Kaiser Permanente Northwest Provider Manual 2018

Self-Funded Program Provider Manual

It's our pleasure to welcome you as a provider for the Kaiser Permanente Self-Funded program. We want this relationship to work well for you, your medical support staff, and our members.

We created this provider manual to help guide you and your staff in understanding Kaiser Permanente Insurance Company's (KPIC's) policies and procedures for the Self-Funded program and related administrative procedures.

If you have a question or concern about information in this manual, contact our Provider Relations Department at 503-813-3376**.**

Terms in this provider manual that are used to describe the Self-Funded program are defined in Section 9: Glossary of Terms.

KAISER PERMANENTE®

Table of Contents

Introduction

This provider manual or set of "Policies" is referenced in your provider agreement with a Kaiser Permanente entity ("Provider Agreement"). The information in this manual is proprietary and may not be used, circulated, reproduced, copied or disclosed in any manner whatsoever, except as permitted by your agreement or with prior written permission from Health Plan.

If there is a conflict between this provider manual and your provider agreement, the terms of your provider agreement will control. Terms used in this provider manual that aren't defined will have the meanings given to them in your provider agreement.

Section 1: Self-Funded Program Overview

1.1 Kaiser Permanente Insurance Company (KPIC)

Kaiser Permanente Insurance Company (KPIC), an affiliate of Kaiser Foundation Health Plan, Inc., will administer Kaiser Permanente's Self-Funded program. Each Self-Funded plan sponsor (an "Other Payer" under your provider agreement) will contract with KPIC to provide administrative services for the plan sponsor's Self-Funded plan. KPIC has a dedicated administrative services team to coordinate administration with the plan sponsors. KPIC will provide network administration services and certain other administrative functions through an arrangement with Kaiser Foundation Health Plan of the Northwest ("KFHP-NW"). KFHP-NW provides or arranges for health care services through agreements with Kaiser Foundation Hospitals ("KFH") and Northwest Permanente, P.C., Physicians and Surgeons ("NWP"), each of which in turn contracts with community providers. Together, KFHP-NW, KFH, and NWP are referred to as "Kaiser Permanente Northwest," "KPNW," "Kaiser Permanente," or "KP."

1.2 Third Party Administrator (TPA)

KPIC has contracted with a Third Party Administrator (TPA), to provide certain administrative services for Kaiser Permanente's Self-Funded program, including claims processing, eligibility information, and benefits.

Harrington Health administers the Self-Funded customer service system, with automated functions as well as access to customer service representatives that allows you to check eligibility, benefit, and claims information for Self-Funded members.

The automated system (interactive voice response, or IVR) is available 24 hours a day, 7 days a week. Customer service representatives are available Monday through Friday from 7 a.m. to 9 p.m. (ET).

1.3 Self-Funded Products

Kaiser Permanente offers Self-Funded products, administered by KPIC, including Self-Funded Exclusive Provider Organization, Self-Funded Point-of-Service, and Self-Funded Preferred Provider Organization.

1.3.1 Exclusive Provider Organization (EPO)

- Mirrors our HMO product, offered on a Self-Funded basis
- Self-Funded EPO members choose a Kaiser Permanente primary care provider and receive care at Kaiser Permanente or plan medical facilities
- Self-Funded EPO members are covered for non-emergent care only at designated plan

medical facilities and from designated plan practitioners (unless referred by a KP primary care provider)

1.3.2 Point of Service (POS) – Two Tier

- Tier 1 is the EPO provider network
- Tier 2 contains all other providers
- Self-Funded members incur greater out-of-pocket expenses in the form of higher copayments, coinsurance, and/or deductibles when they use Tier 2 benefits

1.3.3 Point of Service (POS) – Three Tier

- Tier 1 is the EPO provider network
- Tier 2 contains our contracted PPO network providers
- Tier 3 includes non-contracted providers
- Self-Funded members incur greater out-of-pocket expenses in the form of higher copayments, coinsurance, and/or deductibles when they self-refer to a contracted PPO network provider (Tier 2)
- Generally, out-of-pocket costs will be highest for self-referred services received from non-contracted providers (Tier 3)

1.3.4 Out of Area Preferred Provider Organization (PPO)

The Self-Funded PPO is offered to Self-Funded members living outside the Kaiser Permanente HMO service area. Members receive care from our contracted provider network.

Self-Funded PPO members may choose to receive care from a non-network provider; however, their out-of-pocket costs may be higher.

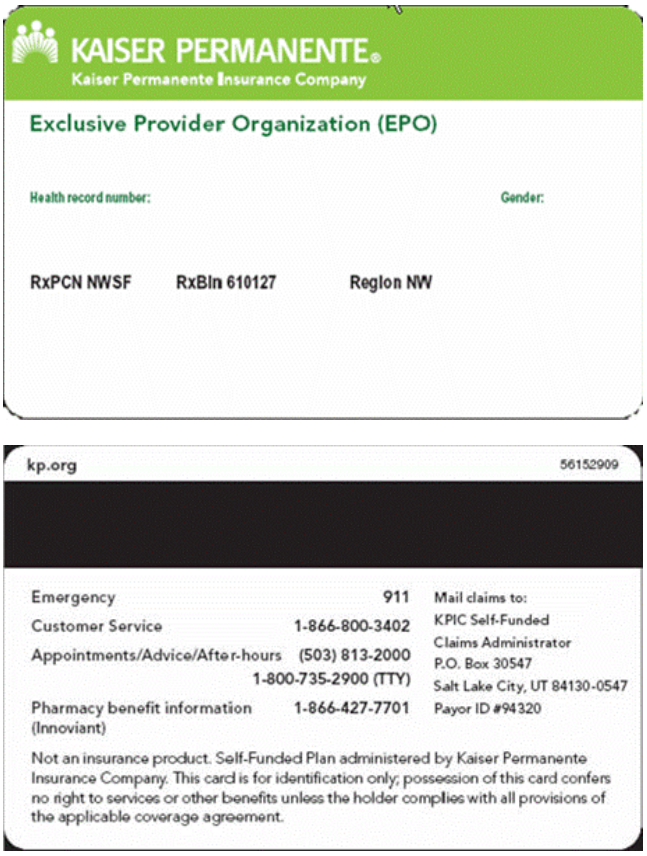
There are no requirements for PCP selection.

1.4 Self-Funded Identification Cards

Each Self-Funded member will be issued a Self-Funded identification card (Self-Funded ID card). Self-Funded members should bring their Self-Funded ID card and a photo ID when they seek medical care.

Each Self-Funded member is assigned a unique Health/Medical Record Number, which is used to locate membership and medical information. Every Self-Funded member receives a Self-Funded ID card that shows his or her unique number. If a replacement card is needed, the Self-Funded member can order a Self-Funded ID card online.

The Self-Funded ID card is for identification only and does not give a Self-Funded member rights to services or other benefits unless he or she is eligible. Anyone not eligible for benefits at the time of service is responsible for payment of services provided.



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Section 2: Key Contacts and Tools

2.1 Key Contacts

Department	Contact information	Help or information available
Self-Funded Customer Service	Customer service representatives available Monday through Friday 7 a.m. to 9 p.m. (ET) Self-Service IVR system available 24 hours/7 days a week at 1-866-800-3402 Website available 24 hours/7 days a week http://provider.kphealthservices.com.	• General enrollment questions • Eligibility and benefit verification • Claims management • Billing and payment inquiries • EDI questions • Appeal and claims dispute questions • Co-pay, deductible, and coinsurance information • Members terminated greater than 90 days • Members presenting with no Kaiser Permanente identification number • Verifying member's PCP assignment
Provider Contracting & Relations	Kaiser Permanente Provider Contracting and Relations 500 NE Multnomah Ste 100 Portland, OR 97232	• Send provider demographic updates such as Tax ID or address changes • Send information regarding practitioner additions or terminations from your office • Provider education and training • Provider agreement questions • Contracted rate payment questions • Form requests • Issues and problem solving

2.2 Self-Funded Customer Service IVR System

Self-Funded customer service IVR can help with a variety of questions. Call 1-866-800-3402 to use this service. Please have the following information available when you call into the system:

- Provider tax ID or National Provider Index (NPI)
- Member's medical record number (MRN) or health record number (HRN)
- Member's date of birth
- For claims, date of service

The IVR can help you verify eligibility, benefits, authorizations, and referrals; check a member's accumulator (amount applied to deductible); inquire about claims and payments; or speak to a customer service representative.

2.3 Website

The Third Party Administrator will maintain a website that allows you and your staff to check eligibility, benefits, and claims information for Self-Funded members.

