers and their descriptions can be found in the most current CPT or HCPCS coding book. Note CMS-1500 Submitters: Kaiser Permanente processes up to (2) modifiers per claim line. When submitting claims, use modifiers to: • Identify distinct or independent services performed on the same day • Reflect services provided and documented in a patient's medical record Modifiers for Professional and Technical Services Modifier 26, Professional Component - Certain procedures consist of a physician component and a technical component. When the physician component is reported separately, adding the Modifier 26 to the CPT procedure code identifies the service. Modifier TC, Technical Component - The modifier TC is submitted with a CPT procedure code to bill for equipment and facility charges, to indicate the technical component. Use with diagnostic tests; e.g. radiation therapy, radiology, and pulmonary function tests. Indicates the Provider performed only the technical component portion of the service. Modifiers Billed with Surgical Procedures Modifier 50 – Bilateral Procedure Add Modifier 50 to the service line of a unilateral 5-digit CPT procedure code to indicate that a bilateral procedure was performed. Modifier 50 may be used to bill surgical procedures at the same operative session, or to bill diagnostic and therapeutic procedures that were performed bilaterally on the same day.
5.31 Modifier Review	KP will review modifier usage based on CPT guidelines. Providers are required to use modifiers according to standards and codes set forth in CPT manuals. KP reserves the right to review use of modifiers to ensure accuracy and appropriateness. Improper use of modifiers may cause claims to be pended and/or returned for correction. Payor will not reimburse for any professional component of clinical diagnostic laboratory services, such as automated laboratory tests, billed

	with a Modifier 26 code, whether performed inside or outside of the hospital setting; provided that (consistent with CMS payment practices) reimbursement for such services, if any, is included in the payment to the applicable facility responsible for providing the laboratory services.
5.32 Coding & Billing Validation	Routinely updated code editing software from a leading national vendor is used for processing all relevant bills in a manner consistent with industry standards, including guidelines from CMS, the National Correct Coding Initiative, the National Library of Medicine, the National Center for Health Statistics, the American Medical Association, and medical and professional associations. Our claims adjudication systems accept and identify all active CPT and HCPCS codes as well as all coding modifiers. Payment for services such as multiple procedures, bilateral procedures, assistant surgeons, co-surgeons and application of modifiers are paid in accordance with Medicare guidelines. When applicable, we request supportive documentation for "unlisted" procedure codes and the application of Modifier 26. We do not allow code unbundling for procedures for which Medicare requires all-inclusive codes and we will re-bundle the procedures and pay according to Medicare's all-inclusive codes for all members. KP will not reimburse for any professional component of clinical diagnostic laboratory services, such as automated laboratory tests, billed with a Modifier 26 code, whether performed inside or outside of the hospital setting; provided that (consistent with CMS payment practices), reimbursement for such services, if any, is included in the payment to the appropriate facility responsible for providing the laboratory services.

5.33 Coding Edit Rules

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

Claims can be subject to the requirement of itemized bills for claims over $20,000.00 dependent on the established agreement set forth with Kaiser Permanente. All billing reviews are based upon and include but are not limited to, the Social Security Act, Code of Federal Regulation, CMS (Center for Medicare and Medicaid Services) guidelines, AMA (American Medical Association) and AHA (American Hospital Associate) billing and coding guidelines, NCCI (National Correct Coding Initiative), False Claims Act, NUCC (National Uniform Claims Committee), Uniform Billing Act, and HIPAA (Health Insurance Portability and Accountability Act).

In the event your facility is not in agreement with our findings of each individual disputed charge, you may submit a written appeal within the timeframes outlined in section 5.20. To dispute our action or decision, you must submit your appeal in writing.

5.34 Clinical Review of Claims	In addition to code review, invoices may be reviewed by a physician or other appropriate clinician to ensure that providers comply with commonly accepted standards of coding and billing, that services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable requirements set forth in your Agreement and/or this Provider Manual. Kaiser Permanente does not reimburse for items or services that are considered inclusive of, or an integral part of, another procedure or service. In accordance with your transplant Agreement with KP, transplant claims can be subject to KP's **Clinical Review Payment Determination** policy or Line Item Deduction rule. This policy outlines that Clinical Review is responsible for reviewing facility and professional claims to ensure that providers comply with billing and coding standards, that services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable contract and/or provider manual requirements. Under this policy National Claims Administration must not reimburse providers for items or services that are not considered inclusive of, or an integral part of, another procedure or service, rather, non-separately payable services must be paid as part of the larger related service and are not eligible for separate reimbursement. Clinical Review must apply commonly accepted standards include CMS, the National Uniform Billing Committee (NUBC), the American Academy of Professional Coders (AAPC), the National Correct Coding Initiative (CCI) standards, and professional and academic journals and publications. For more information on commonly accepted standards applied by Kaiser Permanente, please contact Kaiser Permanente Claims Services at (800) 390-3510.
5.35 Provider Claims Appeals	If your office/facility has questions or concerns about the way a claim was processed by Kaiser Permanente, please contact the Member Services Department in the Member's health plan region. Many questions and issues regarding claim payments, coding and submission policies can be resolved quickly over the phone. If your issue cannot be resolved through this initial contact, you have the right to appeal. See Section 6 of this Manual for a full explanation of this process.

5.36 CMS-1500 (02/12) Field Descriptions

The fields identified in the table below as "Required" must be completed when submitting a CMS-1500 (02/12) claim form for processing:

