5. Billing and Payment

It is your responsibility to submit itemized claims for Services provided to Members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. For Self-Funded products, KPIC utilizes a TPA to process claims. The TPA's claim processing operation is supported by a set of policies and procedures which directs the appropriate handling and reimbursement of claims received. The Member's Plan Sponsor is responsible for payment of claims in accordance with your Agreement. Please note that this Provider Manual does not address submission of claims under the HMO product.

5.1 Whom to Contact with Questions

If you have any questions relating to the submission of claims for services provided to Members for processing, please contact Self-Funded Customer Service at **(866) 213-3062.**

5.2 Methods of Claims Submission

Claims may be submitted by mail or electronically. Whether submitting claims on paper or electronically, only the UB-04 form will be accepted for facility services billing and only the CMS-1500 form (v 02/12), which will accommodate reporting of the individual (Type 1) NPI, will be accepted for professional services billing. Submitting claims that are handwritten, faxed or photocopied will be subject to process delay and/or rejection**.**

When CMS-1500 or UB-04 forms are updated by NUCC/CMS, KP will notify Provider when the KP systems are ready to accept the updated form(s) and Provider must submit claims using the updated form(s).

5.3 Claims Filing Requirements

5.3.1 Record Authorization Number

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

5.3.2 One Member and One Provider per Claim Form

Separate claim forms must be completed for each Member and for each Provider.

- Do not bill for different Members on the same claim form
- Do not bill for different Providers (either billing or rendering) on the same claim form

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

If you must use a second claim form due to space constraints, the second form should clearly indicate that it is a continuation of the first claim. The multiple pages should be attached to each other. Enter the TOTAL CHARGE on the last page of your claim submission.

5.3.4 Billing for Claims That Span Different Years

5.3.4.1 Billing Inpatient Claims that Span Different Years

When an inpatient claim spans different years (for example, the patient was admitted in December and was discharged in January of the following year), it is NOT necessary to submit 2 claims for these services. Bill all services for this inpatient stay on one claim form (if possible), reflecting the actual date of admission and the actual date of discharge.

5.3.4.2 Billing Outpatient Claims That Span Different Years

All outpatient claims, SNF claims and non- Medicare Prospective Payment System (PPS) inpatient claims (e.g. critical access hospitals), which are billed on an interim basis should be split at the calendar year end. Splitting claims is necessary for the following reasons: Proper recording of deductibles, separating expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year.

5.3.5 Interim Inpatient Bills

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

5.4 Paper Claims

5.4.1 Submission of Paper Claims

Mail all paper claims to:

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

5.5 Supporting Documentation for Paper Claims

In general, the Provider must submit, in addition to the applicable billing form, all supporting documentation that is reasonably relevant information and that is information necessary to determine payment. At a minimum, the supporting documentation that may be reasonably relevant may include the following, to the extent applicable to the services provided:

- Authorization if necessary
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment notes as reasonably relevant and necessary to determine payment
- A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier
- A physician report relating to any claim under which a physician is billing an "Unlisted Procedure", a procedure or service that is not listed in the current edition of the CPT codebook
- Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
- Therapy logs showing frequency and duration of therapies provided for SNF services

If additional documentation is deemed to be reasonably relevant information and/or information necessary to determine payment to, you will be notified in writing.

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

5.6 Submission of Electronic Claims

5.6.1 Electronic Data Interchange (EDI)

KPIC encourages electronic submission of claims. Self-Funded claims will be administered by the TPA. The TPA has an exclusive arrangement with Change Healthcare for clearinghouse services. Providers can submit electronic claims directly through Change Healthcare or to, or through, another clearinghouse that has an established connection with Change Healthcare. Change Healthcare will aggregate electronic claims directly from Providers and other clearinghouses to route to the TPA for adjudication.

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

Benefits of EDI Submission

- Reduced Overhead Expenses: Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated.
- Improved Data Accuracy: Because the claims data submitted by the Provider is sent electronically, data accuracy is improved, as there is no need for re-keying or re-entry of data.
- Low Error Rate: Additionally, "up-front" edits applied to the claims data while information is being entered at the Provider's office, and additional payor-specific edits applied to the data by the clearinghouse before the data is transmitted to the appropriate payor for processing, increase the percentage of clean claim submissions.
- Bypass U.S. Mail Delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system.
- Standardized Transaction Formats: Industry-accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple Plan Sponsors.

5.6.2 Where to Submit Electronic Claims

Submit all electronic claims to:

Kaiser Permanente Insurance Company Payor ID #94320

5.6.3 Supporting Documentation for Electronic Claims

If submitting claims electronically, the 837 transaction contains data fields to house supporting documentation through free-text format (exact system data field within your billing application varies). If supporting documentation is required, the TPA will request via Info Request Letters. Paper-based supporting documentation will need to be sent to the address below, where the documents will be scanned, imaged, and viewable by the TPA claim processor. The TPA cannot accept electronic attachments at this time.

COB remittance information can be handled directly on the 837; attachments do not need to be sent in separately via paper.

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

5.6.4 To Initiate EDI Submissions

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

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

5.6.5 EDI Submission Process

Provider sends claims via EDI: Once a Provider has entered all of the required data elements (i.e., 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 (either Change Healthcare or another clearinghouse which has an established connection with Change Healthcare) for further data sorting and distribution.

Providers are responsible for working their reject reports from the clearinghouse.

Exceptions to TPA submission:

- Ambulance claims should be submitted directly to Employers Mutual Inc. (EMI). EMI accepts paper claims on the CMS-1500 claim form at the following address:

  EMI Attn: Kaiser Ambulance Claims
  PO Box 853915
  Richardson, TX 75085-3915

  Customer Claims Service Department
  Monday through Friday 8:00 am to 5:00 pm Pacific Time
  1-888-505-0468

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

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

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

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

In addition, clearinghouses:

- Frequently supply the required PC software to enable direct data entry in the Provider's office
- May edit the data which is electronically submitted to the clearinghouse by the Provider's office, so that the data submission may be accepted by the TPA for processing
- Transmit the data to the TPA in a format easily understood by the TPA's computer system
- Transmit electronic claim status reports from TPA to Providers

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

5.6.6 Electronic Claims Disposition

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

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

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

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

5.6.7 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

5.7 Complete Claim

A claim is considered complete when the following requirements are met:

- Correct Form: All professional claims should be submitted using the CMS-1500 and all facility claims (or appropriate ancillary services) should be submitted using the UB-04based on CMS guidelines.
- Standard Coding: All fields should be completed using industry standard coding, including the use of ICD-10 code sets.
- 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.

A claim is not considered to be complete or payable if one or more of the following are missing or are in dispute:

- The format used in the completion or submission of the claim is missing required fields or codes are not active
- The eligibility of a 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 clean claim.

For further information and instruction on completing claims forms, please refer to the CMS website (http://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.

5.8 Claims Submission Timeframes

It is preferred claims for services provided to Members be submitted for payment within 90 calendar days of such service. However, all claims and encounter data must be sent to the appropriate address no later than 365 calendar days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge, as applicable, as a condition for payment.

If a Self-Funded plan is the secondary payor, any COB claims must be submitted for processing within the same standard claims submission timeframe, determined from the date of the primary payor's Explanation of Benefits (EOB), instead of from the date of service. For example, where the standard timeframe for claim submission is 365 calendar days from date of service, a COB claim must be submitted within 365 calendar days from the date of the primary payor's EOB.

Timely filing requirement for Self-Funded claim submission is based on Payor contract specifications and may vary from Payor to Payor (contract to contract). Please contact Self-Funded Customer Service **(866) 213-3062** to obtain Payor-specific information.

5.9 Proof of Timely Claims Submission

Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate

time frames. The TPA will consider system generated documents that indicate the original date of claim submission and the payor to which the claim was submitted. Please note that hand-written or typed documentation is not acceptable proof of timely filing.

5.10 Claim Corrections

A claim correction can be submitted via the following procedures:

- **Paper Claims**—Write "CORRECTED CLAIM" in the top (blank) portion of the CMS-1500 or UB-04 claim form. Attach a copy of the corresponding page of the EOP to each corrected claim. Mail the corrected claim(s) to the standard claims mailing address listed below.
- **Electronic Claims (CMS-1500)**—Corrections to CMS-1500 claims which were already accepted (regardless whether these claims were submitted on paper or electronically) may be submitted electronically. Corrections submitted electronically may inadvertently be denied as a duplicate claim. If corrected claims for CMS-1500 are submitted electronically, Providers should contact Self-Funded Customer Service to identify the corrected claim electronic submission.
- **Electronic Claims (UB-04)**—Please include the appropriate Type of Bill code when electronically submitting a corrected UB-04 claim for processing. IMPORTANT: Claims submitted without the appropriate 3rd digit (xxX) in the "Type of Bill" code will be denied.

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

5.11 Incorrect Claims Payments

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

- Explain the error by calling Kaiser Permanente Insurance Company at **(866) 213-3062**.
- You may also explain the error by writing to:

Kaiser Permanente Insurance Company
PO Box 30547
Salt Lake City, UT 84130-0547

- Upon verification of the error, appropriate corrections will be made by the TPA.
- The underpayment amount owed will be added to/reflected in the next payment.
- Providers will be notified in writing of the overpayment amount. You may write a refund check to Kaiser Permanente Insurance Co. (KPIC) for the exact excess amount paid to you within the timeframe specified by the Agreement. Attach a copy

of the EOP to your refund check, as well as a brief note explaining the error. Mail the refund check to:

Kaiser Permanente Insurance Co.
Attn: Claims Recovery Unit
P.O. Box 741025
Los Angeles, CA 90074-1025

If an overpayment refund is not received by KPIC in accordance with the terms and timeframe specified by the Agreement, the overpayment amount will be automatically deducted from your next claim payment.

5.12 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).

When completing IRS Form W-9, please note the following:

- Name: This should be the Provider's "entity name," which is used to file tax forms with the IRS.
- Sole Provider/Proprietor: List your name, as registered with the IRS.
- Group Practice/Facility: List the "group" or "facility" name, as registered with the IRS.
- 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.
- Address/City, State, Zip Code: Enter the address where IRS Form 1099 should be mailed.
- 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.
    - Sole Provider/Proprietor: Enter the Provider's taxpayer identification number, which will usually be a social security number (SSN), unless the Provider has been assigned a unique employer identification number (because the Provider is "doing business as" an entity under a different name).
    - Group Practice/Facility: Enter the Provider's taxpayer identification number, which will usually be the Provider's 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.

5.13 Federal Tax ID Number Changes

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

5.14 Self-Funded Member Cost Share

Please verify applicable Member cost share at the time of service. Depending on the benefit plan, Members may be responsible to share some cost of the services provided. Co-payments, co-insurance and deductibles (collectively, "Cost Share") are the fees a Member is responsible to pay a Provider for certain covered services. This information varies by plan. All Providers are responsible for collecting Cost Share in accordance with the Member's benefits. Cost Share information can be obtained from:

Option	Description
#1	Self-Funded Customer Service **(866) 213-3062** Monday - Friday from 1 AM – 3 PM. (Pacific) Self-Service IVR System is available 24 hours / 7 days a week
#2	Self-Funded Plan Website **https://kpclaimservices.com** 24 hours / 7 days a week Please be aware KP maintains Online Affiliate, an online resource for lookup of Members' eligibility and benefits. For additional information on this option, please contact KP Provider Services (see Section 2.4)

5.15 Self-Funded Member Claims Inquiries

Direct claims inquiries to Self-Funded Customer Service at **(866) 213-3062**.

