



2025
Northern California
HMO Provider Manual
Kaiser Foundation Health Plan, Inc.





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/>

Table of Contents

INTRODUCTION XI

1. KAISER PERMANENTE MEDICAL CARE PROGRAM (KPMCP).....1

1.1 HISTORY 1

1.2 ORGANIZATIONAL STRUCTURE..... 1

1.3 KPNC SERVICE AREA 1

1.4 INTEGRATION.....2

1.5 NONDISCRIMINATION.....2

1.6 OTHER PRODUCTS.....2

 1.6.1 Exclusive Provider Organization (EPO)..... 2

 1.6.2 Point of Service (POS)—Two-Tier 3

 1.6.3 Point of Service (POS)—Three-Tier 3

 1.6.4 Out of Area Preferred Provider Organization (PPO) 3

1.7 IDENTIFICATION CARDS AND MEDICAL RECORD NUMBER (MRN) 4

2. KEY CONTACTS 7

2.1 NORTHERN CALIFORNIA REGION KEY CONTACTS7

2.2 MEMBER SERVICES INTERACTIVE VOICE RESPONSE SYSTEM (IVR) 9

2.3 KP OUTSIDE SERVICES 9

2.4 KP FACILITY LISTING..... 11

2.5 NORTHERN CALIFORNIA RESOURCE MANAGEMENT (RM) CONTACTS..... 14

3. ELIGIBILITY AND BENEFITS DETERMINATION.....18

3.1 ELIGIBILITY AND BENEFIT VERIFICATION 18

 3.1.1 After Hours Eligibility Requests.....19

 3.1.2 Benefit Coverage Determination19

3.2 MEMBERSHIP TYPES..... 19

3.3 BENEFIT EXCLUSIONS AND LIMITATIONS20

3.4 DRUG BENEFITS.....20

**4. UTILIZATION MANAGEMENT (UM) AND RESOURCE MANAGEMENT (RM)
.....21**

4.1	OVERVIEW OF UTILIZATION MANAGEMENT AND RESOURCE MANAGEMENT PROGRAM	21
4.1.1	Data Collection and Surveys.....	21
4.2	MEDICAL APPROPRIATENESS.....	22
4.3	“REFERRAL” AND “AUTHORIZATION” – GENERAL INFORMATION	22
4.4	AUTHORIZATION OF SERVICES	23
4.4.1	Hospital Admissions Other Than Emergency Services	24
4.4.2	Admission to Skilled Nursing Facility (SNF)	24
4.4.2.1	Authorization Numbers are Required for Payment.....	25
4.4.3	Home Health/Hospice Services	25
4.4.3.1	Home Health Specific Criteria	25
4.4.3.2	Hospice Care Criteria.....	26
4.4.4	Durable Medical Equipment (DME)/ Prosthetics and Orthotics (P&O)	26
4.4.5	Psychiatric Hospital Services Other Than Emergency Services	26
4.4.6	Non-Emergent Transportation	26
4.4.6.1	Non-Emergency Medical Transport (Gurney Van/Wheelchair Van)	26
4.4.6.2	Non-Emergency Ambulance Transportation	27
4.4.7	Transfers to a KP Medical Center.....	27
4.4.7.1	Required Information for Transfers to KP.....	27
4.4.8	Visiting Member Guidelines.....	28
4.5	EMERGENCY ADMISSIONS AND SERVICES; HOSPITAL REPATRIATION POLICY	29
4.5.1	Emergency Prospective Review Program (EPRP)	30
4.5.2	Post-Stabilization Care	31
4.6	CONCURRENT REVIEW.....	32
4.7	CASE MANAGEMENT HUB CONTACT INFORMATION	33
4.8	DENIALS AND PROVIDER APPEALS.....	33
4.9	DISCHARGE PLANNING	33
4.10	UM INFORMATION	34
4.11	CASE MANAGEMENT	34
4.12	CLINICAL PRACTICE GUIDELINES (CPGs).....	35
4.13	PHARMACY SERVICES / DRUG FORMULARY.....	35
4.13.1	Filling Prescriptions	36