Please Note: The fields required for submission below are required by Kaiser Permanente but not necessarily by CMS or other payers. For Medicare Members, please refer to Medicare's billing requirements for appropriate field requirements and instructions or examples.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
1	MEDICARE/MEDICAID/ CHAMPUS/GROUP HEALTH PLAN/FECA BLK LUNG/OTHER	Not Required	Check the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a	INSURED'S I.D. NUMBER	Required	Enter the subscriber's plan identification number. Note: If this claim is for donor related services, the recipient is responsible for the donor costs. Please complete this section with the recipient's information.
2	PATIENT'S NAME	Required	Enter the patient's name. When submitting newborn claims, enter the newborn's first and last name.
3	PATIENT'S BIRTH DATE AND SEX	Required	Enter the patient's date of birth and gender. The date of birth must include the month, day and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006
4	INSURED'S NAME	Required	Enter the name of the insured, i.e., policyholder (Last Name, First Name, and Middle Initial), unless the insured and the patient are the same—then the word "SAME" may be entered. If this field is completed with an identity different than that of the patient, also complete Field 11. Note: If this claim is for donor related services, the recipient is responsible for the donor costs. Please complete this section with the recipient's information.
5	PATIENT'S ADDRESS	Required	Enter the patient's mailing address and telephone number. On the first line, enter the STREET ADDRESS; the second line is for the CITY and STATE; the third line is for the ZIP CODE and PHONE NUMBER.
6	PATIENT'S RELATIONSHIP TO INSURED	Required	Check the appropriate box for the patient's relationship to the insured.
7	INSURED'S ADDRESS	Required if Applicable	Enter the insured's address (STREET ADDRESS, CITY, STATE, ZIP CODE) and telephone number. When the address is the same as the patient's—the word "SAME" may be entered.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
8	**PATIENT STATUS**	Required if Applicable	Check the appropriate box for the patient's MARITAL STATUS, and check whether the patient is EMPLOYED or is a STUDENT.
9	**OTHER INSURED'S NAME**	Required if Applicable	When additional insurance coverage exists, enter the last name, first name and middle initial of the insured.
9a	**OTHER INSURED'S POLICY OR GROUP NUMBER**	Required if Applicable	Enter the policy and/or group number of the insured individual named in Field 9 (Other Insured's Name) above. NOTE: *For each entry in Field 9A, there must be a corresponding entry in Field 9d.*
9b	**OTHER INSURED'S DATE OF BIRTH/SEX**	Required if Applicable	Enter the "other" insured's date of birth and sex. The date of birth must include the month, day, and FOUR DIGITS for year (MM/DD/YYYY). *Example:* 01/05/2003
9c	**EMPLOYER'S NAME OR SCHOOL NAME**	Required if Applicable	Enter the name of the "other" insured's EMPLOYER or SCHOOL NAME (if a student).
9d	**INSURANCE PLAN NAME OR PROGRAM NAME**	Required if Applicable	Enter the name of the "other" insured's INSURANCE PLAN or program.
10a-c	**IS PATIENT CONDITION RELATED TO**	Required	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. NOTE: *If "yes" there must be a corresponding entry in Field 14 (Date of Current Illness/Injury).* Place (State)- enter the State postal code.
10d	**RESERVED FOR LOCAL USE**	Not Required	Leave blank.
11	**INSURED'S POLICY NUMBER OR FECA NUMBER**	Required if Applicable	If there is insurance primary to Medicare, enter the insured's policy or group number.
11a	**INSURED'S DATE OF BIRTH**	Required if Applicable	Enter the insured's date of birth and sex, if different from Field 3. The date of birth must include the month, day, and FOUR digits for the year (MM/DD/YYYY). Example: 01/05/2006 Note: If this claim is for donor related services, the recipient is responsible for the donor costs. Please complete this section with the recipient's information.
11b	**EMPLOYER'S NAME OR SCHOOL NAME**	Not Required	Enter the name of the employer or school (if a student), if applicable.
11c	**INSURANCE PLAN OR PROGRAM NAME**	Required if Applicable	Enter the insurance plan or program name.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required	Check “yes” or “no” to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If “yes” then fields 9 and 9a-d must be completed.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Required if Applicable	Have the patient or an authorized representative SIGN and DATE this block unless the signature is on file. If the patient’s representative signs, then the relationship to the patient must be indicated.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Required	Have the patient or an authorized representative SIGN this block unless the signature is on file.
14	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	Required if Applicable	Enter the date of the current illness or injury. If pregnancy, enter the date of the patient’s last menstrual period. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006
15	OTHER DATE	Not Required	Leave blank.
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not Required	Enter the “from” and “to” dates that the patient is unable to work. The dates must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required if Applicable	Enter the FIRST and LAST NAME of the referring or ordering physician.
17a	OTHER ID #	Not Required	
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Required if Applicable	Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	RESERVED FOR LOCAL USE	Required if Applicable	If you are “covering” for another physician, enter the name of the physician (for whom you are covering) in this field. If a non-contracting Provider/Provider will be covering for you in your absence, please notify that individual of this requirement.
20	OUTSIDE LAB	Not Required	
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Required	Enter the diagnosis/condition of the patient, indicated by an ICD-10 code number. Enter up to 12 diagnosis codes, in PRIORITY order (primary, secondary condition). Enter the ICD indicator in the upper right corner of this field (“9” = ICD9; “0” = ICD10)

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
22	**RESUBMISSION**	Not Required	
23	**PRIOR AUTHORIZATION NUMBER**	Required if Applicable	For ALL inpatient and outpatient claims, enter the KP referral/authorization number, if applicable, for the episode of care being billed NOTE: this is a 9-digit numeric identifier
24A-J	**SUPPLEMENTAL INFORMATION**	Required	Supplemental information can only be entered with a corresponding, completed service line. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. When reporting additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP – HIBCC codes, OZ – GTIN codes or contract rate, enter the applicable qualifier and number/code/ information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or another separator between the qualifier and the number/code/information. The following qualifiers are to be used when reporting these services. 7 – Anesthesia information ZZ – Narrative description of unspecified code N4 – National Drug Codes (NDC) VP – Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard OZ – Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) CTR – Contract rate
24a	**DATE(S) OF SERVICE**	Required	Enter the month, day, and year (MM/DD/YY) for each procedure, service, or supply. Services must be entered chronologically (starting with the oldest date first). For each service date listed/billed, the following fields must also be entered: *Units, Charges/Amount/Fee, Place of Service, Procedure Code, and corresponding Diagnosis Code.* IMPORTANT: Do not submit a claim with a future date of service. Claims can only be submitted once the service has been rendered (for example: durable medical equipment).
24b	**PLACE OF SERVICE**	Required	Enter the place of service code for each item used or service performed.
24c	**TYPE OF SERVICE**	Required	Enter the “type of service” code, reflecting the type of service rendered.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24d	PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER	Required	Enter the CPT/HCPCS codes reflecting the procedures performed, services rendered, or supplies used. When applicable, also enter the appropriate CPT/HCPCS code modifier(s) in this field, next to the corresponding CPT/HCPCS procedure code(s). IMPORTANT: Enter the anesthesia time, reported as the "beginning" and "end" times of anesthesia in military time under the appropriate procedure code.
24e	DIAGNOSIS CODE	Required	Enter EITHER the diagnosis reference number as shown in Field 21, OR the appropriate ICD-9-CM diagnosis code next to each procedure/service listed.
24f	$ CHARGES	Required	Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc).
24g	DAYS OR UNITS	Required	Enter the number of days or units in this block. (For example: units of supplies, etc.)
24h	EPSDT FAMILY PLAN	Not Required	
24i	EMG	Not Required	
24j	COB	Not Required	
24k	RESERVED FOR LOCAL USE	Not Required	
25	FEDERAL TAX ID NUMBER	Required	Enter the physician/supplier federal tax I.D. number or Social Security number of the billing provider identified in Field 33. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. IMPORTANT: The Federal Tax ID Number in this field must match the information on file with the IRS.
26	PATIENT'S ACCOUNT NO.	Required	Enter the Member's account number assigned by the Provider's/Provider's accounting system, , i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider/Provider.
27	ACCEPT ASSIGNMENT	Not Required	
28	TOTAL CHARGE	Required	Enter the total charges for the services rendered (total of all the charges listed in Field 24f).
29	AMOUNT PAID	Required if Applicable	Enter the amount paid (i.e., Member copayments or other insurance payments) to date in this field for the services billed.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
30	**BALANCE DUE**	Not Required	Enter the balance due (total charges less amount paid).
31	**SIGNATURE OF PHYSICIAN OR SUPPLIER**	Required	Enter the signature of the physician/supplier or his/her representative, and the date the form was signed. For claims submitted electronically, include a computer printed name as the signature of the Provider or person entitled to reimbursement.
32	**SERVICE FACILITY LOCATION INFORMATION**	Required if Applicable	The name and address of the facility where services were rendered (if other than patient's home or physician's office). Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code Do not use commas, periods, or other punctuation in the address (e.g., "123 N Main Street 101" instead of "123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9-digit zip code include the hyphen.
32A	**NPI #**	Required unless provider does not qualify for one	Enter the NPI number of the service facility if it is an entity external to the billing provider.
32B	**OTHER ID #**	Required if provider does not qualify for an NPI in field 32A	Enter the two-digit qualifier (See field 24 I, "ID QUAL") identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number.
33	**BILLING PROVIDER INFO & PH #**	Required	Enter the name, address, and phone number of the billing entity
33A	**NPI #**	Required unless provider does not qualify for one	Enter the NPI number of the billing provider.
33B	**OTHER ID #**	Required if provider does not qualify for an NPI in field 33A	Enter the two-digit qualifier (See field 24 I, "ID QUAL") identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. If available, please enter your unique provider or vendor number assigned by KP.

