2026

Northern California

HMO Provider Manual

Kaiser Foundation Health Plan, Inc.

KAISER PERMANENTE®

KAISER PERMANENTE®

Welcome from Kaiser Permanente

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

This Provider Manual was created to help guide you and your staff in working with Kaiser Permanente's various systems and procedures applicable to our HMO products in Northern California. It is an important part of your relationship with Kaiser Permanente, but this Provider Manual does not cover all aspects of your relationship with us. Please continue to consult your Provider agreement with Kaiser Permanente.

During the term of such agreement, Providers are responsible for (i) maintaining copies of the Provider Manual and its updates as provided by Kaiser Permanente, (ii) providing copies of the Provider Manual to its subcontractors and (iii) ensuring that Provider and its practitioners and subcontractors comply with all applicable provisions. The Provider Manual, including but not limited to all updates, shall remain the property of Kaiser Permanente and shall be returned to Kaiser Permanente or destroyed upon termination of the obligations under such agreement.

If you have questions or concerns about the information contained in this HMO Provider Manual, you can reach our Medical Services Contracting Department by calling **(925) 924-5050**.

Additional resources can also be found on our Community Provider Portal website at: **http://kp.org/providers/ncal/**

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Introduction

This Northern California HMO Provider Manual applies to you as a Provider for HMO products offered by Kaiser Permanente Medical Care Program Affiliated Payors, as referenced in your Agreement with a Kaiser Permanente entity.

To the extent provided in your Agreement, if there is a conflict between this Provider Manual and your Agreement, the terms of the Agreement will control. The term "Member" as used in this Provider Manual refers to currently eligible enrollees of HMO plans offered by Kaiser Permanente Medical Care Program Affiliated Payors, including Kaiser Foundation Health Plan, and their beneficiaries. The term “Provider” as used in this Provider Manual refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement. Additionally, unless the context otherwise requires, “you” or “your” in this Provider Manual refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement and “we” or “our” in this Provider Manual refers to Kaiser Permanente. Operational instructions in this Provider Manual specifically relate to the HMO product. Capitalized terms used in this Provider Manual may be defined within this Provider Manual or if not defined herein, will have the meanings given to them in your Agreement.

1. Kaiser Permanente Medical Care Program (KPMCP)

1.1 History

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

Today, Kaiser Foundation Health Plan, Inc. is one of the country's largest nonprofit, independent, prepaid group practice health maintenance organizations. We are proud of our over 70+ year history of providing quality health care services to our Members and of the positive regard we've earned from our Members, peers, and others within the health care industry.

1.2 Organizational Structure

Kaiser Permanente Northern California Region (KPNC) is comprised of 3 separate entities that share responsibility for providing medical, hospital and business management services. This group of entities is referred to in this Provider Manual as Kaiser Permanente (KP). The entities are:

- **Kaiser Foundation Health Plan, Inc. (KFHP):** KFHP is a California nonprofit, public benefit corporation that is licensed as a health care service plan under the Knox-Keene Act. KFHP offers HMO plans. KFHP contracts with Kaiser Foundation Hospitals and The Permanente Medical Group to provide or arrange for the provision of hospital and medical services, respectively.
- **Kaiser Foundation Hospitals (KFH):** KFH is a California nonprofit public benefit corporation that owns and operates community hospitals and outpatient facilities. KFH provides and arranges for hospital and other facility services, and sponsors charitable, educational, and research activities.
- **The Permanente Medical Group, Inc. (TPMG):** TPMG is a professional corporation of physicians in KPNC that provides and arranges for professional medical services.

1.3 KPNC Service Area

The KPNC was the first of KP's 8 regions. Currently covering an area from south of Fresno to El Dorado in the Sierra foothills, from Santa Cruz to Sonoma on the Pacific coast, KPNC spans more than twenty counties.

1.4 Integration

KP is unique. We integrate the elements of health care providers, hospitals, home health, support functions and health care coverage into a cohesive health care delivery system. Our integrated structure enables us to coordinate care to our Members across the continuum of care settings.

1.5 Nondiscrimination

The KPMCP in Northern California does not discriminate in the delivery of health care based on race/ethnicity, color, national origin, ancestry, religion, sex, sexual orientation, gender (including gender identity or gender related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth), marital status, veteran's status, age, genetic information, medical history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment, or other status protected by applicable law.

It is also the policy of KPMCP to require that facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 ("ADA") including but not limited to the service animal requirements set forth in 28 C.F.R. § 36.302(c), and Section 504 of the Rehabilitation Act of 1973 ("Section 504") and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability.

As a Provider for HMO products offered by KP, you are expected to adhere to KP's "Nondiscrimination in the Delivery of Health Care Policy" (as may be amended from time to time) and to all applicable federal and state laws and regulations that prohibit discrimination. For a copy of the most current policy, Providers may contact Member Service Contact Center (MSCC) (see Section 2 of this Provider Manual).

KP continues to influence the practice of medicine by focusing on keeping the patient healthy and on treating illness and injuries. We encourage Members to seek care on a regular and preventive basis.

1.6 Other Products

In addition to our core HMO plans, KP also offers insurance plans and self-funded products issued or administered by Kaiser Permanente Insurance Company (KPIC). Fully insured and Self-Funded Exclusive Provider Organization, Point-of-Service, and Preferred Provider Organization (PPO) options are addressed in a separate manual.

1.6.1 Exclusive Provider Organization (EPO)

- Mirrors our HMO product, offered on a fully insured or self-funded basis

- EPO Members choose a KP primary care provider (PCP) and receive care at KP or (contracted) plan medical facilities
- Except when referred by a TPMG physician or designee (Plan Physician), EPO Members will be covered for non-emergency care only at designated plan medical facilities and from designated plan practitioners

1.6.2 Point of Service (POS)—Two-Tier

- Tier 1 is the HMO provider network
- Tier 2 is comprised of all other contracted Providers
- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance and/or deductibles when they use Tier 2 benefits
- The POS—Two Tier product is currently offered on a fully insured basis

1.6.3 Point of Service (POS)—Three-Tier

- Tier 1 is the HMO provider network
- Tier 2 is comprised of our contracted PPO network providers
- Tier 3 includes non-contracted providers
- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance and/or deductibles when they self-refer to a contracted PPO network provider (Tier 2)
- Generally, the out-of-pocket costs will be highest for self-referred services received from non-contracted providers (Tier 3)
- The POS—Three Tier product is offered on a fully insured or self-funded basis

1.6.4 Out of Area Preferred Provider Organization (PPO)

- In California, the PPO is currently offered to Members living outside the KP HMO or EPO service area. Members receive care from our PPO provider network, e.g., Private Healthcare Systems, Inc. (PHCS, MultiPlan's national network of providers).
- PPO Members may choose to receive care from a non-network provider; however, their out-of-pocket costs may be higher
- There are no requirements for PCP selection
- The Out of Area PPO is offered on a fully insured basis

1.7 Identification Cards and Medical Record Number (MRN)

Each Member is issued a Health Identification Card (Health ID Card) that shows their unique MRN. Members should present their Health ID Card and photo identification when they seek medical care. If a replacement card is needed, the Member can order a Health ID Card online at http://www.kp.org or call the Member Services Contact Center.

The Health ID Card is for identification only and does not give a Member rights to services or other benefits unless he/she is eligible and enrolled on the date of service. Anyone who is not eligible and enrolled at the time of service is responsible for paying for services provided.

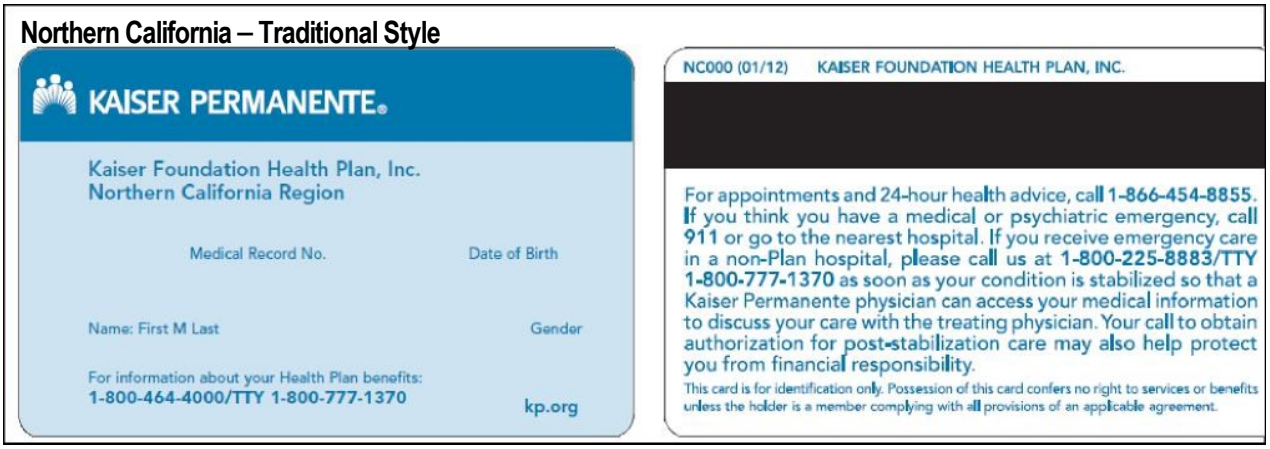
For record-keeping purposes, your business office may wish to photocopy the front and back of a Member's Health ID card and place it in the Member's medical records file.

The MRN is used by KP to identify the Member's medical record, eligibility, and benefit level. If a Member's enrollment terminates and the Member re-enrolls at a later date, the Member retains the same MRN even though employer or other information may change including but not limited to their benefit information. The MRN enables medical records/history to be tracked for all periods of enrollment.

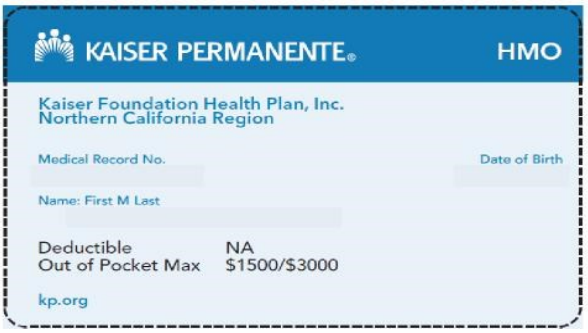
The MRN should be used as the "Patient ID" when submitting bills and encounter data.

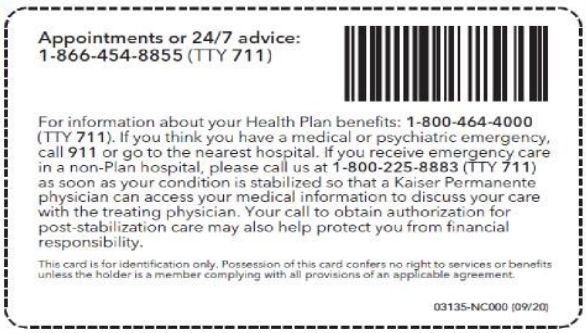
Sample Health ID Cards:

Northern California – Traditional Style

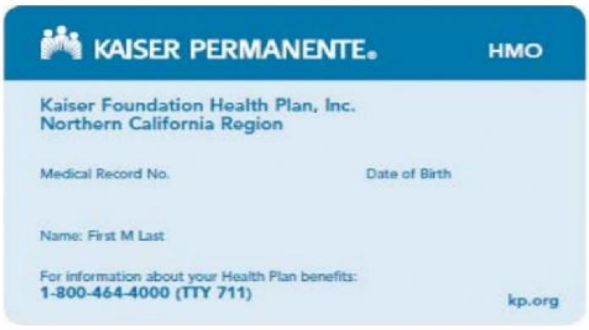


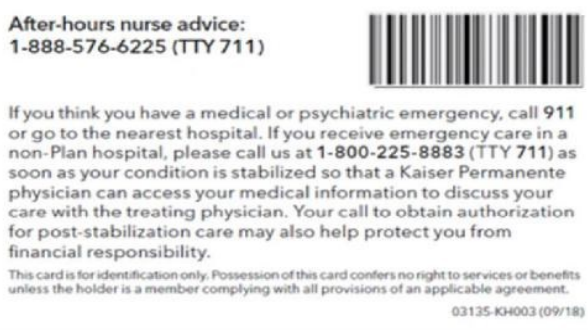
Northern California – New Laminate Style





Older Laminate Style





Northern California - Digital Style

2. Key Contacts

2.1 Northern California Region Key Contacts

Department	Area of Interest	Contact Information
KP Online Affiliate	Online Affiliate allows external providers the ability to: - Submit an online inquiry about payment, or overpayment - File a dispute and appeal - Submit KP Request for Information	To access the portal, visit: http://kp.org/providers/ncal/ and navigate to the **Online Provider Tools** section
KP MSCC	Membership Information* General enrollment questions Eligibility and benefit verification* Co-pay, deductible, and co-insurance information* Members presenting without KP identification number Member grievance and appeals Payment status on submitted claims* Appeals and disputes* Inquiry about a claim, payment, or overpayment*	(888) 576-6789 (Member cost share and eligibility verification) Weekdays: 8a-5p Pacific Interactive Voice Response (IVR) System available 24 hours / 7 days a week
Medical Services Contracting	Contract Network Development and Network Management • Updates to Provider demographics, such as Tax ID, address, and ownership changes • Practitioner additions/terminations to/from your group • Provider education and training • Contract interpretation • Form requests	(925) 924-5050 Fax: (877) 228-8306 5820 Owens Dr, Building E, Floor 2 Pleasanton, CA 94588 mscprovcontractinbox@kp.org
TPMG Consulting Services	Practitioner Credentialing	(510) 625-5608

Department	Area of Interest	Contact Information
Medical Services Contracting	Facility/Organizational Provider Credentialing	(925) 924-5050 MSCOPCRED@kp.org
Medical Staff Office	Kaiser Foundation Hospital Privileges	Facility Listing – Section 2.4
Referral Operations	Authorizations, Referrals by Service • Authorizations, referrals & billing questions for referred services • Coordination of Benefits • Third Party Liability • Workers' Compensation	Referral Coordinators - Facility Listing - Section 2.4
National Claims Administration	Emergency Medical Claims Billing questions for emergency (non-referred) services	(800) 390-3510 P.O. Box 8002 Pleasanton, CA 94588
Department of Research	Clinical Studies	(866) 206-2979
Clinical Reviews	UM Reconsiderations and Appeals 72 Hour Expedited Appeals	(888) 987-7247 (888) 987-2252 (fax) M-F 7am-7pm; Sat 9am-1pm
Emergency Prospective Review Program (EPRP) CA Statewide Service	Emergency Notification	(800) 447-3777 Available 24 hours a day, 7 days a week
The "HUB"	Non-Emergency Ambulance and Medical Transportation	(800) 438-7404
Nephrology Specialty Department	Management of Adult Kidney Transplant patients 91 days and beyond after transplant	San Francisco: (415) 833-8726 So. Sacramento:(916) 688-6985
National Transplant Network	Transplants: All Other	(888) 551-2740 (510) 268-5448
EDI Support	Access the Electronic Claims, Payments and Remittance Advice digital book to get more information on how to enroll with EDI, ERA and EFT. https://online.flippingbook.com/view/704125376/	https://kpnationalclaims.my.site.com/EDI/s/

2.2 Member Services Interactive Voice Response System (IVR)

KP Member Services IVR can assist you with a variety of questions. Call **(888) 576-6789** to use this service. Please have the following information available when you call into the system to provide authentication:

- Provider Tax ID or National Provider Identifier (NPI)
- Member's MRN
- Member's date of birth
- Date of service for claim in question

The IVR can assist you with status of a Member's accumulator (amount applied toward deductible, if any, or out-of-pocket maximum); claims and payment status; or connect you to a Member Services Contact Center (MSCC) representative. Follow the prompts to access these services.

2.3 KP Outside Services

Referral Coordinators and Outside Services Case Managers work directly with Plan Physicians to authorize services to Providers.
Referral inquiries, including requests for additional authorized services, pending authorizations and details regarding the scope of authorized services should be addressed with the Referral Operations department (see Section 2.4). The Member Services Contact Center (MSCC) is an additional contact for questions about authorized referrals such as services and dates authorized.

Providers are invited and encouraged to request access to KP's **Online Affiliate** tool.

Online Affiliate is enabled with a robust set of features that can help simplify the process of obtaining KP member information and performing claim reconciliation. Many actions can be performed with Online Affiliate, such as viewing patient eligibility/benefits, viewing detailed claim status, downloading Explanations of Payment (EOPs), filing disputes/appeals, submitting an online claim or payment inquiry and responding to KP requests for information (RFI). With access to Online Affiliate, these features are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please visit KP's Northern California Community Provider Portal at:

http://kp.org/providers/ncal/

2.4 KP Facility Listing

KP Facilities, Referral Coordinators and Outside Services Case Managers may be reached at the telephone numbers listed on the following pages.