A formal user guide will be published and provided to you.

Note: *This website is restricted to information for individuals enrolled in Self-Funded plans administered by KPIC only. Information regarding members enrolled in Kaiser Permanente's fully funded plans (e.g., HMO), cannot be accessed from the Harrington Health site.*

Access the TPA website at http://provider.kphealthservices.com

Section 3: Eligibility and Benefits Determination

3.1 Eligibility and Benefit Verification

You are responsible for verifying Kaiser Permanente Self-Funded members' eligibility and benefits. Each time a Self-Funded member presents at your office for services, you 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 Kaiser Permanente Self-Funded ID card. Please check a form of photo identification to verify the identity of the Self-Funded member. The effective date of eligibility varies according to the terms of the contract between the plan sponsor and KPIC. Therefore, you must verify that the Self-Funded member has a benefit for the service before providing the service.

Certain services require prior authorization. The Utilization Management section of this Manual provides further details on which services require authorization and the process for obtaining referrals and authorizations.

Contact Self-Funded customer service through one of the methods below to verify the validity of the Self-Funded ID card/number and benefits. Otherwise, you provide services at your own financial risk.

- http://provider.kphealthservices.com
- 1-866-800-3402, Monday through Friday from 7 a.m. to 9 p.m. (ET); please have the member's name and ID card number ready

3.2 Benefit Exclusions and Limitations

Self-Funded benefit plans may be subject to limitations and exclusions. It's important to verify the availability of benefits before rendering services so the Self-Funded member can be informed of any potential payment responsibility.

Contact Self-Funded Customer Service to verify and obtain information on Self-Funded member benefits at 1-866-800-3402.

If you provide services to a Self-Funded member and the service is not a benefit, or the benefit has been exhausted, denied, or not authorized, the plan sponsor will not be obligated to pay for those services.

3.3 Drug Benefits

The drug benefits, drug formulary, and procedures for formulary exception may vary based on benefit plan.

To verify a Self-Funded member's drug benefit, to obtain our drug formulary, or for general questions, please contact Self-Funded Customer Service at 1-866-8003402.

3.4 Retroactive Eligibility Changes

If you have received payment on a claim(s) that's affected by a retroactive eligibility change, a claims adjustment will be made. The reason for the claims adjustment will be shown on the remittance advice.

If you provide services to a member and the service is not a benefit, or the benefit has been exhausted, denied, or not authorized, you do so at your own financial risk.

Section 4: Utilization Management

Appropriate utilization management (UM) contributes to the success of Kaiser Permanente (KP) and its members. UM's goal is to achieve optimum results by determining what resources are medically necessary and appropriate for an individual patient, and to provide those services to the patient in the right setting in a timely manner. Decisions about what is medically necessary and appropriate are based on evidence-based criteria, the practitioner's professional judgment, and assessment of the member's medical condition.

Effective UM doesn't mean withholding necessary services, even if those services may result in less-than-optimum outcomes. Each practitioner uses his/her clinical expertise to evaluate the care needs of the individual and arranges for those medically necessary services in the appropriate setting.

As a contracted provider with Kaiser Permanente, you acknowledge that KP conducts UM programs relating to health care services provided to members. This means you agree to participate in KP's UM programs, comply with KP's UM policies, and cooperate with KP's UM committees and staff. This means providing timely access to Kaiser Permanente Member medical records for KP UM staff.

The Kaiser Permanente Resource Stewardship and Utilization Management (RS/UM) program was designed to ensure the following:

1. Services are medically necessary, consistent with the patient's diagnosis, delivered at appropriate levels of care, and provided at the right time.

2. Authorized care matches the member's benefit.
3. Services are provided by Northwest Permanente providers or contracted providers unless otherwise authorized.
4. Practitioners adhere to guidelines, standards, and criteria set by regulatory and accrediting agencies as is appropriate to health plan product and specific population (e.g., Commercial, Medicare, Medicaid):
    - KPNW uses medical necessity criteria based on sound clinical evidence to make RS/UM decisions (e.g., MCG, Medicare, Medicaid, and those developed by Kaiser Permanente) taking into account the local delivery system and members' individual circumstances.
5. The UM team of physicians, RNs, and support staff are trained and qualified to assess clinical information used to make UM decisions. Appropriately licensed health professionals supervise all review decisions, and licensed physicians review all denials that are based on medical necessity.

Utilization review decision-making is based only on appropriateness or medical necessity of services and the existence of coverage. Kaiser Permanente doesn't reward practitioners or other individuals for issuing denials for coverage nor are decisions about hiring, pay, promotions, or termination of employment based on the likelihood that denials will be supported. UM decision makers don't receive financial incentives for decisions that result in underutilization.

4.2 Referrals and Authorizations

You must contact Kaiser Permanente Regional Referral Center at 503-813-4560 and get referral authorization before services are rendered, or determine whether a service requires prior authorization. Failure to do this may result in denial of payment. Prior written authorization ensures that only necessary and benefit-covered services are provided and that you, in turn, are paid for those services. Authorization is provided with the use of the Prior Authorization Request form.

Most services require prior authorization. To verify benefit coverage for prior authorization contact Member Services at 503-813-2000.

As a contracted provider, you're expected to provide timely feedback to Kaiser Permanente on the outcome of consultations, plans of care, and further testing and follow-up.

Kaiser Permanente provides diagnostic, imaging, and lab testing for members at Kaiser Permanente medical facilities, so please direct members to one of these facilities. For a current list of plan facilities, go to kp.org or call the Kaiser Permanente Member Services Department, Monday through Friday, 8:00 a.m. to 5 p.m., 1-800-813-2000, to request a Kaiser Permanente Medical Facility Directory.

Kaiser Permanente will pay for covered health care services only when Kaiser Permanente Referral and Authorization requirements are met. **This includes instances when Kaiser Permanente is the secondary payer for Kaiser Permanente Traditional/Deductible and Added Choice® Point-of-Service (POS) members and plan sponsors are the secondary payer for self-funded members.**

4.3 Procedure for Authorization Notices

The authorization contracted provider and the member will receive written notification of authorized services within state and federally required timeframes, not to exceed 15 days.

4.3.1 Authorized Contracted Provider Guidelines

Forward all work-up results to the referring plan provider with any other pertinent clinical information pertaining to the consultation. Call the referring plan provider if your findings are urgent.

If the authorized contracted provider determines that additional visits are medically necessary, the visits should be requested before the current date of authorization expires. Fax these requests to the Referral Management and Clinical Review Department at 877-800-5456 using the Pre-Authorization Request Form.

4.4 Authorization and Concurrent Review

Send requests for authorization of admissions (emergency or scheduled) to plan hospitals to the Regional Referral Center.

Authorization and concurrent reviews are determinations by Kaiser Permanente that an admission, extension of stay, or other health care service has been reviewed and meets the clinical requirements for medical necessity, appropriateness, level of care and/or effectiveness, and meets clinical criteria of the member's applicable health benefit plan.

Kaiser Permanente may conduct onsite or telephonic reviews at plan hospitals and/or facilities on a case-by-case basis. The hospital and/or facility's utilization review department is responsible for providing clinical information to Kaiser Permanente daily or as requested. As a contracted provider, you're required to facilitate UM reviews, including providing clinical information requested by KP and arranging for physicians and other staff to confer with KP practitioners.

The Kaiser Permanente UM staff uses approved criteria to determine medical necessity for acute hospital care. If the clinical information meets this criteria, we'll approve a specified number of days/services. If the clinical information doesn't meet this criteria, we'll refer the case to the Kaiser Permanente UM physician reviewer. We'll notify the attending physician and facility of the review results. The attending physician can request an expedited appeal of any Adverse Benefit Determination (see Section 4.9 of this manual).

Failure to provide clinical information for authorized days/services by the next assigned review date can result in a denial of all days/services beyond the initial authorization period, due to untimely clinical review.

4.4.1 Non-Emergent and Elective Inpatient Hospital Admissions and Services

For emergency or elective inpatient care, the health care provider must submit all information through the Community Provider Portal in accordance to regulatory compliance. Gather all supporting documents, including history and physical, clinical notes, physician's order, and the diagnosis codes and procedure codes.

Routine (non-urgent) authorization requests for hospital admissions and services will be handled according to the clinical situation, not to exceed 15 days. When a plan utilization review physician determines services to be time-sensitive, we'll address authorization requests within 72 hours of receipt with appropriate documentation. If we need additional information, we'll

requested it within the first 24 hours of notification, with up to 48 hours given for submission of requested information.