5.36.1 CMS-1500 (02/12) Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

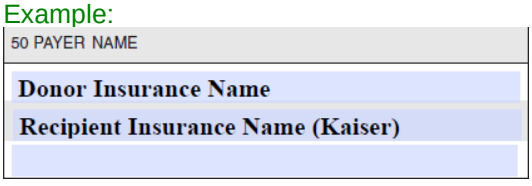
5.37 CMS-1450 (UB-04) Field Descriptions

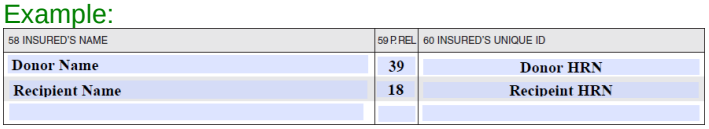
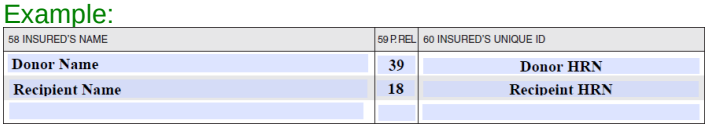
The fields identified in the table below as "Required" must be completed when submitting a CMS-1450 (UB-04) claim form to Kaiser Permanente for processing:

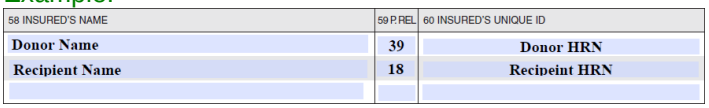
Please Note: The fields required for submission below are required by Kaiser Permanente but not necessarily by CMS or other payers. For Medicare Members, please refer to Medicare's billing requirements for appropriate field requirements and instructions or examples.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
1	PROVIDER NAME and ADDRESS	Required	Enter the name and address of the billing provider which rendered the services being billed.
2	PAY-TO NAME, ADDRESS, CITY / STATE, ID #	Required if Applicable	Enter the name and address of the billing provider's designated pay-to entity.
3a	PATIENT CONTROL NUMBER	Required	Enter the patient's account number assigned by the Provider's accounting system, i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider.
3b	MEDICAL / HEALTH RECORD NUMBER	Required if Applicable	Enter the number assigned to the patient's medical/health record by the Provider. Note: this is not the same as either Field 3a or Field 60.
4	TYPE OF BILL	Required	Enter the appropriate code to identify the specific type of bill being submitted. This code is required for the correct identification of inpatient vs. outpatient claims, voids, etc.
5	FEDERAL TAX NUMBER	Required	Enter the federal tax ID of the hospital or person entitled to reimbursement in NN-NNNNNNN format.
6	STATEMENT COVERS PERIOD	Required	Enter the beginning and ending date of service included in the claim.
7	BLANK	Not Required	Leave blank.
8	PATIENT NAME / ID	Required	Enter the patient's name, together with the patient ID (if different than the insured's ID).
9	PATIENT ADDRESS	Required	Enter the patient's mailing address.
10	PATIENT BIRTH DATE	Required	Enter the patient's birth date in MM/DD/YYYY format.
11	PATIENT SEX	Required	Enter the patient's gender.
12	ADMISSION DATE	Required if Applicable	For inpatient and Home Health claims only, enter the date of admission in MM/DD/YYYY format.
13	ADMISSION HOUR	Required	For either inpatient OR outpatient care, enter the 2- digit code for the hour during which the patient was admitted or seen.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
14	ADMISSION TYPE	Required	Indicate the type of admission (e.g. emergency, urgent, elective, and newborn).
15	ADMISSION SOURCE	Required	Enter the code for the point of origin of the admission or visit.
16	DISCHARGE HOUR (DHR)	Required if Applicable	Enter the two-digit code for the hour during which the patient was discharged.
17	PATIENT STATUS	Required	Enter the discharge status code as of the “Through” date of the billing period.
18-28	CONDITION CODES	Required if Applicable	Enter any applicable codes which identify conditions relating to the claim that may affect claims processing.
29	ACCIDENT (ACDT) STATE	Not Required	Enter the two-character code indicating the state in which the accident occurred which necessitated medical treatment.
30	BLANK	Not Required	Leave blank.
31-34	OCCURRENCE CODES AND DATES	Required if Applicable	Enter the code and the associated date (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
35-36	OCCURRENCE SPAN CODES AND DATES	Required if Applicable	Enter the occurrence span code and associated dates (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
37	BLANK	Not Required	Leave blank.
38	RESPONSIBLE PARTY	Not Required	Enter the name and address of the financially responsible party.
39-41	VALUE CODES and AMOUNT	Required if Applicable	Enter the code and related amount/value which is necessary to process the claim.
42	REVENUE CODE	Required	Identify the specific accommodation, ancillary service, or billing calculation, by assigning an appropriate revenue code to each charge.
43	REVENUE DESCRIPTION	Required if Applicable	Enter the narrative revenue description or standard abbreviation to assist clerical bill review. NOTE: The National Drug Code (NDC) number is REQUIRED in this field on Medicaid claims where a clinic-administered medication (CAM) was given.
44	PROCEDURE CODE AND MODIFIER	Required if Applicable	For ALL outpatient claims, enter BOTH a revenue code in Field 42 (Rev. CD.), and the corresponding CPT/HCPCS procedure code in this field.