SERVICE AREA	FACILITY	GENERAL INFORMATION	REFERRAL COORDINATORS	KIDNEY CARE	UTILIZATION MANAGEMENT
East Bay	Oakland	(510) 752-1000	(510) 752-6610	(510) 752-7513 (510) 752-6526	(510) 752-7645
	Richmond	(510) 307-1500	(510) 307-2496	(510) 752-7518	(510) 307-2943
	San Leandro	(510) 454-1000	(510) 675-6759	(510) 784-2082	(510) 454-4892
	Fremont	(510) 795-3000	(510) 675-6759	(510) 248-3345	(510) 248-7039
Marin/Sonoma	San Rafael	(415) 444-2000	844-359-5661	(415) 492-6522	(415) 444-2638
	West Marin/ Coastal Health Alliance	(415) 899-7525	844-359-5661	(415) 492-6522	(415) 444-2638
	Santa Rosa	(707) 393-4000	(707) 571-3900	(707) 393-4301	(707) 393-3169
Greater San Francisco Service Area	San Francisco	(415) 833-2000	(844) 359-5661	(415) 833-8890	(415) 833-2801
	So. San Francisco	(650) 742-2000	(844) 359-5661	(650) 742-3141	(650) 742-2332
San Mateo	Redwood City	(650) 299-2000	(844) 359-5661	(650) 299-3726	(650) 299-3290
South Bay	Santa Clara	(408) 851-1000	(408) 851-3728	(408) 851-4405	(408) 851-7050
	San Jose	(408) 972-3000	(844) 359-5661	(408) 363-4544	(408) 972-7208
Santa Cruz	Watsonville Community Hospital	(831) 724-4741	(844) 359-5661	(408) 363-4544	NA
Diablo	Walnut Creek	(925) 295-4000	(844) 359-5661	(925) 295-4315	(925) 295-5175
	Antioch	(925) 813-6500	(844) 359-5661	(925) 813-3440	(925) 813-3720
Napa/Solano	Vacaville	(707) 624-4000	N/A -	N/A	(707) 624-2950
	Vallejo	(707) 651-1000	(707) 651-2520	(707) 651-4028	(707) 651-2061
	Vallejo Rehab-KFRC	(707) 651-2311	N/A	N/A	(707) 651-2313
North Valley/ S. Sacramento	Sacramento	(916) 973-5000	(844) 359-5661	(916) 973-6110	(916) 973-6903
	Roseville	(916) 784-4000	(844) 359-5661	(916) 973-6110	(916) 784-4802
	So. Sacramento	(916) 688-2000	(844) 359-5661	(916) 688-6837	(916) 688-2585
Central Valley	Manteca	(209) 825-3700	(844) 359-5661	(209) 476-5099	(209) 825-2441
	St. Joseph's Medical Center	(209) 943-2000	(844) 359-5661	N/A	N/A
	Modesto	(209) 557-1000	(844) 359-5661	(209) 735-4348	(209) 735-5600
Fresno	Fresno	(559) 448-4500	(559) 448-3348	(559) 448-5149	(559) 448-3352
Out of Service Area		(877) 520-4773			

SERVICE AREA	FACILITY	OUTSIDE SERVICES CASE MANAGEMENT HUBS	SKILLED NURSING FACILITY COORDINATOR Mon - Fri (8:30am - 5:00pm)	SKILLED NURSING FACILITY COORDINATOR Evenings, Weekends & Holidays	HOME HEALTH AGENCY	HOSPICE AGENCY
East Bay	Oakland	(925) 926-7303	(510) 675-5539	(877) 233-6752	(510) 752-6295	(510) 752-6390
	Richmond	(925) 926-7303	(510) 675-5539	(877) 233-6752	(510) 752-6295	(510) 752-6390
	San Leandro	(925) 926-7303	(510) 675-5539	(877) 233-6541	(510) 752-6295	(510) 675-5777
	Fremont	(925) 926-7303	(510) 675-5539	(877) 233-6541	(510) 7526295	(510) 675-5777
Marin/Sonoma	San Rafael	(925) 926-7303	(415) 893-4046	(877) 829-8615	(415) 893-4132	(415) 893-4132
	West Marin/ Coastal Health Alliance	(925) 926-7303	(415) 893-4046	(877) 829-8615	(415) 893-4132	(415) 893-4132
	Santa Rosa	(925) 926-7303	(707) 571-3869	(877) 829-8615	(707) 566-5488	(707) 566-5488
Greater San Francisco Service Area	San Francisco	(925) 926-7303	(415) 833-4906	(877) 331-2110	(415) 833-2770	(415) 833-3655
	So. San Francisco	(408) 361-2140, Option 1	(650) 827-6405	(877) 263-5756	(415) 833-2770	(415) 833-3655
San Mateo	Redwood City	(408) 361-2140, Option 1	(650) 299-2708	(877) 263-5756	(650) 299-3940	(650) 299-3971
South Bay	Santa Clara	(408) 361-2140, Option 1	(408) 366-4322	(877) 263-5756	(408) 235-4000	(408) 235-4100
	San Jose	(408) 361-2140, Option 1	(408) 361-2164	(877) 263-5756	(408) 361-2100	(408) 361-2150
Diablo	Walnut Creek	(925) 926-7303	(925) 229-7765	(925) 229-7756	(925) 313-4600	(925) 229-7800
	Antioch	(925) 926-7303	(925) 229-7765	(925) 229-7756	(925) 313-4600	(925) 229-7800
Napa/Solano	Vacaville	(925) 926-7303	(707) 651-2085	(707) 651-2085	(707) 645-2720	(707) 645-2730
	Vallejo	(925) 926-7303	(707) 651-2085	(707) 651-2085	(707) 645-2720	(707) 645-2730
North Valley/ S. Sacramento	Sacramento	(916) 648-6770	(916) 977-3135	N/A	(916) 486-5400	(916) 486-5300
	Roseville	(916) 648-6770	(916) 977-3135	N/A	(916) 486-5400	(916) 486-5300
	So. Sacramento	(916) 648-6770	(916) 977-3135	(877) 829-8616	(916) 486-5400	(916) 486-5300
Central Valley	Manteca	(916) 648-6770	(209) 735-7333	(209) 602-7389	(209) 735-7333	(209) 735-7333
	St. Joseph's Medical Center	(916) 648-6770	(209) 735-7333	(209) 602-7389	(209) 735-7333	(209) 735-7333
	Modesto	(916) 648-6770	(209) 735-7333	(209) 602-7389	(209) 735-7333	(209) 735-7333
Out of Service Area		(877) 520-4773				

Community Based Adult Services (CBAS)	
All Northern California Service Areas	Stephanie.R.Smith@kp.org

SERVICE AREA	FACILITY	PSYCHIATRIC HOSPITAL AUTHORIZATION/ NOTIFICATION: Weekdays	PSYCHIATRIC HOSPITAL AUTHORIZATION/ NOTIFICATION: Evenings/Weekends	PSYCHIATRIC CASE MANAGERS
East Bay	Oakland	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Richmond	(925) 372-1103	(925) 229-7713	(925) 372-1103
	San Leandro	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Fremont	(925) 372-1103	(925) 229-7713	(925) 372-1103
Marin / Sonoma	San Rafael	(925) 372-1103	(925) 229-7713	(925) 372-1103
	West Marin/ Coastal Health Alliance	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Santa Rosa	(925) 372-1103	(925) 229-7713	(925) 372-1103
Greater San Francisco Service Area	San Francisco	(925) 372-1103	(925) 229-7713	(650) 299-4112
	So. San Francisco	(925) 372-1103	(925) 229-7713	(650) 299-4112
San Mateo	Redwood City	(925) 372-1103	(925) 229-7713	(650) 299-4112
South Bay	Santa Clara	(925) 372-1103	(925) 229-7713	(650) 299-4112
	San Jose	(925) 372-1103	(925) 229-7713	(650) 299-4112
Diablo	Walnut Creek	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Antioch	(925) 372-1103	(925) 229-7713	(925) 372-1103
Napa/Solano	Vacaville	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Vallejo	(925) 372-1103	(925) 229-7713	(925) 372-1103
North Valley/ S. Sacramento	Sacramento	(925) 372-1103	(925) 229-7713	(916) 499-4645 – Pager
	Roseville	(925) 372-1103	(925) 229-7713	(916) 499-4645 – Pager
	So. Sacramento	(925) 372-1103	(925) 229-7713	(916) 522-8792 – Pager
Central Valley	Manteca	(925) 372-1103	(925) 229-7713	(209) 476-3111 (925) 372-1103
	Modesto	(925) 372-1103	(925) 229-7713	(209) 476-3111
Fresno	Fresno	(925) 372-1103	(925) 229-7713	(925) 372-1103
Out of Service Area		(925) 372-1336	(925) 372-1336	

Addiction Medicine Recovery Services (AMRS) Day Treatment Programs

Service Area	Facility	Department Number	Program Director/Manager	Email Address
Central Valley	Manteca Modesto Stockton Tracy	(855) 268-4096	Ester Baldwin	Ester.Baldwin@kp.org
Diablo	Antioch Martinez Pleasanton Walnut Creek	(925) 295-4145	Curtis Arthur	Curtis.John.Arthur@kp.org
East Bay	Oakland Richmond	(510) 251-0121	Olena Geller	Olena.A.Geller@kp.org
Fresno	Fresno	(559) 448-4620	Michael Nunes	Michael.A.Nunes@kp.org
Greater Southern Ala meda	Fremont Union City San Leandro	(510) 675-2377	Jennifer Miller	Jennifer.K.Miller@kp.org
Napa/Solano	Petaluma/San Rafael Vallejo Vacaville	(707) 651-2619	Kurt Meyers	Kurt.A.Meyers@kp.org
North Valley	Roseville Sacramento South Sacramento	(916) 482-1132	Kristy Schwee	Kristy.N.Schwee@kp.org
San Francisco	Redwood City San Francisco San Rafael South San Francisco	(415) 833-9402	Sofia Gonzalez	Sofia.N.Gonzalez@kp.org
Santa Clara	Redwood City San Jose Santa Clara Santa Cruz	(408) 366-4200	H.B.(Tresy) Wilder	H.B.Wilder@kp.org
Santa Rosa	San Rafael Santa Rosa	(707) 571-3778	Christopher Evans	Christopher.S.Evans@kp.org

2.5 Northern California Resource Management (RM) Contacts

Coordination of Care Service Directors (COCSD), UM/RM Managers, and Social Workers may be reached at the telephone numbers listed on the following pages.

Location	Address	COCSD	UM/RM Manager	Social Worker
Antioch	4501 Sand Creek Road Antioch, CA 94531	**Haeyong Sohn** (925) 813-6997 (925) 303-8816 (cell)	**Dena Grosse (ANM)** (925) 813-3736 (925) 813-3721	**Charles Brigham** (925) 813-3760

Location	Address	COCSD	UM/RM Manager	Social Worker
Fremont	39400 Paseo Padre Pkwy Fremont, CA 94538	**Elsamma Babu** (510) 248-7601	**Winnie Huang** (510) 248-5302	**Jenny Vo** (510) 248-5327
Fresno	7300 North Fresno Street Fresno, CA 93720	**Michelle Garcia-Wilkins** (559) 448-3323	**Sheila Brillante** (559) 448-3193 (559) 352-2358 (cell)	**Iris DeYoung** (559) 448-5174
Manteca	1777 West Yosemite Ave Manteca, CA 95337	**Julie Ann Gist** (209) 735-4207 (209) 402-6953 (cell)	**Kristine Biehl** (209) 825-2442 (209) 573-3880 (cell)	**Debbie Vieira** (209) 735-5602
Modesto	4601 Dale Road, Ste 1H7 Modesto, CA 95356	**Julie Ann Gist** (209) 735-4207 (209) 402-6953 (cell)	**Lexlee Cunningham** (209) 402-4349 (209) 402-6633 (cell)	**Debbie Vieira** (209) 735-5602
Oakland	275 West MacArthur Blvd Oakland, CA 94611	**Shannon D Bradley** (510) 752-5569 (510) 871-7913 (cell)	**Natalie Archangel-Montijo** (510) 752-8120 (510) 915-6830 (cell)	**Reva Levias** (510) 752-6306 (510) 507-0800 (cell)
Redwood City	1100 Veterans Blvd Redwood City, CA 94063	**Ursula Lavelle** (650) 299-2829 (650) 207-7968 (cell)	**Monica Moniz** (650) 299-4601 (650) 2128-8297 (cell)	**Kathleen Steele** (650) 299-3194
Richmond	901 Nevin Avenue Richmond, CA 94801	**Shannon D Bradley** (510) 752-5569 (510) 871-7913 (cell)	**Heather Rodriguez** (510) 307-2893	**Nancy Jacobson** (510) 307-2972
Roseville	1600 Eureka Road Roseville, CA 95661	**Dee Ford** (916) 784-5297	**Ronaviv M Garcia** (916) 784-4802 (916) 297-1000 (cell)	**Erica Menzer** (916) 784-4483
Sacramento	2025 Morse Avenue Sacramento, CA 95825	**Yvonne Speer** (916) 973-7528 (916) 297-3725 (cell)	**David J Thomas** (916) 973-6931	**VACANT**
San Francisco	2425 Geary Blvd San Francisco, CA 94115	**Rochelle (Marie) Arenas** (415) 833-6686 (415) 314-8531 (cell)	**Joan Ngando-Agbor** (415) 833-7837	**VACANT**
San Jose	250 Hospital Parkway San Jose, CA 95119	**Evigeniy Satanovskiy** (408) 728-1264 (cell)	**Maria C. Arevalo** (408) 972-6424 **Christyle Tabuan** (Interim)	**Greg Dalder** (408) 927-9817
San Leandro	2500 Merced Street San Leandro, CA 94577	**Irina Y. Lewis** (510) 454-4831	**Shirley Ng (Mgr)** (510) 363-6041 **Paula Breen (ANM)** (510) 362-6497	**Clay Van Batenburg** (510) 454-4954

Location	Address	COCSD	UM/RM Manager	Social Worker
San Rafael	99 Montecillo Road San Rafael, CA 94903	**Ruth Vosmek** (415) 444-4689	**Cyntia Boter** (415) 444-4880	**Ruth Vosmek** (415) 444-4689
Santa Clara	700 Lawrence Expressway Dept. 312 Santa Clara, CA 95051	**VACANT**	**Janarei Castillo** (408) 851-7047 (408) 529-7616 (cell) **Shefalia Singla** (408) 594-6383 **Teresa Raya (ANM)** (408) 594-6686 (cell)	**George Fogle** (408) 851-7090
Santa Rosa	401 Bicentennial Way Santa Rosa, CA 95403	**Janet A Cappurro** (707) 393-4619 (707) 328-7098 (cell)	**Karen Hulsey** (707) 393-4302 (707) 806-4617 (cell) **Diana Samour (ANM)** (707) 867-2313	**Diane Sloves** (707) 393-3149
South Sacramento	6601 Bruceville Road, South Sacramento, CA 95823	**Baljinder (Pepi) Lall** (916) 688-2997 (916) 203-0347 (cell)	**Sukheet (Sukhee) Gill** (916) 688-6519 (916) 531-9491 (cell)	**Jennifer Park** (916) 686-2998
South San Francisco	1200 El Camino Real South San Francisco, CA 94080	**Margaret Williams** (925) 788-1278 (cell)	**VACANT**	**Sharmila Grant** (650) 742-3085
Stockton	1800 N California St Stockton, CA 95204	**Julie Ann Gist** (209) 735-4207 (209) 402-6953 (cell)	**Kelly Widger** (209) 402-1840 (cell)	**N/A** **(See Modesto)**
Vacaville	One Quality Drive Vacaville, CA 95687	**Deborah Aragon** (707) 624-1007	**VACANT** (See COCSD)	**Charlotte Richardson** (707) 624-2572
Vallejo and Vallejo Rehab	975 Sereno Boulevard Vallejo, CA 94589	**Carrie Robertshaw** (707) 651-3521 (707) 334-8417 (cell)	**Joan Divinagracia** (707) 651-1593	**Jean Broadnax** (707) 651-4423
Walnut Creek	1425 South Main Street Lilac Building #29 Walnut Creek, CA 94596	**Miraslava Harter** (925) 295-4473 (925) 239-9391 (cell)	**Joanna Macinning** (925) 393-1749 (cell) **Bernadette Yee** (925) 393-4768 (cell)	**Carol McMenamy** (925) 295-5128

Location	Address	COCSD	UM/RM Manager	Social Worker
Watsonville Community Hospital		**See San Jose: Evgeniy Satanovskiy** (408) 728-1264		

Resource Management Functional Unit
5820 Owens Drive, Building E, 4th Floor
Pleasanton, CA 94588

Health Plan Utilization Management

Jeffrey Trinidad, MSN, RN
Regional Director Quality and Safety Oversight Health Plan (925) 354-1204

3. Eligibility and Benefits Determination

3.1 Eligibility and Benefit Verification

Providers are responsible for verifying Members' eligibility and benefits. Each time a Member presents at the office for services, Providers should:

- Verify the patient's current eligibility status
- Verify covered benefits
- Obtain necessary authorizations (if applicable)

Do not assume that eligibility is in effect because a person has a Health ID Card. Please check a form of photo identification to verify the identity of the Member. Except in an emergency situation, the Provider must verify that the Member has a benefit for the service prior to providing services.

Providers are invited and encouraged to utilize KP's **Online Affiliate** to verify member eligibility and benefits.

To access the KP Online Affiliate portal, click on the following link, choose your region and nagivate to the Online Provider section: **https://kp.org/providers**

Alternately, contact the Member Services Contact Center (MSCC) to verify the Member's eligibility and benefits. It is important to verify the availability of benefits for services before rendering the service so the Member can be informed of any potential payment responsibility. If services are provided to a Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, KFHP may not be obligated to pay for those services.

Member Services Contact Center representatives are available Monday - Friday from 8AM to 5PM, Pacific Time (PT) at (888) 576-6789

By calling MSCC, providers may verify Member eligibility and benefits, and/or speak with a Member Services representative. Please be prepared to provide the Member's name and MRN which is located on the KP Health ID card.

Self-Service is available in the IVR System 24 hours per day, 7 days per week at (888) 576-6789.

3.1.1 After Hours Eligibility Requests

Providers may contact KP 24 hours per day, 7 days per week to verify benefits and eligibility. Providers are invited and encouraged to request access to KP's Online Affiliate tool. Please see the Northern California Community Provider Portal (CPP) for more information at:

http://kp.org/providers/ncal/

Alternately, you may call the IVR system of the KP Member Services Contact Center to verify benefits and eligibility 24 hours per day, 7 days per week at: **(888) 576-6789**.

You may also request the patient complete a financial responsibility form that places payment responsibility on the patient in the event they are later found to be ineligible as a Member or the care provided is not a covered benefit. A financial responsibility form is not required for provision of emergency services; however, KFHP will not pay for emergency or unauthorized services provided if the person is not a Member.

3.1.2 Benefit Coverage Determination

In addition to eligibility, Providers must confirm that the Member has coverage for the services at issue prior to providing such services to a Member, usually by requesting an authorization or receiving a referral from KP. Section 4.3 of this Provider Manual provides further details on the process for obtaining referrals and authorizations, except in cases of emergency.

3.2 Membership Types

The table below generally describes the different HMO membership types.

Membership Type	Membership Defined	Covered Benefits Defined By:
Commercial	Members who purchase HMO coverage on an individual basis (other than Medicare) Members who are covered as part of an employer group and are not Medicare-eligible	Evidence of Coverage (EOC)
Medicare Advantage (formerly known as Medicare + Choice) (aka Senior Advantage)	Individual Medicare beneficiaries who have assigned their Medicare benefits to KP by enrolling in the KP Senior Advantage Program	Medicare, with additional benefits provided by KP as described in the EOC
	Employer group retirees or otherwise Medicare- eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to KP by enrolling the KP Senior Advantage Program	Medicare, with additional benefits provided by KP as described in the EOC
State Programs (Medi-Cal, Healthy Families)	Contact the Member Services Contact Center (MSCC) for detailed information specific to your geographic area.	Contact MSCC for detailed information specific to your geographic area.

3.3 Benefit Exclusions and Limitations

KFHP benefit plans may be subject to limitations and exclusions. Before rendering services, it is important to contact MSCC to obtain information on, and verify the availability of, Member benefits for services so the Member can be informed of any potential payment responsibility.

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

3.4 Drug Benefits

The drug benefits vary based on the benefit plan. To verify if a Member has a drug benefit, please contact MSCC.

4. Utilization Management (UM) and Resource Management (RM)

4.1 Overview of Utilization Management and Resource Management Program

KFHP, KFH, and TPMG share responsibility for Utilization Management (UM) and Resource Management (RM). KFHP, KFH, and TPMG work together to provide and coordinate RM through retrospective monitoring, analysis and review of the utilization of resources for a full range of outpatient and inpatient services delivered to our Members by physicians, hospitals, and other health care practitioners and providers. RM does not affect service authorization. KP does, however, incorporate the utilization of services rendered by Providers into the data sets we study through RM.

UM is a process used by KP for a select number of health care services requested by the treating provider to determine whether or not the requested service is medically indicated and appropriate. If the requested service is medically indicated and appropriate, the service is authorized and the Member will receive the services in a clinically appropriate place consistent with the terms of the Member's health coverage. UM activities and functions include the prospective (prior to authorization), retrospective (claims review), or concurrent review (while Member is receiving care) of health care services. The decisions to approve, modify, delay, or deny the request are based in whole or in part on appropriateness and indication. The determination of whether a service is medically indicated and appropriate is based upon criteria developed with the participation of actively practicing physicians. The criteria are consistent with sound clinical principles and processes reviewed and approved annually and updated as needed.

KP's utilization review program and processes follow statutory requirements contained in California's Health and Safety Code (H&SC)/Knox-Keene Health Care Service Plan Act. In addition, the UM process adheres to managed care plan NCQA accreditation, CMS, DMHC, and DHCS standards.

4.1.1 Data Collection and Surveys

KP collects UM data to comply with state and federal regulations and accreditation requirements. Evaluation of UM data identifies areas for improvement in inpatient and outpatient care.

KP conducts Member and practitioner satisfaction surveys on a regular basis to identify patterns, trends, and opportunities for performance improvement related to UM processes.

UM staff also monitor and collect information about the appropriateness and indication of health care services and benefits-based coverage decisions. Appropriately licensed health care professionals supervise all UM and RM processes.