4.13.1.1 Prescribing Non-Formulary Drugs	36
4.13.1.2 Pharmacies.....	37
4.13.1.3 Telephone and Internet Refills.....	37
4.13.1.4 Mail Order.....	37
4.13.1.5 Restricted Use Drugs	38
4.13.1.6 Emergency Situations.....	38
5. BILLING AND PAYMENT	39
5.1 WHOM TO CONTACT WITH QUESTIONS	39
5.2 METHODS OF CLAIMS SUBMISSION	39
5.3 CLAIMS FILING REQUIREMENTS.....	40
5.3.1 Record Authorization Number.....	40
5.3.2 One Member and One Provider per Claim Form.....	40
5.3.3 Submission of Multiple Page Claim (CMS-1500 Form and UB-04 Form)	40
5.3.4 Billing for Claims That Span Different Years.....	41
5.3.4.1 Billing Inpatient Claims That Span Different Years	41
5.3.4.2 Billing Outpatient Claims That Span Different Years	41
5.3.5 Interim Inpatient Bills.....	41
5.3.6 Psychiatric and Recovery Services Provided to Medi-Cal Members	42
5.4 PAPER CLAIMS.....	42
5.4.1 Submission of Paper Claims -Referred Services	42
5.4.1.1 Contacting KP Regarding Referred Services Claims	43
5.4.2 Submission of Paper Claims – Emergency Services	43
5.4.2.1 Calling KP Regarding Emergency Claims	43
5.4.3 Supporting Documentation for Paper Claims.....	44
5.4.4 Ambulance Services.....	45
5.5 SUBMISSION OF ELECTRONIC CLAIMS.....	45
5.5.1 Electronic Data Interchange (EDI)	45
5.5.2 Where to Submit Electronic Claims	45
5.5.3 EDI Claims Acknowledgement.....	46
5.5.4 Supporting Documentation for Electronic Claims	46

5.5.5	HIPAA Requirements	46
5.6	COMPLETE CLAIM.....	47
5.7	CLAIMS SUBMISSION TIMEFRAMES.....	48
5.8	PROOF OF TIMELY CLAIMS SUBMISSION	48
5.9	CLAIMS RECEIPT VERIFICATION AND STATUS	49
5.10	CLAIM CORRECTIONS	49
5.11	INCORRECT CLAIMS PAYMENTS	52
5.11.1	Underpayments	52
5.11.2	Overpayments.....	53
5.11.2.1	Overpayment Identified by Provider	53
5.11.2.2	Overpayment Identified by KP	54
5.11.2.3	Contested Notice	54
5.11.2.4	No Contest.....	54
5.11.2.5	Offset to Payments	54
5.11.3	Inconsistent Payments	55
5.12	MEMBER COST SHARE	55
5.13	BILLING FOR SERVICE PROVIDED TO VISITING MEMBERS	56
5.14	CODING FOR CLAIMS.....	57
5.15	CODING STANDARDS.....	57
5.16	MODIFIERS USED IN CONJUNCTION WITH CPT AND HCPCS CODES	59
5.17	MODIFIER REVIEW.....	59
5.18	CLAIMS REVIEW AND ADJUSTMENTS; CODING AND BILLING VALIDATION	59
5.18.1	Compensation Methodologies.....	59
5.18.2	Code Review and Editing	60
5.18.3	Coding Edit Rules	61
5.18.4	Clinical Review	61
5.18.5	Do Not Bill Events (DNBE)	62
5.18.6	Claims for Do Not Bill Events	64
5.19	COORDINATION OF BENEFITS (COB).....	65
5.19.1	How to Determine the Primary Payor.....	65
5.19.2	Description of COB Payment Methodology	66
5.19.3	COB Claims Submission Requirements and Procedures	66

5.19.4	Direct Patient Billing	67
5.20	MEDI-CAL COST AVOIDANCE.....	67
5.21	THIRD PARTY LIABILITY (TPL)	68
5.21.1	First and Third Party Liability Definitions	68
5.21.2	Third Party Liability Guidelines.....	69
5.22	WORKERS' COMPENSATION.....	69
5.23	PROHIBITED MEMBER BILLING PRACTICES.....	69
5.24	EXPLANATION OF PAYMENT AND REMITTANCE ADVICE.....	70
5.25	INVOICES.....	70
5.25.1	Other Contracted Functions Related to Professional Services	71
5.25.2	Other Contracted Functions Related to Services Delivered at KFH (Non-Professional).....	73
5.25.3	1099 Tax Documents.....	73
6.	PROVIDER DISPUTE RESOLUTION PROCESS.....	75
6.1	TYPES OF DISPUTES	75
6.2	SUBMITTING PAYMENT DISPUTES.....	75
6.2.1	Directions for Submission of Payment Disputes	75
6.2.1.1	Payment Disputes Related to Referred Service Claims.....	75
6.2.1.2	Payment Disputes Related to Emergency Services Claims	76
6.2.1.3	Payment Disputes Related to Visiting Member Claims.....	76
6.2.2	Required Information for Provider Payment Dispute Notices.....	77
6.2.3	Time Period for Submission of Provider Dispute Notices.....	78
6.2.4	Timeframes for Acknowledgement of Receipt and Determination of Provider Dispute Notices	78
6.2.5	Instructions for Resolving Substantially Similar Payment Disputes	78
6.3	DISPUTING REQUESTS FOR OVERPAYMENT REIMBURSEMENTS.....	79
6.4	OTHER DISPUTES	79
7.	MEMBER RIGHTS AND RESPONSIBILITIES	80
7.1	MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT.....	80
7.2	NON-COMPLIANCE WITH MEMBER RIGHTS AND RESPONSIBILITIES.....	86
7.2.1	Members	87