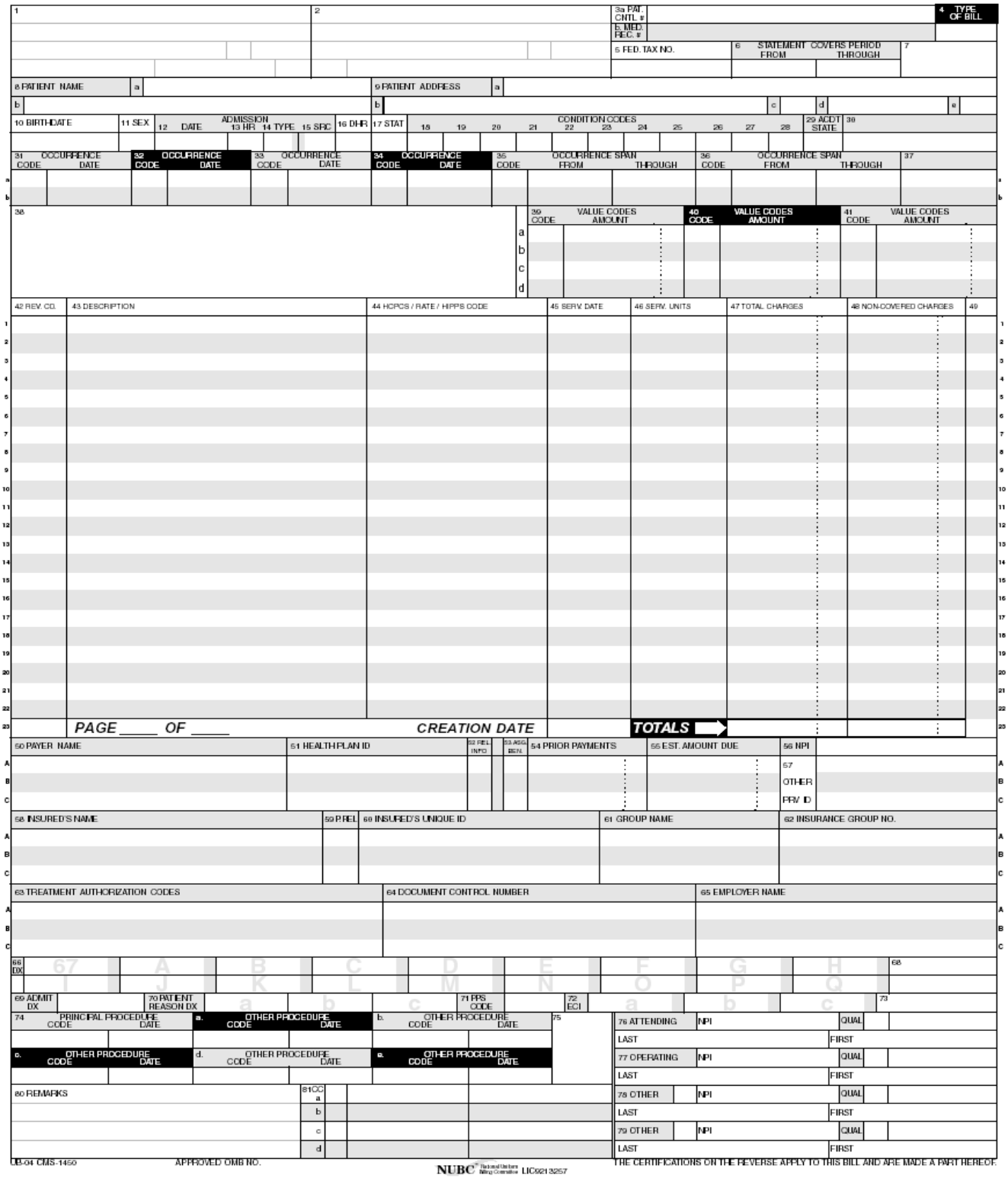
FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
45	SERVICE DATE	Required	Outpatient Series Bills: A service date must be entered for all outpatient series bills whenever the “from” and “through” dates in Field 6 (Statement Covers Period: From/Through) are not the same. Submissions that are received without the required service date(s) will be rejected with a request for itemization. Multiple/Different Dates of Service: Multiple/different dates of service can be listed on ONE claim form. List each date on a separate line on the form, along with the corresponding revenue code (Field 42), procedure code (Field 44), and total charges (Field 47).
46	UNITS OF SERVICE	Required	Enter the units of service to quantify each revenue code category. IMPORTANT: SNF Providers billing for Supportive Services and Home Health Providers billing for Services in excess of a 2-hour visit should enter the total number of 15 minute units of authorized Services provided to Members, regardless of the time unit assigned to the applicable payment rate in your contract (e.g., rate per hour).
47	TOTAL CHARGES	Required	Indicate the total charges pertaining to each related revenue code for the current billing period, as listed in Field 6.
48	NON-COVERED CHARGES	Required if Applicable	Enter any non-covered charges.
49	BLANK	Not Required	Leave blank.
50	PAYER NAME	Required	Enter (in appropriate ORDER on lines A, B, and C) the NAME and NUMBER of each payer organization from which you are expecting payment towards the claim. Note: If this claim is for donor related services, the recipient is responsible for the donor costs. Please complete this section with the recipient’s information and each of the responsible party’s information. Example: 
51	HEALTH PLAN ID	Not Required	Enter the Plan Sponsor identification number.
52	RELEASE OF INFORMATION (RLS INFO)	Required if Applicable	Enter the release of information certification indicator(s).

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
53	ASSIGNMENT OF BENEFITS (ASG BEN)	Required	Enter the assignment of benefits certification indicator.
54A-C	PRIOR PAYMENTS	Required if Applicable	If payment has already been received toward the claim by one of the payers listed in Field 50 (Payer) prior to the billing date, enter the amounts here.
55	ESTIMATED AMOUNT DUE	Required if Applicable	Enter the estimated amount due from patient. Do not report collection of patient's cost share.
56	NATIONAL PROVIDER IDENTIFIER (NPI)	Required	Enter the billing provider's NPI.
57	OTHER PROVIDER ID	Required	Enter the service Provider's KP-assigned Provider ID, if any
58	INSURED'S NAME	Required	Enter the insured's name, i.e. policyholder. Note: If this claim is for donor related services, the recipient is responsible for the donor costs. Please complete this section with the recipient's information and each of the responsible party's information. Example:  58 INSURED'S NAME / 59 P.REL / 60 INSURED'S UNIQUE ID Donor Name / 39 / Donor HRN Recipient Name / 18 / Recipeint HRN
59	PATIENT'S RELATION TO INSURED	Required	Enter the patient's relationship to the insured. Note: If this claim is for donor related services, the recipient is responsible for the donor costs. Please complete this section with the recipient's information and each of the responsible party's information. For the donor line (relationship code) the value is 39 For the recipient line (relationship code) the value is 18 Example:  58 INSURED'S NAME / 59 P.REL / 60 INSURED'S UNIQUE ID Donor Name / 39 / Donor HRN Recipient Name / 18 / Recipeint HRN