5.16 Billing for Services Provided to Visiting Self-Funded Members

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

- Claims must be submitted to the "Mail claims to" address on the back of the visiting Member's Health Insurance ID Card.
- If the Member does not have their Health Insurance ID Card, submit your claims to:

KPIC Self-Funded Claims Administration
P. O. Box 30547
Salt Lake City, UT 84130-0547

- **Always** use the visiting Member's "Host" region MRN on the claim form
- Claims for services requiring prior KP authorization **must** include the authorization number

Please contact KPIC Self-Funded Customer Service at **(866) 213-3062** during the hours of 7:00 am to 9:00 pm EST.

5.17 Coding for Claims

It is the Provider's responsibility to ensure that billing codes used on claims forms are current and accurate, that codes reflect the services provided and they are in compliance with KPIC's coding standards. Incorrect and invalid coding may result in delays in payment or denial of payment. All coding must follow KPIC's standards, including those specified in Section 5.18below. Submitting 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 subject the claim to processing delay and/or rejection.

5.18 Coding Standards

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

ICD-10
To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 10th Revision-Clinical Modification (ICD-10-CM) and International Classification of Diseases – 10th Revision – Procedure Coding System (ICD-10-PCS) developed by the Commission on Professional and Hospital Activities. ICD-10-CM codes appear as three-, four-, five-, six-, or seven-digit codes, depending on the specific disease or injury being described. ICD-10-PCS hospital inpatient procedure codes appear as seven-digit codes.

CPT-4
The Physicians' Current Procedural Terminology, Fourth Edition (CPT) code set is a systematic listing and coding of procedures and services performed by Providers. CPT codes are developed by the American Medical Association (AMA). Each procedure code or service is identified with a five-digit code.

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

Revenue Codes & Condition Codes
Consult your NUBC UB-04 Data Specifications Manual for a complete listing.

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

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

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

5.19 Modifiers Used in Conjunction with CPT and HCPCS Codes

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.

When submitting claims, use modifiers to:

- Identify distinct or independent services performed on the same day
- Reflect services provided and documented in a patient's medical record

5.20 Modifier Review

The TPA will review modifier usage based on CPT guidelines. Providers are required to use modifiers according to standards and codes set forth in CPT manuals.

KPIC 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, 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.

5.21 Coding Edit Rules

The table below identifies common edit rules.

Edit Category	Description	Self-Funded Edit

Edit Category	Description	Self-Funded Edit
Rebundling	Recoding a claim featuring two (2) or more component codes billed for a group of procedures which are covered by a single comprehensive code	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

5.22 Do Not Bill Events (DNBE)

Depending on the terms of your Agreement, you may not be compensated for Services directly related to any Do Not Bill Event (as defined below) and may be required to waive Member Cost Share associated with and hold Members harmless from any liability for Services directly related to any DNBE. KP expects you to report every DNBE as set forth in Section 7.4.5of this Provider Manual. KP ASO will reduce compensation for Services

directly related to a DNBE when the value of such Services can be separately quantified in accordance with the applicable payment methodology. DNBE shall mean the following:

In any care setting, the following surgical errors identified by CMS in its National Coverage Determination issued June 12, 2009[2] (SE):

- Wrong surgery or invasive procedure[3] on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part

Specifically, in an acute care hospital setting, the following hospital acquired conditions identified by CMS on August 19, 2008[4] (together, with RFO-HAC, as defined below (HACs)) if not present upon admission:

- Intravascular air embolism
- Blood incompatibility (hemolytic reaction due to administration of ABO/HLA incompatible blood or blood products)
- Pressure ulcer (stage three or four)
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Manifestation of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following orthopedic procedures (spine, neck, shoulder, elbow)
- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)

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

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

[4] See, 73 Federal Register 48433, pages 48471-48491 (August 19, 2008) (http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf; https://www.cms.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf).

- Surgical site infection following Cardiac Implantable Electronic Device (CIED)
- Iatrogenic Pneumothorax with Venous Catheterization
- Deep vein thrombosis or pulmonary embolism following orthopedic procedures (total knee or hip replacement)
- Any new Medicare fee-for-service HAC later added by CMS

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

- Removal (if medically indicated) of foreign object retained after surgery

5.23 Claims for Do Not Bill Events

You must submit Claims for Services directly related to a DNBE according to the following requirements and in accordance with the other terms of your Agreement and this Provider Manual related to Claims.

- CMS 1500 – If you submit a CMS 1500 Claim (or its successor) for any inpatient or outpatient professional Services provided to a Member wherein a SE or RFO-HAC has occurred, you must include the applicable ICD-10 codes and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.
- UB-04 – If you submit a UB-04 Claim (or its successor) for inpatient or outpatient facility Services provided to a Member wherein a HAC (Including an RFO-HAC) has occurred, you must include the following information:
    - **DRG.** If, under the terms of your Agreement, such Services are reimbursed on a DRG basis, you must include the applicable ICD-10 codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.
    - **Other Payment Methodologies.** If, under the terms of your Agreement, such Services are reimbursed on a payment methodology other than a DRG and the terms of your Agreement state that you will not be compensated for Services directly related to a DNBE, you must split the Claim and submit both a Type of Bill (TOB) '110' (no-pay bill) setting forth all Services directly related to the DNBE including the applicable ICD-10) codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program, and a TOB '11X (with the exception of 110)' setting forth all Covered Services not directly related to the DNBE.

Completion of the Present on Admission (POA) field is required on all primary and secondary diagnoses for inpatient Services for all bill types. Any condition labeled with a

POA indicator other than 'Y' [5] shall be deemed hospital-acquired.[6] All claims must utilize the applicable HCPCS modifiers with the associated charges on all lines related to the surgical error, as applicable.

5.24 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:

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
1	MEDICARE/ MEDICAID/ TRICARE / CHAMPVA/ 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 patient's KP Medical Record Number (MRN)
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.
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 nine digits ZIP CODE and PHONE NUMBER.

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

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

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
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, and nine digits ZIP CODE) and telephone number. When the address is the same as the patient's—the word "SAME" may be entered.
8	RESERVED FOR NUCC USE	Not Required	Leave blank.
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	RESERVED FOR NUCC USE	Not Required	Leave blank.
9C	RESERVED FOR NUCC USE	Not Required	Leave blank.
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'S 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	CLAIM CODES (Designated by NUCC)	Not Required	Leave blank.
11	INSURED'S POLICY NUMBER OR FECA NUMBER	Required if Applicable	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

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
11B	OTHER CLAIM ID (Designated by NUCC)	Not Required	Leave blank.
11C	INSURANCE PLAN OR PROGRAM NAME	Required if Applicable	Enter the insured's insurance plan or program name.
11D	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required	Check "yes" or "no" to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If "yes" then fields 9 and 9A-9D 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 (LMP)	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: 01/05/2003
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required if Applicable	Enter the FIRST and LAST NAME of the KP referring or KP ordering physician.
17A	OTHER ID #	Not Required	
17B	NPI NUMBER	Required	Enter the NPI number of the KP referring provider
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.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Not Required	Leave blank.
20	OUTSIDE LAB CHARGES	Not Required	
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Required	Enter the diagnosis/condition of the patient, indicated by an ICD-10 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)
22	RESUBMISSION	Not Required if Applicable	If submitting a corrected claim, please enter one of the following codes: 7 – Replacement claim 8 – Voided claim
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.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
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 other separator between the qualifier and the number/code/information. The following qualifiers are to be used when reporting these services. 7 – Anesthesia information ZZ – Narrative description of unspecified code N4 – National Drug Codes (NDC) VP – Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard OZ – Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) CTR – Contract rate
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).

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24B	PLACE OF SERVICE	Required	Enter the place of service code for each item used or service performed.
24C	EMG	Required if Applicable	Enter Y for "YES" or leave blank if "NO" to indicate an EMERGENCY as defined in the electronic 837 Professional 4010A1 implementation guide.
24D	PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER	Required	Enter the CPT/HCPCS codes and MODIFIERS (if applicable) reflecting the procedures performed, services rendered, or supplies used. IMPORTANT: Enter the anesthesia time, reported as the "beginning" and "end" times of anesthesia in military time above the appropriate procedure code.
24E	DIAGNOSIS POINTER	Required	Enter the diagnosis code reference number (pointer) as it relates the date of service and the procedures shown in Field 21. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference character(s) should be an A through L; or multiple letters as explained. IMPORTANT: (ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.)
24F	$ CHARGES	Required	Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc.). Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24G	DAYS OR UNITS	Required	Enter the number of days or units in this block. (For example: units of supplies, etc.) IMPORTANT: As noted in the instructions for Field Number 24D, enter the total anesthesia time in minutes, reported as the "beginning" and "end" times, in military. When entering the NDC units in addition to the HCPCS units, enter the applicable NDC 'units' qualifier and related units in the shaded line. The following qualifiers are to be used: F2 - International Unit ML - Milliliter GR - Gram UN Unit ME – Milligram
24H	EPSDT FAMILY PLAN	Not Required	
24I	ID. QUAL	Required if provider does not qualify for NPI	Enter the 2 digit qualifier of the non-NPI identifier. In the shaded area. The non-NPI identifier number for the qualifier of the rendering provider is reported in 24J in the shaded area. The NUCC defines the following qualifiers: 0B - State License Number 1B - Blue Shield Provider Number 1C - Medicare Provider Number 1D - Medicaid Provider Number 1G - Provider UPIN Number 1H - CHAMPUS Identification Number EI - Employer's Identification Number G2 - Provider Commercial Number LU - Location Number N5 - Provider Plan Network Identification Number SY - Social Security Number (The social security number may not be used for Medicare.) X5 - State Industrial Accident Provider Number ZZ - Provider Taxonomy

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24J	RENDERING PROVIDER ID #	NPI required unless provider does not qualify for one OTHERWISE Other ID number as applicable	Enter the NPI number for the rendering provider in the non-shaded area of the field OTHERWISE Enter the non-NPI identifier number in the shaded area of the field. Report the Identification Number in Items 24I and 24J only when different from data recorded in Fields 33A and 33B.
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 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.
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 amount paid by other payer. Do not report collections of patient cost share
30	BALANCE DUE	Not Required	Enter the balance due (total charges less amount paid).
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Required	Enter the signature of the physician/supplier or their representative, and the date the form was signed. For claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
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 facility does not qualify for an NPI in field 32A	Enter the two digit qualifier (See filed 24 I, "ID QUAL") identifying the non-NPI identifier followed by the ID number of the service facility. 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 filed 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.