4.2 Medical Appropriateness

In making UM decisions, KP relies on written criteria of appropriateness and indication developed in collaboration with practicing physicians. The criteria are based on sound clinical evidence and developed in accordance with established policies and compliance with statutory requirements. Only appropriately licensed health care professionals make UM decisions to deny, delay or modify provider requested services. All UM decisions are communicated in writing to the requesting physician. Each UM denial notification includes a clinical explanation of the reasons for the decision and the criteria or guidelines used to determine appropriateness and indication of care or services. UM decisions are never based on financial incentive or reward to the reviewing UM physician.

Plan Physicians designated as UM reviewers may be physician leaders for Outside Referral Services, physician experts and specialists (e.g., DME), and/or members of physician specialty boards or committees (e.g., Organ Transplant). These physicians have current, unrestricted licenses to practice medicine in California and have appropriate education, training, and clinical experience related to the requested health care service. When necessary, consultation with board certified physicians in the associated subspecialty is obtained to make a recommendation with respect to a UM decision.

4.3 "Referral" and "Authorization" – General Information

Prior authorization is a UM process that is required for certain health care services. However, no prior authorization is required for Members seeking emergency care.[1]

Plan Physicians offer primary medical, behavioral health, pediatric, and OB-GYN care as well as specialty care. However, Plan Physicians may refer a Member to a non-plan Provider when the Member requires covered services and/or supplies that are not available in Plan or cannot be provided in a timely manner. The referrals process originates at the

[1]An emergency medical condition means (i) as defined in California Health & Safety Code 1317.1 for Members subject to the Knox-Keene Act (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the Member's health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or (b) a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member an immediate danger to themselves or others, or immediately unable to provide for, or utilize, food, shelter or clothing due to the mental disorder; or (ii) as otherwise defined by applicable law (including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) in 42 United States Code 1395dd and its implementing regulations)

facility level and the Assistant Physicians-In-Chief (APICs) for Outside Services (Referrals) are responsible for reviewing the appropriateness, indication and availability of services for which a referral has been requested.

The request for a referral to a non-Plan provider (Outside Referrals) is subject to prior authorization and managed at the local facility level. Once the referral is submitted, it is reviewed by the facility and the APICs for Outside Referrals to determine whether services are available in Plan. If not, the APIC will confirm appropriateness and indication with the requesting physician or designated specialist based on their clinical judgment and approve the Outside Referral request. Outside Referrals for specific services such as DME, solid organ and bone marrow transplants are subject to prior authorization using specific UM criteria. These health care service requests are reviewed for appropriateness and indication by specialty boards and physician experts.

When KP approves Referrals for a Member, the provider receives a written Authorization for Medical Care communication, which details the name of the referring Plan Physician, the level and scope of services authorized, and the number of visits and/or duration of treatment. The Member receives a letter that indicates a referral has been approved for the Member to see a specific Provider. Any additional services beyond the scope of the authorization must have prior approval. To receive approval for additional services, the Provider must contact the referring physician.

Authorized services must be rendered before the authorization expires or before notice from KP that the authorization is canceled. The expiration date is noted in the Authorization for Medical Care communication and/or the Patient Transfer Referral form.

For assistance in resolving administrative and patient issues (e.g., member benefits and eligibility), please contact MSCC. For authorization status or questions about the referral process, please call the number for Referral Questions listed on the Authorization form.

4.4 Authorization of Services

Prior authorization is required as a condition of payment for any inpatient and outpatient services (excluding emergency services) that are otherwise covered by a Member's benefit plan.

In the event additional services were rendered to the Member without prior authorization (other than investigational or experimental therapies or other non-covered services), the Provider will be paid for the provision of such services in a licensed acute care hospital if the services were related to services that were previously authorized and when all the following conditions are met:

1. The services were medically necessary at the time they were provided;
2. The services were provided after KP normal business hours; and

3. A system that provides for the availability of a KP representative or an alternative means of contact through an electronic system, including voice mail or electronic mail, was not available. For example, KP could not/did not respond to a request for authorization within 30 minutes after the request was made.

NOTE: Authorization from KP is required even when KP is the secondary payor.

4.4.1 Hospital Admissions Other Than Emergency Services

A Plan Physician may refer a Member to a hospital for admission without prior UM review. The RM staff conducts an initial review within 24 hours of admission using hospital stay criteria to confirm the appropriate level of care and the provision of services. KP Referral Patient Care Coordinator Case Managers (PCC-CMs) are responsible for notifying the treating physician of the review outcome.

4.4.2 Admission to Skilled Nursing Facility (SNF)

If the level of care is an issue or other services better meet the clinical needs of the Member, a PCC-CM will notify the ordering/treating physician to discuss alternative treatment plans, including admission to a SNF.

A Plan Physician may refer a Member for skilled level of care at a SNF. The service authorization is managed by a PCC-CM and includes a description of specific, approved therapies and other medically necessary skilled nursing services per Medicare Guidelines.

The initial skilled care authorizations are based on the Member's medical needs at the time of admission, the Member's benefits, and eligibility status. The Member is informed by a PCC-CM as to what their authorized and anticipated length of stay may be. The Member's clinical condition and physician assessment will inform the final determination during the Member's course of care in the SNF.

The SNF may request an extension of an authorization for continued stay. This request is submitted to the SNF Care Coordinator. This request is reviewed for appropriateness and indication and may be denied when the patient does not meet skilled services criteria per Medicare Guidelines. The SNF Care Coordinator conducts telephonic or onsite reviews at least weekly to evaluate the Member's clinical status, level of care needs, and to determine if continuation of the authorization is appropriate. Based on the Member's skilled care needs and benefit eligibility, more SNF days may be approved. If additional days are authorized, the SNF will receive a written authorization from KP.

Other services associated with the SNF stay are authorized when either the Member's Plan Physician or other KP designated specialist expressly orders such services. These services may include, but are not limited to, the following items:

- Laboratory and radiology services

- Special supplies or DME
- Ambulance transport (when Member meets criteria)

4.4.2.1 Authorization Numbers are Required for Payment

KP requires that authorization numbers be included on all claims submitted by not only SNFs, but all ancillary providers that provide services to KP Members (e.g., mobile radiology vendors).

These authorization numbers **must** be provided by the SNF to the rendering ancillary services provider, preferably at time of service. Because authorization numbers may change, it is critical that the authorization number reported on the claim be valid for the date of service provided. Please note that the correct authorization number for the ancillary service providers may not be the latest authorization issued to the SNF.

It is the responsibility of the SNF to provide the correct authorization number(s) to all ancillary service providers at time of service. If SNF personnel are not sure of the correct authorization number, please contact KP's SNF Care Coordinator for confirmation.

4.4.3 Home Health/Hospice Services

Both home health and hospice services must meet the following criteria for the Member to be admitted to service:

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

4.4.3.1 Home Health Specific Criteria

Criteria for coverage include:

- The services are medically necessary for the Member's clinical condition
- The patient is homebound, which is defined as an inability to leave home without the aid of supportive devices, special transportation or the assistance of another person.

A patient may be considered homebound if absences from the home are infrequent and of short distances. A patient is not considered homebound if lack of transportation or inability to drive is the reason for being confined to the home

- The patient and/or caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals

4.4.3.2 Hospice Care Criteria

Criteria for coverage include:

- The patient is certified as being terminally ill and meets the criteria of the benefit guidelines for hospice services.

4.4.4 Durable Medical Equipment (DME)/ Prosthetics and Orthotics (P&O)

Prior Authorization is required for DME and P&O. KP evaluates authorization requests for appropriateness based on, but not limited to:

- The Member's care needs
- The application of specific benefit guidelines
- For further information on ordering DME, please contact the assigned KP Case Manager

4.4.5 Psychiatric Hospital Services Other Than Emergency Services

Plan Physicians admit Members to psychiatric facilities by contacting the KP Psychiatry/ Call Center Referral Coordinator. Once a bed has been secured, KP will generate an authorization confirmation for the facility Provider.

4.4.6 Non-Emergent Transportation

To serve our Members and coordinate care with our Providers, KP has a 24 hour, 7 day per week, centralized medical transportation department called the "HUB", to coordinate and schedule non-emergency medical transportation. The HUB can be reached at **(800) 438-7404**.

4.4.6.1 Non-Emergency Medical Transport (Gurney Van/Wheelchair Van)

Non-Emergency Medical Transport services requires prior authorization from KP. Providers must call the KP HUB to request non-emergency medical transportation.

Non-emergency medical transportation may or may not be a covered benefit for the Member. Payment may be denied for non-emergency medical transportation unless KP issued a prior authorization and the transportation was coordinated through the HUB.

4.4.6.2 Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation must be authorized and coordinated by the KP HUB. If a Member requires non-emergency ambulance transportation to a KP Medical Center or any other location designated by KP, Providers may contact KP to arrange the transportation of the Member through the HUB. Providers should not contact any ambulance company directly to arrange an authorized non-emergency ambulance transportation of a Member.

Non-emergency ambulance transportation may or may not be a covered benefit for the Member. Payment may be denied for ambulance transport of a Member unless KP issued a prior authorization and the transportation was coordinated through the HUB.

4.4.7 Transfers to a KP Medical Center

If, due to a change in a Member's condition, the Member requires a more intensive level of care than your facility can provide, you can request a transfer of the Member to a KP Medical Center. The Care Coordinator or designee will arrange the appropriate transportation through KP's medical transportation HUB.

Transfers to a KP Medical Center should be made by the facility after verbal communication with the appropriate KP staff, such as a TPMG SNF physician or the Emergency Department physician. Contact a Care Coordinator for a current list of telephone numbers for emergency department transfers.

If a Member is sent to the Emergency Department via a 911 ambulance and it is later determined by KP that the 911 ambulance transport or emergency department visit was not medically necessary, KP may not be obligated to pay for the ambulance transport.

4.4.7.1 Required Information for Transfers to KP

Please send the following written information with the Member:

1. Name of Member's contact person (family member or authorized representative) and telephone number
2. Completed inter-facility transfer form
3. Brief history (history and physical, discharge summary, and/or admit note)
4. Current medical status, including presenting problem, current medications and vital signs

5. A copy of the patient's Advance Directive/Physician Orders for Life Sustaining Treatment (POLST)
6. Any other pertinent medical information, i.e., lab/x-ray

If the Member is to return to the originating facility, KP will provide the following written information:

1. Diagnosis (admitting and discharge)
2. Medications given; new medications ordered
3. Labs and x-rays performed
4. Treatment(s) given
5. Recommendations for future treatment; new orders

4.4.8 Visiting Member Guidelines

KP Members who access routine and specialty health services while they are visiting another KP region are referred to as "visiting Members." Certain KP health benefit plans allow Members to receive non-urgent and non-emergent care while traveling in other KP regions. The KP region being visited by the Member is referred to as the "Host" region, and the region where a Member is enrolled is their "Home" region.

Visiting Members to KPNC are subject to the UM and prior authorization requirements set forth in the visiting Member's coverage documents.

Your first step when a visiting Member has been referred to you by KP:

- Review the Member's Health ID Card. The KP "Home" region is displayed on the face of the card. Confirm the Member's "Home" region MRN.

- Verify "Home" region benefits, eligibility and cost share via Online Affiliate (see Section 3.1).or by calling the "Home" region's Member Services Contact Center (number provided on the identification card).

- If the Member does not have their Health ID Card, call the Member's "Home" region at the number provided in the table at the end of this section.

- Services are covered according to the Member's contract benefits, which may be subject to exclusions as a visiting Member. Providers should identify the Member as a visiting Member when verifying benefits with the "Home" region.

The KP MRN identified on the KP authorization will not match the MRN on the visiting Member's KP ID card:

- Visiting Members require KPNC to establish a "Host" MRN for all authorizations. * When communicating with KPNC about authorization matters, reference the "Host" MRN. The "Home" MRN should only be used on claims, as detailed in Section 5.2.

- Contractors should always verify any Member's identity by requesting a picture ID prior to rendering services.

*EXCEPTION: for DME authorizations, contact the "Home" region at their number below.

Regional Member Services Call Centers	
Northern California	(800)-464-4000
Southern California	(800)-464-4000
Colorado	(800) 632-9700
Georgia	(888) 865-5813
Hawaii	(800) 966-5955
Mid Atlantic	(800) 777-7902
Northwest	(800) 813-2000
Washington (formerly Group Health)	(888) 901-4636

4.5 Emergency Admissions and Services; Hospital Repatriation Policy

Consistent with applicable law, KP Members are covered for emergency care to stabilize their clinical condition. An emergency medical condition means (i) as defined in California Health & Safety Code 1317.1 for Knox-Keene Members (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the Member's health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part or (b) a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member an immediate danger to themselves or others, or immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental disorder; or (ii) as otherwise defined by applicable law (including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) in 42 United States Code 1395dd and its implementing regulations).

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

Emergency Services

- If Emergency Services are provided to screen and stabilize a patient in California, they are covered in situations when an emergency condition (as defined above) existed
- Once a patient is stabilized, the treating physician is required to communicate with KP for approval to provide further care (see Section 4.5.1) or to effect transfer

Emergency Claim

The following circumstances will be considered when the bill is processed for payment:

- Whether services and supplies are covered under the Member's benefit plan
- Members have varying benefit plans, and some benefit plans may not cover continuing or follow-up treatment at a non-plan facility. Therefore, the Provider should contact KP's Emergency Prospective Review Program (EPRP) prior to furnishing post-stabilization services.

4.5.1 Emergency Prospective Review Program (EPRP)

EPRP provides a statewide notification system relating to emergency services for Members. Prior authorization is not required for emergency admissions. Post-stabilization care at a non-Plan facility must have prior authorization by EPRP. EPRP must be contacted prior to a stabilized Member's admission to a non-Plan facility. KP may arrange for medically necessary continued hospitalization at the facility or transfer of the Member to another hospital after the Member is stabilized.

When a Member presents in an emergency room for treatment, we expect the Provider to triage and treat the Member in accordance with EMTALA requirements, and to contact EPRP once the Member has been stabilized or stabilizing care has been initiated.* The Provider may contact EPRP at any time, including prior to stabilization to the extent legally and clinically appropriate, to receive relevant patient-specific medical history information which may assist the Provider in its stabilization efforts and any subsequent post-stabilization care. EPRP has access to Member medical history, including recent test results, which can help expedite diagnosis and inform further care.

* Under the EMTALA regulations Providers may, but are not required to, contact EPRP once stabilizing care has been initiated but prior to the patient's actual stabilization if such contact will not delay necessary care or otherwise harm the patient.

EPRP
(800) 447-3777
Available 7 days a week
24 hours a day

EPRP is available 24 hours a day, every day of the year and provides:

- Access to clinical information to help the Provider in evaluating a Member's condition and to enable our physicians and the treating physicians at the facility to quickly determine the appropriate treatment for the Member
- Emergency physician to emergency physician discussion regarding a Member's condition
- Authorization of post-stabilization care or assistance with making appropriate alternative care arrangements

4.5.2 Post-Stabilization Care

If there is mutual agreement at the time of the phone call as to the provision of post-stabilization services, EPRP will authorize the Provider to provide the agreed services and issue a confirming authorization number. If requested, EPRP will also provide, by fax or other electronic means, a written confirmation of the services authorized and the confirmation number. KP will send a copy of the authorization to the facility's business office within 24 hours of the authorization decision. This authorization number must be included with the claim for payment for the authorized services. The authorization number is required for payment, along with all reasonably relevant information relating to the post-stabilization services on the claim submission consistent with the information provided to EPRP as the basis for the authorization.

EPRP must have confirmed that the Member was eligible for and had benefit coverage for the authorized post-stabilization services provided prior to the provision of post-stabilization services.

If EPRP authorizes the admission of a clinically stable Member to the facility, KP's Outside Services Case Manager will follow that Member's care in the facility until discharge or transfer.

EPRP may request that the Member be transferred to a KP-designated facility for continuing care or EPRP may authorize certain post-stabilization services in your facility. In many cases, such post-stabilization services will be rendered under the management of a physician who is a member of your facility's medical staff and who has contracted with KP to manage the care of our Members being treated in community hospitals.
EPRP may deny authorization for some or all post-stabilization services. The verbal denial of authorization will be confirmed in writing. If EPRP denies authorization for requested post-stabilization care, KP shall not have financial responsibility for services if the Provider nonetheless chooses to provide the care. If the Member insists on receiving such unauthorized post-stabilization care from the facility, we strongly recommend that the facility require that the Member sign a financial responsibility form acknowledging and accepting his or her sole financial liability for the cost of the unauthorized post-stabilization care and/or services.

If the Member is admitted to the facility as part of the stabilizing process and the facility has not yet been in contact with EPRP, the facility must contact the local Outside Services Case Manager at the appropriate number (see contact information in Section 2 of this Provider Manual) in order to discuss authorization for continued admission as well as any additional appropriate post-stabilization care once the Member's condition is stabilized.

4.6 Concurrent Review

The Northern California Outside Utilization Resource Services (NCAL OURS) Office and Plan Physicians will conduct concurrent review in collaboration with facilities. The review may be done telephonically or on site in accordance with the facility's protocols and KP's onsite review policy and procedure, as applicable.

Prior authorization is not required for out-of-plan hospitals rendering screening and stabilizing services in California. Outside Services Case Managers work with physicians to concurrently evaluate the appropriateness and indication of the out-of-plan care. KP will facilitate transfer and coordinate the continuing care needed by Members who are determined to be clinically stable for transfer to a KFH or contracting hospital.

When utilization problems are identified, KP will work with the facility to develop and implement protocols that are intended to improve the provision of services for our Members. A joint monitoring process will be established to observe for continued improvement and cooperation.

NCAL OURS and the Providers collaborate on concurrent review activities that include, but are not limited to:

- monitoring length of stay/visits
- providing day/service authorization, recertification, justification
- attending patient care conferences and rehabilitation meetings
- utilizing community benchmarking for admissions and average length of stay (ALOS)
- setting patient goal for Members
- conducting visits or telephonic reports, as needed
- developing care plans

4.7 Case Management Hub Contact Information

The specific contact information for NCAL OURS is as follows:

Main Phone Line:	**(925) 926-7303**
Toll free phone line:	**1-888-859-0880**
eFax:	**1-877-327-3370**

The NCAL OURS office is located in Walnut Creek, providing support for all Northern California KP Members admitted in any non-KP hospital, including those Members admitted out of the KP service area and out of the country.

4.8 Denials and Provider Appeals

Information about a denial or the appeal procedures is available via **Online Affiliate** (see section 3.1) or by contacting the Coverage Decision Support Unit (CDSU) or Member Services Contact Center (MSCC). Please refer to the written denial notice for applicable contact information or contact MSCC.

When a denial is made, the Provider is sent a UM denial letter accompanied by the name and direct telephone number of the decision-maker. All decisions concerning appropriateness and indication are made by physicians or licensed clinicians (as appropriate for behavioral health services). Physician UM decision-makers include, but are not limited to, DME physician champions, APICs for Outside Services, Pediatric Developmental Care Coordination Program (PDCP), other board-certified physicians or behavioral health practitioners.

If the physician or behavioral health practitioner does not agree with a decision concerning appropriateness and indication, the Provider may contact the UM decision-maker on the cover page of the letter or the Physician-in-Chief for discussion at the local facility. Providers may also contact the issuing department that is identified in the letter for additional information.

4.9 Discharge Planning

Providers such as hospitals and inpatient psychiatric facilities are expected to provide discharge planning services for Members, and to cooperate with KP to assure timely and appropriate discharge when the treating physician determines that the member no longer needs acute inpatient level care.