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
60	INSURED'S UNIQUE ID	Required	Enter the patient's Kaiser Medical Record Number (MRN). Note: If this claim is for donor related services, the recipient is responsible for the donor costs. Please complete this section with the recipient's information and each of the possible responsible party's information. Example:  58 INSURED'S NAME / 59 P.REL / 60 INSURED'S UNIQUE ID Donor Name / 39 / Donor HRN Recipient Name / 18 / Recipeint HRN
61	INSURED'S GROUP NAME	Required if Applicable	Enter the insured's group name.
62	INSURED'S GROUP NUMBER	Required if Applicable	Enter the insured's group number. For Prepaid Services claims enter "PPS".
63	TREATMENT AUTHORIZATION CODE	Required if Applicable	For ALL inpatient and outpatient claims, enter the KP referral/authorization number, if applicable, for the episode of care being billed. NOTE: this is a 9-digit numeric identifier
64	DOCUMENT CONTROL NUMBER	Not Required	Enter the document control number related to the patient or the claim as assigned by KP.
65	EMPLOYER NAME	Required if Applicable	Enter the name of the insured's (Field 58) employer.
66	DX VERSION QUALIFIER	Required	Indicate the ICD version indicator of codes being reported. ("9" = ICD9; "0" = ICD10)
67	PRINCIPAL DIAGNOSIS CODE	Required	Enter the principal diagnosis code, on all inpatient and outpatient claims. Enter POA (Present on Admit) indicator in the shaded area on the right side of the principal ICD
67A-Q	OTHER DIAGNOSES CODES	Required if Applicable	Enter other diagnoses codes corresponding to additional conditions that coexist or develop subsequently during treatment. Diagnosis codes must be carried to their highest degree of detail. Enter POA (Present on Admit) indicator (for each ICD entered) in the shaded area on the right side for each ICD
68	BLANK	Not Required	Leave blank.
69	ADMITTING DIAGNOSIS	Required	Enter the admitting diagnosis code on all inpatient claims.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
70a-c	REASON FOR VISIT (PATIENT REASON DX)	Required if Applicable	Enter the diagnosis codes indicating the patient's reason for outpatient visit at the time of registration.
71	PPS CODE	Required if Applicable	Enter the DRG number to which the procedures group, even if you are being reimbursed under a different payment methodology.
72	EXTERNAL CAUSE OF INJURY CODE (ECI)	Required if Applicable	Enter an ICD-10 "VWXY" code in this field (if applicable).
73	BLANK	Not required	Leave blank.
74	PRINCIPAL PROCEDURE CODE AND DATE	Required if Applicable	Enter the ICD-10 procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed (if applicable).
74a-e	OTHER PROCEDURE CODES AND DATES	Required if Applicable	Enter other ICD-10 procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims (in fields "A" through "E) for any additional surgical and/or obstetrical procedures which were performed (if applicable).
75	BLANK	Not required	Leave blank.
76	ATTENDING PHYSICIAN / NPI / QUAL / ID	Required	Enter the NPI and the name of the attending physician for inpatient bills or the KP physician that requested the outpatient services. Inpatient Claims—Attending Physician Enter the full name (first and last name) of the physician who is responsible for the care of the patient. Outpatient Claims—Referring Physician For ALL outpatient claims, enter the full name (first and last name) of the KP physician who referred the Patient for the outpatient services billed on the claim.
77	OPERATING PHYSICIAN / NPI/ QUAL/ ID	Required If Applicable	Enter the NPI and the name of the lead surgeon who performed the surgical procedure.
78-79	OTHER PHYSICIAN/ NPI/ QUAL/ ID	Required if Applicable	Enter the NPI and name of any other physicians.
80	REMARKS	Not Required	Special annotations may be entered in this field.
81	CODE-CODE	Required if Applicable	Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate.

5.37.1 CMS-1450 (UB-04) Form



5.38 Billing Requirements and Instruction for Specific Services

Topic	Instructions
5.38.1 Emergency Claims	An emergency claim is submitted when a center furnishes medically necessary emergency health services or supplies to a Kaiser Permanente Member without obtaining an authorization. The following circumstances must be present for Kaiser Permanente to consider payment of bills as part of an emergency claim: 1. The services and supplies would have been covered under the Members Health Plan, if they had been ordered, authorized, prescribed, or directed by a Plan Physician. 2. The services provided were immediately required because of an unforeseen illness or injury. Coverage depends on the advice of the treating physician, as well as the Kaiser Permanente determination of the situation in which care was provided and in consideration of the prudent layperson guidelines. **Please Note:** Kaiser Permanente makes a distinction between a "Claim for Authorized Services" or "Referral" and "Emergency Claim", in terms of processing payment for contracted Providers. As a result, payment processing may be done by two different departments within Kaiser Permanente for referrals as opposed to claims. If a Member has received a transplant services referral, the Provider submits claims to the address listed on the authorization form.
5.38.2 Member Cost Share	Member Cost Share refers to the fees a Member is responsible to pay a Provider for certain covered services, for example, in the form of a co-payment, co-insurance or deductible. Depending on the benefit plan, Members may be responsible to share some cost of the services provided. Providers are invited and encouraged to request access to KP's Online Affiliate tool. Many functions, including but not limited to obtaining information on benefits and eligibility, Member Cost Share and claim status are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please select your applicable region from the following list to learn more about gaining access to Online Affiliate Link and the guest access feature: California – Northern* California – Southern* Colorado* Georgia* Hawaii* Mid-Atlantic States* Northwest*

	*This link will open a new window. If you can't view this new page, please make sure that you've disabled any pop-up blockers on your computer. Please verify applicable copayments, co-insurance and/or deductibles (Member Cost Share) at the time of service by utilizing Online Affiliate. • Providers are responsible for collecting Member Cost Share as explicitly required by your Agreement and in accordance with Member benefits • Claims submitted by Providers who are responsible for collecting Member cost share will be paid at the applicable rate(s) under your Agreement, less the applicable Member Cost Share amount due from the Member • You must not waive any Member Cost Share you are required to collect, except as expressly permitted under applicable law and your Agreement When a Medicare Advantage Member is also enrolled in Medi-Cal (or another State's Medicaid program) and any such Medicaid program is responsible for the Member's Medicare Advantage cost share if applicable. Providers should either accept payment pursuant to their Agreement as payment in full or bill the applicable Medicaid program for the Member's Cost Share. As required by Medicare regulations and as outlined in your Agreement, you are prohibited from collecting cost-sharing for Medicare covered services from Members dually enrolled in the Medicare and Medicaid programs. This requirement also applies to individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program, a program that pays for Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Accordingly, it is imperative that you take steps to avoid inappropriate billing/collection of cost-sharing from dual eligible beneficiaries, including QMB enrollees. KP's contract with the Medicare program requires that we actively educate contracted providers about this requirement and promptly address any complaints from dual-eligible beneficiaries/Members alleging that cost-sharing was inappropriately requested or collected. If you have questions about these requirements or regarding a Member's eligibility status, please contact the MSCC in section 5.1.
5.38.3 Balance Billing Members	NOTICE TO ALL PROVIDERS: In no event including, but not limited to, nonpayment by or insolvency of a Payer or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, reimbursement, or remuneration from; impose surcharges; or have any recourse against any Member, person acting on the Member's behalf, state Medicaid plan, or any person other

	than the Payer for Covered Services provided under this Agreement. This Agreement does not prohibit Provider from collecting Member Cost Share amounts or fees for non-Covered Services billed in accordance with the terms of the applicable Membership Agreement. The terms of this Section shall survive the termination or expiration of this Agreement regardless of the cause giving rise to termination, shall be construed to be for the benefit of Members, and shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf. Without limiting the foregoing, Provider shall not seek payment from Members for: (1) amounts denied by Payer because billed charges were not customary or reasonable, (2) amounts denied because they were not medically necessary as determined under the Membership Agreement, or (3) Provider's failure to obtain Authorization for Services delivered; submit clinical data promptly; or submit a claim in accordance with the appropriate billing procedures, within the appropriate time frame, or in accordance with commonly accepted standard coding practices.