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? PLACE (State) YES NO

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

5.25 UB-04 (CMS-1450) Field Descriptions

The fields identified in the table below as "Required" must be completed when submitting a UB-04 claim form for processing:

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. The National Drug Code (NDC) number is REQUIRED in this field on claims for which a clinic-administered medication (CAM) was provided.
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.

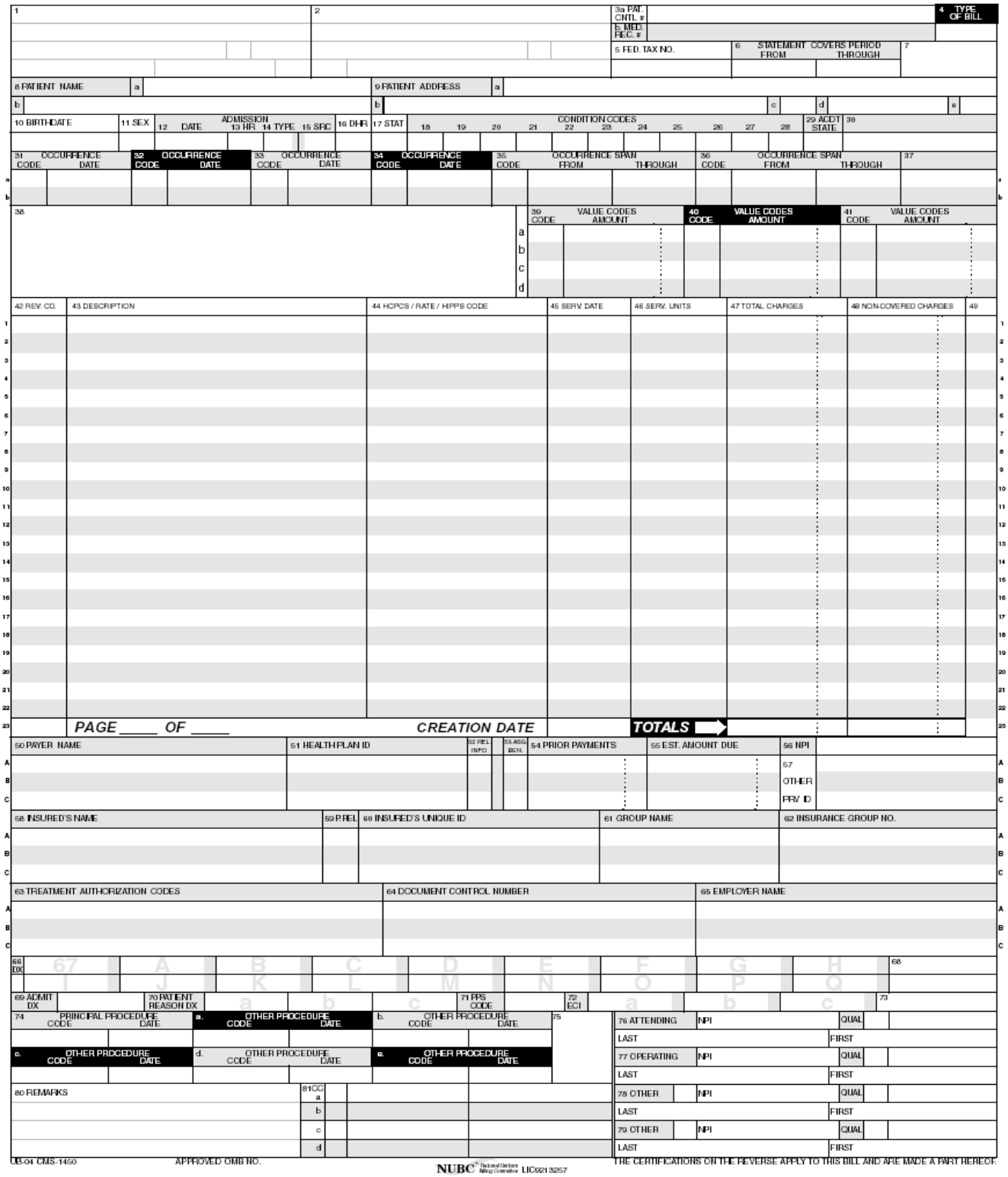
Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
45	SERVICE DATE	Required	Outpatient Series Bills: A service date must be entered for all outpatient series bills whenever the "from" and "through" dates in Field 6 *(Statement Covers Period: From/Through*) are not the 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.
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).
53	ASSIGNMENT OF BENEFITS (ASG BEN)	Required	Enter the assignment of benefits certification indicator.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
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.
59	PATIENT'S RELATION TO INSURED	Required	Enter the patient's relationship to the insured.
60	INSURED'S UNIQUE ID	Required	Enter the patient's KP Medical Record Number (MRN).
61	INSURED'S GROUP NAME	Required if Applicable	Enter the insured's group name.
62	INSURED'S GROUP NUMBER	Required if Applicable	Enter the insured's group number. For Prepaid Services claims enter "PPS".
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	Not 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.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
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. At the time of printing, KP only accepts ICD-10-CM diagnosis codes on the UB-04. ICD-10 standards for paper and EDI claims will be implemented by KP for outpatient dates of service and inpatient discharge dates on/after October 1, 2015. Enter POA (Present on Admit) indicator in the shaded area on the right side of the principal ICD.
68	BLANK	Not Required	Leave blank.
69	ADMITTING DIAGNOSIS	Required	Enter the admitting diagnosis code on all inpatient claims.
70a-c	REASON FOR VISIT (PATIENT REASON DX)	Required if Applicable	Enter the diagnosis codes indicating the patient's reason for outpatient visit at the time of registration.
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.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
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.

Form UB-04


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 ADMISSION DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
UB-04 CMS-1450
APPROVED OMB NO.
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

5.26 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.

Providers are responsible for identifying the primary payor and for billing the appropriate party. If a Member's plan is not the primary payor, then the claim should be submitted to the primary payor as determined via the process described below. If a Member's plan is the secondary payor, then the primary payor payment must be specified on the claim, and an EOP needs to be submitted as an attachment to the claim.

Providers are required to cooperate with the administration of COB, which may include, without limitation, seeking authorization from another payor (if authorization is required) and/or responding to requests for medical records.

5.26.1 How to Determine the Primary Payor

Primary coverage is determined using the following guidelines. Examples are:

- The benefits of the plan that covers an individual as an employee or subscriber other than as a dependent are applied 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
- Step-parent with custody pays next
- Natural parent without custody pays next
- Step-parent 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. For questions, call Self-Funded Customer Service at **(866) 213-3062**.

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

- Medicare is generally primary for retired Medicare Members over age 65, and for active, employee group health Members with End Stage Renal Disease (ESRD) after the first 30 months of dialysis treatment (the coordination period).
- In cases of work-related injuries, Workers Compensation is primary unless coverage for the injury has been denied.
- In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. Submit the claim as if the Self-Funded plan is the primary payor. The TPA will follow its standard payment procedures.

5.26.2 Description of COB Payment Methodology

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

5.26.3 COB Claims Submission Requirements and Procedures

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

Paper Claims

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

- CMS-1500 claim form: Complete Field 29 (Amount Paid)
- UB-04 claim form: Complete Field 54 (Prior Payments)

Electronic Claims

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

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

5.26.4 Direct Patient Billing

Members may be billed only for Member Cost Share where applicable according to the Member's benefit coverage and your Agreement, which payments may be subject to an out-of-pocket maximum.

The circumstances above are the only situations in which a Member can be billed directly for covered services.

5.26.5 Workers' Compensation

If a Member indicates that their illness or injury occurred while the Member was "on the job", you should do the following:

- Document that the Member indicates the illness or injury occurred "on the job" on the claim
- Complete applicable fields on the billing form indicating a work related injury
- Submit the claim to the patient's Workers' Compensation carrier/plan

If the Member's Workers' Compensation carrier/plan ultimately denies the Workers' Compensation claim, you may submit the claim for covered services to KP in the same manner as you submit other claims for services. You must also include a copy of the denial letter or Explanation of Payment from the Workers Compensation carrier

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

5.26.6 Members Enrolled in Two KP Plans

Some Members may be enrolled under 2 separate plans offered through KP (dual coverage). In these situations, Providers need only submit ONE claim under the primary plan and send to either the TPA (for Self-Funded plan) or KP (for fully insured plan) depending on which plan is primary. KP and the TPA will coordinate available benefits.

5.26.7 COB Claims Submission Timeframes

If a Self-Funded plan is the secondary payor, any COB claims must be submitted for processing within the timely filing period according to the standard claims submission timeframe as specified in Section 5.8 of this Provider Manual. The determination is based on the date of the primary payor's EOB, instead of from the date of service.

5.26.8 COB Fields on the CMS-1500 Claim Form

The following fields should be completed on the CMS-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?).
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?).

837P Loop#	Field Number	Field Name	Instructions/Examples
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** **--Illness (First symptom)** **--Injury (Accident)** **--Pregnancy (LMP)**	Enter the date of the current illness or injury. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). **Example: 01/05/2004**
2300 H1	**21**	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**	Enter the diagnosis and if applicable, enter the Supplementary Classification of External Cause of Injury and Poisoning Code. **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.

5.26.9 COB Fields on the UB-04 Claim Form

The following fields should be completed on the **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

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

837I Loop #	Field Number	Field Name	Instructions/Examples
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** payer
2320 SBR	**65**	**EMPLOYER NAME** *(Employer Name of the Insured)*	Enter the **name of the employer** who provides health care coverage for the insured individual *(listed in **Field 58**)*. Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2300 H1	**67-76 (UB-92) 67 A-Q (UB-04)**	**DIAGNOSIS CODE**	The **primary diagnosis** code should be reported in **Field 67**. Additional diagnosis code can be entered in **Field 68-76**.
2300H1	**77 (UB-92) 72 (UB-04)**	**EXTERNAL CAUSE OF INJURY CODE (E-CODE)**	If applicable, enter an ICD-10 "VWXY" code in this field.

5.27 EOP

KAISER PERMANENTE®
Kaiser Permanente Insurance Company
PO BOX 30547
Salt Lake City, UT 84130-0547

[redacted]

Client ID: 00080001
Customer Service Number: 1-866-213-3062

See Last Page for Explanation of Code

Provider #: [redacted]
Tax # [redacted]
Date: 05/16/2017
Check# [redacted]0
EDI Payer ID: 94320

Patient Name Account #	Member ID # Claim #	Dates of Service	Code	Submitted Charges	Negotiated Discount	EXPL code	Non COVD Charges	Allowed Amount	Copay	Deductible	Co-ins	Total Benefit
[redacted]	[redacted]	03/28/2017	124	$2,199.98	$1,446.99	P9 EOP	$0.00	$752.99	$250.00	$0.00	$0.00	$502.99
		03/28/2017	124	$4,400.02	$2,894.01	P9 EOP	$0.00	$1,506.01	$0.00	$0.00	$0.00	$1,506.01
		Claim Totals		**$6,600.00**	**$4,341.00**		**$0.00**	**$2,259.00**	**$250.00**	**$0.00**	**$0.00**	**$2,009.00**
		Previous Claim Amount		**$0.00**				**Other Insurance**	**$0.00**	**Payment to Provider**		**$2,009.00**
								Patient Responsibility	**$250.00**	**Payment to Member**		**$0.00**
											Total Paid	**$2,009.00**

Code Descriptions

EOP Charges are priced according to the provider contract. Patient not responsible if charges are above contracted rate.
P9 Plan payment reduced by Patient's applicable copay amount

Depending on your plan, providers may have up to 365 days from date of service to submit a claim. Providers also have 365 days from claim process date to submit a written and complete Provider Dispute/Reconsideration form to challenge a claim determination. If multiple services are included in the provider's request for dispute/reconsideration, the latest date of action on the Claim/Explanation of Payment(s) (EOPs) will be used to start the clock. If additional information is needed, the clock is stopped and the provider will have 45 days from the date of request to provide the information before the clock is restarted.