Providers should designate staff to provide proactive, ongoing discharge planning. Discharge planning services should begin upon the Member's admission and be completed by the medically appropriate discharge date. The Provider's discharge planner must be able to identify barriers to discharge and determine an estimated date of discharge. Upon request by KP, Providers will submit documentation of the discharge planning process.

The Provider's discharge planner, in consultation with the Care Coordinator, will arrange and coordinate transportation, DME, follow-up appointments, appropriate referrals to community services and any other services requested by KP.

The Provider must request prior authorization for medically necessary follow-up care after discharge.

4.10 UM Information

To facilitate KP UM oversight, the Provider may be requested to provide information to the KP UM staff concerning the Provider's facility. Such additional information may include, but is not limited to, the following data:

- Number of inpatient admissions
- Number of inpatient readmissions within the previous 7 days
- Number of emergency department admissions
- Type and number of procedures performed
- Number of consults
- Number of deceased Members
- Number of autopsies
- Average Length of Stay (ALOS)
- Quality Assurance/Peer Review process
- Number of cases reviewed
- Final action taken for each case reviewed
- Committee Membership (participation as it pertains to Members and only in accordance with the terms of your contract)
- Utilization of psychopharmacological agents
- Other relevant information KP may request

4.11 Case Management

Care Coordinators work with treating Providers to develop and implement plans of care for acutely ill, chronically ill or injured Members. KP case management staff may include nurses and social workers, who assist in arranging care in the most appropriate setting and help coordinate other resources and services.
The PCP continues to be responsible for managing the Member's overall care. It is the Provider's responsibility to send reports to the referring physician, including the PCP, of any consultation with, or treatment rendered to, the Member. This includes any requests for authorization or Member's inclusion in a case management program.

4.12 Clinical Practice Guidelines (CPGs)

KP supports the development and use of evidence-based CPGs to aid clinicians and Members in the selection of appropriate prevention, screening, diagnostic, and treatment options. The CPGs provide recommendations for the preferred course of action for most individuals, while recognizing the role of clinical judgment and informed decision making in determining exceptions. Established guidelines are reviewed and updated every two years or earlier when new evidence emerges. CPGs are distributed to practitioners and copies of the guidelines can be obtained by calling (510) 625-6343 or on the clinical library: http://clm.kp.org.

4.13 Pharmacy Services / Drug Formulary

KP has developed a quality, cost effective pharmaceutical program which includes therapeutics and formulary management. The Regional Pharmacy and Therapeutics (P&T) Committee reviews and promotes the use of the safest, most effective, and cost-effective drug therapies, and shares "Best Practices" with all KP Regions. The Regional P&T Committee's Formulary evaluation process is used to develop the applicable KP Drug Formulary (Formulary) for use by KP practitioners. Contracted practitioners are encouraged to use and refer to the Regional Drug Formulary when prescribing medication for Members (available at **http://kp.org/formulary**). Drug Coverage and Benefit policies can be found at:
https://kpnortherncal.policytech.com under the section, Pharmacy Policies: Drug Coverage Benefits.
For KP Medi-Cal Members without an alternate, primary coverage, medically necessary
drugs, supplies and supplements are covered by DHCS, not KP. Coverage is based on the DHCS Contract Drug List guidelines and Medi-Cal coverage criteria. The DHCS Drug Formulary, called the Contract Drug List, can be accessed on-line at:

https://medi-calrx.dhcs.ca.gov/home/cdl/

Pharmacy Benefits

Pharmacy services are available for Members who have benefit plans that provide coverage for a prescription drug program. For information on specific member benefit plans, please contact MSCC.

4.13.1 Filling Prescriptions

The Formulary can be accessed online in a searchable format. It provides the list of drugs approved for general use by prescribing practitioners. For access to the online version of the Formulary on the Internet or to request a paper copy, please refer to the instructions at the end of this section.

KP pharmacies do not cover prescriptions written by non-Plan Physicians unless an authorization for care by that non-Plan Physician has been issued. Please remind Members they must bring a copy of their authorizations to the KP pharmacy when filling the prescription. In limited circumstances, members may have a benefit plan design that covers prescriptions from non-KP Providers, such as for psychotropic drugs or IVF medications.

Practitioners are expected to prescribe drugs included in the Formulary unless at least one of the exceptions listed under "Prescribing Non-Formulary Drugs" in this section is met. If there is a need to prescribe a non-Formulary drug, the exception reason must be indicated on the prescription.

A Member may request a Formulary exception by contacting their KP physician directly through secure messaging or through the MSCC and will typically receive a response, including the reason for any denial, within 2 Business Days from receipt of the request.

Members will be responsible for paying the full price of their medication if the drugs requested are (i) non-Formulary drugs not required by their health condition, (ii) excluded from coverage (i.e., cosmetic use, weight loss) or (iii) not prescribed by an authorized or Plan Provider. Any questions should be directed to the MSCC.

4.13.1.1 Prescribing Non-Formulary Drugs

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

- **New Members**
  If needed and the Member's benefit plan provides, new Members may be covered for an initial supply (up to 100 days for Commercial Members and at least a month's supply of medication for Medicare Members) of any previously prescribed "non-Formulary" medication to allow the Member time to make an appointment to see a KP provider. If the Member does not see a KP provider within the first 90 days of enrollment, they must pay the full price for any refills of non-Formulary medications.
- **Existing Members**
  A non-Formulary drug may be prescribed for a Member if they have an allergy, or intolerance to, or treatment failure with all Formulary alternatives or has a special need that requires the Member to receive a non-Formulary drug. In order for the Member to continue to receive the non-Formulary medication covered under their drug benefit, the exception reason must be provided on the prescription.

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

The KP Formulary may be found at**: http://kp.org/formulary.**

4.13.1.2 Pharmacies

KP pharmacies provide a variety of services including: filling new prescriptions, transferring prescriptions from another pharmacy, providing refills and medication consultations.

4.13.1.3 Telephone and Internet Refills

Members may request refills on their prescriptions, with or without refills remaining, by calling the pharmacy refill number on their prescription label. All telephone requests should be accompanied by the Member's name, MRN, daytime phone number, prescription number and credit or debit card information.

Members may also refill their prescriptions online by accessing the KP Member website at **http://www.kp.org/refill**.

4.13.1.4 Mail Order

Members with a prescription drug benefit are eligible to use the KP "Prescription by Mail" service. For more information regarding mail order prescriptions please contact the Mail Order Pharmacy at **(888) 218-6245**.

Only maintenance medications should be ordered for delivery by mail. Acute prescriptions such as antibiotics or pain medications should be obtained through a KP pharmacy to avoid delays in treatment.

4.13.1.5 Restricted Use Drugs

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

4.13.1.6 Emergency Situations

If emergency medication is needed when KP pharmacies are not open, Members may use non-KP pharmacies. The Member will have to pay the full retail price in this situation, they should be instructed to submit or download a claim form on **https://kpclaimservices.com/Resources/Submit-a-Claim** or to call Member Services at **(800) 464-4000** (**TTY: 711)** to obtain a claim form in order to be reimbursed for the cost of the prescription less any copayments, co-insurance and/or deductibles (sometimes called Member Cost Share) which may apply.

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. KFHP is responsible for payment of claims in accordance with your Agreement. Please note that this Provider Manual does not address submission of claims for fully insured or self-funded products underwritten or administered by Kaiser Permanente Insurance Company (KPIC).

5. Claim Billing and Payment Policies and Procedures

5.0 Introduction

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

Provider Manual | Kaiser Permanente Washington

5.1 Provider Responsibilities to Ensure Prompt Billing and Payment

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

5.2 Claim Payment Policy

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

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

5.3 Electronic Claim Submission

KP requests Providers submit claims electronically via Electronic Data Interchange (EDI).
EDI is an automated exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI replaces the submission of physical paper claims and allows for faster and more efficient claims adjudication and payment. Providers must submit their EDI claim through a clearinghouse. Each clearinghouse assigns a unique payer identifier (Payer ID) for KP. The table below lists Payer IDs for KP's affiliated direct clearinghouses.
If your current clearinghouse is not listed below, it is still possible to send EDI claims to KP. Clearinghouses have channel partner agreements that allow them to route claims to KP. Please contact your clearinghouse for guidance on which of the below clearinghouses they partner with, and which Payer ID to use.

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

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

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

5.3.1 EDI Claims Acknowledgement

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

NOTE: If you are not receiving electronic claim reports from your clearinghouse, contact your clearinghouse to request them.
Click here to access KP's EDI Guide and a listing of KP contracted clearinghouses by region: https://online.flippingbook.com/view/704125376/i/

5.4 Supporting Documentation

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

When additional information is required, it will be requested.

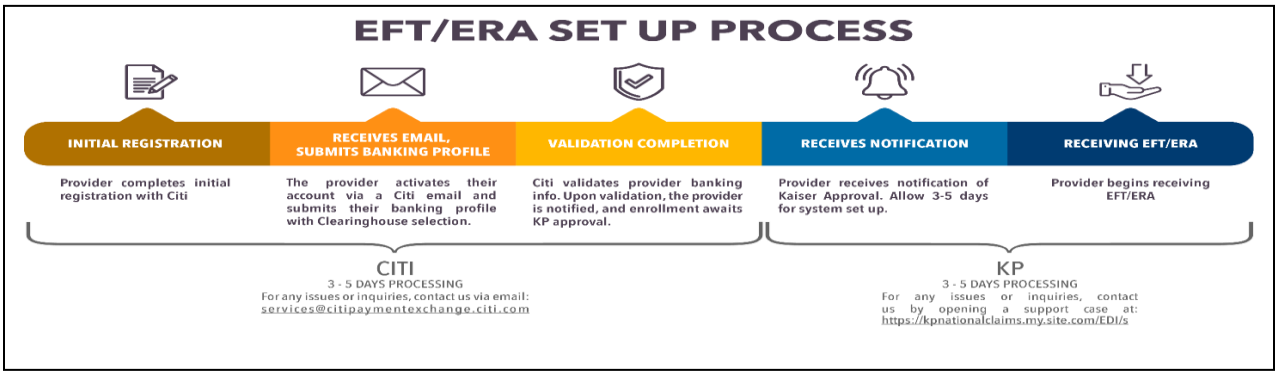
Examples of additional information include but are not limited to:

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

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

5.5 Electronic Payment and Remittance Advice Online Enrollment

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



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

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

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

NOTE: To receive electronic payments or Electronic Remittance Advices, Providers MUST be contracted with KP or MUST have successfully submitted a claim to the applicable KP Region.
For additional enrollment information, please click on the following link: https://online.flippingbook.com/view/704125376/i/.
For questions regarding enrollment status or failure to receive EFT payments and ERAs, after allowing 7-10 business days for initial enrollment, please contact KP EDI Support team by clicking on the following link: https://kpnationalclaims.my.site.com/EDI/s/.

5.6 Self-Service Provider Portal (KP Online Affiliate) Enrollment

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

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

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

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

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

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

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

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

5.7 Claims Submission

5.7.1 Methods of Paper Claims Submission

KP requests (and your Agreement may require) electronic submission of claims; however, if electronic claim submission is not possible, paper claims may be submitted.
Providers must submit itemized claims for Covered Services provided to Members using a Centers for Medicare & Medicaid Services (CMS)-approved Claims Billing Form. KP does not accept claims that are handwritten, faxed, or photocopied. All claims must be submitted with appropriate coding.

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

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

All Claims should be sent to the appropriate KP Region as listed in section 5.24.1.

5.8 Claim Submission Requirements

5.8.1 Member Information

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

5.8.2 Record Authorization Number

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

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

5.8.3 One Member and One Provider per Claim Form

Complete separate claim forms for each Member and each Provider.

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

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

5.8.5 Billing Inpatient Claims That Span Different Years

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

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

5.8.6 Billing Outpatient Claims That Span Different Years

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

5.8.7 Interim Inpatient Bills

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

- Follow CMS billing requirements for interim inpatient facility claims.
- Use the same patient control number/account number for interim facility claims as on the initial claim.
- KP accepts the initial interim claim with Bill Type 112.
- Subsequent interim claims must be billed as adjusted claims with Bill Type 117, including cumulative charges up to each “through” date.
- Original claim must be finalized before submitting additional replacement/adjusted interim claims.

Northern CA and Southern CA Only - for inpatient services, submit separate claims weekly as required by California Law (28 CCR 1300.71 (a)(7)(B)).

5.8.8 Telehealth

- Telehealth is the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member’s health care.

- Telehealth interactions between Providers and Members are subject to all applicable laws regarding telehealth, including the confidentiality of health care information and a Member's rights to the Member's medical information. Telehealth includes synchronous interactions, and asynchronous store-and-forward transfers. Telehealth may be conducted using audio and video or audio only.
- For purposes of reimbursement for Covered Services provided via telehealth, it is important to reference your Agreement and, to the extent applicable, resources on billing and reimbursement for Medicare, Medicaid, and private insurers. Claims for payment must contain the appropriate CPT-4 or HCPCS codes.
- It is essential to reference applicable **Federal and State laws**, as well as specific contractual guidelines, according to each **line of business** to ensure compliance with regulations and billing practices.

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

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

5.9 Corrected Claims Processing Guidelines

5.9.1 Claim Corrections

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

5.9.2 Correcting a Previously Submitted Claim

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

5.9.3 Justifications for Claim Corrections

Providers can submit a claim correction for the following reasons:

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

5.9.4 Electronic Replacement/Corrected Claim Submissions

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

5.9.5 Paper Replacement/Corrected Claim Submissions

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

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

5.10 Claims Review and Adjustments

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

5.11 Compensation Methodologies

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

5.12 Code Review and Editing

The standards for determining payable items or services are outlined in the following policies:

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

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

5.13 Clinical Review

Institutional and professional claims may be reviewed by physicians or appropriate clinicians to ensure compliance with coding and billing standards, medical appropriateness, medical necessity, and to ensure payment is supported by your Agreement, the Provider Manual, and KP claims payment policies.
The standards for determining payable items or services are outlined in POL-020, "Clinical Review Payment Determination Policy." Providers must code and bill according to laws, regulations, contracts, and industry standards, including KP's Payment Determination Policies. Commonly accepted standards that KP applies come from sources such as CMS, the National Uniform Billing Committee (NUBC), the NCCI, and professional journals. KP reviews claims for items or services that are inclusive of or integral to another procedure and may deny payment accordingly.
KP claims payment policies are available on the Community Provider Portal website. Website links can be found at section 5.24.2 of the Appendix.

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

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

5.14 Prohibited Member Billing Practices

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

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

Except for Member Cost Share (defined below) and as expressly permitted by your Agreement and applicable law, Providers must seek compensation for Covered Services from KP or other responsible payers (e.g., Medicare).
Fees for missed appointments, "no-show" fees, and late cancellation fees cannot be charged to or paid by KP. These fees also cannot be charged to Medicaid/ Medi-Cal Members. Medicare members may be charged a fee for missed appointments only if the Provider has an established policy for doing so, that policy is applied to all patients equally, and the member is billed directly. For Commercial Members, these fees may be collected only if the Provider has a written policy detailing the circumstances under which such fees may be imposed, and the Commercial Member has agreed in writing to be financially responsible for these fees before receiving services.

5.14.1 Member Cost Share

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

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

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

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

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

If you are presented with a Member complaint or inquiry regarding any direct Member billing (including any billing for Member Cost Share or other Member liability described above) you should direct the Member to contact KP Member Services in the appropriate region as listed in section 5.24.1 of the Appendix.

5.15 Do Not Bill Events (DNBE)

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

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

CMS-defined HCACs are updated annually and include:

- Wrong surgery or invasive procedure on a patient
- Surgery or invasive procedure on the wrong patient
- Surgery or invasive procedure on the wrong body part
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma (e.g., fractures, dislocations, intracranial injuries, crushing injuries, burns)
- Manifestations of poor glycemic control (e.g., diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis or hyperosmolarity)
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infections (e.g., mediastinitis following coronary artery bypass graft, infections following bariatric surgery, orthopedic procedures, cardiac implantable electronic devices)
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures (e.g., total knee replacement, hip replacement)
- Latrogenic pneumothorax with venous catheterization
- Any new Medicare fee-for-service HCACs added by CMS not listed here are also included.

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

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

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

5.16.1 Additional Requirements

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

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

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

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

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

5.17 Coordination of Benefits (COB)

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

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

5.17.1 Provider Responsibilities

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

5.17.2 Payment Determination

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

5.17.3 Cooperation Requirements

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

5.17.4 Determining the Primary Payer

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

- **Adults**

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

- **Dependent Children**

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

  Joint Custody: The birthday rule above still applies.

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

  No Court Order: Apply benefits in this order:

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

- **Medicare Members**

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

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

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

5.17.5 Workers' Compensation/Third Party Liability (TPL)

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

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

For questions regarding COB please contact KP Member Services for the appropriate KP Region as listed in section 5.24.1 of the Appendix.

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

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

5.18 COB Claims Submission Requirements and Procedures

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

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

- **Two Fully Funded or Two Self-Funded Plans**: Submit one claim under the primary plan to KP.

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

5.18.2 Secondary Claims Submission via EDI

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

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

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

Contact your clearing house for assistance with electronic COB claims.

5.19 Third Party Liability (TPL)

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

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

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

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

Guidelines (Information Required)

Providers must enter the following on the billing form:

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

5.20 Workers' Compensation

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

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

If Authorized by KP

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

5.21 Copayments, Coinsurance and Deductibles

Copay Collection Responsibilities

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

Claims Submission

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

Verification

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

5.22 Overpayment Policy

Notification and Return

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

Overpayment Identified by KP

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

Contesting Overpayment

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

Information Required for Returning Uncontested Overpayments

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

5.23 Overpayment Recoupment

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

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

Evidence of Payment (EOP)

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

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

KP California (Northen and Southern) Only - Medi-Cal Cost Avoidance
You are responsible for identifying the primary payer, seeking authorization from the primary payer (if authorization is required), and billing the appropriate party. See Section VI, "Member Eligibility and Benefits".

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

- To determine whether a Medi-Cal Member may have OHC prior to delivering services, please access the DHCS Automated Eligibility Verification System at 800-427-1295 or the Medi-Cal Online Eligibility Portal available at: **https://www.medi-cal.ca.gov/Eligibility/Login.aspx**
- If a Medi-Cal Member has active OHC and the requested service is covered by the OHC, you must instruct the Member to seek the service through the OHC carrier. Regardless of the presence of OHC, however, you must not refuse to provide Covered Services to Medi-Cal Members as authorized by KP.

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

5.24 Appendix

5.24.1 KP Contact Information

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

5.24.2 Community Provider Portal (CPP)

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

6. Provider Dispute Resolution Process

KP actively encourages our contracted Providers to utilize MSCC staff to resolve billing and payment issues.

If you remain unable to resolve your billing and payment issues, KP makes available to all Providers a fast, fair and cost-effective dispute resolution mechanism for disputes regarding invoices, billing determinations, or other contract issues. This dispute resolution mechanism is handled in accordance with applicable law and your Agreement. Please note that the process described in this section applies to disputes subject to the Knox-Keene Act. While we expect to use this process for other types of disputes, we are not required to do so.

This section of the Provider Manual gives you information about our dispute resolution process, but it is not intended to be a complete description of the law or the provisions of your Agreement. Please make sure that you review your Agreement and the applicable law for a complete description of the dispute resolution process. To the extent your Agreement expressly sets forth any longer time frame or additional process than as described below, the contractual provisions will apply to the extent not prohibited under applicable law.