5.39 Coordination of Benefits (COB)

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

Kaiser Permanente Providers are responsible for determining the primary payor and for billing the appropriate party. If Kaiser Permanente is not the primary carrier, an EOB is required with the claim CMS 1500 (HCFA 1500) submission.

Topic	Instructions
5.39.1 How to Determine the Primary Payor	The benefits of the plan that covers an individual as an employee, Member or subscriber other than as a dependent are determined before those of a plan that covers the individual as a dependent. When both parents cover a child, the “birthday rule” applies – the payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor. When determining the primary payor for a child of separated or divorced parents, inquire about the court agreement or decree. In the absence of a divorce decree/court order stipulating parental healthcare responsibilities for a dependent child, insurance benefits for that child are applied according to the following order: Insurance carried by the: • Natural parent with custody pays first • Stepparent with custody pays next • Natural parent without custody pays next • Stepparent without custody pays last If the parents have joint custody of the dependent child, then benefits are applied according to the birthday rule referenced above. If this does not apply, call the Member Services Department in the Member’s Health Plan Region. Kaiser Permanente is generally primary for working Medicare-eligible Members when the CMS Working Aged regulation applies. Medicare is generally primary for retired Medicare Members

Topic	Instructions
	over age 65, and for employee group health plan (EGHP) Members with End Stage Renal Disease (ESRD) for the first thirty (30) months of dialysis treatment. This does not apply to direct pay Members.
5.39.2 Description of COB Payment Methodologies	Kaiser Permanente Coordination of Benefits allows benefits from multiple carriers to be added on top of each other so that the Member receives the full benefits from their primary carrier and the secondary carrier pays their entire benefit up to 100% of allowed charges. When Kaiser Permanente has been determined as the secondary payor, Kaiser Permanente pays the difference between the payment by the primary payor and the amount which would be have been paid if Kaiser Permanente was primary, less any amount for which the Member has financial responsibility. Benefit carve-out calculations are based on whether the Provider accepts Medicare assignment for the Provider contract corresponding to the claim. Medicare assignment means the Provider has agreed to accept the Medicare allowed amount as payment.
5.39.3 COB Claims Submission Requirements and Procedures	Whenever Kaiser Permanente is the SECONDARY payer, claims can be submitted EITHER electronically or on one of the standard paper claim forms: Electronic Claims: If Kaiser Permanente is the secondary payer, send the completed electronic claim with the payment fields from the primary insurance carrier entered as follows: • 837P claim transaction: Complete Field 29 (Amount Paid) • 837I claim transaction: Complete Field 54 (Prior Payments) Paper Claims If Kaiser Permanente is the secondary payer, send the completed claim form with a copy of the corresponding Explanation of Benefit (EOB) or Explanation of Medicare Benefits (EOMB)/Medicare Summary Notice (MSN) from the primary insurance carrier attached to the paper claim to ensure efficient claims processing/adjudication. Kaiser Permanente cannot process a claim without an EOB or EOMB/MSN from the primary insurance carrier. • CMS-1500 claim form: Complete Field 29

Topic	Instructions
	(Amount Paid) • CMS-1450 claim form: Complete Field 54 (Prior Payments)
5.39.4 Members Enrolled in Two Kaiser Permanente Plans	Some Members may be enrolled under two separate plans offered through Kaiser Permanente (dual coverage). In these situations, Providers need only submit ONE claim under the primary plan to Kaiser Permanente for processing.
5.39.5 COB Claims Submission Timeframes	If Kaiser Permanente is the secondary payer, any Coordination of Benefits (COB) claims must be submitted for processing within 45 days of the date of the Explanation of Benefits (EOB) or EOMB/MSN.

5.39.6 COB FIELDS ON THE UB-04 CLAIM FORM

The following fields should be completed on the **CMS-1450 (UB-04)** claim form to ensure timely and efficient claims processing. Incomplete, missing, or erroneous COB information in these fields may cause claims to be denied or pended and reimbursements delayed. For additional information, refer to the current *UB-04 National Uniform Billing Data Element Specifications Manual*.

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

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2300 H1	**31-36** (UB-04)	**OCCURRENCE CODE/DATE**	Enter the appropriate occurrence code and date defining the specific event(s) relating to the claim billing period. **NOTE**: If the injuries are a result of an accident, please complete **Field 77 (E-Code)**
2330B NM	**50**	**PAYER** *(Payer Identification)*	Enter the **name** and **number** *(if known)* for each **payer organization** from whom the Provider expects (or has received) payment towards the bill. List payers in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2320 AMT	**54**	PRIOR PAYMENTS *(Payers and Patient)*	Enter the **amount(s)**, if any, that the Provider has received **toward payment of the bill** PRIOR to the billing date, by the indicated payer(s). List prior payments in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2330A NM	**58**	INSURED'S NAME	Enter the **name** *(Last Name, First Name)* of the individual in whose name insurance is being carried. List entries in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer**NOTE:** For each entry in ***Field 58*****,** there MUST be corresponding entries in ***Fields 59 through 62*** (UB-92 and UB-04) AND ***64 through 65 (Field 65 only on the UB-04).***
2320 SBR	**59**	**Patient's Relationship To Insured**	Enter the **code** indicating the **relationship** of the patient to the insured individual(s) listed in **Field 58** *(Insured's Name)*. List entries in the **following order:** A = **primary** payer B = **secondary** payer C = **tertiary** payer
2320 SBR	**65**	**EMPLOYER NAME** *(Employer Name of the Insured)*	Enter the **name of the employer** who provides health care coverage for the insured individual *(listed in Field 58)*. Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper
2300 H1	**67-76 (UB-92) 67 A-Q (UB-04)**	**DIAGNOSIS CODE**	The **primary diagnosis** code should be reported in **Field 67**. Additional diagnosis code can be entered in **Field 68-76.**
2300H1	**77(UB-92) 72 (UB-04)**	**EXTERNAL CAUSE OF INJURY CODE (E-CODE)**	If applicable, enter an ICD-9-CM "E-code" in this field.