If an audit shows a Provider owes reimbursement to the Plan Sponsor(s), the identified overpayment(s) will be offset against any money payments owed to the Provider, to the maximum extent permitted by Law.

5.28 Provider Claims Payment Inquiries and Disputes

For disputes of claims payment and other payment inquiries, contact Kaiser Permanente Insurance Company at **(866) 213-3062**. Most questions regarding claim payments can be resolved quickly over the phone. The TPA will review the claim, to verify if the claim(s) was adjudicated correctly, according to the Member's benefits and the contracted rates. If the TPA determines the correct payment was made but you choose to pursue the matter as a payment dispute, please submit a written payment dispute to the Self Funded Customer Service department and provide detail of why you believe the payment was incorrect. Providers have up to 365 calendar days from the date of the TPA's claim processing to submit a payment dispute. Payment disputes must be submitted to:

Kaiser Permanente Insurance Co.
P.O. Box 30547
Salt Lake City, UT 84130-0537

6. Provider Rights and Responsibilities

As a Provider, you are responsible for understanding and complying with terms of your Agreement and this section. If you have any questions regarding your rights and responsibilities under the Agreement and as described in this section of the Provider Manual, we encourage you to call Provider Services.

6.1 Providers' Responsibilities

All Providers are responsible for the following:

- Providing health care services without discriminating on the basis of health status or any other unlawful category.
- Maintaining open communication with a Member to discuss treatment needs and recommended alternatives, without regard to any covered benefit limitations or KP administrative policies and procedures. KP encourages open provider-patient communication regarding appropriate treatment alternatives and does not restrict Providers from discussing all available care options with Members.
- Providing all services in a culturally competent manner.
- Providing for timely transfer of Member medical records when care is to be transitioned to a new provider, or if your Agreement terminates.
- Participating in KP Quality Improvement and UM Programs. KP Quality Improvement and UM Programs are designed to identify opportunities for improving health care provided to Members. These programs may interact with various functions, including, but not limited to, the complaint or grievance process, disease management, preventive health, or clinical studies. KP will communicate information about the programs and extent of Provider participation through special mailings, and updates to the Provider Manual. These programs are also described in various sections of this Provider Manual.
- Securing authorization or referral from KP prior to providing any non-emergency services.
- Verifying eligibility of Members prior to providing services.
- Collecting applicable co-payments, co-insurance and/or deductibles from Members as required by your Agreement and the Provider Manual.
- Complying with this Provider Manual and the terms of your Agreement.
- Cooperating with and participate in the Member complaint and grievance process, as necessary.
- Encouraging all Providers and their staff to include patients as part of the patient safety team by requesting patients to speak up when they have questions or concerns about the safety of their care.

- Discussing adverse outcomes related to errors with the patient and/or family.
- Ensuring patients' continuity of care including coordination with systems and personnel throughout the care delivery system.
- Fostering an environment which encourages all Providers and their staff to report errors and near misses.
- Pursuing improvements in patient safety including incorporating patient safety initiatives into daily activities.
- Ensuring compliance with patient safety accreditation standards, legislation, and regulations.
- Providing orientation of this Provider Manual to all subcontractors and participating practitioners and ensuring that downstream providers adhere to all applicable provisions of the Provider Manual and the Agreement.
- Notifying Provider Services in writing of any practice changes that may affect access for Members.
- Reporting to the appropriate state agency any abuse, negligence or imminent threat to which the Member might be subject. You may request guidance and assistance from the local KP's Social Services Department to help provide you with required information that must be imparted to these agencies.
- Contacting your local county Public Health Department if you treat a patient for a reportable infectious disease.

Providers also have the right to:

- Receive payment in accord with applicable laws and applicable provisions of your Agreement
- File a provider dispute
- Participate in the dispute resolution processes established by KP in accord with your Agreement and applicable law
- Rely on eligibility information provided by KP about any Member in accordance with the contract between the Plan Sponsor and KPIC

6.2 Required Notices

6.2.1 Provider Changes That Must Be Reported

Providers may notify Provider Services of the changes identified below by calling **(844) 343-9370**. Verbal notification must be followed by faxed documentation to **(510) 987-4138** or email to TPMG-MSC-ProvSvcs@kp.org. Please check your contract as it may contain provisions that limit your ability to add, delete or relocate practice sites, service locations or practitioners.

6.2.1.1 Provider Illness or Disability

If an illness or disability leads to a reduction in work hours or the need to close a practice, Providers must immediately notify Provider Services.

6.2.1.2 Practice Relocations

Notify Provider Services at least 90 calendar days prior to relocation to allow for the transition of Members to other Providers, if necessary.

6.2.1.3 Adding/Deleting New Practice Sites

Notify Provider Services at least 90 calendar days prior to opening an additional practice site.

6.2.1.4 Adding/Deleting Practitioners to/from the Practice

Notify Provider Services immediately when adding/deleting a practitioner to/from your practice. Before Members can be seen by the new practitioner, the practitioner must be credentialed according to applicable KP policy.

6.2.1.5 Changes in Telephone Numbers

Notify Provider Services at least 30 calendar days prior to the implementation of a change in telephone number. If the initial notification is given verbally, you must send written confirmation to the Notice address in your contract.

6.2.2 Other Required Notices

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

From time to time, KP will request Providers complete a Provider Profile Information Form (PPIF). When requested, you must provide updated information listing the name, location, and address of each physical site at which you and your practitioners and subcontractors provide services to Members under the Agreement. This information is needed to assure that our payment systems appropriately recognize your locations and practitioners. Additionally, it facilitates verification that Providers seeing Members are appropriately credentialed and is essential for KP to continue to meet its legal, business and regulatory requirements.

6.3 Call Coverage Providers

Your Agreement may require that you provide access to services 24 hours per day, 7 days per week. If you arrange for coverage by practitioners who are not part of your practice or contracted directly with KP, the practitioners must agree to all applicable terms of your Agreement with KP, including the KP accessibility standards, our Quality Assurance & Improvement and UM Programs and your fee schedule.

6.4 Health Information Technology

As Providers implement, acquire, or upgrade health information technology systems, your office or organization should use reasonable efforts to utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services ("Interoperability Standards"), have already been pilot tested in a variety of live settings, and demonstrate meaningful use of health information technology in accordance with the HITECH Act. Providers should also encourage its subcontracted providers to comply with applicable Interoperability Standards.

7. Quality Assurance and Improvement (QA & I)

7.1 Northern California Quality Program and Patient Safety Program

The KP Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation and licensing and other elements. The KP quality improvement program assures that quality improvement is an ongoing, priority activity of the organization. Information about our quality program is available to you in the "Quality Program at Kaiser Permanente Northern California" document, including:

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

To obtain a copy of the "Quality Program at Kaiser Permanente Northern California" document, call our Member Services Contact Center (MSCC) at **1-(800) 464-4000** or TTY: **711**. Ask for a copy of the "Quality Program at KP". Alternatively, you can view and print the document by visiting the KP website at http://www.kaiserpermanente.org. Click on "Locate our Services," select "Forms and Publications," then "Quality Report" and finally "Quality Program at Kaiser Permanente". Additional information on KP's Northern California Quality Program and Patient Safety Program can be found at: http://www.kp.org/quality

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

At KP, patient safety is every patient's right and everyone's responsibility. As a leader in patient safety, our program is focused on safe care, safe staff, safe support systems, safe place, and safe patients.

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

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

KP is currently accredited by NCQA, and we periodically undergo re-accreditation. KP Northern California Region (KPNC) provides the appropriate information related to quality and utilization upon request, so that KP may meet NCQA standards and requirements, and maintain successful NCQA accreditation. You can review the report card for KFHP, Northern California, at http://www.ncqa.org.

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

The Office of the Patient Advocate (OPA) provides data to demonstrate the quality of care delivered at KPNC, as well as a comparison of our performance to other health plans in the state. To view the Clinical and Patient Experience Measures along with explanations of the scoring and rating methods used visit: http://reportcard.opa.ca.gov/rc2013/medicalgroupcounty.aspx.

The Joint Commission (TJC) is a hospital accreditation organization that is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain its accreditations, KFH hospitals must undergo an onsite surveying by The Joint Commission survey team at least every 3 years. Providers who are privileged to practice at any KFH hospital are expected to adhere to TJC standards when practicing within the facility(ies). For further information, visit http://www.jointcommission.org

7.2 Quality Assurance and Improvement (QA & I) Program Overview

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

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

- Patient access to care
- Patient complaint and satisfaction survey data of both administrative and quality of care issues
- Compliance with KP policies and procedures
- UM statistics

- Quality of care indicators and provision of performance data as necessary for KP to comply with requirements of NCQA, CMS (Medicare), TJC, and other regulatory and accreditation bodies
- Performance standards in accordance with your Agreement
- Credentialing and recredentialing of Providers

In any of the above situations, when KP reasonably determines that the Provider's performance may adversely affect the care provided to Members, KP may take corrective actions in accordance with your Agreement. As a Provider, you are expected to investigate and respond in a timely manner to all quality issues and work with KP to resolve any quality and accessibility issues related to services for Members. Each Provider is expected to remedy, as soon as reasonably possible, any condition related to patient care involving a Member that has been determined by KP or any governmental or accrediting agencies, to be unsatisfactory.

7.3 Provider Credentialing and Recredentialing

As an important part of KP's Quality Management Program, all credentialing, recredentialing, and privileging activities are structured to assure applicable Providers are qualified to meet KP, NCQA, and other regulatory standards for the delivery of quality health care and service to Members.

The credentialing, recredentialing and privileging policies and procedures approved by KP are intended to meet or exceed the managed care organization standards outlined by the NCQA.

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

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

7.3.1 Practitioners

KP requires that all practitioners within the scope of KP's credentialing program be credentialed prior to treating Members and must maintain credentialing. Recredentialing will occur at least every 36 months. Recredentialing may be adjusted to 24 months if privileges are required at a Kaiser Foundation Hospital. Credentialing may occur more frequently.