Once processed and approved, an authorization notice, with authorization number, will be returned by fax to the admitting physician. A copy will also be sent to the admitting plan facility.

4.4.2 Skilled Nursing Facility (SNF) Admissions

Patients who need admission for skilled nursing require authorization from the SNF placement desk at 503-499-5438. The SNF registered nurse (RN) placement coordinator will help transition the patient from the inpatient, clinic, emergency room, or home setting to a Kaiser-contracted SNF. The SNF RN placement coordinator can also help determine Kaiser SNF benefits and available skilled days. The SNF placement desk is available 8:30 a.m. to 5:00 p.m., 7 days a week.

4.4.3 Scheduled Ambulance Transfers

Kaiser Permanente will pay for covered health care services only when Kaiser Permanente Authorization requirements are met. Failure to get authorization before a scheduled transport can result in a denial of payment for the transport.

All scheduled ambulance transfers, including air ambulance, will be reviewed against Centers for Medicare and Medicaid Services (CMS) ambulance criteria as described in Chapter 10, Ambulance Services, Paragraph 4 of this document: cms.gov/manuals/Downloads/bp102c10.pdf

Transportation by wheelchair van is not a covered benefit. The member is financially responsible for wheelchair transportation and the transferring facility should arrange the service.

Physicians and staff at any facilities can talk directly with a Northwest Permanente physician at the RTMC 24/7 at 877-813-5993 (toll free) or 503-735-2595 to arrange a safe transfer.

4.4.4 Home Health and Home Based Palliative Care

To get authorization for home health services, call the home health utilization nurse at 503-499-5200 or fax a request to 503-778-2504.

To get authorization for hospice and home based palliative care services, call the continuing care services utilization manager or back office supervisor at 503-778-2526 or 503-499-5239.

4.4.5 Transplants

Kaiser Permanente developed a national transplant network that consists of numerous centers of excellence across the nation. The health care provider must submit all information through the Community Provider Portal. All requests will be evaluated by the applicable specialty.

Completed the form with the patient's information and your provider information as outlined. Attach all supporting documents, including history and physical, clinical notes, physician's order, and the diagnosis codes and procedure codes with the Request for Internal Services.

4.5 Ancillary Services

The following sections of this manual summarize guidelines for lab, imaging, and therapy services.

4.5.1 Laboratory Services

All outpatient lab services are provided by Kaiser Permanente labs or the plan facilities identified in the Kaiser Permanente facility provider directory at kp.org. Include an ICD-10 code, NPI, and plan provider signature on all lab orders. If this information is not supplied to a Kaiser Permanente lab, a staff member will contact the requesting plan provider to ask for it. Orders will be returned via fax to the plan provider's office for completion. Once the completed order is received, the lab will process the samples for testing. Testing may be delayed and/or cancelled if the information is not received the following business day.

Please visit our Community Provider Portal for additional lab services information at: http://www.providers.kaiserpermanente.org/html/cpp_knw/laboratory.html

4.5.2 Imaging (Radiology) Services

All outpatient imaging services are provided by Kaiser Permanente medical facilities or the plan facilities identified in the Kaiser Permanente ancillary provider directory at kp.org. The written imaging order must include an ICD-10 code and the plan provider's signature. If this information is not supplied to a Kaiser Permanente imaging department, a staff member will contact the requesting plan provider to ask for it. A completed order can then be faxed to the imaging department. An imaging procedure can't be scheduled or performed without a written order signed by the requesting plan provider.

For a current list of plan facilities, see the Kaiser Permanente medical facility directory on the Community Providers website at www.kp.org.

4.6 Clinical Trials

Commercial member contracts don't cover clinical trials. However, if a member enrolls in one, routine costs for medically necessary conventional services received in connection with the clinical trial are covered if the service would've been covered absent the clinical trial, consistent with the coverage provided in the health benefit plan. This includes the type and frequency of any diagnostic modality typically covered for a patient who isn't enrolled in a clinical trial, isn't needed solely because of the trial, and is medically necessary as determined by a participating provider.

Excluded from coverage are:

- A service, item, or drug that is the subject of the clinical trial.
- A service, item, or drug provided only to satisfy data collection and analysis needs for the clinical trial and not used in the direct clinical management of the patient.
- An investigational or experimental drug or device that hasn't been approved for market by the Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient, a family member, or companion of the patient that are associated with the travel to or from a facility providing the clinical trial.
- An item or drug provided by the clinical trial sponsors free of charge for any patient.

The Medicare payment rules for Medicare-qualified clinical trials apply to Kaiser Permanente Medicare (Senior Advantage) Members. If a Kaiser Permanente Medicare (Senior Advantage) member wants to participate in a Medicare qualifying clinical trial, the member doesn't have to ask Kaiser Permanente for permission to do so. Medicare will pay most of the cost of the

services associated with clinical trials less any deductible or coinsurance. In this instance, the member, not Kaiser Permanente, is responsible to pay any deductibles or coinsurance. Kaiser Permanente will continue to cover medically necessary conventional care consistent with the coverage provided in the member's health benefit plan.

For a service(s) related to a Humanitarian Device Exemption, authorization is required.

If a KP UM medical director provides approval, KP will reimburse at the rate specified in the provider contract, or if the provider contract is silent, then at the provider's acquisition rate.

4.7 Denied Authorizations

We may deny a referral or request for authorization for the following reasons:

- Services are deemed not medically appropriate.
- The patient doesn't meet membership eligibility requirements.
- The request for services is not a covered benefit or the benefit is exhausted.
- Services were performed without prior authorization.
- Refusal to use plan providers of the Permanente Medical Group

The reason for the denial will be stated in the Adverse Benefit Determination sent to the member and contracted provider. Adverse Benefit Determination letters will also inform contracted providers of their right to have the denial reconsidered (reconsiderations are only offered for medical necessity denials). See Section 4.9 of this manual for more information.

All requests to appeal pre-service denials must be accompanied by the written permission of the member. You can find criteria used for making the decision by contacting the Member Relations Department at 503-813-4480. Members receive similar notices informing them of the decision and their appeal rights.

If you feel an Adverse Benefit Determination has been issued in error, write the Appeals Unit to request an Appeal of the Adverse Benefit Determination. See Sections 4.9 and 4.10 of this manual for more information regarding contracted provider appeal policies and procedures for fully insured members. For self-funded members, see Section 14 of this manual.

Contracted provider requests for retroactive authorizations are not accepted by the Referrals Management and Clinical Review Department. See Sections 4.9 and 4.10 of this manual for more information regarding provider appeal policies and procedures for fully insured members. For self-funded members, see Section 14 of this manual.

4.8 Medical Necessity Criteria

All services authorized by the Kaiser Permanente Resource Stewardship/Utilization Management Department will be evaluated for medical necessity based on these criteria:

- MCG (formerly Milliman Care Guidelines)
- Medicare criteria and regulations
- Medicaid criteria and regulations
- Kaiser Permanente internally developed criteria

You can review specific criteria by contacting Kaiser Permanente's Resource Stewardship/Utilization Management Department Regional Referral Center at 503-813-4560.

4.9 Reconsiderations and Appeals

NOTE: For self-funded members, see the Self-Funded Provider Manual.

Contracted providers can request a Reconsideration of any Medical Necessity initial pre-service decision made by Kaiser Permanente. Contracted providers can also, when appointed by their Kaiser Permanente patient, appeal any pre-service decision made by Kaiser Permanente. The following sections describe the Kaiser Permanente Contracted Provider Reconsideration and Provider-appointed Appeal Guidelines and Processes. For information regarding Post-service Appeals, Payment Disputes, and Provider Appeals, see Section 5 of this manual.

4.9.1 Reconsideration of Decisions Following Initial Pre-Service Denial Determination

A plan provider can request, verbally or in writing and on behalf of a fully insured member, a Reconsideration of an Adverse Benefit Determination. Note: This process doesn't apply to benefit denials or Post-Service Claim payment denials.

Reconsiderations (also known as peer-to-peer discussions) are conducted between the contracted provider and the Kaiser Permanente physician reviewer who made the adverse benefit determination. If the physician reviewer cannot be available within three business days, he or she can designate another physician to review the reconsideration. To request reconsideration, contracted providers can call the Regional Referral Center at 503-813-4560.

Decisions on the reconsideration are made within three business days after receipt of the request for reconsideration, unless the medical condition of the member requires a quicker decision. If the reconsideration doesn't resolve the difference of opinion, plan providers can file a written appeal on behalf of the member. This requires the member's written consent.