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2330A NM	**60**	**CERT. – SSN – HIC – ID NO.** *(Certificate/Social Security Number/Health Insurance Claim/Identification Number)*	Enter the insured person's *(listed in Field 58)* unique **individual Member identification number** (medical/health record number), as assigned by the payer organization. List entries in the **following order:** A = **primary** payer B = **secondary** payer C = **tertiary** paper
2320 SBR	**61**	**GROUP NAME** *(Insured Group Name)*	Enter the **name** of the **group or plan** through which the insurance is being provided to the insured individual *(listed in Field 58)*. Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper
2320 SBR	**62**	**INSURANCE GROUP NO.**	Enter the **identification number**, **control number**, or **code** assigned by the carrier or administrator to identify the **GROUP** under which the individual *(listed in Field 58)* is covered. List entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper
2320 SBR	**64**	**ESC** *(Employment Status Code of the Insured)* ***Note:*** *This field has been deleted from the UB-04.*	Enter the code used to define the **employment status** of the insured individual *(listed in Field 58)*. Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper

5.39.7 COB FIELDS ON THE CMS-1500 (HCFA-1500) CLAIM FORM

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

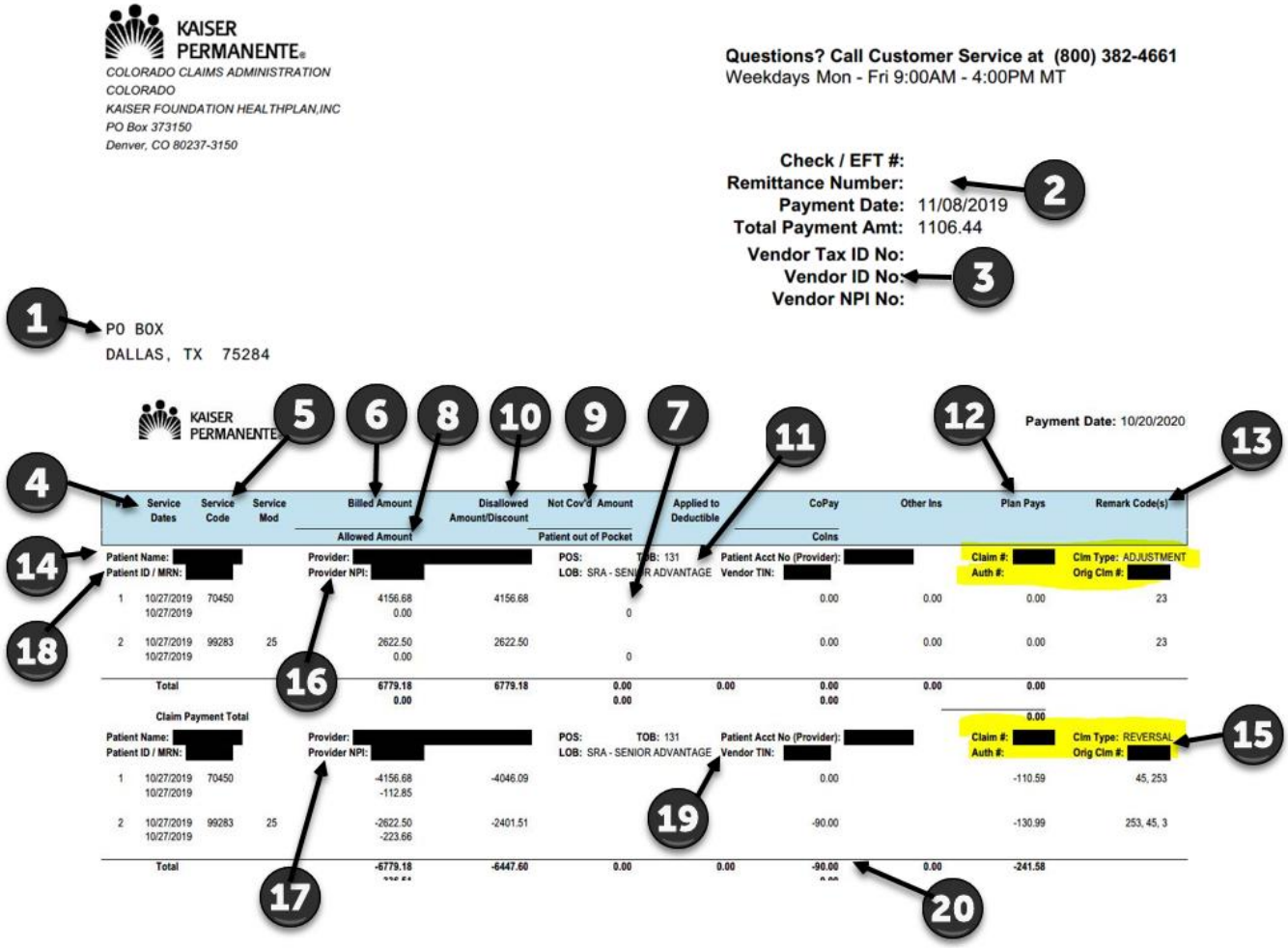
Claims submitted electronically must meet the same data requirements as paper claims. For electronic claim submissions, refer to a HIPAA website for additional information on electronic loops and segments.

837P LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2330A NM	**9**	**OTHER INSURED'S NAME**	When **additional** insurance coverage exists (through a spouse, parent, etc.) enter the LAST NAME, FIRST NAME, and MIDDLE INITIAL of the insured. **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**

837P LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2330A NM	**9a**	**OTHER INSURED'S POLICY OR GROUP NUMBER**	Enter the policy and/or group number of the insured individual named in **Field 9**. If you do not know the policy number, enter the Social Security number of the insured individual. **NOTE: Field 9a must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).** **NOTE: For each entry in this field, there must be a corresponding Entry in 9d (Insurance Plan Name or Program Name).**
2320 DMG	**9b**	**OTHER INSURED'S DATE OF BIRTH/SEX**	Enter date of birth and sex, of the insured named in **Field 9**. The date of birth must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). **Example: 01/05/1971** **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**
N/A	**9c**	**EMPLOYER'S NAME or SCHOOL NAME**	Enter the name of the employer or school name (if a student), of the insured named in **Field 9**. **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**
2330B NM	**9d**	**INSURANCE PLAN NAME or PROGRAM NAME**	Enter the name of the insurance plan or program, of the insured individual named in **Field 9**. **NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).**
2300 CLM	**10**	**IS PATIENT'S CONDITION RELATED TO:** **a. Employment?** **b. Auto Accident?** **c. Other Accident?** **PLACE (State) →**	Check "yes" or "no" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in **Field 24**. **NOTE: If yes, there must be a corresponding entry in Field 14 (Date of Current Illness/ Injury) and in Field 21 (Diagnosis).** **PLACE (State) →** Enter the state the Auto Accident occurred in.
N/A	**11d**	**IS THERE ANOTHER HEALTH BENEFIT PLAN?**	Check "yes" or "no" to indicate if there is another health benefit plan. (For example, the patient may be covered under insurance held by a spouse, parent, or some other person). **NOTE: If "yes," then Field Items 9 and 9a-d must be completed.**
2300 DTP	**14**	**DATE OF CURRENT**	Enter the date of the current illness or injury. The date must

837P LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
		--Illness (First symptom) **--Injury (Accident)** **--Pregnancy (LMP)**	include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). **Example: 01/05/2004**
2300 H1	**21**	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**	Enter the diagnosis and if applicable, enter the Supplementary Classification of External Cause of Injury and Poisoning Code. **NOTE: This field must be completed when there is an entry in Field 10 (Is The Patient's Condition Related To).**
2320 AMT	**29**	**AMOUNT PAID**	Enter the amount paid by the primary insurance carrier in Field 29.