Requirements for initial and recredentialing for practitioners include, but are not limited to:

- Complete, current and accurate credentialing/recredentialing application
- Current healing arts licenses, certificates and/or permits as required by law
- Evidence of appropriate education, clinical training and current competence in practicing specialty
- No history of State or Federal sanctions/limitations/exclusions
- Evidence of current insurance, in amounts as required by KP
- Complete clinical work history
- Complete malpractice claim history
- Evidence practitioner is not currently opted out of Medicare
- No significant events as identified through KP performance data (at recredentialing only)

KP adheres to the NCQA standards for credentialing and recredentialing of hospitalists. Hospitalists who provide services exclusively in the inpatient setting and provide care for Members only as a result of Members being directed to the hospital setting are deemed appropriately credentialed and privileged in accordance with state, federal, regulatory and accreditation standards when credentialed and privileged by the hospital in which they treat Members. However, KP reserves the right to credential any practitioner.

A KP Credentials and Privileges Committee (RCPC) will communicate credentialing determinations in writing to practitioners. In the event the committee decides to deny initial credentialing, terminate existing credentialing or make any other negative decision regarding the practitioner, appeal rights will be granted in accordance with applicable legal requirements and KP policies and procedures. The practitioner will be notified of those rights at the time the practitioner is notified of the committee's determination.

All information obtained by KP during the practitioner credentialing and recredentialing process is considered confidential as required by law. For additional information regarding credentialing and recredentialing requirements and policies, please contact TPMG Consulting Services.

7.3.2 Practitioner Rights

7.3.2.1 Practitioner Right to Correct Erroneous or Discrepant Information

The credentials staff will notify the practitioner, orally or in writing of information received that varies substantially from the information provided during the credentialing process. The practitioner will have 30 calendar days in which to correct the erroneous or discrepant information. The notification will state to whom, and in what format, to submit corrections.

7.3.2.2 Practitioner Rights to Review Information

Upon written request, and to the extent allowed by law, a practitioner may review information submitted in support of the credentialing application and verifications obtained by KP that are a matter of public record. The credentials file must be reviewed in the presence of KP credentialing staff. Upon receipt of a written request, an appointment time will be established in which to review the file.

7.3.2.3 Practitioner Rights to Be Informed of the Status of the Credentialing Application

The credentials staff will inform the practitioner of their credentialing or recredentialing application status upon request. Requests and responses may be written or oral. Information regarding status is limited to:

- Information specific to the practitioner's own credentials file
- Current credentialing status
- Estimated committee review date, if applicable and available
- Outstanding information needed to complete the credentials file

7.3.2.4 Practitioner Right to Credentialing and Privileging Policies

Upon written request, a practitioner may receive a complete and current copy of KFHP, Northern California Region Credentialing & Privileging Policies and Procedures. For those hospitals where the practitioner maintains active privileges, the practitioner may also request and receive complete and current copies of Professional Staff Bylaws and The Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital.

7.3.3 Organizational Providers (OPs)

KP requires all OPs within the scope of its credentialing program be credentialed prior to treating Members and maintain credentialing. Recredentialing will occur at least every 36 months and may occur more frequently. Requirements for both initial and recredentialing for OPs include, but are not limited to:

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

7.3.3.1 Corrective Action Plan or Increased Monitoring Status for OPs

Credentialing and recredentialing determinations are made by the KP Northern California Regional Credentials and Privileges Committee (RCPC). At the time of initial credentialing, newly operational OPs may be required to undergo monitoring.

Newly operational OPs are typically monitored for at least 6 months. These providers may be required to furnish monthly reports of applicable quality and/or clinical indicators for a minimum of the first 3 months of the initial credentialing period. This monitoring may include onsite visits.

If deficiencies are identified through KP physicians, staff or Members, the OP may be placed on a Corrective Action Plan (CAP) or Performance Improvement Plan (PIP) related to those deficiencies.

The OP will be notified in writing if deficiencies are identified. The notice will include the reason(s) for which the CAP or PIP is required, the monitoring time frames and any other specific requirements that may apply regarding the monitoring process. Within 2 weeks of such notice, the OP must create, for KP review, a time-phased plan that addresses the reason for the deficiency and their proposed actions toward correcting the deficiency. KP will review the draft CAP or PIP and determine whether it adequately addresses identified issues. If the plan is not acceptable, KP representatives will work with the OP to make necessary revisions to the plan. OPs subject to a CAP or PIP will be monitored for 6 months or longer.

For additional information regarding credentialing and recredentialing requirements and policies, please contact Provider Services.

7.4 Monitoring Quality

7.4.1 Compliance with Legal, Regulatory and Accrediting Body Standards

KP expects all applicable Providers to be in compliance with all legal, regulatory and accrediting requirements, to have and maintain accreditation as appropriate, to maintain a current certificate of insurance, and to maintain current licensure. If any adverse action is

taken regarding your licensure or accreditation, you will be expected to provide KP's Medical Services Contracting Department with a copy of the report and the action plan to resolve the identified issue(s) or concern(s), within 90 calendar days of the receipt of the report.

7.4.2 Member Complaints

Written complaints lodged by Members about the quality of care provided by the Provider or Provider's medical staff or KP representatives must be reported within 30 calendar days. The above aggregate reporting is part of the quality management process and is independent of any broader requirements contained in your Agreement concerning the procedure for handling specific complaints (either written or oral).

7.4.3 Infection Control

KP requests the cooperation of Providers in monitoring their own practice for reporting of communicable diseases, preventing transmission of communicable diseases and efforts aimed at prevention of hospital associated infection (HAI) including, but not limited to, multi-drug resistant organisms such as MRSA, VRE, and C.difficile (C.diff), postoperative surgical site infections, central line associated bloodstream infections, and catheter-associated urinary tract infection. Targeted HAI should be tracked, rates determined and compared to CDC benchmarks when available. When a potential infection is identified, notify the local Infection Preventionist. Confirmed HAI should be tracked, and rates determined and entered into NHSN database if required per mandated public reporting. When a trend is identified by the affiliated practitioner or Provider, this should be shared with local Infection Control Committee (ICC) and a collaborative approach should be undertaken to improve practices related to infection prevention and control. All HAI summary reports and analysis should be submitted for review on an ongoing basis to the KP ICC and Quality Management (QM) Departments. Results of this review should then be shared with the affiliated practitioner or Provider. The IP and QM Departments will request certain actions and interventions be taken to maximize patient safety, as appropriate.

7.4.4 Practitioner Quality Assurance and Improvement Programs

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

7.4.5 DNBEs / Reportable Occurrences for Providers

As part of its required participation in KP's QI Program and in addition to the Claims submission requirements in Section 5.8 of this Provider Manual, and to the extent

permitted by Law, the Provider must promptly notify KP and, upon request, provide information about any DNBE (as defined in Section 5.22 that occurs at its Location or Locations covered by its Agreement in connection with Services provided to a Member. Notices and information provided pursuant to this section shall not be deemed admissions of liability for acts or omissions, waiver of rights or remedies in litigation, or a waiver of evidentiary protections, privileges or objections in litigation or otherwise. Notices and information related to DNBEs should be sent to:

Medical Services Contracting
Attn: Provider Services
P.O. Box 23380
Oakland, CA 94623-2338

Phone: **(844) 343-9370**
Fax: **(510) 987-4138**

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

- KP MRN
- Date(s) of service
- Place of service
- Referral number or emergency claim number
- General category description of DNBE(s) experienced by the Member

7.5 Peer Review for Practitioners

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

- Practitioner Performance Review and Oversight – Practitioner profiling for individual re-credentialing as well as oversight and evaluation of the quality of care provided by practitioners in a department
- Practitioner Peer and System Review – Quality of care concern
- Focused Practitioner Review and Practice Improvement Plan – provides an objective evaluation of all or part of a practitioner's practice when issues are identified around the performance of that practitioner

The primary use of the information generated from these activities is for peer review and quality assurance purposes. Such information is subject to protection from discovery under

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

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

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

7.5.1 Confidentiality

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

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

7.5.2 Quality Review

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

- Allegations of professional negligence (formal or informal)
- Member complaints / grievances related to quality of care
- Risk Management (adverse events)
- Medical legal referrals
- Inter- or intra-departmental or facility referrals
- Issues identified by another practitioner
- Utilization Management
- Member complaints to external organizations

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

- Concerns regarding the possibility of any breach of professional judgment or conduct towards patients
- Concerns regarding the possibility of failure to appropriately diagnose or treat a Member/patient
- Adverse patterns of care identified through aggregate review of performance measures (e.g., automatic triggers)

To assist in review, the reviewer will use appropriate information from sources that include, but are not limited to:

- Nationally recognized practice standards, preferably evidence-based
- Professional practice requirements
- KP and other clinical practice guidelines
- KP Policies and procedures, including policies related to patient safety
- Regulatory and accreditation requirements
- Community standard of care

7.5.3 OPs' Quality Assurance & Improvement Programs (QA & I)

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

7.5.4 Sentinel Events / Reportable Occurrences for HDO

Applicable to Acute Hospitals, Chronic Dialysis Centers, Ambulatory Surgery Centers, Psychiatric Hospitals, Skilled Nursing Facilities and Transitional Residential Recovery Services Providers All Providers must report sentinel events and reportable occurrences as defined below. OPs must report events and occurrences at its facility or facilities covered by its Agreement.

7.5.4.1 Definitions: Sentinel Events and Reportable Occurrences

A sentinel event is a Member safety event (not primarily related to the natural course of the Member's illness or underlying condition) that reaches a Member and results in death, permanent harm, severe temporary harm, and other adverse events defined by the Joint Commission and National Quality Forum.

Examples of sentinel events and reportable occurrences include, but are not limited to the following:

- Member falls resulting in serious injury, requiring subsequent medical intervention
- Medication error requiring medical intervention, including transfer
- Surgical or invasive procedure resulting in a retained foreign item, or was performed on a wrong Member, wrong side/site, wrong body part, or was a wrong procedure, or used a wrong implant
- Member suicide or attempted suicide resulting in permanent or severe temporary harm while being cared for in a healthcare setting
- A stage 3, 4 or unstageable pressure ulcer acquired after admission
- A cluster of nosocomial infections or significant adverse deviation events
- Outbreaks of infectious disease reportable to the County Health Department
- Official notice concerning revocation (requested or actual) of Medicare/Medi-Cal Certification or suspension of Medicare/Medi-Cal admissions

7.5.4.2 Notification Timeframes

Practitioners and OPs will report sentinel events and reportable occurrences within 24 hours of becoming aware of the event or occurrence. The KP contact will notify the local KP Risk Management Department about all reports. Providers should make reports to KP as follows:

Provider	KP Contact	Timeframe
Practitioner	Referral Coordinator	Within 24 hours
Acute Hospital	Care Coordinator	Within 24 hours
Chronic Dialysis Center	Renal Case Manager or Nephrologist	Within 24 hours
Ambulatory Surgery Center	Care Coordinator	Within 24 hours
Psychiatric Hospital	Care Coordinator	Within 24 hours
Skilled Nursing Facility	Care Coordinator	Within 24 hours
Transitional Residential Recovery Services Provider	Care Coordinator	Within 24 hours

7.5.5 Sentinel Events/Reportable Occurrences—Home Health & Hospice Agency Providers

7.5.5.1 Report Within 24 Hours

Immediately upon discovery, verbally report to the referring KP Home Health Agency, Hospice Agency or facility any sentinel event (as defined above in Section 7.5.4.1) and the following adverse events. The verbal report must be followed by a written notification sent within 24 hours or by the end of the next Business Day by certified mail, return receipt.