Contact Kaiser Permanente Membership Services Unit at 800-813-2000 or 503-813-2000 with any questions or to get an Appointment of Representation (AOR) form. The reconsideration process isn't a prerequisite to the appeal process and isn't considered an appeal.

4.9.2 Standard Appeal Process of Initial Adverse Pre-Service Benefit Determinations

These guidelines for standard pre-service appeals apply to services that aren't urgent in nature:

- The requesting plan provider may submit a written appeal request along with a signed Appointment of Representation (AOR) form from the member to the Kaiser Permanente Appeals Unit at the following address:

  Kaiser Permanente
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232

  Note: If the service requested is urgent, the plan provider can ask for an expedited appeal without the member's consent by calling 1-800-813-2000 or 503-813-2000 or faxing a written appeal request to the Appeals Unit at 503-813-3985.

- If we don't get a signed AOR form with the standard appeal request, we'll notify the member in writing and ask him or her to complete the necessary AOR form, which will authorize the contracted provider to act on the member's behalf.

- The Kaiser Permanente Appeals Unit staff will review the documentation and contact the appealing contracted provider for additional information, if needed.
- We'll review pre-service appeals and provide written notification within state and federal required timeframes, no longer than 30 calendar days within receipt of the appeal request. An appropriate physician or behavioral health clinician makes all denial decisions when based on medical appropriateness. Physician reviewers participating in the appeal process will not have been involved in the initial determination nor be subordinates of a physician involved in the initial determination.
- If the initial decision is overturned, the Appeals Unit staff will process the request per department procedures. If the initial decision is upheld, the Appeals Unit staff explain the decision to you and, if applicable, provide information on any further appeal rights.

For Kaiser Permanente Senior Advantage Members: If the initial decision is upheld, the case will automatically be forwarded to the independent review entity used by Medicare for the final determination.

4.9.3 Expedited Pre-Service or Urgent Concurrent Appeals

An expedited appeal process is available when waiting the time period to resolve a standard appeal could seriously jeopardize the member's life, health, or ability to regain maximum function, or subject the member to severe pain that can't be adequately managed without the services that are the subject of the request. The requesting contracted provider can fax a written appeal request to the Kaiser Permanente Appeals Unit at 503-813-3985 or call 800-813-2000 or 503-813-4480.

- The Kaiser Permanente Appeals Unit staff will review the documentation and contact the appealing contracted provider for additional information if needed.
- We'll review the appeal as quickly as possible, not to exceed 72 hours of the appeal request. An appropriate physician or behavioral health clinician makes all denial decisions for medical appropriateness. Physician reviewers participating in the appeal process will not have been involved in the initial determination nor be subordinates of a physician involved in the initial determination.
- If the initial decision is overturned, the Appeals Unit staff will contact the contracted provider and the member verbally and in writing immediately after the determination. The request will be processed per department procedures.
- If the initial decision is upheld, the Appeals Unit staff will contact the contracted provider and the member verbally and in writing immediately after the determination. They'll explain the decision and, if applicable, provide information on any further appeal rights.

For Kaiser Permanente Senior Advantage Members: If the initial decision is upheld, the case will automatically be forwarded to the independent review entity used by Medicare for the final determination.

4.10 Retrospective or Post Service Review

Retrospective review occurs after the member has received care and after they or their provider has submitted a claim for payment. Staff in the Claims Department review and make benefit decisions on claims. Staff in Clinical Review support the Claims Department in reviewing claims without a referral or authorization if there is an issue of medical necessity. These same staff

review claims for appropriate coding and billing that require clinical expertise. Issues such as unbundling, upcoding, or undocumented services are reviewed in the Post Service area. All issues related to medical necessity decisions, experimental or investigational services, or issues related to potentially cosmetic services are reviewed by physician reviewers before a denial is issued.

We use these resources during the Post Service Review process:

- Centers for Medicare and Medicaid Services (CMS) policies
- Kaiser Permanente medical or payment policy
- American Medical Association (AMA) guidelines (e.g., Current Procedural Terminology, CPT®)
- Professional specialty organizations (e.g., American College of Surgeons, American Academy of Orthopaedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Subscriber benefit contracts
- Provider contracts
- Specialty expert consultants

Therefore, our policies and review rules are developed using information gleaned from many sources. We designed our review rules to verify the clinical accuracy of procedure codes as they relate to those submitted on claim forms.

Note: While all codes may be acceptable to report, separate reimbursement might not be made. Reimbursement is based on many factors, such as the member's coverage; coding rules outlined by CMS, CPT and other nationally recognized entities such as those listed above; and federal and state regulations. We may perform line item reviews to verify coding and reimbursement.

This ensures that our members receive the right care at the right level at the right time at the appropriate cost. To accurately adjudicate claims and administer subscriber benefits, it's often necessary to request medical records or itemized statements. The following is a list of claims categories from which we may routinely ask you to submit clinical information. Some (e.g., specific modifiers) are discussed in more detail throughout this manual.

- Procedures or services that require precertification/preauthorization but did not go through the normal process before services were rendered
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies/criteria
- Procedures or services that are or may be considered cosmetic or experimental/investigational
- Claims that require us to review medical records to determine if the service provided is covered
- Procedures or services reported with "unlisted," "not otherwise classified," or "miscellaneous" codes

- Procedures or services reported with CPT® modifiers 22, 62, 66, and 78
- Quality of care and/or quality improvement activities (e.g., data collection as required by accrediting agencies, such as NCQA)
- Claims involving coordination of benefits
- Claims being appealed
- Claims being investigated for fraud and abuse or potential inappropriate billing practices
- Claims for which services reported appear to have been unbundled
- Charges that aren't in line with the diagnoses on the claim submitted

This list is not intended to limit the ability of Kaiser Foundation Health Plan of the Northwest to request clinical records. There may be additional individual circumstances when we may ask for these records.

Services classified under the Humanitarian Device Exemption (HDE) must have an authorization prior to usage. Once authorized, the reimbursement would be based on invoice unless otherwise contracted. Medical Necessity Review does monitor claims for usage and reimbursement of such devices.

4.11 Payment Disputes

NOTE: See the Self-Funded Provider Manual for self-funded members.

Contracted providers should contact the Kaiser Permanente Provider Inquiry Department Monday through Friday, 9:00 a.m. to 4 p.m., at 503-735-2727 or 866-441-1221 with questions or concerns about a specific claim. Many questions and issues regarding claim payments and/or denials can be resolved quickly over the phone or via fax.

If, after contacting the Provider Inquiry Department, you don't agree with the answer or outcome, you can file a formal Payment Dispute using this process:

1. Submit a formal Payment Dispute using a document that contains the information necessary to investigate your issue.

   Send the Payment Dispute and any supporting documentation to:

   Kaiser Permanente
   Attention: Provider Appeals
   500 NE Multnomah St., Suite 100
   Portland, OR 97232

   Or fax to: 503-813-2017

2. Your Payment Dispute will receive special handling by a dedicated research specialist. We'll review your rationale for request, along with any applicable enclosures. We'll also consider all data available internally when researching your claims payment or denial.
3. If the initial decision is overturned, the research specialist will process the claim in dispute within 60 calendar days of receipt of the Payment Dispute form. Your Provider's Explanation of Payment (EOP) will serve to notify you that the claim has been paid.

4. If the initial decision is upheld, the research specialist will contact you in writing within 60 calendar days of receipt of the Payment Dispute form to explain the decision and offer information on any further appeal rights.

The payment dispute process is not a prerequisite to the appeal process described above. The plan provider can initiate an appeal, in writing and on behalf of the member, without going through the payment dispute process. The member's written consent might be required before an appeal can be filed on their behalf. Contact the Kaiser Permanente Appeals Unit at 800-813-2000 or 503-813-2000 to determine if this written consent is required.

4.12 Drug Formulary

The KP Regional Pharmacy Department uses the formulary system and evidence-based decision-making to determine which medications will be made available for practitioners to order. Plan providers must follow the KP formulary when prescribing medications to Kaiser Permanente members. Criteria for choosing medications to be included in the formulary are, in order of priority: safety, efficacy, and cost. Drugs are listed by the product our pharmacies dispense, which may be brand-name or generic.