6.1 Types of Disputes

The following describes the most common types of disputes:

- **Claims Payment Disputes:** Challenging, appealing or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted or contested by KP
- **Responding to Requests for Overpayment Reimbursements:** Disputing a request initiated by KP for reimbursement by you of overpayment of a claim
- **Other Disputes:** Seeking resolution of a contract dispute (or bundled group of contract disputes) between you and KP

6.2 Submitting Payment Disputes

If you have a dispute relating to the adjudication of a claim or a billing determination (collectively referred to herein as "payment dispute") you may submit such payment disputes online via **Online Affiliate** or as a written notice to KP by Mail. Either notice of a payment dispute is referred to in this Provider Manual as a "Provider Dispute Notice".

6.2.1 Directions for Submission of Payment Disputes

6.2.1.1 Payment Disputes Related to Referred Services or Emergency Services Claims

If the payment dispute is related to a claim for referred services or emergency services provided to a Member, the dispute may be submitted online via **Online Affiliate** or by mail.

Online submission:	For more information or to register for Online Affiliate, please visit KP's Northern California Community Provider Portal at: **http://kp.org/providers/ncal/**
By mail:	**Kaiser Foundation Health Plan, Inc.** **National Claims Administration** **Attention: Provider Dispute Services Unit** **P.O. Box 8002** **Pleasanton, CA 94588**

6.2.1.2 Payment Disputes Related to Visiting Member Claims

For information concerning provider payment disputes related to claims for services rendered to visiting Members, please contact the Member's "Home" region's Medical Service call Center at their number provided in Section 5.24.1of this manual.

6.2.2 Required Information for Provider Payment Dispute Notices

Your Provider Dispute Notice must contain at least the information listed below, as applicable to your payment dispute. If your Provider Dispute Notice does not contain all the applicable information listed below, we will reject the Provider Dispute Notice and will identify in writing the missing information necessary for us to consider the payment dispute. If you choose to continue the payment dispute, you must submit an amended Provider Dispute Notice to us within 30 Business Days from the date of such notification letter (but in no case later than 365 Calendar Days from KP's last action on the claim), making sure to include all elements noted therein as missing from your payment dispute. If KP does not receive your amended payment dispute within this time, our previous decision will be considered final, and you will have exhausted our provider payment dispute process.

Required Information

- Your name, the tax identification number under which services were billed and your contact information
- If the payment dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item using KP's original claim number, the date of service, and a clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If the payment dispute involves a Member or a group of Members, the name(s) and KP Medical Record Number(s) (MRN(s)) of the Member(s) must be included in addition to the information above

Your Provider Dispute Notice may be submitted by you or by a representative (for example, a billing service, a collection agency or an attorney) authorized by you to perform this function. If your authorized representative submits your Provider

Dispute Notice, that representative will be required to provide confirmation that an executed business associate agreement between you, as the provider of health care services, and such representative is in place and that it complies with HIPAA. If the copy of the business associate agreement is not included, the dispute documentation will be returned to the submitting third party/representative until the business associate agreement is included.

We recommended you or your representative submit each Provider Dispute Notice, related to either an emergency or referred services claim, with KP's Provider Dispute Resolution Request form (PDRR). You may contact KP at the telephone number indicted on the explanation of payment (EOP) or call KP's Provider Dispute Resolution Unit at **(925) 924-5050** to obtain the PDRR form. Alternately, you or your representative may submit a payment dispute in writing without a PDRR, including all the required information outlined above, or online via Online Affiliate (see Section 6.2.1).

6.2.3 Time Period for Submission of Provider Dispute Notices

Subject to any longer period specifically permitted under your Agreement or required under applicable law, Provider Dispute Notices must be received by KP within 365 Calendar Days from our action (or the most recent action if there are multiple actions) that led to the dispute, or in the case of inaction, the Provider Dispute Notice must be received by KP within 365 Calendar Days after our time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

6.2.4 Timeframes for Acknowledgement of Receipt and Determination of Provider Dispute Notices

We will acknowledge receipt of your Provider Dispute Notice submitted in accordance with the above requirements within 15 Business Days after KP's receipt of hardcopy submission, or within 2 Business Days after KP's receipt of online submission. We will reject any payment dispute you submit that does not include all required information as described above as an incomplete payment dispute and will take no further action on that incomplete submission unless it is resubmitted completely as required above and within the applicable time frame. KP will issue a resolution letter explaining the reasons for our determination, to the extent required by applicable law, within 45 Business Days after the date of receipt of the complete Provider Dispute Notice.

6.2.5 Instructions for Resolving Substantially Similar Payment Disputes

If you are considering submitting more than twenty (20) substantially similar payment disputes, you are encouraged to first reach out to one of the following KP resources as we may be able to identify a root cause and streamline the resolution process:

Referral and Continuum of Care claims payment disputes: **(925) 924- 5050.**

Emergency services claims payment disputes: (**800) 390-3510**

Online Affiliate cannot be utilized to submit batches of substantially similar payment disputes. If you proceed with filing substantially similar multiple payment disputes, they may be filed in writing in batches, submitted via mail, and include the following information:

Each claim being disputed must be individually numbered and contain the provider's name, the provider's tax identification number, the provider's contact information, the original KP claim number (if the dispute is claim related), the Member's MRN (if the dispute concerns care provided to a specific Member or Members), date(s) of service, clear identification of the item(s) being disputed for each claim and an explanation of the basis for each dispute.

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

6.3 Disputing Requests for Overpayment Reimbursements

Follow the instructions of this Section 6, Provider Dispute Resolution Process.

6.4 Other Disputes

For disputes not based on claim adjudication or billing determination(s), refer to your KP Health Care Services Agreement.

7. Member Rights and Responsibilities

KP recognizes that Members have both rights and responsibilities in the management of their health care.

Providers may direct Members to the Member Resource Guide at:

kp.org/resourceguide

Members have certain rights to which they are entitled when they interact with representatives of KP: Providers, and the employees of those Providers, as well as KP employees and physicians.

Members are also expected to be responsible for knowing about their health care needs and coverage. They are also responsible for maintaining appropriate attitudes and behavior when receiving health care as a Member.

This section addresses our Members' rights and responsibilities as well as their opportunities to address any situation where they may believe that they have not received appropriate services, care, or treatment.

7.1 Member Rights and Responsibilities Statement

KP has developed a statement of Member rights which includes a Member's right to participate in the Member's own medical care decisions. These decisions range from selecting a PCP to making informed decisions regarding recommended treatment plans. Providers and their staff are expected to accept and honor these Member Rights and Responsibilities.

The Member Rights and Responsibilities Statement also includes a Member's responsibility to understand the extent and limitations of their health care benefits, to follow established procedures for accessing care, to recognize the impact lifestyle has on physical condition, to provide accurate information to caregivers, and to follow agreed upon treatment plans.

Upon enrollment and annually thereafter, KP provides notification to each subscriber that a Member Rights and Responsibilities Statement is available which includes the following statements directed to Members:

> Active communication between you and your physician as well as others on your health care team helps us to provide you with the most appropriate and effective care. We want to make sure you receive the information you need about your Health Plan, the people who provide your care, and the services available, including important preventive care guidelines. Having this information contributes to your being an active participant in your own medical care.

We also honor your right to privacy and believe in your right to considerate and respectful care.

This section details your rights and responsibilities as a Kaiser Permanente member and gives you information about member services, specialty referrals, privacy and confidentiality, and the dispute resolution process.

As an adult member, you exercise these rights yourself. If you are a minor or are unable to make decisions about your medical care, these rights will be exercised by the person with the legal responsibility to participate in making these decisions for you.

YOU HAVE THE RIGHT TO:

Receive information about Kaiser Permanente, our services, our practitioners and providers, and your rights and responsibilities.

We want you to participate in decisions about your medical care. You have the right and should expect to receive as much information as you need to help you make decisions. This includes information about:

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

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

Participate in a candid discussion of appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they're not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you don't agree with it or if it conflicts with your beliefs.

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Medical emergencies or other circumstances may limit your participation in a treatment decision. However, in general, you will not receive any medical treatment before you or your representative gives consent. You and, when appropriate, your family will be informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.

Participate with practitioners and providers in making decisions about your health care. You have the right to choose an adult representative, known as your agent, to make medical decisions for you if you are unable to do so and to express your wishes about your future care. Instructions may be expressed in advance directive documents such as an advance health care directive. See http://www.kp.org/advancedirectives for more information about advance directives.

For more information about these services and resources, please contact our Member Service Contact Center 24 hours a day, 7 days a week (closed holidays) at **1800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY**: **711**.

Have ethical issues considered. You have the right to have ethical issues that may arise in connection with your health care considered by your health care team. Kaiser Permanente has a Bioethics/Ethics Committee at each of our medical centers to assist you in making important medical or ethical decisions.

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

To review, receive, or release copies of your medical records, you'll need to complete and submit an appropriate written authorization or inspection request to our Medical Records Office at the facility where you get your care. They can provide you with these forms and tell you how to request your records. Visit http://www.kp.org to find addresses and phone numbers for these departments.

Receive care with respect and recognition of your dignity. We respect your cultural, psychosocial, spiritual, and personal values; your beliefs; and your personal preferences.

Kaiser Permanente is committed to providing high-quality care for you and to building healthy, thriving communities. To help us get to know you and provide culturally competent care, we collect race, ethnicity, language preferences (spoken and written) and religion data. This information can help us develop ways to improve care for our members and communities. This information is kept private and confidential and not used in underwriting, rate setting, or benefit determination. We believe that providing quality health care includes a full and open discussion regarding all aspects of medical care and want you to be satisfied with the health care you receive from Kaiser Permanente.

Use interpreter services. When you call or come in for an appointment or call for advice, we want to speak with you in the language you are most comfortable using. For more about our interpreter services, please refer to http://info.kaiserpermanente.org/html/gethelp/california.html or call our Member Services Contact Center at **1-800-464-4000** or **TTY: 711**.

Be assured of privacy and confidentiality. All Kaiser Permanente employees and physicians, as well as practitioners and providers with whom Kaiser Permanente contracts, are required to keep your protected health information (PHI) confidential. PHI is information that includes your name, Social Security number, or other information that reveals who you are, such as race, ethnicity, and language data. For example, your medical record is PHI because it includes your name and other identifiers.

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

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

Please review the section titled "Privacy Practices" at:
https://healthy.kaiserpermanente.org/privacy-practices

For more information about your rights regarding PHI as well as our privacy practices, please refer to our Notice of Privacy Practices on our website http://www.kp.org, or call MSCC at **1-800-464-4000** or **TTY: 711**.

Participate in physician selection without interference. You have the right to select and change your personal physician within the Kaiser Permanente Medical Care Program without interference, subject to physician availability. To learn more

about nurse practitioners, physician assistants, and selecting a primary care practitioner, please visit http://www.kp.org "Doctors and Locations".

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

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

A description of your dispute-resolution process is contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services Department or our Member Service Contact Center to request another copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy. When necessary, we will provide you with interpreter services, including Sign Language, at no cost to you.

For more information about our services and resources, please contact our Member Service Contact Center at **1-800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711.**

Make recommendations regarding Kaiser Permanente's member rights and responsibilities policies. If you have any comments about these policies, please contact our Member Services Contact Center at **1-800-464-4000** or **TTY: 711.**

YOU ARE RESPONSIBLE FOR THE FOLLOWING:

Being civil and respectful. Kaiser Permanente, is committed to ensuring a safe, secure, and respectful environment for everyone, including our members, patients, visitors, clinicians, providers, health care teams, and employees. We expect all individuals to demonstrate civil and respectful behavior while on our premises or in virtual or home health care interactions.

As part of our new Member/Patient/Visitor Code of Conduct, we expressly prohibit the following:

- Abusive language including threats and slurs
- Sexual harassment
- Physical assault
- Possession or use of weapons, including firearms

We reserve the right to take appropriate measures to address abusive, disruptive, inappropriate, or aggressive behavior.

Knowing the extent and limitations of your health care benefits. A detailed explanation of your benefits is contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services Contact Center office to request another copy. If you receive your Kaiser Permanente coverage through your employer, you can also contact your employer for a current copy of your *Evidence of Coverage* booklet or *Certificate of Insurance*.

Notifying us if you are hospitalized in a non–Kaiser Permanente Hospital. If you are hospitalized in any hospital that is not a Plan Hospital, you are responsible for notifying us as soon as reasonably possible so we can to monitor your care. You can contact us by calling the number on your Kaiser Permanente ID card.

Identifying yourself. You are responsible for carrying your KP identification (ID) card and photo identification with you at all times to use when appropriate, and for ensuring that no one else uses your ID card. If you let someone else use your card, we may keep your card and terminate your membership.

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

Keeping appointments. You are responsible for promptly canceling any appointment that you do not need or are unable to keep.

Supplying information (to the extent possible) **that Kaiser Permanente and our practitioners and providers need in order to provide you with care**. You are responsible for providing the most accurate information about your medical condition and history, as you understand it. Report any unexpected changes in your health to your physician or medical practitioner.

Understanding your health problems and participating in developing mutually agreed treatment goals to the highest degree possible. You are responsible for telling your physician or medical practitioner if you don't clearly understand your treatment plan or what is expected of you. You are also responsible

for telling your physician or medical practitioner if you believe you cannot follow through with your treatment plan.

Following the plans and instructions for care you have agreed on with your practitioners. You are responsible for following the plans and instructions that you have agreed to with your physician or medical practitioner.

Recognizing the effect of your lifestyle on your health. Your health depends not only on care provided by Kaiser Permanente but also on the decisions you make in your daily life—poor choices such as smoking or choosing to ignore medical advice or positive choices such as exercising and eating healthy foods.

Being considerate of others. You are responsible for treating physicians, health care professionals, and your fellow Kaiser Permanente members with courtesy and consideration. You are also responsible for showing respect for the property of others and of Kaiser Permanente.

Fulfilling financial obligations. You are responsible for paying on time any money owed to Kaiser Permanente.

Knowing about and using the member satisfaction resources available to you, including the dispute-resolution process.

For more about the dispute resolution process, see http://www.kp.org. A description of your dispute-resolution process is also contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact our Member Services Contact Center to request a copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy of your *Evidence of Coverage* booklet or *Certificate of Insurance*. Our Member Services Contact Center can also give you information about the various resources available to you and about Kaiser Permanente's policies and procedures. If you have any recommendations or comments about these policies, please contact our Member Services Contact Center 24 hours a day, 7 days a week (closed holidays) at **1-800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711.**

7.2 Non-Compliance with Member Rights and Responsibilities

Failure to act in a way that is consistent with the Member Rights and Responsibilities Statement can result in action against the Member, the Provider, or KP, as appropriate.

7.2.1 Members

In the event a Member has a complaint or grievance, the Member may file a complaint using the grievance form, as instructed on http://www.kp.org and their EOC, or *Certificate of Insurance*, or discuss the situation with MSCC online, by mail, or by chat with Member Services. Members can file a grievance for any issue, including complaints against the Provider and/or the Provider's staff. Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.

Although the Member should contact the Member Services Contact Center about a grievance, you may be approached directly by the Member. If you do receive a complaint from or on behalf of a Member which, in your reasonable judgment, is not resolvable within 2 Business Days, you must notify Provider Services as soon as possible.

KP's grievance forms for Medicare and non-Medicare Members can be downloaded at: http://providers.kp.org/nca/grievances.html.

7.2.2 Providers

If a Member fails to meet an obligation as outlined in the Member Rights and Responsibilities Statement and you have attempted to resolve the issue, please contact the KP Threat Management office of the Member's primary KP service facility. If you are uncertain of the Member's primary KP service facility, please contact the Member Services Contact Center (MSCC) and have the Member's KP Medical Record Number available.

You should advise a KP Threat Management office if a Member performs any of the following acts. Please see Section 2.4 for General Information phone numbers of local KP facilities.

- Displays disruptive behavior or is not able to develop a positive provider/patient relationship
- Unreasonably and persistently refuses to follow your instructions/ recommendations to the extent that you believe it is jeopardizing the patient's health
- Commits a belligerent act or threatens bodily harm to physicians, physician staff, hospital personnel, and/or home health/hospice/SNF staff
- Purposely conceals or misrepresents medical history or treatment
- Uses documents with your signature without proper authorization or forges/falsifies your name to documents, including prescriptions
- Allows someone to misrepresent the Member as a KFHP Member

KP reserves the right at its discretion to:

- Conduct informal mediation to resolve a relationship issue
- Move the Member to another provider
- Pursue termination of the individual's membership or take other appropriate action, as allowed under that Member's specific EOC and applicable law

7.3 Health Care Decision-Making

KP and contracted hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for Members' medical needs. KP does not compensate anyone for denying coverage or services, nor does KP use financial incentives to encourage denials. In order to maintain and improve the health of Members, all Providers should be especially vigilant in identifying any potential underutilization of care or service.

KP encourages open Provider-patient communication regarding available treatment alternatives. We do not penalize Providers for discussing all available care options with our Members.

Our Members have the right to choose among treatment or service options, regardless of benefit coverage limitations. Providers are expected to inform our Members of appropriate care options, even when one or more of the options are not covered benefits under the Member's benefit plan. If the Provider and the patient decide upon a course of treatment that is not covered in the Member's EOC, the Member must be advised they are responsible for the cost of that care.

If the Member is dissatisfied with this arrangement, the Member should be advised to contact MSCC for an explanation of the Member's benefit plan. If the Member persists in requesting non-covered services and the Provider is willing to provide such service, the Provider should make payment arrangements with the Member in advance of any non-emergent treatment to be provided.

KP's UM program and procedures are:

- Based on objective guidelines adopted by KP
- Used to determine appropriateness and indication of care
- Designed to establish whether services provided or to be provided are covered under a Member's benefit plan

Please refer to Section 4 and Section 9 of this Provider Manual for more details.

The ultimate decision on whether to proceed with treatment rests with the Provider and the Member.

7.4 Advance Directives

An Advance Directive is a written instruction recognized under California and/or federal law, such as a living will or a Durable Power of Attorney for Health Care. An Advance Directive allows Members to appoint a representative to make personal health care decisions on their behalf. A Member's representative must be at least 18 years old. The Member's representative is referred to as a Health Care Agent. To avoid potential conflicts of interest, neither Kaiser Permanente Medical Care Program (KPMCP) personnel nor physicians may serve as witnesses for a Member's Advance Directive.

KP requires that all Providers comply with the federal Patient Self-Determination Act of 1990, which mandates that a patient must have the opportunity to participate in determining the course of their medical care, even when the patient is unable to speak for themself. The federal law applies to emancipated minors but does not apply to all other minors. Providers must also comply with California's Health Care Decisions law and any other California State Laws concerning Advance Health Care Directives.

To ensure compliance with governing law, the existence of any Advance Directive must be documented in a prominent place in the medical record. An institutional Provider is required to provide written information regarding Advance Directives to all Members admitted to the facility and provide staff and patient education regarding Advance Directives.

Members should be encouraged to provide copies of their completed Advance Directives to all Providers of their medical care. Members should also be informed that they can register their Advance Directive with California Secretary of State's Office. The State will provide the Member with a Registry Card that the Member can carry with them.

If a Member who is a patient wishes to execute or modify an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss the decision with the Member. The attending physician must document any changes to an Advance Directive in the Member's medical record.

An Advance Directive may be revoked by the Member at any time, orally or in writing if the Member is capable of doing so. Upon divorce, if the spouse was designated as the surrogate decision-maker, by law, the chosen agent is invalidated unless the patient specifically states to the contrary in their Advance Directive. If a Member has more than one written Advance Directive, then the most recently executed document should be recognized. Please note, revoked forms should not be discarded but remain a part of the Member's Medical Record.

Members are provided with information regarding Advance Directives in the Evidence of Coverage and the website at **https://healthy.kaiserpermanente.org/northern-california/health-wellness/life-care-plan** Members may also contact MSCC regarding Advance Directives for an informational brochure and appropriate forms.