- Falls resulting in death or serious injury
- Any unexpected death or any Member safety events resulting in permanent or severe temporary Member harm not primarily related to the natural course of the Member's illness or underlying condition
- The event or related circumstances has the potential for significant adverse media (press) involvement
- Significant drug reactions or medication errors resulting in harm to the Member
- Medication errors resulting in harm to the patient
- Permanent or severe temporary harm to a Member associated with the use of physical restraints or bedrails while being cared for in a health care facility

- Member is either a perpetrator or victim of a crime or reportable abuse while under home health or hospice care
- Loss of license, certification or accreditation status
- Release of any toxic or hazardous substance that requires reporting to a local, state or federal agency

7.5.5.2 Report Within 72 Hours

You must report to the referring KP Home Health Agency, Hospice Agency or facility during KP business hours the following events involving Members that may impact the quality of care and/or have the potential for a negative outcome. Such report should be made within 72 hours of the occurrence. KP will notify the local KP Risk Management Department about all reports. These include but are not limited to the categories below.

- Reportable, communicable diseases, outbreaks of scabies or lice, and breaks in infection control practices
- Re-admission to a hospital
- Medication errors without harm (wrong patient, wrong drug, wrong dose, wrong route, wrong time, wrong day, or an extra dose, or an omission of an ordered drug)
- Disciplinary action taken against a practitioner caring for a KP Member that requires a report to the applicable state board or the National Practitioner Data Bank
- Noncompliance with regulatory and/or accreditation standards requiring corrective action plan

7.6 QA & I Reporting Requirements for Home Health & Hospice Providers

Quality monitoring activities will be conducted at each individual home health and hospice agency site and branch location.

7.6.1 Annual Reporting

On an annual basis, Providers of Home Health and Hospice services, and licensed/certified Providers who manage Members' plan of care on referral, must submit to KP:

- Copy of current license and insurance
- Reports of any accreditation and/or regulatory site visits occurring within the last 12 calendar months
- Copy of current quality plan and indicators
- Results of most recent patient satisfaction survey

- Action plans for all active citations, conditions, deficiencies and/or recommendations

7.6.2 Site Visits and/or Chart Review

A site visit and/or chart review may be requested by KP at any time to monitor quality and compliance with regulations. When onsite reviews are requested by the referring KP Home Health Agency, Hospice Agency, or facility or regional representative, your agency will make the following available:

- Personnel records
- Quality plan and indicators
- Documentation for Member complaints and follow-up
- Member medical records
- Policy and procedure manuals
- Other relevant quality and compliance data

7.6.3 Personnel Records

Providers providing home health and hospice services shall cooperate with KP audits of staff personnel records. Audits are designed to assure personnel providing care to KP Members are qualified and competent. Information reviewed may include but not be limited to:

- Professional License
- Current CPR certification
- Tuberculin or PPD testing
- Evidence of competency for those services provided to KP Members
- Continuing education
- Annual evaluation

7.7 QA & I Reporting Requirements for SNFs

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

7.7.1 Quarterly Reporting

Quarterly, SNF Quality Assessment indicator trend reports will include, at a minimum, the following:

- Patient falls
- Pressure Ulcers/Injuries
- Medication errors
- Previously reported adverse events and DNBEs
- Any CMS deficiency with a CAP or California Department of Public Health (CDPH) deficiency or citation with a CAP
- Reports to DHCS of unusual occurrences involving KP Members

7.7.2 Medical Record Documentation

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

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

Medical record documentation shall include at least the following:

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

7.8 QA & I Reporting Requirements for Chronic Dialysis Providers

7.8.1 Reporting Requirements

Providers who provide chronic dialysis services are expected to provide the following on a monthly basis via a hard copy or electronic file:

- Patients dialyzing for the first time ever
- Patient transferring into the contracted dialysis center from another dialysis center
- Patients returning after transplant
- Patients recovering renal function
- Patients receiving a transplant
- Patients transferring to another dialysis center
- Patients deceased
- Change in modality

7.8.2 Vascular Access Monitoring (VAM)

Pursuant to your Agreement, the chronic dialysis Provider is responsible for monitoring the blood flow in all grafts and fistulas of Members at the levels prescribed by the assigned nephrologist. Your Agreement will specify whether you are obligated to perform VAM services either using the Transonic Flow QC System® another method of VAM approved by Governing Body or office of Chief Medical Officer (CMO).

Desirable levels for flow rates are >400 ml/min for fistulas and >600 ml/min for grafts. When blood flow rates fall below the desirable targets, notify the nephrologist and/or KP renal case manager so that an appropriate intervention to prevent the access from clotting can be planned.

7.8.2.1 Surveillance Procedure for an Established Access

1. Obtain an access monitoring order from the nephrologist.
2. The Provider performs monthly access flow measurements once prescribed blood flow and optimal needle size are achieved at the intervals described below:

Grafts

- ✓ VAM services testing frequency
  - o Transonic Flow QC System®—Monthly*
  - o Another method of VAM approved by Governing Body of office of CMO
  - o As otherwise prescribed by a Nephrologist
- ✓ Graft flow > 600 ml/min—continue to test at monthly intervals and trend results
- ✓ Graft flow rate 500 to 600 ml/min - review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation
- ✓ If trends remain constant and are not decreasing, repeat the test at the scheduled time
- ✓ Graft flow rate < 500 ml/min—refer for angiogram and evaluation

Fistula

- ✓ VAM services testing frequency
  - o Transonic Flow QC System®—Every other month*
  - o Another method of VAM approved by Governing Body of office of CMO
  - o As otherwise prescribed by a nephrologist
- ✓ Fistula flow rate >400 ml/min—continue to test at monthly intervals and trend results.
- ✓ Fistula flow rate 300 to 400 ml/min - Review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation.
- ✓ If trends remain constant, use slower blood flows and perform a clinical evaluation to verify the adequacy of the treatments at a lower pump speed.
- ✓ Fistula flow rate < 300 ml/min—Refer for angiogram and evaluation

*In the case of the Transonic Flow QC System®, recirculation should be zero percent (0%) when testing the vascular access.

3. The Provider performs access flow measurements at frequencies other than that outlined above under the following conditions:
   - ✓ After a surgical procedure to create a new vascular access
   - ✓ Within a week following an access intervention, including but not limited to, a fistulogram, de-clotting, angioplasty or a surgical revision
   - ✓ As ordered by a Nephrologist

8. Compliance

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

8.1 Compliance with Law

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

8.2 KP Principles of Responsibility and Compliance Hotline

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

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

8.3 Gifts and Business Courtesies

You are expected to comply with all applicable state and federal laws governing remuneration for health care services, including anti-kickback and physician self-referral laws. Even if certain types of remuneration are permitted by law, KP discourages Providers from providing gifts, meals, entertainment or other business courtesies to KP Personnel, in particular:

- Gifts or entertainment of any kind or value
- Gifts, meals or entertainment that are provided on a regular basis
- Cash or cash-equivalents, such as checks, gift certificates/cards, stocks, or coupons
- Gifts from government representatives
- Gifts or entertainment that reasonably could be perceived as a bribe, payoff, deal or any other attempt to gain advantage

- Gifts or entertainment given to KP Personnel involved in KP purchasing and contracting decisions
- Gifts or entertainment that violate any laws or KP policy

8.4 Conflicts of Interest

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

8.5 Fraud, Waste and Abuse

Providers must be aware that funds received from KP are in whole or in part derived from federal funds. You are expected to comply with all applicable state and federal laws governing remuneration for health care services, including anti-kickback and physician self-referral laws. KP will investigate allegations of Provider fraud, waste or abuse, related to services provided to Members, and where appropriate, will take corrective action, including but not limited to civil or criminal action. The Federal False Claims Act and similar state laws are designed to reduce fraud, waste and abuse by allowing citizens to bring suit on behalf of the government to recover fraudulently obtained funds (i.e., "whistleblower" or "qui tam" actions). No individual may be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

8.6 Providers Ineligible for Participation in Government Health Care Programs

KP requires the Provider to (a) disclose whether any of its officers, directors, employees, or subcontractors are or become sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program or is convicted of a criminal offense related to the provision of health care and (b) assume full responsibility for taking all necessary steps to assure that Provider's employees, subcontractors and agents directly or indirectly involved in KP business have not been and are not currently excluded from participation in any federal program and this shall include, but not be limited to, routinely screening all such names against all applicable lists of individuals or entities sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program published by government agencies (including the U.S. Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities at http://oig.hhs.gov/exclusions/exclusions_list.asp and U.S. General Services Administration, Excluded Parties List System at https://www.sam.gov) as and when those

lists are updated from time to time, but no less often than upon initial hiring or contracting and annually thereafter. Providers are required to document their actions to screen such lists, and upon request certify compliance with this requirement to KP. KP will not do business with any entity or individual who is or becomes excluded by, precluded from, debarred from, or otherwise ineligible to participate in any federal health care program or is convicted of a criminal offense related to the provision of health care.

8.7 Visitation Policy

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

8.8 Compliance Training

KP requires certain providers, including those who provide services in a KP facility, to complete KP's Compliance Training, as required by your Agreement, applicable law or regulatory action. Where applicable, you must ensure that your employees and agents involved in KP business complete the relevant KP Compliance Training. Please refer to your KP Contract Manager for more guidance regarding these requirements.

8.9 Confidentiality of Patient Information

Health care providers, including KP and you or your facility, are legally and ethically obligated to protect the privacy of patients and Members. KP requires that Providers keep Members' medical information confidential and secure. These requirements are based on state and federal laws, as well as policies and procedures created by KP. Services provided via telehealth through any medium must meet all laws regarding confidentiality of medical information and a Member's right to the Member's own medical information.

Providers may not use or disclose the personal health information of a Member, except as needed to provide medical care to Members or patients, to bill for services or as necessary to regularly conduct business. Personal health information refers to medical information, as well as information that can identify a Member, for example, a Member's address or telephone number.

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

8.9.1 HIPAA and Privacy Rules

As a Provider, you may have signed a document that creates a "Business Associate" relationship with KP, as such relationship is defined by federal regulations commonly known as HIPAA. If you are providing standard patient care services that do not require a

business associate agreement, you still must preserve the confidentiality, privacy and security of our common patients' medical information.

If you did not sign a business associate agreement, you are a "Covered Entity" as that term is defined under HIPAA, and the Privacy and Security Rules issued by the Department of Health and Human Services. As a Covered Entity, you have specific responsibilities to limit the uses and disclosures and to ensure the security of protected health information (PHI), as that term is defined by the Privacy Rule (45 CFR Section 160.103).