The KPNW Regional Formulary & Therapeutics Committee (RFTC) annually reviews and maintains the pharmaceutical management procedures on an ongoing basis. You'll find the following policies and information on the Kaiser Permanente Northwest Community Provider Portal: http://providers.kaiserpermanente.org/html/cpp_knw/pharmacypolicies.html

- Therapeutic Equivalents
- Formulary Exception Process and Excluded Drug Review
- Formulary Change Request Form
- The Formulary Process
- Criteria-Based Consultation Prescribing/Step Therapy
- Copay/Coinsurance Requirements for Prescriptions

The RFTC also maintains the formulary and reviews medications to add or delete. Any practitioner may petition to have a medication added to the formulary by completing a Drug Formulary Change Request form (http://www.providers.kaiserpermanente.org/info_assets/cpp_knw/Formulary%20Change%20Request%20Form.pdf), by contacting Pharmacy Drug Information at 503-261-7910, or via email at NW.Drug.Information@kp.org. An exception process is in place to request the use of a non-formulary drug when deemed medically necessary by the practitioner.

You can review the RFTC Formulary at https://prospectivemembers.kaiserpermanente.org/kpweb/entryPage.do?cfe=422. This site is accessible to all members, practitioners, and providers. We post updates on the third Tuesday of each month. People without Internet access can get print copies by contacting the Pharmacy Department as noted below.

For more information about the KPNW Formulary Process or other pharmaceutical management policies and procedures, including criteria-based consultation prescribing, co-payment requirements and any other restrictions and/or limitations, or to get a copy of the

KPNW drug formulary, contact Pharmacy Services at 503-261-7900, toll free at 1-888-572-7231, or via fax at 503-261-7978.

4.13 Extenuating Circumstances

These extenuating circumstances around pre-authorization and admission notification are based on the Best Practice Recommendations (BPR) put forth by the Washington Healthcare Forum operated by OneHealthPort but are applicable to all lines of business in Oregon and Washington.

Note: This practice is in addition to and **does not replace** the pre-authorization and admission notification practices currently in place with Kaiser Permanente. You must follow those practices unless one of the specific extenuating circumstances outlined in this document exist.

The terms *prospective review* and *pre-authorization* will be used interchangeably throughout this document.

Summary:

It is recognized that there are a number of extenuating circumstances where providers aren't able to request a pre-authorization before treating the patient and/or to notify the health plan within a pre-defined time period of the patient's admission. If/when these circumstances occur, the recommended best practices will be followed so that claims and related appeals will be processed **as if** a pre-authorization had been requested or admission notification had been submitted within the required time period. ***Benefit coverage and medical necessity will still be evaluated for the service(s) requested.***

Extenuating Circumstances:

The circumstances below outline a number of extenuating situations when providers are not able to contact a patient's health plan prior to treating a patient and/or within a pre-defined period of the patient's admission. In these situations, claims will not be automatically denied for lack of timely admission notification (e.g., 24 hours) or for lack of prior-authorization as long as the services are covered benefits for the patient and meet Kaiser Permanente's criteria for medical necessity.

I. Unable to Know Coverage

II. Unable to Anticipate Service

III. Inherent Components

IV. Misinformation

V. Delayed Notification

*Notes***:**

- Any service for which a pre-authorization was previously denied for that patient does not qualify as an extenuating circumstance.
- Medical necessity criteria and benefit coverage **must be** met even in cases of extenuating circumstances. Only the prior authorization requirement does not need to be met in these circumstances.

I. Unable to Know Coverage

These are circumstances where the provider organization made every reasonable attempt but was unable to ascertain the responsible health plan so that any pre-authorization requirements, including admission notification, could be known or met.

In these circumstances, the provider organization does not have current insurance information on file for the patient and are unable to get correct insurance information from the patient. As such, it is impossible for providers to request a pre-authorization or to notify the health plan of admission.

The scenarios are:

A. The patient is **unable to tell** the provider about their insurance coverage before treatment. Acceptable reasons include:

- **Trauma or unresponsive patients**: These patients are usually brought in via 911 with no family or ID and might be admitted as Jane/John Doe.
- **Psychiatric patients**: These patients are admitted through the Emergency Department for clinical conditions related to cognitive impairment.
    - **Child not attended by parent**: These patients are children who need immediate medical attention and are brought in by someone other than their parents, e.g., babysitter, grandparent, etc.
    - **Non-English-speaking patients**: These patients don't speak English and a translator cannot be obtained in a timely manner.

B. The patient initially indicated **they were self-pay and that no medical coverage was in place at time of treatment.** It was later determined that medical coverage was actually in place or that the patient was retroactively enrolled.

C. The provider asked the patient about current coverage prior to the service, the patient provided current insurance coverage information, and the **provider verified that the coverage was in force at time of treatment**. After the patient was treated, it was discovered that another health plan is primary and responsible for coverage.

D. The patient falsely posed as another individual using that individual's health information as coverage for services. Coverage was verified. After the patient is treated, the provider discovers that the patient either:

a. Had other insurance in their name that was applicable, or

b. Has no insurance, qualifies for Medicaid, and helps enroll the patient post-service with coverage retroactive to the time of service (aka 'B' above)

Unable to Know Coverage situations **do not include:**

When the provider was able to communicate with the patient before giving treatment, but insurance coverage information was not obtained or was not verified before the service(s). (The provider may have had insurance information on file for the patient and assumed it was still in force, or may have copied the patient's insurance card but not verified it). The provider later discovered that the coverage was not in force.

Providers are expected to verify each time that the patient's current insurance information is obtained from the patient by asking the following questions:

a. What is the current insurance coverage for this patient?

b. Are there any other insurance coverages for this patient, such as multiple employers, multiple responsible parties, etc.?

c. What are the birthdates of both parents?

For a. & b. above, it's important to send to the health plan when checking on eligibility so that they can determine if a coordination of benefit situation applies

II. Unable to Anticipate Procedure

Defined as circumstances where the provider organization, prior to seeing the patient, could not anticipate the need for a procedure requiring a pre-authorization and any delay in the delivering the procedure in order to obtain an authorization would adversely impact the health of the patient. (See A.1. and A.2. below for definitions of *urgent* and *non-urgent-time-sensitive* circumstances.)

Procedure is defined as a treatment, e.g., injection, medication, limb support, or diagnostic test such as imaging or biopsy.

A. In the course of an E&M visit

The patient made an appointment with a provider and the need for any service except the E&M visit was not known at that time. In the course of the visit, the provider determines the need for an in-office procedure to be urgent or non-urgent-time-sensitive. That procedure is then provided in the course of the E&M visit and/or the patient is referred to another provider for the urgent/time-sensitive procedure. The secondary provider may also determine the need for an alternative/additional urgent/time-sensitive procedure.

1. Need for the procedure was *urgent*

In the course of the visit, the provider determines the need for an in-office procedure to be urgent (identified and documented for the date of service). In other words not providing the care would:

- Seriously jeopardize the life or health of the patient
- Seriously jeopardize the patient's ability to regain maximum function
- Subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

2. Need for the procedure was *non-urgent-time-sensitive*

Note: The following are **possible examples** of applicable procedures:

- Joint injection for pain, biopsy, imaging and/or limb support.
- A change in treatment or medication where delay could diminish clinical outcome.

However, any/all services would need to meet this criteria:

In the course of the visit, the provider identifies a clinical condition for which they could not have anticipated the services that had to be provided in order to avoid negative health outcomes, those outcomes including but not limited to:

- Adverse impact to the quality of health of the patient, e.g., pain/restricted function

- Extending the timeframe for diagnostic confirmation/care coordination of a suspected acute condition and the delay would compromise health outcomes
- Patient incurs excessive travel and/or expense to return to obtain the service

These services might include but are not limited to curative, rehabilitative, or palliative actions whose clinical effectiveness largely depends on time-sensitive intervention.

An extenuating circumstance does not apply when the service(s) occurs in the course of visit solely for the convenience of the provider.

B. In the course of a procedure (which may or may not require pre-authorization).

Once the procedure begins, a different procedure or the need for an add-on procedure is clinically indicated. That newly indicated procedure requires pre-authorization.

This scenario is only considered an extenuating circumstance if the newly indicated procedure is performed at the time of the original procedure or on the same day,

Both Unable to Anticipate circumstances (A & B) **do not include when**:

- The provider performs a procedure or provides a service considered experimental or investigational.
- The service is scheduled for provider convenience rather than for clinical need.
- The service does not meet benefit coverage or medical necessity criteria.

III. Inherent Component Services

These are circumstances where the provider organizations obtained a pre-authorization for at least one service in an inherently related set of services but not for other inherently related services in the set.

Some services have multiple inherent components (see **definition** below). In some cases, some health plans require each component to have its own pre-authorization review. In these cases:

When pre-service review is requested by a provider and, at the time of review (based on regulatory timelines consistent with the submitted requests), the health plan notices the absence of one or more inherent components of a service for which separate pre-authorization or medical necessity review will be required, the health plan will contact the provider to determine if all component services are submitted. The preferred method is phone or electronic notification.