7.4.1 Physician Orders for Life Sustaining Treatment (POLST)

A POLST form is a document that is completed with the Member's input (or that of their decision maker) and is signed by their physician. It documents the Member's choices about resuscitation, medical interventions, use of antibiotics, and use of artificially administered fluids and nutrition.

POLST is a physician's order form that outlines a plan of care that reflects the Member's wishes concerning end-of life care. It is voluntary and is intended only for people who are seriously ill. It can be revoked by the Member at any time. This form can assist physicians, nurses, health care facilities, and emergency personnel in honoring the Member's wishes for life-sustaining treatment.

The POLST form complements the advance directive and is not intended to replace that document. Information on the POLST form will be incorporated into the medical record when presented to the individual's Provider.

For more information on POLST, visit **http://www.capolst.org**.

7.5 Member Grievance Process

Members are assured a fair and equitable process for addressing their complaints, grievances and appeals ("grievances") against Providers, their staff, and KP employees. Providers may act as a Member's Authorized Representative is duly appointed in accordance with the Member's applicable EOC. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the Member and the organization, including you, our Provider. Members are notified of the processes available for resolving grievances in their *Evidence of Coverage* and on **http://www.kp.org**.

A Member grievance may relate to dissatisfaction with quality of care, access to services, Provider or staff attitude, operational policies and procedures, benefits, eligibility and requests for services and care they believe are available under their coverage. Valid Member complaints and grievances against a Provider are included in the Provider's quality file at KP and reviewed as part of the recredentialing process. Grievances are tracked and trended on an ongoing basis to identify potential problems with a Provider or with our own policies and procedures.

The grievance information provided in this Provider Manual is a general overview and is not all inclusive. There are variations to the Member's rights and remedies depending on the membership type (e.g., Medicare, Medi-Cal, etc.), Therefore, Members should be referred to MSCC or to their *Evidence of Coverage* brochure for more information.

7.5.1 Provider Participation in Member Grievance Resolution

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

7.5.2 Member Grievance Resolution Procedure

One of the rights that Members are apprised of on http://www.kp.org is that they have the right to participate in a candid discussion with the Provider of all available options regardless of cost or benefit coverage. Members are told, "You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they're not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you do not agree with it or if it conflicts with your beliefs."

If the issue cannot be resolved this way, we encourage the Member to contact a Patient Assistance Coordinator or a Member Services representative at the local KP facility (see also MSCC contact information in Section 2.1). If the Provider presents a grievance on behalf of a Member, and the issue is felt to be of an emergent nature, one that could seriously jeopardize the Member's life, health, or ability to regain maximum function, the Provider or the Member may contact the Expedited Review Unit (ERU) through the Member Service Contact Center to request a review.

7.5.3 Processes for Grievance Resolution

If the problem is not amenable to immediate resolution at the point of service, the Member may submit a grievance through any of the following methods:

- in person to a Patient Assistance Coordinator or Member Services Representative in the Member Services Department at the local KP facility
- via our website at **http://www.kp.org**
- by calling the Member Service Contact Center at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711**
- by completing a Grievance Form or writing a letter and mailing it to a Member Services office at a Plan Facility (member can refer to **http://www.kp.org** for addresses)

Our representatives will advise the Member about the resolution process and ensure that the appropriate parties review the complaint.

Sample Medicare and Non-Medicare Grievance Forms can be found at the end of this section.

Grievances reviewed through the standard process are generally acknowledged within 5 Calendar Days, and resolved as quickly as the member's health requires, but no longer than regulatory timeframes. Depending on the issue and the applicable regulatory requirements, the resolution time frame is generally within 14-30 days.

NOTE: For expedited processing, see Section 7.5.3.2.

7.5.3.1 Quality of Care Grievances

Members' grievances which contain potential quality of care concerns are forwarded by Member Services to the Member Services Clinical Consultants for case review. Clinical Consultants will forward cases to the responsible Quality departments as appropriate. The treating practitioner is expected to respond Promptly to requests from KP Quality representatives for supporting documentation related to the Member's care, including medical records, questionnaires, outcome assessments, appointment scheduling and/or other pertinent information. The grievance process is governed by regulation and is time sensitive. The process is protected by peer review rules and therefore all exchanges of information must remain confidential between the treating practitioner and KP Quality representatives.

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

7.5.3.2 Expedited Review

A Member who believes that the standard timeframe of grievance resolution could seriously jeopardize their life, health, or ability to regain maximum function may request an expedited review. Providers, Members, or the Member's advocate may contact MSCC for further support on an expedited review.

The Member will be notified of the expedited decision verbally and in writing, as quickly as the member's health requires but no later than the required expedited timeframes – generally within 72 hours.

Requests that do not meet the qualifying criteria for expedited review will be processed in accordance with standard review timeframes.

7.5.3.3 Instructions for Filing a Grievance

The following instructions are to be included with any Grievance Form supplied by Providers to our Members. Providers may reproduce this page and the forms immediately following for that purpose.

HOW TO FILE A GRIEVANCE

KP is committed to providing Members with quality care and with a timely response to their concerns. Members can discuss their concerns with our Member Services representatives at most Plan Facilities, or they can call the MSCC.

Members can file a grievance for any issue. Their grievance must explain the issue, such as the reasons why they believe a decision was in error or why they are dissatisfied about Services they received. Members must submit their grievance orally or in writing within 60 Calendar Days (Medicare) or 180 Calendar Days (Commercial) of the date of the incident that caused their dissatisfaction, or without time limitation (Medi-Cal) as follows:

- To a Member Services representative at their local Member Services Department at a Plan Facility (Member should refer to **http://www.kp.org** for locations), or by calling our Member Service Contact Center:

English:	**1-800-464-4000**
Spanish:	**1-800-788-0616**
Chinese dialects:	**1-800-757-7585**
TTY:	**711**

- Through our website at: **http://www.kp.org**

We will acknowledge receipt of a Member's grievance after receiving it and provide a resolution as soon as their health requires but no later than regulatory time frames allow, which is generally within 14-30 Calendar Days. If we do not approve a Member's request, we will tell them the reason and inform them about additional dispute resolution options.

NOTE: If we resolve a Member's issue by the end of the next business day after we receive their grievance and Member Services representative notifies them orally about our decision, we will not send them a written decision unless their grievance involves a quality of care issue, breach of privacy, Hospital grievances, coverage dispute, a dispute about whether a service is medically necessary, an experimental or investigational treatment, or those grievances for which they request a written response.

Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-443-0815 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-443-0815 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-443-0815（TTY：711）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-443-0815 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita kang Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-443-0815 (TTY: 711).

Korean
주의: 한국어를 사용하는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-443-0815 (TTY: 711)으로 전화하십시오.

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-443-0815 (TTY՝ 711):

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-443-0815 (телетайп: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-443-0815（TTY：711）まで、お電話にてご連絡ください。

Punjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। 1-800-443-0815 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាគឺមានសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទ 1-800-443-0815 (TTY: 711)។

Hmong
LUS CEEB TOOM: Yog koj tab tes hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-443-0815 (TTY: 711).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-443-0815 (TTY: 711) पर कॉल करें।

Thai
ข้อควรทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-800-443-0815 (TTY: 711).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-443-0815 (TTY: 711) تماس بگیرید.

Arabic
تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم 1-800-443-0815 (رقم هاتف الصم والبكم: 711).

Member Grievance Form

KAISER PERMANENTE®

You may file your Grievance/Appeal by one of the following ways:

- By mail to Kaiser Foundation Health Plan:
  Member Case Resolution Center (For non-urgent/emergent standard grievances)
  P.O. Box 1809
  Pleasanton, CA 94566
  OR
  Expedited Review Unit and Part D Unit (For urgent/emergent pre-service grievances when the non-urgent time frame (a) could seriously jeopardize your life, health, or ability to regain maximum function, (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services that are subject of the grievance, or (c) a provider has told us that the matter is urgent).
  P.O. Box 1809
  Pleasanton, CA 94566
- To a Member Services representative at your local Member Services Department.
- Orally, to the Member Services Contact Center, 24 hours a day, seven days a week, excluding holidays:
  English: 1-800-464-4000
  Spanish: 1-800-788-0616
  Chinese dialects: 1-800-757-7585
  TTY: 711
- Online, through our Web site at kp.org

Notice of Nondiscrimination

Kaiser Foundation Health Plan (KFHP) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at 1-800-443-0815 (TTY 711), 8 a.m. to 5 p.m., seven days a week.

If you believe that KFHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

In California, Kaiser Permanente is an HMO plan and a Cost plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

KAISER PERMANENTE® GRIEVANCE/APPEAL FORM – Medicare California

Member/Patient Name | Medical Record Number

Address: Street | City | ZIP Code

Daytime Telephone Number | Alternate Telephone Number | Birth Date

Name of Person Filing: (If different than above, a Statement of Authorized Representative form will be mailed to the member for completion) | Relationship | Daytime Telephone Number

Department/Location and Medical Facility where issue occurred | Date Issue Occurred

Please describe the nature of the issue (attach additional sheets if needed):

Please explain how you tried to resolve this issue:

What would you consider a proper solution to this issue?

Signature | Date

For Program Representative Use Only

Name of Program Representative | Facility | Date Received

☐ Medicare Grievance ☐ Part D Drug Coverage Determination ☐ Part D Drug Redetermination ☐ Medicare Organization Determination ☐ Medicare Reconsideration ☐ Medi-Medi ☐ Fed-Med ☐ PERS-Medi

You will be advised of any additional procedural and appeal rights to which you are entitled as we move forward with your issue.

DO NOT FILE IN PATIENT CHART

KAISER PERMANENTE®

COMPLAINT OR BENEFIT CLAIM/REQUEST FORM – Non-Medicare California

Member/Patient Name	Medical Record Number	
Address Street	City	ZIP Code
Daytime Telephone Number	Alternate Telephone Number	Birth Date
Name of Person Filing: (if different than above, a Statement of Authorized Representative form will be mailed to the member for completion)	Relationship	Daytime Telephone Number
Department/Location and Medical Facility where issue occurred		Date Issue Occurred

Please describe the nature of the issue (attach additional sheets if needed):

Please explain how you tried to resolve this issue.

What would you consider a proper solution to this issue?

Signature	Date

For Program Representative Use Only

Name of Program Representative	Facility	Date Received

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Department of Managed Health Care Complaint Process*

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone Kaiser Foundation Health Plan at **1-800-464-4000** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

* Not available to Medi-Cal members in Cal-Optima, Gold Coast Health Plan, and Partnership HealthPlan of California.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

Please mail this form to the P.O. Boxes listed on page 15 for processing. If you prefer, you may file a grievance online at kp.org, in person at your local Member Service office, or by phone by calling **1-800-464-4000**.

Questions, Concerns, Service Request, or Dissatisfaction with Care or Service

Kaiser Permanente's goal is to provide the highest possible member satisfaction. Each physician, employee, and volunteer is responsible for creating an outstanding care experience for every member every time. This includes responding to any concerns or dissatisfaction that you might have. Our highest priority is to resolve every concern or dissatisfaction whenever you receive care.

Please ask to speak to the manager of the department if you have a question, concern, or are dissatisfied regarding the care or service you received. If you prefer to request a service, voice an issue or complaint, or file a benefit claim, you may file it with the **Health Plan** using the form provided here.

How to File a Grievance

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction. However, if you are a Medi-Cal member, you may submit your grievance at any time. You may submit a grievance in any one of the following ways indicated below.

- By mail to Kaiser Foundation Health Plan:
  Member Case Resolution Center (For non-urgent/nonurgent standard grievances)
  P.O. Box [illegible]
  San Diego, CA [illegible]
  OR
  Expedited Review Unit (For urgent/emergent grievances when the issue involves a threat that (a) could seriously jeopardize your life, health, or ability to regain maximum function, (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services that are the subject of the grievance, or (c) a provider has indicated the matter is urgent)
  P.O. Box 1809
  Pleasanton, CA 94566
- To a Member Services representative at your local Member Services Department
- Orally to the Member Services Contact Center, 24 hours a day, seven days a week, excluding holidays
  - English: **1-800-464-4000**
  - Spanish: **1-800-788-0616**
  - Chinese dialects: **1-800-757-7585**
  - TTY: **711**
- Online through our website at kp.org

California Department of Health Care Services Office of the Ombudsman (For Medi-Cal members)

You may also call the California Department of Health Care Services Office of the Ombudsman. They can offer help and tell you more about your rights and responsibilities. Call them at **1-888-452-8609**.

7.5.4 Department of Managed Health Care Complaint Process—Non-Medicare

The DMHC is responsible for regulating health care service plans. If a Member has a grievance against KP, the Member should notify Kaiser Foundation Health Plan at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711** to lodge the grievance with MSCC. The Member will have the opportunity to seek resolution of the problem using KP's grievance process. If the Member is not satisfied with the outcome of the grievance process, or if the grievance has remained unresolved for more than 30 Calendar Days, the Member may contact the DMHC for assistance. The DMHC will determine whether the Member is eligible to participate in the Independent Medical Review Program, described below.

7.5.4.1 Independent Medical Review Program Availability—Non-Medicare

California law requires health plans to offer an independent medical review program to Members who have been denied services because the services were deemed not medically necessary or considered experimental or investigational. This includes denial of emergency and urgent care services from non-KP providers. The Independent Medical Review Program ("IMR") is administered by the California DMHC. If the DMHC determines that the Member's case qualifies for an IMR, medical experts not affiliated with KP will conduct the review. KP will honor the DMHC decision.

A Member may qualify for IMR if the issue has been denied or is unresolved after 30 Calendar Days, or 3 Calendar Days for requests that meet expedited review criteria, if KP:

- Denies, changes, or delays a service or treatment because the plan determines it is not medically necessary
- Will not cover an experimental or investigational treatment for a serious medical condition
- Will not pay for emergency or urgent medical services that you have already received

Members can request an IMR by completing an IMR Application Form, which comes with a grievance resolution letter. Along with the Application, Members should attach copies of letters or other documents about the treatment or service that KP denied. Members can Mail or fax the form and any attachments to:

Department of Managed Health Care
980 9th Street Suite 500
Sacramento CA 95814-2725

Help Center FAX: **(916) 255-5241**

The numbers to the DMHC are: **(888) 466-2219** and **(877) 688-9891** (TDD). The DMHC web address is http://www.dmhc.ca.gov.

7.5.5 Demand for Arbitration

Under certain circumstances, a Member may file a demand for arbitration after receiving an appeal decision, or at any earlier step in the process. For more information on arbitration procedures, please advise the Member to contact the Member Services Department at the local KP facility or contact MSCC at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711.**

NOTE: The complaint and appeals information provided in this Provider Manual may not address the rights and remedies of every category of Member, for example, Medicare, Medi-Cal, as well as Members employed/retired from the State of California and/or the Federal Government, each of whom may have different rights and remedies. Members in these categories should be directed to contact MSCC for applicable grievance and appeal provisions, or they may refer to their Evidence of Coverage brochure for more information.

8. 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 the Provider Services Department.

8.1 Providers' Rights and Responsibilities

All Providers are responsible for:

- Providing health care services without discriminating on the basis of health status or any other unlawful category
- Upholding all applicable responsibilities outlined in the Member Rights & Responsibilities Statement in this Provider Manual
- 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 copayments, co-insurance and/or deductibles from Members as required by your Agreement and this Provider Manual
- Complying with this Provider Manual and the terms of your Agreement
- Cooperating with and participating 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

8.2 Complaint and Patient Care Problems

KP will work with a Provider to resolve complaints regarding administrative or contractual issues, or problems encountered while providing health care to Members.

8.2.1 Administrative and Patient Related Issues

For assistance in resolving administrative and patient related issues, please contact a Referral Coordinator (or assigned Outside Services Case Manager), if applicable from the referring KP facility. Examples of administrative issues include clarification of the authorization or referral process, and billing and payment issues.

8.2.2 Claim Issues

Regarding claims for referred services or emergency services, you may contact KP by calling **(800) 390-3510**.

For questions and clarification on how payments were computed, you may contact the office that issued the payment identified on the remittance advice and EOP. The phone number will be listed on the remittance advice.

For assistance in filing a Provider Dispute, please refer to Section 6.2 of this Provider Manual.

8.3 Required Notices

8.3.1 Provider Changes That Must Be Reported

Providers may notify Provider Services of the changes identified below by calling **(925) 924-5050**. Verbal notification must be followed by faxed documentation to **(877) 228-8306** 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.

8.3.1.1 Provider Illness or Disability

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

8.3.1.2 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.

8.3.1.3 Adding/Deleting New Practice Site or Location

Notify Provider Services at least 90 Calendar Days prior to opening an additional practice site or closing an existing service location.

8.3.1.4 Adding/Deleting Practitioners to/from the Practice

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

8.3.1.5 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.

8.3.1.6 Federal Tax ID Number and Name Changes

If your Federal Tax ID Number or name should change, please notify us immediately so that appropriate corrections can be made to KP's files. The notification should include a copy of your W9 to support the requested change(s).

8.3.1.7 Mergers and Other Changes in Legal Structure

Please notify us in advance and as early as possible of any planned changes to your legal structure, including pending merger or acquisition.

8.3.1.8 Provider Directories Information per Health and Safety Code § 1367.27

Provider shall provide the following information to KP regarding Provider and all practitioners contracted with Provider who are eligible for referrals to provide professional services to Members. Provider shall notify KP in writing on a weekly basis when any changes to the following occur:

1. A Provider is not accepting new patients;
2. A Provider, who had previously not accepted new patients, is currently accepting new patients;
3. A Provider has retired or otherwise has ceased to practice; and
4. There is a change to the following information:
    a. A Provider's name, practice location or locations, and contact information;
    b. National Provider Identifier number;
    c. Area of specialty, including board certification, if any;
    d. Office email address, if available;
    e. The name of each affiliated provider group currently under contract with KP through which the provider sees Members;

f. A listing for each of the following practitioners that are under contract with the Provider or part of the Provider Group:

   i. For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with KP.

   ii. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in H&S Code Section 1374.73, nurse midwives, and dentists.

   iii. For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

   iv. For any provider described in subparagraph (i) or (ii) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with Provider, the name of the provider, and the name of the federally qualified health center or clinic.

g. Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with H&S Code Section 1367.04, if any, on the Provider's staff.

h. Identification of Participating Practitioners who no longer accept new patients for some or all the Benefit Plans.

If KP receives a report regarding the possible inaccuracy of information relating to a Provider, whether from a Member, a participating practitioner, or KP, KP shall promptly investigate, and either verify the accuracy of the information or, if necessary, update the Provider information. When investigating a report, KP shall comply with the requirements of H&S Code section 1367.27(o)(2), including:

1. Contacting the affected Provider no later than five Business Days following receipt of the report; and
2. Documenting the receipt and outcome of each report. The documentation shall include the Provider's name, location, and a description of KP's investigation, the outcome of the investigation, and any changes or updates made to the information provided to KP. KP shall make this documentation available in a timely manner as requested by the DMHC.

In accordance with your Agreement, you must cooperate with KP in maintaining our compliance with the Knox-Keene Laws. Providers are therefore required to periodically attest to the accuracy of your directory profile information in accordance with KP protocols, as may be updated from time to time.

8.3.2 Contractor Initiated Termination (Voluntary)

Your Agreement requires that you give advance written notice if you plan on terminating your contractual relationship with KP. The written notice must be sent in accordance with the terms of your Agreement.

When you give notice of termination, you must immediately advise Provider Services of any Members who will be in the course of treatment during the termination period.

Provider Services may contact you to review the termination process, which may include transferring Members and their medical records to other providers designated by KP.