7.2.2	Providers.....	87
7.3	HEALTH CARE DECISION-MAKING.....	88
7.4	ADVANCE DIRECTIVES	89
7.4.1	Physician Orders for Life Sustaining Treatment (POLST)	90
7.5	MEMBER GRIEVANCE PROCESS.....	90
7.5.1	Provider Participation in Member Grievance Resolution	91
7.5.2	Member Grievance Resolution Procedure	91
7.5.3	Processes for Grievance Resolution	91
	7.5.3.1 Quality of Care Grievances	92
	7.5.3.2 Expedited Review	92
	7.5.3.3 Instructions for Filing a Grievance	93
7.5.4	Department of Managed Health Care Complaint Process—Non-Medicare	96
	7.5.4.1 Independent Medical Review Program Availability—Non-Medicare	96
7.5.5	Demand for Arbitration.....	97

8. PROVIDER RIGHTS AND RESPONSIBILITIES 98

8.1	PROVIDERS’ RIGHTS AND RESPONSIBILITIES	98
8.2	COMPLAINT AND PATIENT CARE PROBLEMS.....	99
8.2.1	Administrative and Patient Related Issues.....	100
8.2.2	Claim Issues.....	100
8.3	REQUIRED NOTICES.....	100
8.3.1	Provider Changes That Must Be Reported.....	100
	8.3.1.1 Provider Illness or Disability.....	100
	8.3.1.2 Practice Relocations	100
	8.3.1.3 Adding/Deleting New Practice Site or Location.....	100
	8.3.1.4 Adding/Deleting Practitioners to/from the Practice.....	101
	8.3.1.5 Changes in Telephone Numbers	101
	8.3.1.6 Federal Tax ID Number and Name Changes.....	101
	8.3.1.7 Mergers and Other Changes in Legal Structure.....	101
	8.3.1.8 Provider Directories Information per Health and Safety Code § 1367.27	101

8.3.2	Contractor Initiated Termination (Voluntary).....	103
8.3.3	Other Required Notices	103
8.4	CALL COVERAGE PROVIDERS	103
8.5	HEALTH INFORMATION TECHNOLOGY	104
9.	QUALITY ASSURANCE AND IMPROVEMENT (QA & I).....	105
9.1	NORTHERN CALIFORNIA QUALITY PROGRAM AND PATIENT SAFETY PROGRAM.....	105
9.2	QUALITY ASSURANCE AND IMPROVEMENT (QA & I) PROGRAM OVERVIEW.....	106
9.3	PROVIDER CREDENTIALING AND RECREDENTIALING.....	107
9.3.1	Practitioners	108
9.3.2	Practitioner Rights	109
9.3.2.1	Practitioner Right to Correct Erroneous or Discrepant Information.	109
9.3.2.2	Practitioner Rights to Review Information.....	109
9.3.2.3	Practitioner Right To Be Informed of the Status of the Credentialing Application	109
9.3.2.4	Practitioner Right to Credentialing and Privileging Policies.....	109
9.3.3	Organizational Providers (OPs)	110
9.3.3.1	Corrective Action Plan or Increased Monitoring Status for OPs ...	110
9.4	MONITORING QUALITY	111
9.4.1	Compliance with Legal, Regulatory and Accrediting Body Standards ...	111
9.4.2	Member Complaints.....	111
9.4.3	Infection Control.....	111
9.4.4	Practitioner Quality Assurance and Improvement Programs.....	112
9.5	QUALITY OVERSIGHT	112
9.5.1	Quality Review	113
9.5.2	OPs’ Quality Assurance & Improvement Programs (QA & I).....	114
9.5.3	Sentinel Events / Reportable Occurrences for OPs.....	114
9.5.3.1	Definitions: Sentinel Events and Reportable Occurrences.....	114
9.5.3.2	Notification Timeframes	115
9.5.4	Sentinel Event/Reportable Occurrences—Home Health & Hospice Agency Providers	115
9.5.4.1	Report Within 24 Hours	115