There may be situations when, at the time of a pre-service review, the provider did not include all inherent component services **and** the health plan did not notice the absent components. Later, at the time of post-service medical necessity review, the health plan may notice that a pre-authorization was obtained for only a subset of the inherent components that were submitted on a claim. In these cases, the health plan will not deny the added inherent component service(s) for lack of pre-authorization.

An ***inherent component*** extenuating circumstance is when the health plan denies, for lack of pre-authorization, one or more services within an inherent component set when at least one of the services in the set had been pre-authorized.

Definition: Inherent component services where one service is an essential attribute of

another, i.e., one can't be provided without the other. Examples include:

- An infused/injectable medication and the service to administer that medication
- A device and the procedure related to implanting the device
- A sleep study and the interpretation of the study
- The placement of a drainage tube and the radiological guidance
- Hyperbaric oxygen under pressure and the physician supervision

IV. Misinformation

These are circumstances where the provider organization can demonstrate that a health plan representative and/or the health plan's web site gave inaccurate information about the need for a pre-authorization or admission notification.

V. Delayed Notification

These are circumstances when the health plans decision/notification took longer than the timeframes outlined in the WAC 284-43-2000 (or BPR-Standard Timeframes for health plans where the WAC does not apply) and the provider can demonstrate that they met all supporting documentation and timeframe requirements in submitting requested information, i.e., the service was provided after the pre-authorization was requested and after associated WAC/BPR documentation submission and notification timeframes had passed, but before a pre-authorization notification decision was given to the provider.

Best Practice Recommendation

A. Providers will provide the following documentation to support the extenuating circumstance.

Extenuating Circumstance	Documentation from provider organization
I. Unable to Know Coverage	Identify extenuating circumstance condition that applies from section I. above along with appropriate documentation to support attempts made to determine coverage, and response from other health plan(s)that were queried, e.g., below as appropriate to the circumstance: • Dated documentation, e.g., admission face sheet, obtained at the time of service indicating: o The insurance information provided by the patient/representative o The patient's/representative's inability to provide insurance information o The patient's/representative's reporting self-pay • Verification of no Medicaid coverage (ProviderOne result) at the time of inquiry (though eligibility at date of service was later confirmed) • Dated documentation obtained at time of service showing eligibility confirmation from another payer, e.g., web

Extenuating Circumstance	Documentation from provider organization
	eligibility screen shot or copy of electronic eligibility confirmation, **and/or** that payer's EOB denying the service as not eligible for coverage (e.g., denied due to alternate primary coverage).
II. Unable to Anticipate Service In the course of an E&M visit (or referred-to visit)	Identify clinical rationale that applies. Applicable office visit chart note for either the date of service or the referral along with other clinical documentation (as needed), e.g., diagnosis, H & P, failed alternative treatment(s), or interim/alternative treatment(s) as appropriate, indicating the medical necessity for the procedure and the rationale for providing the procedure at that time without prior authorization, i.e., procedure is time sensitive. The treatment decision and supporting document may be submitted by the E&M provider and/or the referred-to provider, as appropriate, as outlined in section II. A. above.
IV. Delayed Notification	Identify that supporting documentation and timeframe requirements associated with a pre-authorizations request were met. Timely submission of pre-authorization request and support documentation: • Documentation indicating the date the pre-authorization request was made and any faxes where supporting information was provided, **and/or** • Documentation of a call to the health plan to provide information, including if available, a reference number, time of call and name of who was spoken with and what was discussed, **and/or** • Evidence of mailed-in documentation in form of tracking number or postage stamp date Non-timely documentation request or decision notification from health plan Documentation (e.g., dated office phone log or dated electronic submission) indicating that a request for supporting documentation and/or a decision notification was not received (timely) from the health plan. Timely verification of status of the pre-authorization request Documentation that the status of the request was checked within the decision timeframe to determine if information

Extenuating Circumstance	Documentation from provider organization
	submitted by the provider, and the website shows no indication of outstanding actions or documentation required of the provider.

Note: Submission of the above referenced documentation does not guarantee payment. Even if the extenuating circumstance applies, the service is subject to benefit coverage and medical necessity.

B. The health plan's decision-making/notification process will be completed within 30 days of notification of the extenuating circumstance by the provider organization. In addition to assessing the extenuating circumstance, the health plan will conduct a benefit coverage review and a medical necessity review and inform the provider of the result, via phone, fax, and/or letter.

   If the provider submits a claim for the service prior to the health plan completing this process, the claim may be denied for lack of pre-authorization.

   If the provider organization's claim is denied for lack of pre-authorization, the provider organization may request an appeal of the denial. Once an appeal has been initiated, the health plan's decision-making/notification process will be completed within the states' required timeframes for post-service review.

C. If the provider organization follows these recommended best practices for extenuating circumstances, health plans will process the service **as if** a pre-authorization had been requested prior to service delivery or notification of admission was given within the specified time period of admission, e.g., 24 hours. Services will subject to benefit coverage and medical necessity.

Section 5: Billing and Payment

For Self-Funded products, Kaiser Permanente Insurance Company (KPIC) utilizes a third-party administrator (TPA) to process claims.

The TPA's claim-processing operation is supported by a set of policies and procedures that direct the appropriate handling and reimbursement of claims received.

It is your responsibility to submit itemized claims for services provided to Self-Funded members in a complete and timely manner in accordance with your provider agreement, this manual and applicable law. The Self-Funded member's plan sponsor is responsible for payment of claims in accordance with your provider agreement. Please note that this manual does not address submission of claims under tiers 2 and 3 of the Self-Funded POS product.

5.1 Whom to Contact with Questions

If you have questions on submitting claims, please contact Self-Funded Customer Service at 1-866-800-3402.

5.2 Methods of Claims Filing

You can submit claims by postal mail or email.

5.3 Paper Claim Forms

For facility services billing, use the UB-04 (CMS-1450) form.

For professional services billing, use the CMS-1500 form.

5.4 Record Authorization Number

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

On **CMS 1500 Form**, if applicable, enter the authorization number (Field 23) and the name of the referring provider (Field 17) on the claim form, to ensure efficient claims processing and handling.

5.5 One Member/Provider per Claim Form

- Do not bill for different members on the same claim form
- Do not bill for different providers on the same claim form
- Complete separate claim forms for each member and provider

5.6 Submission of Multiple Page Claim

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

5.7 Billing Inpatient Claims That Span Different Years

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

5.8 Interim Inpatient Bills

Submit interim hospital billings under the same Self-Funded member account number as the initial bill submission.

5.9 Supporting Documentation for Paper Claims

Self-funded claims for after-hours medical services require supporting documentation that includes the following:

- Office notes
- Patient sign-in sheet
- Normal office hours

If anesthesia is included in the claim, please bill with physical status code 4s.

Additional specifications within plan sponsor contracts for Self-Funded products will supersede terms specified here. Additional documentation requirements will be communicated by the TPA via an Info Request Letter.

5.10 Where to Mail Paper Claims

We prefer EDI (electronic) claims over paper, but if you do submit a paper claim, please note that **no handwritten claims are accepted.**

Mail all paper claims to:

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

We don't accept paper claims via fax due to HIPAA regulations.

5.11 Where to Submit EDI (electronic) Claims

Submit EDI (electronic claims to:

Kaiser Permanente Insurance Company Payor ID #94320

5.12 Electronic Data Interchange (EDI)

KPIC encourages electronic submission of claims. Self-Funded claims will be administered by Harrington Health, our contracted third party administrator (TPA). Harrington Health has an exclusive arrangement with Change Healthcare or clearinghouse services. Providers can submit electronic claims directly through Change Healthcare or through another clearinghouse that has an established connection with Change Healthcare. Change Healthcare will collect electronic claims directly from providers and other clearinghouses and route them to Harrington Health for adjudication.

EDI is an electronic exchange of information in a standardized format that follows all HIPAA requirements. EDI transactions replace paper claims. Required data elements (such as claims data elements) are entered into the computer only once—typically at the provider's office, or at another location where services were rendered.

Benefits of EDI Submission

- **Reduced overhead expenses**, because the need for handling paper claims is eliminated.
- **Improved data accuracy**, because claims data is submitted electronically, so there's no need for re-keying or re-entry of data.
- **Low error rate**, because up-front edits are applied to the claims data while information is being entered at the provider's office. Additional payer-specific edits applied to the data by the clearinghouse before the data is transmitted to the appropriate payer increase the percentage of clean claim submissions even more.
- **Save time and supplies** by bypassing U.S. Mail delivery.
- **Standardized transaction formats** using industry-accepted medical claim formats may reduce the number of "exceptions" currently required by multiple plan sponsors.