KP will make every effort to notify all affected Members of the change in providers at least 60 Calendar Days prior to the termination, so that the Members can be given information related to their continuity of care rights, and to assure appropriate transition to ensure that they will have appropriate access to care. KP will implement a transition plan to move the Members to a provider designated by KP, respecting each Member's legal continuity of care rights, and making every effort to minimize any disruption to medical treatment. You are expected to cooperate and facilitate the transition process. You will remain obligated to care for the affected Members in accordance with the written terms of the Agreement, state and federal law.

8.3.3 Other Required Notices

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

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.

8.4 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 prohibition against balance billing Members, the KP accessibility standards, our Quality Assurance & Improvement and UM Programs and your fee schedule.

8.5 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 their subcontracted providers to comply with applicable Interoperability Standards.

9. Quality Assurance and Improvement (QA & I)

9.1 Northern California Quality 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 to KP
- 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 the Member Services Contact Center at **1-(800) 464-4000** or **TTY: 711**. Additional information on KP's Northern California Quality 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 our 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 culture, 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.

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 national nonprofit organization founded by large employers and purchasers to drive movement in quality and safety in American health care. The group gathers information about medical care and patient safety relevant to urban hospitals via an annual Leapfrog Survey. The survey assesses hospital safety, quality, and efficiency based on national performance measures that are of specific interest to health care purchasers and consumers. All KP hospitals in California participated in the most recent survey. Survey results are publicly reported and provide hospitals with information to benchmark their progress in improving the care that is delivered.

To review KP hospital survey results, visit:

http://www.leapfroggroup.org/cp

To review the hospital's Safety Grades, visit:

https://www.hospitalsafetygrade.org/

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: https://reportcard.opa.ca.gov/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.

9.2 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 Member and Provider satisfaction.

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

- Patient access to care
- Patient complaint and satisfaction survey data 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.

9.3 Provider Credentialing and Recredentialing

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

The credentialing and recredentialing 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, physician assistants, advanced practice nurses, licensed nurse midwives, behavioral health practitioners, acupuncturists and optometrists. Organizational Providers (OPs) include, but are not limited to, hospitals, SNFs, home health agencies, hospice agencies, dialysis centers, congregate living facilities, behavioral health facilities, ambulatory surgical centers, clinical laboratories, comprehensive outpatient rehabilitation facilities, portable x-ray suppliers, federally qualified health centers and community based adult services centers. Services to Members may be provided only when the Provider meets KP's applicable credentialing criteria and has been approved by the appropriate Credentials and Privileges Committee.

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

9.3.1 Practitioners

KP requires that all practitioners within the scope of KP's credentialing program be credentialed prior to treating Members and must maintain credentialing at all times. 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, valid healing arts licenses, certificates and/or permits to practice in the State of California
- Clinical privileges are current and in good standing, if applicable
- Evidence of board certification or other national certification is current and in good standing, if applicable
- Evidence of appropriate education, clinical training, and current competence in practicing specialty
- Evidence of professional liability coverage equal to, or greater than, current KP standards
- Supporting References of Competence
- No history of State, Federal, Medicaid or Medicare sanctions/limitations/exclusions
- 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 will communicate credentialing determinations in writing to practitioners. In the event the committee decides to deny initial credentialing, terminate existing credentialing or make any other adverse decision regarding the practitioner's ability to treat Members, appeal rights will be granted in accordance with

applicable legal requirements and KP policies and procedures. The practitioner will be notified of those rights when notified of the committee's determination.

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

9.3.2 Practitioner Rights

9.3.2.1 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 notice will state to whom, and in what format, to submit corrections.

9.3.2.2 Practitioner Rights to Review Information

Upon written request, and to the extent allowed by law, a practitioner may review information submitted in support of their 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 during which practitioners may review the file.

9.3.2.3 Practitioner Right 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

9.3.2.4 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.

9.3.3 Organizational Providers (OPs)

KP requires that all OPs within the scope of its credentialing program be credentialed prior to treating Members and maintain credentialing at all times. 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

9.3.3.1 Corrective Action Plan or Increased Monitoring Status for OPs

Credentialing and recredentialing determinations are made by the KP 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.

9.4 Monitoring Quality

9.4.1 Compliance with Legal, Regulatory and Accrediting Body Standards

KP expects all Providers to be in compliance with all applicable legal, regulatory and accrediting requirements, to have and maintain accreditation as appropriate, to maintain a current certificate of insurance, and to maintain current licensure. If any entity takes any adverse action regarding licensure or accreditation, this must be reported to KP's Medical Services Contracting Department, along with a copy of the report, the action plan to resolve the identified issue or concern, within 90 Calendar Days of the receipt of the report.

9.4.2 Member Complaints

Written complaints 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 other requirements contained in your Agreement concerning the procedure for addressing specific complaints made by Members (either written or oral). If the problem is not amenable to immediate resolution at the point of service, the Member may submit a grievance. Refer to Section 7.5.3 for information on Member grievances.

9.4.3 Infection Control

KP requests the cooperation of Providers in monitoring their own practice for reporting of communicable diseases including COVID-19 during the pandemic, 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. When a potential infection is identified, notify the local Infection Preventionist. Confirmed HAI cases in the facility are tracked and entered into the Centers for Diseases and Control (CDC) database called National Health and Safety Network (NHSN) as required per mandated public reporting. When a trend is identified by the affiliated practitioner or Provider, this should be shared with 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.

9.4.4 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.

9.5 Quality Oversight

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.

9.5.1 Quality Review

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

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

9.5.2 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.

9.5.3 Sentinel Events / Reportable Occurrences for OPs

This section is 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.

9.5.3.1 Definitions: Sentinel Events and Reportable Occurrences

Sentinel event is a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) which results in a patient's death, severe harm (regardless of the duration of harm), or permanent harm (regardless of the severity of harm), and other adverse events defined by the Joint Commission and National Quality Forum.

- **Severe Harm**: An event or condition that results in life-threatening bodily injury to an individual (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life and requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition.

- **Permanent Harm**: An event or condition that results in any level of harm that permanently alters and/or affects an individual's baseline health.

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

9.5.3.2 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	Kidney Care Coordinator or Nephrologist	Within 24 hours
Ambulatory Surgery Center	Care Coordinator	Within 24 hours
Psychiatric Hospital	Care Coordinator	Within 24 hours
SNF	Care Coordinator	Within 24 hours
Transitional Residential Recovery Services (TRRS)	Care Coordinator	Within 24 hours

9.5.4 Sentinel Event/Reportable Occurrences—Home Health & Hospice Agency Providers

9.5.4.1 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 9.5.3.1) 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 email. The KP contact will notify the local KP Risk Management Department about all the reports.

- Falls resulting in death or serious injury

- Any unexpected death or any Member safety events resulting in severe, permanent or 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
- Severe permanent or temporary harm to a Member associated with the use of physical restraints or bedrails
- Member is a perpetrator or victim of a crime or of 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

9.5.4.2 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
- Medication administration 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

9.6 QA & I Reporting Requirements for Chronic Dialysis Providers

9.6.1 Reporting Requirements

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

- dialyzing for the first time
- transferring into the contracted dialysis center from another dialysis center
- returning after transplant
- recovering renal function
- receiving a transplant
- transferring to another dialysis center
- deceased
- changing treatment modality

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

9.6.2 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® or 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 Kidney Care Coordinator so that an appropriate intervention to prevent the access from clotting can be planned.

9.6.2.1 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

- Transonic Flow QC System®—Monthly*
- Another method of VAM approved by Governing Body or office of CMO
- As otherwise prescribed by a Nephrologist

1' Graft flow > 600 ml/min—continue to test at monthly intervals and trend results

1' 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

1' If trends remain constant and are not decreasing, repeat the test at the scheduled time

1' Graft flow rate < 500 ml/min—refer for angiogram and evaluation

Fistula

1' VAM services testing frequency

- Transonic Flow QC System®—Every other month*
- Another method of VAM approved by Governing Body or office of CMO
- As otherwise prescribed by a Nephrologist

1' Fistula flow rate >400 ml/min—continue to test at monthly intervals and trend results.

1' 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.

1' 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.

1' 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.

The Provider performs access flow measurements at frequencies other than that outlined above under the following conditions:

1' After a surgical procedure to create a new vascular access

1' Within a week following an access intervention, including but not limited to, a fistulogram, de-clotting, angioplasty or a surgical revision

1' As ordered by a Nephrologist

9.6.3 Performance Target Goals/Clinical Indicators

9.6.3.1 Chronic Dialysis Patients

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

REGIONAL RENAL ESRD QUALITY IMPROVEMENT PROGRAM DIALYSIS FACILITY SPECIFIC TARGETS			
MODALITY	**MEASUREMENT**	**DESCRIPTION**	**TARGET**
In-Center HD	Vascular Access	Percentage of patients in a given reporting period with a central venous catheter in place. If Fistula or Graft in use, but CVC in place, CVC will count as the highest risk access.	< 18%
	Adequacy of Dialysis	Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.2	≥ 95%
	Positive Blood Cultures	Report all positive blood cultures according to NHSN guidelines	100% of known positive blood cultures are reported
PD	Adequacy of Dialysis	Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.7	≥ 95%
	Peritonitis Rates	12-month rolling peritonitis rate	</= to 0.33 episodes per patient year

9.6.4 DNBE/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 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 5.15) 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:

Regional Medical Services Contracting Department
Attn: Provider Services
5820 Owens Drive, Building E, Floor 2
Pleasanton, CA 94588
Phone: **(925) 924-5050**
Fax: **(877) 228-8306**

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

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

9.7 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.

9.7.1 Annual Reporting

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

- Copies of current license and insurance
- Reports of any accreditation and/or regulatory site visits occurring within the last 12 calendar months
- 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

9.7.2 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

9.7.3 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

9.8 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.

9.8.1 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 CDPH of unusual occurrences involving KP Members

9.8.2 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

9.9 Medical Record Review and Standards

KP recommends that all Providers maintain their medical records following standards applicable to their specialty to assure the consistency and completeness of patient medical records.

NOTE: A Provider may demonstrate compliance with these standards by preparing a sample medical record and discussing it with the reviewer or by redacting several medical records for existing patients.

KP MEDICAL RECORD STANDARDS

Summary of Medical Record Standards	Information Required
Patient Identification*	All entries (entry, page, or screen) in a patient's medical record must include the patient's last name, first name, and the patient's unique KP medical record number (MRN).
Personal/Biographical Data*	Patient demographic information which includes: • Birth date • Gender • Marital status • Home address and • Home/work telephone numbers NOTE: For pediatric medical records, this information should also address the child's parent/guardian.
Medical Record Entries*	All notes/entries • Include the name of the rendering provider and, if paper documentation, are authenticated by the provider • Are dated and in sequential order • Are legible to someone other than the writer • Are done in a timely manner
Problem List (PCP only) *	Medical records include a completed "problem list" which notes significant illnesses or medical conditions.
Allergies*	Allergies and adverse reactions to medications or immunizations are noted and prominently displayed inside or on the cover of a hard copy of a medical record, and in any computer based program. If the patient has no known allergies or history of adverse reactions, this must be also noted.

Summary of Medical Record Standards	Information Required
Medical History"	Medical history must include: • Date of birth • Documentation of past medical history for which includes serious illnesses, past surgeries, or significant procedures. • Pertinent family and social history For **Pediatric Patients**, the history should also include: • Birth history including location, child's birth weight, and any special circumstances regarding the birth. • Growth chart with height, weight, and head circumference to (HC age 2) • Operations and childhood illnesses • Immunizations
Substance Abuse/Tobacco Products	For patients 14 years and older, medical records should document use/non-use of tobacco products, alcohol, or other substances. If the patient has been seen 3 or more times, they should be asked about substance abuse history.
Pertinent History/Exams for Patient "Complaints"	Pertinent history, physical exam for presenting complaints is completed and noted. The patient's vital signs are also noted.
Laboratory/Radiology Tests	Lab and Radiology and other testing are ordered as appropriate, and the ordering practitioner must make a notation in the record indicating abnormal results.
Working Diagnosis Consistent With Findings	Impression/working diagnosis clearly documented for each visit (except for preventive visits where no illness, complaint, etc. is identified.)
Treatment Plans	Treatment plans are consistent with diagnosis.
Follow-up Care/Visits	Date for return visit or other follow-up plan(s) for each encounter are noted when appropriate. The specific time of the follow-up visit is noted in weeks, months, or as needed.
Instruction in Self-Care	Date training/instruction on self-care provided to patient noted.
Unresolved Problems	Problems from previous visits are addressed in subsequent visits.
Use of Consultants	There is evidence of appropriate use of consultants.
Consultant Notes	There is evidence of continuity and coordination of care between primary and specialty providers. If consults are requested, copies of consultant notes are included in the medical record.

Summary of Medical Record Standards	Information Required
PCP Review of Consult/Lab Reports	Consultation summaries and lab & imaging reports indicate provider review. There is evidence that follow-up plans are in place for significant abnormal
Patient at Inappropriate Risk	There is no evidence that patient is placed at inappropriate risk by diagnostic or therapeutic intervention.
Immunizations*	An immunization record is present and up to date for all pediatric patients. Adult immunizations are noted as appropriate.
Advance Directive	Document in record, prominently placed, to denote whether an Advance Directive has been executed.
Preventive Services	There is evidence that preventive screening and services are offered according to nationally accepted standards and practice guidelines.
Medications	A medication list is included.
NOTE: Information and data recorded in the Medical Record and in other Member health & enrollment records must be accurate, complete, and truthful.	

* Medical records must comply with these standards if only general medical recordkeeping practices are being reviewed.

9.10 Access and Availability Guidelines

Access to care is evaluated according to applicable law and regulation and considers responses to member satisfaction questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider surveys, and Member complaints and grievances.

To assure all Members can access medical care in a safe and timely manner, KP utilizes access guidelines. KP's compliance with regulated access guidelines is measured by DHCS and/or DMHC through email or phone surveys conducted among contracted providers of professional services. Providers may be contacted by a regulator's third party contractor requesting information about available appointment times. HSAG/DataStat surveys providers on behalf of DHCS; Mazars surveys providers on behalf of DMHC. Results of such surveys are part of KP's QI Program because they help KP monitor our success in providing accessible care. In accordance with the Quality Assurance and Quality Improvement section of your KP Agreement (typically section 2.4.1 therein), Providers have an obligation to cooperate with KP's QI Program, including participation in phone surveys evaluating access to care.

Safe, efficient, and accessible practice sites are also essential components to delivering accessible, high quality care and services to Members. Facility standards are measured through KP office site reviews (for select Provider types). Results are used to inform KP quality improvement activities. Adhering to the guidelines in this section 9.10 increases access to care and overall Member satisfaction.

Access Indicator	Maximum Appointment/Response Timeframe
Primary Care Practitioners	
Preventive Gynecological Exam	7 Business Days
Non-urgent Care	7 Business Days
Routine/Preventive Care	7 Business Days
Behavioral Health Providers	
Urgent Care	Within 48 hours
Non-Urgent Care	Within 10 Business Days (therapist and any other non-physician treating providers) Within 15 Business Days (physician)
Routine Follow-Up (for Members undergoing a course of treatment for an ongoing mental health or substance use disorder condition)	Within 10 Business Days of the previous appointment (therapist and any other non-physician treating providers)
Specialists and Ancillary Services Practitioners	
Non-urgent symptomatic visit	14 Business Days. The timeframe begins on the day a referral is generated by the PCP and ends the day the patient is scheduled to see the specialist.
Routine Follow-Up	14 Business Days
ALL Providers	
Urgent care (non-life threatening, if left untreated could lead to harmful outcome)	Within 24 hours
Emergency care	Immediately
Wait times in physician's office	Less than 30 minutes. If an emergency occurs that will substantially lengthen a Member's waiting time, the office staff should inform the patient of the delay as soon as possible, and offer to: Reschedule appointments for Members if medically acceptable Have Members see another provider in the office if one is available, and the option is acceptable to the Member
Access to after-hours care	Continuous coverage must be available

Access Indicator	Maximum Appointment/Response Timeframe
Calls Placed to a Provider's	
During business hours	Returned same day the call is received
After business hours	Returned within 24 hours

Providers shall ensure covered services are available (i) during normal business hours, (ii) when medically indicated, on a prompt or same-day basis, and (iii) as otherwise specified in the Agreement, this Provider Manual or applicable laws. Providers shall ensure covered services are readily available and accessible to Members; provided in a timely manner, without delays in appointment scheduling and waiting times; and provided in a manner appropriate for the nature of a Member's condition, and consistent with good professional practice, KP policies and applicable laws. If it is necessary for Provider, a Commercial or Medi-Cal Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs, and ensures continuity of care consistent with good professional practice, and as otherwise required by applicable law.

If Provider provides covered services to treat Commercial or Medi-Cal Members who are undergoing a course of treatment for an ongoing mental health (including an autism diagnosis) or substance use disorder condition, Provider must offer follow-up appointments as follows, except as otherwise required or permitted by applicable laws:

- Nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder Provider must be offered within 10 business days of the Member's prior appointment, except as otherwise permitted by law and as described in below. This requirement does not limit coverage for nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.
- The 10 business day timeframe for a follow-up appointment may be extended if the referring or treating health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

When Members request same day or future appointments and their medical condition warrants, the appointment should be scheduled as close to the requested day and time as possible. If the Member does not request a specific day or time, an appointment within the time frames noted in the table above should be offered.

The applicable waiting time for an appointment may be extended if the KP referring or treating licensed health care provider, or the KP health professional providing triage or screening services to Members, as applicable, has determined that a longer waiting time

will not have a detrimental impact on the health of the Member. If any Member declines an appointment offered within these guidelines, or if the Provider, in consultation with the KP referring or treating health care provider, determines that a longer waiting time will not have a detrimental impact on the health of the Member, the declination or the professional determination and underlying clinical basis for a delayed appointment should be documented in the Member's medical record maintained by the treating Provider.

For inquiries regarding timeliness of referrals, providers should contact the KP office which issued the referral as noted in the authorization communication. If Members have inquiries regarding timeliness of referrals, Members may contact the Member Services Contact Center. If a Member's plan is regulated by the DMHC, the Member or a Provider may file a complaint with the DMHC regarding timeliness of referrals. Members can file a DMHC complaint as provided in Section 7.5.4, and Providers may file a complaint by contacting the DMHC's provider complaint line at **(877) 525-1295**.

10. Compliance

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

10.1 Compliance with Law

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

10.2 Code of Ethical Conduct and Compliance Hotline

The Code of Ethical Conduct - 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 POR at: Code of Ethical Conduct - Kaiser Permanente's Principles of Responsibility v.10 (policytech.com) and are encouraged to do so. The POR is 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.

10.3 Gifts and Business Courtesies

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

- Gifts or entertainment of any 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

10.4 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 **(888) 774-9100** for further guidance on potential conflicts of interest.

10.5 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.

10.6 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.

10.7 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.

10.8 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 or as required by any government health care program contract to which KP is a party. Where applicable, you must ensure that your employees and agents involved in KP business complete, and provide evidence of completion of, the relevant KP Compliance Training. Please refer to your KP Contracts Manager for more guidance regarding these requirements.

10.9 Confidentiality and Security 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 both applicable to Providers and KP, 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.

10.9.1 HIPAA and Privacy and Security 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 likely 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 (collectively “HIPAA”). 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 his or her PHI, as applicable to allow that patient to amend his or her PHI, and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures. You must extend these same rights to Members who are patients.

10.9.2 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.

10.10 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**

11. Additional Information

11.1 Affiliated Payors

In accordance with the terms of your Agreement with KP, the mutually agreed upon rates in the Agreement may be extended to Affiliated Payors as identified below:

Kaiser Foundation Health Plan, Inc. (Northern California, Southern California, Hawaii)

Kaiser Foundation Health Plan of Colorado

Kaiser Foundation Health Plan of Georgia, Inc.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Kaiser Foundation Health Plan of the Northwest

Kaiser Foundation Health Plan of Washington

Kaiser Foundation Health Plan of Washington Options, Inc.