9.5.4.2	Report Within 72 Hours	116
9.6	QA & I REPORTING REQUIREMENTS FOR CHRONIC DIALYSIS PROVIDERS	117
9.6.1	Reporting Requirements	117
9.6.2	Vascular Access Monitoring (VAM)	117
9.6.2.1	Surveillance Procedure for an Established Access	117
9.6.3	Performance Target Goals/Clinical Indicators	119
9.6.3.1	Chronic Dialysis Patients	119
9.6.4	DNBEs / Reportable Occurrences for Providers	119
9.7	QA & I REPORTING REQUIREMENTS FOR HOME HEALTH & HOSPICE PROVIDERS	120
9.7.1	Annual Reporting	120
9.7.2	Site Visits and/or Chart Review	121
9.7.3	Personnel Records	121
9.8	QA & I REPORTING REQUIREMENTS FOR SNFS	121
9.8.1	Quarterly Reporting	122
9.8.2	Medical Record Documentation.....	122
9.9	MEDICAL RECORD REVIEW AND STANDARDS	123
9.10	ACCESS AND AVAILABILITY GUIDELINES.....	126
10.	COMPLIANCE	131
10.1	COMPLIANCE WITH LAW.....	131
10.2	KP PRINCIPLES OF RESPONSIBILITY AND COMPLIANCE HOTLINE.....	131
10.3	GIFTS AND BUSINESS COURTESIES	131
10.4	CONFLICTS OF INTEREST.....	132
10.5	FRAUD, WASTE AND ABUSE	132
10.6	PROVIDERS INELIGIBLE FOR PARTICIPATION IN GOVERNMENT HEALTH CARE PROGRAMS	132
10.7	VISITATION POLICY.....	133
10.8	COMPLIANCE TRAINING.....	133
10.9	CONFIDENTIALITY AND SECURITY OF PATIENT INFORMATION	133
10.9.1	HIPAA and Privacy and Security Rules	134
10.9.2	Confidentiality of Alcohol and Drug Abuse Patient Records.....	135
10.10	PROVIDER RESOURCES.....	135

11. ADDITIONAL INFORMATION	136
11.1 AFFILIATED PAYORS.....	136
11.2 SUBCONTRACTORS AND PARTICIPATING PRACTITIONERS	136
11.2.1 Regulatory Compliance	137
11.2.2 Licensure, Certification and Credentialing.....	137
11.2.3 Billing and Payment	138
11.2.4 Encounter Data.....	138
11.2.5 Identification of Subcontractors	138
11.3 KP'S HEALTH EDUCATION PROGRAMS.....	138
11.3.1 Health Education Program.....	139
11.3.2 Focused Health Education Efforts	139
11.3.3 Preventive Health and Clinical Practice Guidelines (CPGs).....	139
11.3.4 Telephonic Wellness Coaching Service	140
11.4 KP'S LANGUAGE ASSISTANCE PROGRAM	140
11.4.1 Using Qualified Bilingual Staff.....	141
11.4.2 When Qualified Bilingual Staff Is Not Available.....	141
11.4.2.1 Telephonic Interpretation	141
11.4.2.2 In-Person Interpreter: American Sign Language Support	142
11.4.3 Documentation	143
11.4.4 Family Members as Interpreters.....	143
11.4.5 How to Offer Free Language Assistance	143
11.4.6 How to Work Effectively with an Interpreter	144
12. ADDITIONAL SERVICE SPECIFIC INFORMATION	145
12.1 SERVICE AUTHORIZATIONS FOR SNFs	145
12.2 GENERAL ASSISTANCE FOR SNFs.....	145
12.2.1 Requesting Ancillary Services for SNFs	145
12.2.2 Supplies, Drugs, Equipment and Services Excluded from the Long Term Care SNF Per Diem	145
12.2.3 Laboratory Services Ordering For SNFs	145
12.3 PSYCHIATRIC CARE SETTINGS	146
12.4 ADDICTION MEDICINE AND RECOVERY SERVICES	147
12.5 KP DIRECT MENTAL HEALTH NETWORK.....	148

12.6 SPECIAL NEEDS PLAN (SNP)149

12.7 AUTISM SPECTRUM DISORDER (ASD) SERVICES150

Appendix: POL-020 Clinical Review Payment Determination Policy..... 151

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.