Certain data which may be exchanged as a consequence of your relationship with KP is subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and its regulations or as updated and amended by Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and the Health Information Technology and Economic and Clinical Health Act (HITECH), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as each are codified in the United States Code, and all regulations issued under any of the foregoing statutes, as and when any of them may be amended from time to time. To the full extent applicable under HIPAA, you must comply with HIPAA, including but not limited to the HIPAA standards for (i) privacy, (ii) code set, (iii) data transmission standards, and (iv) security regarding physical storage, maintenance, transmission of and access to individual health information.

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

Providers are required by HIPAA to provide a patient with access to their PHI, to allow that patient to amend their PHI, and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures. You must extend these same rights to Members who are patients.

8.9.2 Confidentiality of Alcohol and Drug Abuse Patient Records

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

8.10 Provider Resources

- KP's National Compliance Office: **(510) 271-4699**
- KP's Compliance Hotline: **(888) 774-9100**
- Regional Compliance Office: **(510) 625-2400**
- Medical Services Contracting Department: **(844) 343-9370**
- TPMG Regional Compliance: **(510) 625-3885**

9. Additional Information

9.1 Subcontractors and Participating Practitioners

KP defines a "subcontractor" as an individual participating practitioner, participating practitioner group, or any other entity that provides or arranges for services to KP Members pursuant to a direct or indirect contract, agreement, or other arrangement with a Provider contracted with KP.

Subcontractor participating practitioners may be locum tenens, members of the Provider's call group, and others who may provide temporary coverage excluding employees, owners and/or partners of the contracting entity. For assistance in determining whether a participating practitioner is a subcontractor, please contact Provider Services.

All rights and responsibilities of the Provider are extended to the subcontractor, individual participating practitioner, participating practitioner group and facilities providing services to Members. The Provider is responsible to distribute this Provider Manual and subsequent updates to all its subcontractors and participating practitioners, assuring that its subcontractors and participating practitioners and facilities adhere to all applicable provisions of this Provider Manual.

9.1.1 Billing & Payment

Services provided for KP Members should be billed by the Provider to include services provided by any of its subcontractors. Subcontractor bills will not be paid directly but will be returned to the subcontractor for submitting to the Provider.

9.1.2 Licensure, Certification & Credentialing

Subcontractors and participating practitioners are subject to the same credentialing, recredentialing, and privileging requirements as the Provider. The Provider is responsible to ensure that all subcontractors and participating practitioners are properly licensed by the State of California or the state(s) in which services are provided, and that the licensure and/or certification is in good standing in accordance with all applicable local, state, and federal laws. Further, the Provider is responsible to ensure that its subcontractors and participating practitioners participate in KP's credentialing, recredentialing and privileging processes (privileging applies to practitioners providing services to Members at a KP facility), and that any site where Members may be seen is properly licensed. For additional information on credentialing requirements, please refer to Section 7.3of this Provider Manual.

9.1.3 Encounter Data

KP is required to certify the accuracy, completeness and truthfulness of data that CMS and other state and federal governmental agencies and accrediting organizations request. Such data includes encounter data, payment data, and any other information provided to KP by its contractors and subcontractors. As such, KP may request such certification from the Provider in order to meet regulatory and accreditation requirements.

9.1.4 Identification of Subcontractors

Each Provider at the time of initial contracting, and periodically thereafter, is required to complete and submit to KP a completed Provider Profile Information Form (PPIF) (incorporated into your Agreement by reference). This form identifies all participating facilities and practitioners, including those practitioners that are employed by the Provider, facilities that are operated by the Provider and those which are subcontractors.

9.2 KP's Health Education Programs

KP is dedicated to providing quality care for its Members. A key step towards this goal is to make available and encourage the use of health education programs and to provide preventive health services and screenings which are based on the latest scientific information presented in medical specialty journals, sub-specialty organization guidelines, and the US Preventive Services Task Force Guide.

KP's health education programs support KP clinicians by providing expertise in evidence-based patient health communication, behavior change, and technology. Health Education supports physicians in motivating and informing patients at the point of care while enhancing KP's reputation for excellence in prevention, health promotion, and care of chronic conditions.

The local health education departments oversee the development and implementation of educational services for KP Members. All Members and Providers have access to the KP health education departments for information and patient education materials. Health education departments can also offer Providers assistance with the planning or delivery of health education programs.

For more information contact your local KP facility and ask to be connected to the health education department.

9.2.1 Health Education Program

KP health education programs generally include:

- Health Education Centers, located at KP Medical Centers, provide free educational materials and support including direct services to patients to supplement or provide alternatives to doctor office visits. Members can also get answers to health questions

from knowledgeable staff, help with registering on the Member website (http://www.kp.org) and downloading mobile apps exclusively for use by Members, watch training and self-care videos, sign up for classes and programs or purchase health products.

- Health education provides patients and clinicians easy access to understandable and actionable health information they need, when they need it, and in a form they can use. These resources include print materials, patient instructions, and a rich variety of online tools and information, which may also be used in classes and office visits.
- Health education classes and programs that are available throughout Northern California and cover a wide variety of topics. Most classes are taught in groups, but for Members who prefer an individual approach, one-to-one counseling is also available in person or by telephone. Each KP facility maintains its own schedule of classes, some which require a fee for enrollment. For more information, contact your local KP Health Education Center.
- Members can also find health information, preventive care recommendations, and access to interactive online tools on their physician's home page at http://www.kp.org/mydoctor
- The Appointment and Advice Call Center (Call Center) available to all Members, 24 hours a day, 7 days a week. The Call Center is staffed by registered nurses who have special training to help answer questions about certain health problems or concerns and to advise on an appropriate response to symptoms. The advice nurses are not an impediment to seeing a physician but serve as a complement to any appropriate physician or practitioner care.

9.2.2 Focused Health Education Efforts

As part of the Quality Management Program, KP conducts focused health education efforts to address clinical or preventive health quality improvement activities. Many of these programs are developed regionally and are intended to address the specific health care issues of Members and the general community. Practitioners are generally made aware of these programs to obtain their support or participation.

9.2.3 Preventive Health and Clinical Practice Guidelines (CPGs)

KP supports the development and use of evidence-based CPGs and Practice Resources to aid clinicians and Members in the selection of the best preventive health care and screening options. The best options are those that have a strong basis in evidence regarding contribution to improved clinical outcomes, quality of care, cost effectiveness, and satisfaction with care and service. The Northern California guidelines include CPGs for key preventive care services. These guidelines recommend the preferred course of action while recognizing the role of clinical judgment and informed decision making in determining exceptions.

9.2.4 Telephonic Wellness Coaching Service

Wellness Coaching by phone is available at no charge for KP Members who want to get more active, manage weight, quit tobacco, eat healthier, sleep better or handle stress. Our Wellness Coaches are master's degree level Clinical Health Educators who are specially trained in Motivational Interviewing. They employ a collaborative approach designed to help Members overcome obstacles and tap into their own internal motivation for achieving behavior change. Coaches can also help match Members' needs, preferences, and readiness with the appropriate support resources.

Wellness coaching typically takes place through a series of 4 to 6 telephone sessions. Members can find out more about Wellness Coaching and book an appointment at: http://www.kp.org/mydoctor/wellnesscoaching. Members can also call toll free, **(866) 251-4514**, to schedule an appointment with a KP Wellness Coach. Spanish speaking coaches are available.

9.3 KP's Language Assistance Program

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

Providers must ensure that Members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language. Providers should offer language assistance to Members who appear to need it even if they do not ask for it or if their language preference was not indicated on the referral form. Should a LEP Member refuse to access KP's language interpreter services, the Provider must document that refusal in the Member's medical record.

If companion/caregiver involved in care decisions for a Members require language assistance to communicate with the Member or Provider regarding those care decisions, then all such encounters warrant the offer of free language assistance services to the companion/caregiver. The use of interpreter services in such encounters must be documented in the patient's chart. In addition, a note should be included that language assistance services were provided to the member's companion or caregiver.

Questions regarding the following information on language assistance can be discussed with KP's Language Assistance Program by calling **(510) 987-3422**, or by emailing NCAL-Language-Assistance-Program@kp.org.

9.3.1 Using Qualified Bilingual Staff

Our expectation is that you will provide interpreter services in-person using your own qualified bilingual staff if you have them.

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

- Documented and demonstrated proficiency in both English and the other language and
- Fundamental knowledge in both languages of health care terminology and concepts and
- Education and training in interpreting ethics, conduct and confidentiality

9.3.2 When Qualified Bilingual Staff Is Not Available

If you do not have qualified bilingual staff at the time services are needed, KP has made the following arrangements available to Providers when providing services to Members. KP will directly reimburse the companies below for interpreter services provided to Members. Neither Members nor Providers will be billed by these companies for interpreter services.

9.3.2.1 Telephonic Interpretation

Language Line is a company with the capability to provide telephonic interpreter services in more than 150 different languages. Phone interpreter services are available 24 hours per day, 7 days per week through the Language Line by calling: **(888) 898-1301**. This phone number is dedicated to the interpreter needs of Members. While no lead time is needed to engage an interpreter through this service, Providers must have the following data elements available before placing the call:

- The KP Client ID number (Provided to you, in writing, together with your authorization)
- KP referral or authorization number
- Member's MRN

If you require access to language assistance for a KP Member but were not provided a KP Client ID number with your authorization, please contact the referrals staff which issued the authorization for a KP Client ID number. Language Line customer service can be reached at **(800) 752-6096** Option #2 (6:00AM–6:00 PM PST M–F). After hours and weekends, access Option #1 and request a Supervisor. In addition, Language Line offers an online support tool called "Voice of the Customer" (VOC) to enter an issue (http://www.languageline.com/client-sevices/provide-feedback). You will receive an instant receipt acknowledgement and a follow-up response within 48 hours.

9.3.2.2 In-Person Interpreter: American Sign Language Support

KP contracts with multiple companies to provide in-person interpreter services for Members requiring American Sign Language (ASL). In-person interpreter services require a minimum of 24 hours lead time for scheduling and are available 24 hours per day, 7 days a

week. In-person interpreters are available according to the following schedule: Mon-Fri, 8:00am-5:00pm.

The KP contracted American Sign Language companies are:

Company	Customer Service/Scheduling	Cancellation Policy
Interpreting and Consulting Services, Inc.	1-888-617-0016 1-707-747-8200	Cancellations must be made 32 hours in advance of appointment
Partners in Communication LLC	1-800-975-8150 Please use extension 805 after hours and on weekends.	Cancellations must be made 48 hours in advance of appointment. Note, time lapsed during weekends does not count towards 48 hours of advance notice.

Providers may arrange in-person interpreter services for multiple dates of service with one call, but must have the following data elements available before placing the call to schedule:

- KP referral or authorization number
- Member's KP referring facility
- Member's KP referring provider or MD
- Member's MRN
- Date(s) of Member's appointment(s)
- Time and duration of each appointment
- Specific address and location of appointment(s)
- Any access or security measures the interpreter will need to know and plan for to gain entry to the place of service

9.3.3 Documentation

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

- that language assistance was offered to an LEP Member and/or their companion/caregiver
- if the language assistance was refused by the Member
- what type of service was utilized (telephonic, in-person interpreter services or bilingual staff), for those Members who accept language assistance

Providers must capture information necessary for KP to assess compliance and cooperate with KP by providing access to that information upon request.