Kaiser Foundation Hospitals

Kaiser Permanente Insurance Company

KP Cal, LLC

The Permanente Medical Group, Inc.

Southern California Permanente Medical Group

Colorado Permanente Medical Group, P.C.

Hawaii Permanente Medical Group, Inc.

Mid-Atlantic Permanente Medical Group, P.C.

Northwest Permanente, P.C.

Permanente Dental Associates

The Southeast Permanente Medical Group, Inc.

Washington Permanente Medical Group, P.C.

11.2 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 extend 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.

11.2.1 Regulatory Compliance

CMS, DHCS, DMHC, NCQA and other state and federal agencies and accrediting organizations conduct surveys of KP to measure compliance with legal, regulatory and accreditation requirements and standards. Regulatory requirements related to the use of subcontractors obligate KP to validate subcontracts are in place where applicable, and they meet all regulatory and contractual requirements. Upon request, Provider must provide KP a copy of its subcontract template along with executed signature pages for each subcontractor. When a subcontract is amended or altered, Provider should notify KP within 30 Calendar Days. Provider must furnish copies of executed subcontracts, and other documents related to subcontractors, upon the request of governmental, regulatory or accreditation agency personnel and/or when KP is preparing for internal and/or regulatory or accreditation agency audits.

Additionally, upon request, the Provider is responsible to furnish copies of its policies and procedures related to any economic profiling information that is used to evaluate participating practitioner or subcontractor performance. Further the Provider is responsible to provide a copy of the information, upon request, to the subcontractor or participating practitioner. Economic profiling is defined as an evaluation based in whole or in part on the economic costs or utilization of services associated with providing medical care.

11.2.2 Licensure, Certification and Credentialing

Subcontractors and participating practitioners are subject to the same credentialing and recredentialing 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 and recredentialing processes and that any site where Members may be seen is properly licensed. For additional information on credentialing requirements, please refer to Section 9.3 of this Provider Manual.

11.2.3 Billing and Payment

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

11.2.4 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.

11.2.5 Identification of Subcontractors

Each Provider at the time of initial contracting, and periodically thereafter, is required to complete and submit to KP a completed PPIF (incorporated by reference in your Agreement). 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.

11.3 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.

11.3.1 Health Education Program

KP health education programs generally include:

- Health Education Centers, located at or operated virtually by 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 are available throughout Northern California and cover a wide variety of topics. Most classes are taught in groups, but for Members who prefer an individualized approach, one-to-one counseling is also available in person, by telephone, or by video visit. 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.

11.3.2 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.

11.3.4 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 up 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.

11.4 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) Members and Members who are Deaf or Hard of Hearing 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 a companion/caregiver involved in care decisions for a Member requires 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.

The offer of qualified interpreter services to Members and/or their companion/caregiver shall not be limited to in-person encounters only, but also applies to telehealth visits.

Questions regarding the following information on language assistance can be discussed with KP's Language Assistance Program by emailing

NCAL-Language-Assistance-Program@kp.org

11.4.1 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
- Fundamental knowledge in both languages of health care terminology and concepts
- Education and training in interpreting ethics, conduct and confidentiality

11.4.2 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.

11.4.2.1 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. This number will be 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-services/provide-feedback). You will receive an instant receipt acknowledgement and a follow-up response within 48 hours.

11.4.2.2 In-Person Interpreter: American Sign Language Support

Kaiser Permanente contracts with multiple companies to provide in-person interpreter services for Members who are Deaf or Hard of Hearing and require American Sign Language (ASL). In-person interpreter services require a minimum of 48 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 Kaiser Permanente contracted American Sign Language companies are:

Company	Customer Service/Scheduling	Cancellation Policy
Interpreting and Consulting Services, Inc.	1-707-747-8200 1-888-617-0016 (After hours emergency) icsinterpreting@gmail.com	Cancellations must be made 48 hours in advance of appointment
Partners in Communication LLC	1-800-975-8150 Please use extension 805 after hours and on weekends. partners@partnersincommunicationllc.com	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

11.4.3 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.

11.4.4 Family Members as Interpreters

The KP Language Assistance Program discourages using family members as interpreters. 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.

- 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 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.

11.4.5 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."

11.4.6 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.

12. Additional Service Specific Information

12.1 Service Authorizations for SNFs

Service Authorizations for SNFs are generated by the KP Continuum of Care team as part of discharge planning and case management processes and with consideration of the Member's benefits, eligibility and, if any, other healthcare coverage. SNFs may also request a service Authorization/reauthorization by contacting:

Northern California SNF Complex Hub
snf-authorizations@kp.org
(510) 675-5090

12.2 General Assistance for SNFs

SNFs can contact their local KP Skilled Nursing Department for general assistance and requesting Authorizations for ancillary services to Members. Please refer to the Skilled Nursing Facility Coordinator contact list in section 2.4, KP Facility Listing.

12.2.1 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 Facility Coordinator (see Section 2.4, KP Facility Listing, of this Provider Manual). KP will work with you to determine the most appropriate provider and venue for providing the requested ancillary service to the Member.

12.2.2 Supplies, Drugs, Equipment and Services Excluded from the Long Term Care SNF Per Diem

SNFs should follow the procurement and reimbursement protocol for supplies, drugs, equipment and services excluded from the Long Term Care SNF per diem as directed in their Agreement.

12.2.3 Laboratory Services Ordering For SNFs

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

Members receive covered services of a SNF under either their "skilled" or Long Term Care (i.e., "custodial") benefit. Identifying the Member's benefit is essential to processing the claim correctly. Lab services are paid in the following manner depending on the Member's benefit and whether the service has been authorized by a Plan Physician:

Benefit 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 benefit as described above, should be noted on the lab requisition form. This benefit is usually found in the patient's chart or in the SNF census reports.

12.3 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 (involuntary) 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 (involuntary) 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 behavioral health 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 at risk for hospitalization or recently discharged from an inpatient hospital and at risk for re-hospitalization.

12.4 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 Recovery Services. Residential Recovery Services are authorized through Addiction Medicine and Recovery Services 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 hour/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 hour/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, typically 14-21 days in length, providing therapy and educational services 6-8 hours each day

Service	Description
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
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 by KP 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, they 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.

12.5 KP Direct Mental Health Network

The KP Direct Mental Health Network (KP Direct) consists of behavioral health providers contracted with and credentialed by KP to expand access to outpatient mental health services. KP's Northern California Mental Health teams will determine appropriate care and proper placement for KP members, including referral to contracted providers.

KP promotes measurement-based Feedback Informed Care, prioritizing the patient voice in their mental health treatment. To that end, KP provides KP Direct providers with access to Lucet's digital platform where KP Direct providers can:

Create and update a practice profile of patient facing information;

- Manage availability and facilitate scheduling of new referrals;
- Administer Treatment Progress Indicator (TPI) assessments at every session;
- Complete documentation of key care points, including initial evaluation, clinical reviews when requested, safety plan when clinically appropriate, a discharge summary, and free form notes as appropriate;
- Partner with our clinical quality review consultants to ensure members are engaged in treatment supporting improved patient outcomes;

12.6 Special Needs Plan (SNP)

KFHP offers a Medicare Advantage Special Needs Plan (SNP) enrolling beneficiaries who are eligible for Medicare and full benefits under Medi-Cal. As a Special Needs Plan Sponsor, KFHP is required to provide a Model of Care (MOC) that addresses the special needs of these Members. All SNP MOCs must include the following elements:

- Description of Overall SNP Population
- Description of Subpopulation – Most Vulnerable Beneficiaries
- SNP Staff Structure
- Health Risk Assessment Tool
- Interdisciplinary Care Team
- Care Transition Protocols
- Specialized Expertise for Provider Network
- Use of Clinical Practice Guidelines and Care Transitions Protocols
- Training for the Provider Network
- Quality Improvement Performance Plan
- Measurable Goals and Health Outcomes
- SNP Member Satisfaction
- Ongoing Performance Evaluation of MOC
- Dissemination of SNP Quality Performance

SNPs must collect data on quality indices as required and in concert with the KP program plan.

Please contact your local SNP clinical lead or team members if you have additional questions about the program or your SNP patients.

12.7 Autism Spectrum Disorder (ASD) Services

If Provider provides covered services encompassing Behavioral Health Treatment (as defined by California Health and Safety Code Section 1374.73(c)(1), including applied behavior analysis and evidence-based behavior intervention programs for pervasive developmental disorder or autism, Provider shall provide such Behavioral Health Treatment in accordance with the requirements set forth in California Health and Safety Code Section 1374.73, including providing Services under a treatment plan described and administered by Qualified Autism Service Providers, Qualified Autism Service Professionals and/or Qualified Autism Service Paraprofessionals (as those terms are defined by California Health and Safety Code Section 1374.73(c)(3)). Providers must provide documentary evidence to KP upon request to demonstrate the criteria set forth in California Health and Safety Code Section 1374.73 for all Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals have been met, including but not limited to making treatment plans available as required by California Health and Safety Code Section 1374.73(c)(1)(D).

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

NTL

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

1.0 Business Policy

1.1 Payment Policy Statement

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

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

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

. American Academy of Professional Coders (AAPC)

. American Medical Association (AMA)

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

1.2 Scope

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

2.0 Rules

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

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

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

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

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

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

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

2.2 Reimbursement Guidelines

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

2.2.1.1 The following types of charges are examples of charges that a KFHP clinician may determine to be inclusive of, or an integral part of another procedure or service and therefore not separately payable. KFHP will use clinical discretion and judgment and will

consider commonly accepted standards as applicable to the facts and circumstances of each case.

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

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

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

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

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

2.2.5 Charges for services that are necessary or otherwise integral to the provision of a specific service and/or delivery of services in a specific location are considered routine services and are not separately reimbursable. This applies to both the inpatient and outpatient settings. These services are part of the room and board charges.
Examples include, without limitation, the following:

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

- Saline flushes
- Urinary catheterization
- Venipuncture

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

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

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

2.2.8 KFHP follows the Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS) Fee Scheduled for all codes that are covered but not separately reimbursed. Examples include but are not limited to:

2.2.8.1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.0 Guidelines

N/A

4.0 Definitions

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

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

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

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

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

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

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

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

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

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

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

5.0 References

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

Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual. Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS). Section 240 – Inpatient Part B Hospital Services
Centers for Medicare & Medicaid Services website. The Provider Reimbursement Manual – Part 1. Chapter 22 – Determination of Cost of Services. Sections 2202.4, 2202.6, 2202.8 and 2203

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

National Uniform Billing Committee | NUBC

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

Implants and Prosthetics | FDA (implants section)

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

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

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

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

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

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

6.0 Related Topics

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/25)

Revision History

Approvals

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

NTL

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

1.0 Business Policy

1.1 Payment Policy Statement

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

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

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

. American Academy of Professional Coders (AAPC) .

American Medical Association (AMA)

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

1.2 Scope

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

2.0 Rules

2.1 Clinicians within the Clinical Review department will review the medical records to determine whether the billed services are medically appropriate or necessary, and correctly coded for reimbursement. When medical records or clinical information is requested, all the specific information required to make the medical determination must be clearly documented in the records. In addition, services must be considered a covered benefit. Determinations of medical necessity adhere to the standard of care and focus on the direct care and treatment of the patient. KFHP Clinical Review follows CMS and other industry guidelines, clinical literature, and accepted medical necessity criteria.

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

2.3 Reimbursement Guidelines

2.3.1 Clinical Review will review the medical records to assess:

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

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

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

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

2.3.1.5 Whether the coding and billing is accurate and appropriate. **2.3.1.6**

Whether the authorization reflects what is billed.

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

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

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

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

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

2.4 Trauma Activation

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

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

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

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

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

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

2.5 Level of Care (LOC) Review

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

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

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

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

2.6 Neonatal Intensive Care Level of Care (NICU)

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

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

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

2.7 Post Stabilization

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

2.8 Short Stay/2 Midnight Rule

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

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

2.8.3 The patient dies during the stay.

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

2.9 Present on Admission (POA):

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

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

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

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

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

2.10 Provider Preventable Conditions (PPC)

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

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

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

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

2.10.4.1 Wrong surgery/invasive procedure.

2.10.4.2 Surgery/invasive procedure performed on the wrong patient.

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

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

2.11 Thirty Day Readmissions

2.11.1 KFHP does not allow separate reimbursement for claims that have been identified as readmission to the same hospital or Hospital System reimbursed by DRG pricing for the same, similar or related condition unless

provider, state, federal or CMS contracts and/or requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, KFHP will use the following standards: (a) readmission within 30 days from discharge; (b) same diagnosis or diagnoses that fall into the same grouping.

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

2.12.1 KFHP follows CMS guidelines for CAR-T reimbursement.

3.0 Guidelines

N/A

4.0 Definitions

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

4.2 Post Stabilization Care Following stabilization of the member's emergency medical condition, post-stabilization care are those medically necessary services needed to maintain a member's stabilized condition, or as otherwise defined by applicable law.

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

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

5.0 References

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0 Eliminating Serious, Preventable, and Costly Medical Errors - Never Events | CMS Hospital Acquired Conditions | CMS Hosp. Readmission Reduction | CMS

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

National Uniform Billing Committee | NUBC

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/2025)

Revision History

Approvals

POL-020.3 Clinical Review Coding Payment Determination Policy

NTL

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

1.0 Business Policy

1.1 Payment Policy Statement

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

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

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

. American Academy of Professional Coders (AAPC) .

American Medical Association (AMA)

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

1.2 Scope

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

2.0 Rules

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

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

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

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

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

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

2.2 Reimbursement Guidelines

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

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

2.3 Medically Unlikely Edits (MUE)

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

2.4 Bundled Procedures

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

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

2.5 Modifiers

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

2.6 Documentation Required:

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

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

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

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

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

2.7 Multiple Modifiers:

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

2.8 Site of Service Modifier:

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

2.9 TC Technical Component:

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

2.10 Modifier 24:

2.10.1 When using Modifier 24 the following shall apply:

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

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

2.11 Modifier 25:

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

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

2.12 Modifier 26 Professional Component:

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

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

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

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

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

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

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

2.14 Bilateral Surgery (LT/RT/50)

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

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

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

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

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

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

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

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

2.16 Co-Surgeons (Modifier 62):

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

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

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

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

2.17 Team Surgery (Modifier 66)

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

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

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

2.17.1.3 Payment Indicator 2: Team surgeons are permitted.

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

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

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

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

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

2.18.2.2 Payment Indicator 1: Assistant surgeon not permitted.

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

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

2.19 Global Period

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

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

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

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

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

2.19.6 XXX Global concept does not apply.

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

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

2.20 Multiple Procedure Payment Rules

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

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

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

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

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

2.21 MPFS Status Indicator Codes:

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

2.22 Anesthesia

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

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

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

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

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

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

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

2.25 Robotic Assisted Surgery

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

2.26 Unlisted Codes

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

2.27 Outpatient Observation Services

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

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

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

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

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

2.28 Diagnosis Related Group (DRG) Payment

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

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

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

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

2.28.1.3.1 Physician ordered inpatient status.

2.28.1.3.2 Accuracy of diagnostic code assignment.

2.28.1.3.3 Accuracy of the procedural code assignments.

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

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

2.28.1.3.6 Accuracy of the DRG grouping assignment and associated payment.

2.28.1.3.7 Accuracy of the Discharge Disposition Status Code assignment.

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

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

3.0 Guidelines

N/A

4.0 Definitions

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

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

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

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

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

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

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

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

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

4.10 National Coverage Determinations (NCD) Policy decisions by the Centers for Medicare & Medicaid Services (CMS) that specify whether a particular item or service is considered reasonable and necessary for Medicare coverage on a nationwide basis.

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

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

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

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

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

5.0 References

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

https://www.aapc.com/resources/what-are-relative-value-units-rvus?srsltid=AfmBOooizLh65MIlBqpJ0rYEhtEamQBpt7Lc6_sfJ2hTxMR0bCqsOj0x
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Medicare Claims Processing Manual: Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 290 Outpatient Observation Services. Accessed 03/16/2010 at http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf 2

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

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

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy POL-

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- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

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

2.0 Rules

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

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

2.2 Reimbursement Guidelines

2.2.1 Humanitarian Use Device (HUD)

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

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

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

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

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

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

2.2.2 Non-Covered Examples

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.0 Guidelines

N/A

4.0 Definitions

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

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

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

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

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

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

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

5.0 References

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

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

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

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

5.5 HCPCS Level II Manual, published by CMS

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

6.0 Related Topics

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

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/2025)

Revision History

Approvals

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

NTL

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

1.0 Business Policy

1.1 Payment Policy Statement

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

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

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

. American Academy of Professional Coders (AAPC) .

American Medical Association (AMA)

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

1.2 Scope

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

2.0 Rules

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

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

2.3 Reimbursement Guidelines

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

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

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

2.4 Preventable/Inappropriate Readmissions

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

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

3.0 Guidelines

3.1 Exclusions

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

- Admissions associated with malignancies (limited to those who are in an active chemotherapy regimen-both infusion and oral), burns, or cystic fibrosis.
- Admissions with a documented discharge status of "left against medical advice."
- Behavioral health readmissions.

- In-network facilities that are not reimbursed based on contracted DRG or case rate methodology (e.g., per diem).
- Obstetrical readmissions for birth after an antepartum admission.
- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, for similar repetitive treatments, or for elective surgery. These include:
    - Transfers from one acute care hospital to another.
    - Critical Access Hospitals (CAHs).
    - Exclusions for the Washington State region ONLY: (a) Readmission due to patient nonadherence; (b) End-of-life and hospice care; (c) Obstetrical readmissions for birth after an antepartum admission; (d) Neonatal readmissions; (e) Transplant readmissions within 180 days of transplant.
- Substance use readmissions.
- Transplant services (within 180 days of transplant), including organ, tissue, or bone marrow transplantation from a live or cadaveric donor.

4.0 Definitions

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

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

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

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

5.0 References

1.5 Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at:

http://www.cms.gov/manuals/downloads/clm104c03.pdf. Accessed September 29, 2011.

1.6 Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available at: http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf. Accessed September 29, 2011

1.7 Hospital-Acquired Condition Reduction Program | CMS

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

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy POL-020.4

Clinical Review Implant Payment Determination Policy

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

(Updated: 09/08/2025)

Revision History

Approvals

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

NTL

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

1.0 Business Policy

1.1 Payment Policy Statement

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

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

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

. American Academy of Professional Coders (AAPC) .

American Medical Association (AMA)

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

1.2 Scope

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

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

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

2.0 Rules

2.1 Criteria

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

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

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

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

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

- IONM codes should be reported based upon the time spent monitoring only, and not the number of baseline tests performed, or parameters monitored.
- The monitoring professional should be solely dedicated to the intraoperative neurophysiologic monitoring service, and available to intervene immediately, if necessary, throughout the duration of the procedure.
- Time reported should not include items such as time to set up, record, and interpret baseline studies, time to remove electrodes at the end of the procedure, or standby time.

3.0 Guidelines

N/A

4.0 Definitions

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

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

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

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

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

5.0 References

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

CMS Article A56722. Billing and Coding: Intraoperative Neurophysiological Testing

Healthcare Common Procedure Coding System (HCPCS) Manual

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

National Correct Coding Initiative (NCCI) Policy Manual

National Uniform Billing Committee (NUBC) – UB-04 Data Specifications ManualMedical Policy Manual for Intraoperative Neuromonitoring (found on provider portal)

6.0 *Related Topics*

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Payment Implant Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

(Updated: 09/08/2025)

Revision History

Approvals