5.13 Supporting Documentation for Electronic Claims

If submitting claims electronically, the 837 transaction contains data fields for supporting documentation through free-text format (exact system data field within your billing application

varies). If supporting documentation is required, the TPA will request it via Info Request Letters. You'll need to send paper-based supporting documentation to the address below, where the documents will be scanned, imaged, and viewable by a TPA claim processor. The TPA cannot accept electronic attachments at this time.

Coordination of Benefits (COB) claims may be submitted electronically if you include primary payer payment info on the claim and specify in the notes that Explanation of Payment (EOP) is being sent via paper.

Mail all supporting documentation to:

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

5.14 To Initiate EDI Submissions

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

Please contact the TPA at 1-866-800-3402 with any questions.

5.15 EDI Submission Process

Provider sends claims via EDI: Once a provider has entered all required data elements (i.e., all required data for a particular claim) into a their claims processing system, the provider then electronically sends all the information to a clearinghouse (either Change Healthcare or another clearinghouse with an established connection with Change Healthcare) for further data sorting and distribution.

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

Exceptions to TPA Submission

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

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

When a Self-Funded plan sponsor is secondary to another coverage, providers can send the secondary claim electronically by (a) ensuring that the primary payment data element within the 837 transaction is specified; and (b) mailing the primary payer payment info (EOP) to the address below.

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

Clearinghouse receives electronic claims and sends to plan sponsor: Providers should work with their EDI vendor to route their electronic claims within the Change Healthcare

clearinghouse network. Change Healthcare will collect electronic claims directly from providers and other clearinghouses for further data sorting and distribution.

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

In addition, clearinghouses:

- Frequently supply the required PC software to enable direct data entry in the provider's office
- May edit electronically submitted data so the data submission can be accepted by the appropriate plan sponsor for processing
- Transmit the data to the correct payer in a format easily understood by the payer's computer system
- Transmit electronic claim status reports from plan sponsors to providers

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

5.16 Rejected Electronic Claims

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

Note: If you don't receive an electronic claim receipt from the clearinghouse, you're responsible for contacting the clearinghouse to request it.

Detailed Error Report: The electronic claim acknowledgement reports include a reject report, which identifies specific errors on non-accepted claims. Once the claims listed on the reject report are corrected, you can re-submit these claims electronically through the clearinghouse. If claims errors can't be resolved, submit the claim on paper to the TPA at.

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

5.17 HIPAA Requirements

All electronic claim submissions must follow HIPAA requirements. These websites include more information on HIPAA and electronic loops and segments:

www.dhhs.gov

www.wedi.org

www.wpc-edi.com

5.18 Clean Claim

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

- Correct form: Submit all professional claims using CMS Form 1500, and submit all facility claims (or appropriate ancillary services) using CMS Form CMS 1450 (UB04) based on CMS guidelines.
- Standard coding: Complete all fields using industry-standard coding.
- Applicable attachments: Include attachments in your submission when circumstances require additional information.
- Completed field elements for CMS Form 1500 or CMS 1450 (UB-04): Complete all applicable data elements of CMS forms.

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

- The format used in the completion or submission of the claim is missing required fields or codes are not active.
- The eligibility of a member cannot be verified.
- The service from and to dates are missing.
- The rendering physician is missing.
- The vendor is missing.
- The diagnosis is missing or invalid.
- The place of service is missing or invalid.
- The procedures/services are missing or invalid.
- The amount billed is missing or invalid.
- The number of units/quantity is missing or invalid.
- The responsibility of another payer for all or part of the claim is not included or sent with the claim.
- Other coverage has not been verified.
- Additional information is required for processing such as COB information, operative report, or medical notes (these will be requested upon denial or pending of claim).
- The claim was submitted fraudulently..

Note: Failure to include all information will result in a delay in claim processing and payment and will be returned for any missing information.

For further information and instruction on completing claims forms, please refer to the CMS website (www.cms.hhs.gov), where manuals for completing both the CMS 1500 and CMS 1450(UB04) can be found in the “Regulations and Guidance/Manuals” section.

5.19 Claims Submission Timeframes

Timely filing requirement for Self-Funded claim submission is based on payer contract specifications and may vary from payer to payer (contract to contract). The standard timeframe for claim submission is 12 months from date of service, although it can vary with each plan sponsor.

Please contact Self-Funded Customer Service to obtain payer-specific information.

5.20 Proof of Timely Claims Submission

Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that shows the claim was initially submitted within the appropriate timeframes. The TPA will consider system-generated documents that show the original date of claim submission and the payer the claim was submitted to. Please note that handwritten or type documentation is not an acceptable form of proof of timely filing.

5.21 Claim Adjustments/Corrections

A claim correction can be submitted via the following procedures:

- Paper claims: Write “CORRECTED CLAIM” at the top (blank) part of the CMS-1500 or UB-04 claim form. Attach a copy of the corresponding page of the KPIC EOP to each corrected claim. Mail the corrected claim(s) to KPIC using the standard claims mailing address.
- Underpayment error: Write or call Self-Funded Customer Service and explain the error. Upon verification of the error, TPA will make appropriate corrections, and the underpayment amount owed will be added to/reflected in the next payment.
- Electronic claims (CMS-1500): Corrections to CMS-1500 claims that were already accepted (regardless of whether these claims were submitted on paper or electronically) should be submitted on paper claim forms. Corrections submitted electronically may inadvertently be denied as a duplicate claim. If corrected claims for CMS-1500 are submitted electronically, providers should contact Self-Funded Customer Service to identify the corrected claim electronic submission.
- Electronic claims (UB-04): Please include the appropriate Type of Bill code when electronically submitting a corrected UB-04 claim for processing. **Important**: Claims submitted without the appropriate third digit (*xxX) in the “Type of Bill” code will be denied.

Additional specifications within plan sponsor contracts for Self-Funded products will supersede terms specified here.

5.22 Incorrect Claims Payments

Please follow these steps when an incorrect payment is identified on the Explanation of Payment (EOP):

Overpayment Error: There are two options to notify the TPA of overpayment errors

A. Write or call Self-Funded Customer Service. Appropriate corrections will be made and the overpayment amount will be automatically deducted from the next payment.

B. Write a refund check to Kaiser Permanente Insurance Co. (KPIC) for the exact overpayment amount within the timeframe specified by the provider agreement. Attach a copy of the KPIC EOP to your refund check, as well as a brief note explaining the error. Mail to:

Kaiser Permanente Insurance Co. (KPIC)
P.O. Box 894197
Los Angeles, CA 90189-4197

If for some reason an overpayment refund is not received by KPIC within the terms and timeframe specified by the provider agreement, the TPA on behalf of KPIC may deduct the refund amount from future payments.

Additional specifications with other plan sponsors for Self-Funded products will supersede terms specified here.

5.23 Federal Tax ID Number

The Federal Tax ID Number (TIN) reported on any and all claim form(s) must match the information filed with the Internal Revenue Service (IRS).

1. When completing IRS Form W-9, please note the following:
   - Name: This should be the equivalent of your "entity name," which you use to file your tax forms with the IRS.
   - Sole Provider/Proprietor: List your name, as registered with the IRS.
   - Group Practice/Facility: List your "group" or "facility" name, as registered with the IRS.
2. Business Name: Leave this field blank, unless you have registered with the IRS as a "Doing Business As" (DBA) entity. If you are doing business under a different name, enter that name on the IRS Form W-9.
3. Address/City, State, Zip Code
4. TIN: The number reported in this field (either the Social Security number or the employer identification number) **must** be used on all claims submitted.
   - Sole Provider/Proprietor: Enter your TIN, which will usually be your Social Security number (SSN), unless you have been assigned a unique employer identification number (because you're "doing business as" an entity under a different name).
   - Group Practice/Facility: Enter your taxpayer identification number, which will usually be your unique employer identification number (EIN).

If you have questions regarding the proper completion of IRS Form W-9 or the correct reporting of your Federal TIN on your claim forms, please contact the IRS help line in your area or refer to the following website.

http://www.irs.gov/formspubs/

Mail completed IRS Form W-9 to:

Kaiser Permanente
500 NE Multnomah Street, Suite 100
Portland, OR 97232

5.24 Changes in Federal Tax ID Number

If your Federal Tax ID Number should change, please notify us immediately, so we can make appropriate corrections to the appropriate files.