9.3.4 Family Members as Interpreters

The KP Language Assistance Program does not prohibit adult family members from serving as interpreters for Members; however, using family members to interpret is discouraged. Members must first be offered language assistance and informed of the benefits of using professional language assistance. If after that offer, the Member refuses and prefers to use a family member, that refusal must be documented in the Member's medical record. Minor children should not to be used as interpreters, except in extraordinary situations such as medical emergencies where any delay could result in harm to a patient, and only until a qualified interpreter is available.

- Family members and friends typically may not understand the subtle nuances of language and culture that may influence the interaction and may not question the use of medical terminology that they and the patient do not understand.

- Minor children should not to be used as interpreters, except in extraordinary situations such as medical emergencies where any delay could result in harm to a patient, and only until a qualified interpreter is available.

9.3.5 How to Offer Free Language Assistance

Asking Members if they would like to use an interpreter may be uncomfortable for both Providers and Members. Members may feel that their language skills are being questioned, or they may fear that use of an interpreter will delay care or incur extra cost. The following is scripting that may be used by your office staff to offer free language assistance:

- "We want to make sure you have the best possible communication with your Provider so that you receive the highest quality of care. I am going to arrange for <insert language assistance of choice> to help us. Don't worry, language assistance services are free of charge."
- "In case you'd like to use an interpreter, I'd be happy to call one. Don't worry, language assistance services are free of charge."
- "I can understand why you'd feel more comfortable with your husband interpreting for you today, however, interpreters are trained in medical terminology and can provide you and your Provider with quality interpretation and confidentiality. May I call an interpreter to help us? Don't worry, language assistance services are free of charge."

9.3.6 How to Work Effectively with an Interpreter

Knowing how to effectively work with an interpreter contributes to effective communication, which promotes a better health outcome and increases Member satisfaction. The following recommendations will contribute to a successful discussion:

- Ask one question at a time

- Keep statements short, pausing to allow for interpretation
- Don't say anything you don't want the Member to hear
- Speak in a normal voice, clearly, and neither too fast nor too slow
- Avoid slang and technical terms that may not be understood by the Member
- Be prepared to repeat yourself and rephrase statements if your message is not understood
- Observe the Member's body language for signs of misunderstanding
- Check to see if the message is understood by having the Member repeat important instructions/directions
- Avoid asking the interpreter for opinions or comments. The interpreter's job is to convey the meaning of the source of language
- Members and providers that speak directly to each other during the medical encounter will strengthen the Member-provider relationship. To do this:
    - Position yourself to look directly at the Member and not the interpreter
    - Address yourself to the Member, not to the person providing language assistance
    - Do not say "tell him" or "tell her"
- With respect to Deaf or Hard of Hearing Members:
    - Do not ask the interpreter if the deaf Member understands
    - Allow the interpreter time to finish signing a question before expecting a Deaf or Hard of Hearing Member to be able to respond
    - If the communication process breaks down, address the situation with the Deaf or Hard of Hearing Member first. You may need to explore using a different interpreter or communication mode

10. Additional Service Specific Information

10.1 General Assistance for SNFs

SNFs can contact their local KP Skilled Nursing Department for general assistance and requesting Authorizations for ancillary services to Members. The following table indicates which KP Skilled Nursing Department to call based on your location:

Service Area	Phone Number
Antioch, Martinez, Walnut Creek	(925) 229-7765
Fremont, San Leandro, Hayward, Union City, Richmond, Oakland	(510) 675-5571 or (510) 675-5542
Fresno	(559) 448-4606
Manteca, Modesto, Stockton	(209) 735-7333
Redwood City	(650) 299-2708
Roseville, Sacramento, South Sacramento	(916) 648-6839
San Francisco, South San Francisco	(415) 833-4909
San Jose, Santa Clara	(408) 366-4080
Marin – San Rafael	(415) 893-4046
Sonoma – Santa Rosa	(707) 571-3869
Vacaville, Vallejo	(707) 651-2085

10.1.1 Requesting Ancillary Services for SNFs

Members residing in SNFs may require ancillary services during their stay. These services may include, but are not limited to, therapies, physician specialty consultation, vision, hearing, podiatry, imaging, and lab services.

Once a Provider has written an order for an ancillary service, an Authorization should be requested by contacting your local KP Skilled Nursing Department as indicated in the table in Section 12.1 above. KP will work with you to determine the most appropriate provider and venue for providing the requested ancillary service to the Member.

10.1.2 Laboratory Services Ordering for SNFs

Below is information that will assist contracted SNFs, KP SNF managers, and KP's contracted laboratory vendors in addressing claims for laboratory services provided to Members at SNFs as efficiently as possible.

The main status categories of Members most likely to receive services in your SNF are "Skilled" or "Custodial." Identifying the Member's status category is essential to processing the claim correctly. Lab services are paid in the following manner depending on the Member's status category and whether the service has been authorized by a Plan Physician:

Status Category	Payment Responsibility
Skilled	Lab services are SNF responsibility
Custodial, if authorized by Plan Physician	KP responsibility
Custodial, not authorized by Plan Physician	CMS if patient has Medicare Part B coverage, or patient, or other responsible party

When a Member receives lab services at the SNF, the Member's status category as described above, should be noted on the lab requisition form. This status is usually found in the patient's chart or in the SNF census reports.

10.2 Psychiatric Care Settings

KP authorizes psychiatric services for Members at different levels of care, depending on the Member's clinical conditions. Authorizations must be obtained as set forth in Section 4.4 of this Provider Manual.

The primary types of settings in which KP authorizes Members' care are:

Inpatient Hospitalization. This represents the highest level of control and treatment. Hospitalization is intended for interventions requiring very high frequency or intense treatment.

Psychiatric Health Facility. This is an inpatient-like setting, but not in an acute care hospital. This type of licensed facility provides a restrictive setting for high frequency or intense treatment.

23 Hour Observation. This level of care provides a restrictive setting for voluntary or involuntary patients and provides a high degree of safety and security for patients who may be dangerous to themselves or others. This level of care allows for an extended diagnostic assessment to permit a more targeted referral to the appropriate level of care and provides active crisis intervention and triage.

Partial Hospitalization. This level of care provides structured treatment and treatment comparable to that of an inpatient unit, however patients live and sleep at home. This level of care provides daily supervision of high risk patients, medication monitoring, milieu therapy, and other interventions.

Hospital Alternative Program. This is a hospital diversion program in a residential setting for voluntary patients. This level of care is less restrictive than inpatient and 23-hour holding

units, but allows for relatively intensive or frequent interventions, and provides 24 hour monitoring and supervision by non-medical clinicians with physician case supervision and consultation.

Intensive Outpatient Program. This level of care provides a short-term comprehensive program designed as an alternative to psychiatric hospitalization and is generally appropriate for persons recently discharged from an inpatient hospital who are at risk for re-hospitalization.

10.3 Addiction Medicine and Recovery Services

Addiction Medicine and Recovery Services are offered at all KP Medical Centers. At 9 KP Medical Centers, comprehensive and intensive programming is available through KP's Addiction Medicine and Recovery Services. Residential Recovery Services are authorized through Addiction Medicine and Recovery Services department and are based on a determination of appropriateness and indication after evaluation by a department provider.

The 8 levels of addiction medicine and recovery services are listed below. It is important that you contact Addiction Medicine and Recovery Services in your sub-region for provision of services. All services are offered based on appropriateness and indication and in accordance with the patient's Evidence of Coverage (EOC).

Service	Description
Residential Recovery Services – Inpatient Detoxification	Residential/ "inpatient" detoxification, 3-5 days in a medical facility with nursing-level care overseen by a physician.
Residential Recovery Services – Brief Residential Detoxification (BRD)	Brief residential treatment, 3-7 days, in a non-medical setting where Members may be dispensed detox medications within a sober living environment
Residential Recovery Services – Residential Treatment Program (RTP)	Provides 24 hours/day residential programming with counseling and educational services. Medical support for detoxification may be offered with nursing-level care overseen by a physician. Length of stay is determined by appropriateness and indication but is typically 30 days.
Residential Recovery Services – Transitional Residential Recovery Services (TRRS)	Provides 24 hours/day non-medical residential programming with counseling and educational services. Length of stay is based on appropriateness and indication but is typically 30 days.
Day Treatment Program	Daily outpatient program, typically14-21 days in length, providing therapy and educational services 6-8 hours each day.
Intensive Recovery Program (IRP)	An 8 week program of outpatient therapy and educational services provided at least 4 days/week for 2-3 hours each day.

Service	Description
EARLY Recovery Program	A program of outpatient therapy and educational services provided at least 1-3 days/week for 1-2 hours each day.
Medication Assisted Treatment (MAT)	A program of office-based therapy, including Opioid agonist treatment using methadone therapy which is provided outside KP by contractors upon referral. Buprenorphine treatment and other medications as indicated are provided by KP.

Levels of Care and Description of Addiction Medicine and Recovery Services Provided by KP

Early Intervention Program. This is a 6 week program for individuals who are unsure whether they have a serious problem with substances, even though there is some evidence suggesting that they do. This program consists of at least one process group per week and is designed to help patients evaluate their relationship with addictive chemicals. If a patient decides at any time that the problem is indeed serious, the patient may transfer immediately to the appropriate level of treatment. The program may vary slightly by sub-region.

Family and Codependency Programs. These are a series of programs ranging from brief education for family members to intensive treatment for serious codependency issues. These programs are available to Members regardless of whether the chemically dependent person is in treatment.

Adolescent Treatment Program. This is a multilevel program designed to help adolescents and their parents evaluate the extent of their problems with psychoactive chemicals, to decide what steps they are willing to take to address these problems, and to provide more intensive treatment. The program may include adolescent groups, parent groups, multifamily groups, and individual and family sessions with a therapist.

10.4 Autism Spectrum Disorder (ASD) Services

Depending on the Plan Sponsor's Self-Funded plan, Providers may be required to provide Behavioral Health Treatment (including, but not limited to, Applied Behavior Analysis Services) as defined by California Health and Safety Code Section 1374.73(c)(1), Speech Therapy, Physical Therapy and Occupational Therapy in accordance with the requirements set forth in California Health and Safety Code Section 1374.73, including providing Services through Qualified Autism Service Providers who supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment (as those terms are defined by California Health and Safety Code Section 1374.73(c)(3)-(5)). Providers must ensure (and provide documentary evidence to KP upon request) that all such Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals meet the licensure, certification, experience, competence, approval, training and other requirements set forth in California Health and Safety Code Section 1374.73 in order to provide Behavioral

Health Treatment and, if necessary, Providers shall at its cost provide necessary training and experience to such individuals.

Beyond the requirements set forth in California Health and Safety Code Section 1374.73, effective July 1, 2018 KP requires contracted providers to ensure all Qualified Autism Services Paraprofessionals hold a certificate or credential as a Registered Behavior Technician (RBT), Board Certified Autism Technician (BCAT) or Applied Behavior Analysis Technician (ABAT) unless KP expressly permits an exception in writing.