5.40 Explanation of Payment (EOP)



Number in Screen-print	Field Name	Explanation
1	Vendor Name/ Address	Name and address of the vendor.
2	Check Number/Date/Amount	The check number issued to the provider, the check date and the net amount of the check.
3	Vendor ID	The Vendor ID number.
4	Service Dates	The dates on which the services were provided.
5	Service Description	The description of the medical services or procedures provided.
6	Billed Amount	The amount billed by the Provider for a specific service.
7	Other Insurance Amount	Amounts paid by another insurance carrier under coordination of benefits, third party liability or workers compensation.
8	Allowed Amount	This is the allowed amount for a specific service.
9	Not Covered Amount	This is the amount billed by a Provider for a specific service that is not covered due to limitations or exclusions from a Member's benefit plan or Provider reductions.
10	Applied to Deductible	The portion of the Allowed Amount applied to the Members benefit plan deductible if any.
11	Copay/Coinsurance	A specific dollar amount or percentage of the Allowed Amount that is the Member's responsibility to pay towards a specific service.
12	Plan Pays	The total amount paid by the Health Plan for all services on the claim.
13	Remark Code	Codes describing how the claim was processed.
14	Insured	The subscriber who applied for coverage and agrees to be responsible for payment.
15	Claim Number	The unique number assigned to this claim.
16	Provider Name	The Provider of services associated with this claim.
17	Provider ID	Provider's ID number.
18	Patient	This is the name of the patient to whom the services were provided on this claim.
19	Patient ID	Kaiser Permanente Medical Record Number (MRN) of the patient.
20	Patient Responsibility	This may include a portion of the amount listed in the "Not Covered Amount" column and any amount listed in the "Applied to Deductible" and the "Copay/Coinsurance" columns.

UNDERSTANDING YOUR EXPLANATION OF PAYMENT (EOP) STATEMENT:

*[Line Number]* - The line number that coincides with the line number on the submitted claim.

of claims *[Number of Claims]* - The total number of claims covered by this Explanation of Payment (EOP).

Allowed Amount -The total allowable amount as determined by contract, other provider agreement, or reasonable and customary payment guidelines.

Applied to Deductible - The amount of member's deductible applied to the claim.

Auth # *[Authorization Number]* - An assigned number that identifies the authorization for approved services identified on the claim.

Billed Amount - The amount billed by the provider for a specific service or set of services.

Check/EFT Amount *[Check/Electronic Funds Transfer Amount]* - The net amount of the check/EFT payment.

Check/EFT No *[Check/Electronic Funds Transfer Number]* - The payment instrument number issued on a check/EFT paid to the vendor or member/subscriber.

Claim # *[Claim Number]* - A number assigned by Kaiser Permanente to an individual claim.

Claim Payment Amount - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP).

Claim Payment Total - The total amount of the claim, interest, and penalty paid by the Health Plan.

Coins *[Coinsurance]* - A percentage of the payment amount the insured pays against a claim.

CoPay - A fixed amount the insured pays against a claim.

Disallowed Amount/ Discount - Reflects contractual allowances, usual and customary (U&C) charges, provider responsibility/not covered, and discounts.

Interest Amount - The interest penalty amount required under governing rules for the specific Line of Business.

LOB *[Line of Business]* - The relevant rules under which the patient is enrolled as Kaiser Foundation Health Plan member.

Method of Payment - Describes the method of payment for the Claim Payment Total or Total Payment Amount (e.g. check/EFT, recoupment, prepayment, etc., as applicable) .

Not Cov'd Amount *[Not Covered Amount]* - Services not included under the terms of the insured's health care coverage.

Other Claim Related Transactions - Includes reversal claims,refunds received, recoupments applied, prepayments, write-ons and write-offs.

Other Ins *[Other Insurance]* - The amount paid by another financially responsible insurance carrier as primary on the claim, under Coordination of Benefits, Third Party Liability or Workers' Compensation.

Patient Acct No (Provider) *[Patient Account Number (Provider)]* - Your account number for the patient.

Patient ID/MRN *[Patient Identification Number/Medical Record Number]* - The Kaiser Permanente identification number or medical record number for the patient.

Patient Name - The name of the patient to whom the services were provided on this claim.

Patient Out of Pocket - Remaining cost share from the amount determined by primary coverage that the patient owes after additional payment by Kaiser Permanente on non-primary claims

Payment Date - The date that the claims represented on this Explanation of Payment (EOP) were paid.

Penalty Amount - A payment amount other than interest that may be required to pay the provider under governing rules for the specific Line of Business.

Plan Pays - The total amount paid by Kaiser Permanente for all payable services on the individual claim or total of all claims.

POS *[Place of Service]*- The location where the service was provided.

Prepayments - Funds paid to provider in advance of services used to satisfy liability of submitted claims consistent with the terms of the provider's contractual agreement.

Provider - The provider of services associated with the claim.

Provider NPI *[Provider National Provider Identification Number]* - A CMS number assigned to the vendor for billing and identification purposes.

Recoupments - Funds used from previous overpayments that are applied to offset payment of claims.

Refunds Received - Funds received from the vendor for identified overpaid claims.

Remark Code - Codes describing how the claim was processed.

Remittance Number - A unique number identifying this Explanation of Payment (EOP).

Reversal Claims - Used to account for adjusted claims.

Service Code - A code used to describe the medical services and procedures provided.

Service Dates - The dates on which the services were provided.

Service Mod *[Service Modifier]* - An alpha and/or numeric code appended to a CPT/HCPCS procedure code to clarify the services or procedures being billed.

Total Payment Amount - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP). Total Payment Amount = Claims Payment Amount + Interest Amount + Penalty Amount.

TOB *[Type of Bill]* - A three digit code located on a claim form that describes the type of bill a provider is submitting.

Vendor ID No *[The Vendor Identification Number]* -The internal account number that Kaiser Permanente assigns each vendor.

Vendor NPI No *[Vendor National Provider Identification Number]* - A CMS number assigned to the vendor for billing and identification purposes.

Vendor Tax ID No *[Vendor Tax Identification Number/Vendor TIN]* - Federally issued tax identification number.

Withheld Amount - Payments made to 3rd parties/ lien holders on behalf of the vendor.

Write Offs - Vendor balance forgiven by Kaiser Permanente

Write Ons - Used to account for existing overpayment balances.