5.25 National Provider Identification (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all providers to use a standard unique identifier on all electronic transactions. Use your National Provider Identifier (NPI) on all HIPAA-standard electronic transactions.

For additional information on the NPI, including how to apply and report, contact the Center for Medicare & Medicaid Services (CMS) **or** refer to the following website: http://www.cms.hhs.gov/NationalProvIdentStand/

5.26 Self-Funded Member Cost Share

Please verify applicable Self-Funded member cost share at the time of service.

Depending on the benefit plan, Self-Funded members may be responsible to share costs of services. Copayment, co-insurance, and deductible (collectively, “cost share”) are the fees a Self-Funded member is responsible to pay a provider for certain covered services. This information varies by plan and all providers are responsible for collecting cost share in accordance with the Self-Funded member’s benefits.

You can find cost share information in one of these ways:

- Self-Funded Customer Service, 1-866-800-3402, Monday–Friday 7 a.m. to 9 p.m. (ET). Self-service is available 24 hours/7 days a week
- Harrington Health, http://provider.kphealthservices.com

5.27 Self-Funded Member Claims Inquiries

Please call 1-866-800-3402.

5.28 Billing for Services Provided to Visiting Self-Funded Members

For visiting Self-Funded members, the claim submission process is the same as for other members. Reimbursement for visiting Self-Funded members will reflect the Self-Funded visiting member’s benefits. **Note**: At least the MRN displayed on the Self-Funded ID card must be identified on the submitted claim.

5.29 Coding for Claims

It’s the provider’s responsibility to ensure that billing codes used on claims forms are current and accurate, reflect the services provided, and comply with KPIC’s coding standards. Incorrect and invalid coding can result in payment delay or denial. All coding must follow standards specified in 5.30 Coding Standards.

5.30 Coding Standards

Coding: Complete all fields using industry-standard coding as shown below.

ICD-10: To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 9th Revision-Clinical Modification (ICD-10-CM) developed by the Commission on Professional and Hospital Activities. ICD-10-CM Volumes 1 & 2 codes appear as three-, four-, or five-digit codes, depending on the specific disease or injury being described. Volume 3 hospital inpatient procedure codes appear as two-digit codes and require a third and/or fourth digit for coding specificity.

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

If you'd like to request a new code or suggest deleting or revising an existing code, obtain and complete a form from the AMA's website at www.ama-assn.org/ama/pub/category/3112.html, or submit your request and supporting documentation to:

CPT Editorial Research and Development
American Medical Association
515 North State Street
Chicago, IL 60610

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

Revenue Code: Approved by the Health Services Cost Review Commission for a hospital located in the State of Maryland, or of the national or state uniform billing data elements specifications for a hospital not located in that state.

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

ASA (American Society of Anesthesiologists): For anesthesia services, these codes are maintained and distributed by the ASA.

DSM-IV (American Psychiatric Association): For psychiatric services, these codes are distributed by the American Psychiatric Association (APA).

5.31 Modifiers in CPT and HPOCS

Modifiers submitted with an appropriate procedure code further define and/or explain a service provided. You can find valid modifiers and their descriptions in the most current CPT or HCPCS coding book. Note to CMS-1500 submitters: The TPA will process up to four modifiers per claim line.

When submitting claims, use modifiers to:

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

5.31.1 Modifiers in CPT and HPOCS

Modifiers Billed with Evaluation and Management (E/M) Services

- Modifier 25, Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the

symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. You can report this circumstance by adding modifier 25 to the appropriate level of E/M service. Note: this modifier is not used to report an E/M service that resulted in a decision to perform surgery.

- Modifier 26, Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier "-26" to the usual procedure number.
- Modifier TC, Technical Component: The modifier TC is submitted with a CPT procedure code to bill for equipment and facility charges, to indicate the technical component.
    - Use with diagnostic tests, such as radiation therapy, radiology, and pulmonary function tests.
    - Indicates the provider performed only the technical component portion of the service.

Modifiers Billed with Surgical Procedures (Modifier 50 – Bilateral Procedure)

Add Modifier 50 to the service line of a unilateral 5-digit CPT procedure code to indicate that a bilateral procedure was performed. Use it to bill surgical procedures at the same operative session, or to bill diagnostic and therapeutic procedures performed bilaterally on the same day.

5.32 Modifier Review

The TPA will adjudicate modifier usage based on Current Procedural Terminology (CPT) guidelines. Providers are required to use modifiers according to standards and codes set forth in CPT4 manuals.

KPIC reserves the right to review use of modifiers to ensure accuracy and appropriateness. Improper use of modifiers may cause claims to pend or be returned for correction.

5.33 Coding & Billing Validation

For Self-Funded products, KPIC uses a third-party administrator (TPA), Harrington Health, to process claims. Harrington Health in turn uses ClaimCheck, McKesson's commercial code editor application, to evaluate and ensure accuracy of outpatient claims data (including HCPCS and CPT codes) and associated modifiers. ClaimCheck provides a set of rules with complex coding situations and specifies when certain combinations of codes that have been billed by a provider are inappropriate. This process is intended to result in accurate coding and consistent claims payment procedures.

5.34 Coding Edit Rules

Edit Category	Description	Self-Funded Edit
Rebundling	Use a single comprehensive CPT code when two or more codes are billed.	**Apply**

Incidental	Procedure performed at the same time as a more complex primary procedure. Procedure is clinically integral component of a global service. Procedure is needed to accomplish the primary procedure.	**Deny** if procedure deemed to be incidental
Mutually Exclusive	Procedures that differ in technique or approach but lead to the same outcome.	**Deny** procedure that's deemed to be mutually exclusive
Medical Visits Pre- & Post-Op Visits	Based on Surgical Package guidelines; audits across dates.	**Deny** E&M services within pre- and post-op timeframe
Duplicate Procedures	Category I—Bilateral: shown twice on submitted claim Category II—Unilateral/bilateral shown twice on submitted claim Category III—Unilateral/single CPT shown twice Category IV—Limited by date of service, lifetime or place of service	**Allow one procedure per date of service;** second procedure denied. **Allow only one procedure per date of service;** second procedure denied. **Replace with corresponding bilateral or multiple code; allow/deny based on plan's allowable limits**
	Category V—Not addressed by Category I-IV.	**Pend for Review**
Medical Visits/Pre- & Post-Op Visits	Based on Surgical Package guidelines; audits across dates.	**Deny** E&M services within pre- and post-op timeframe
Cosmetic	Identifies procedures requiring review to determine if they were performed for cosmetic reasons only.	**Review** for medical necessity
Experimental	Codes defined by CMS and AMA in CPT and HCPCS manuals to be experimental.	**Pend for Review**
Obsolete	Procedures no longer performed under prevailing medical standards.	**Review** for medical necessity

5.35 Coordination of Benefits (COB)

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

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

5.35.1 How to Determine the Primary Payer

1. The benefits of the plan that covers an individual as an employee, patient, or subscriber other than as a dependent are determined before those of a plan that covers the individual as a dependent.
2. When both parents cover a child, the “birthday rule” applies—the payer for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payer.

When determining the primary payer for a child of separated or divorced parents, inquire about the court agreement or decree. In the absence of a divorce decree or court order stipulating parental healthcare responsibilities for a dependent child, insurance benefits for that child are applied according to the following order:

1. Natural parent with custody
2. Step-parent with custody
3. Natural parent without custody
4. Step-parent without custody

If the parents have joint custody of the dependent child, benefits are applied according to the birthday rule referenced above. If this does not apply, call Self-Funded Customer Service at 1-866-800-3402.

Please note these additional guidelines:

1. The Self-Funded plan is generally primary for working Medicare-eligible members when the CMS Working Aged regulation applies.
2. Medicare is generally primary for retired Medicare members over age 65, and for employee group health plan (EGHP) members with end stage renal disease (ESRD) for the first thirty (30) months of dialysis treatment. This doesn’t apply to direct pay members.
3. In cases of work-related injuries, Workers Compensation is primary unless coverage for the injury has been denied.

In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payer status is determined on a jurisdictional basis. Submit the claim as if the Self-Funded plan is the primary payer. TPA will follow their standard “pay and chase” procedures.

5.35.2 Description of COB Payment Methodologies

COB allows benefits from multiple carriers to be added on top of each other so the Self-Funded member receives the full benefits from their primary carrier and the secondary carrier pays their entire benefit up to 100% of allowed charges.

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

5.35.3 COB Claims Submission Requirements and Procedures

Whenever the Self-Funded plan is the **secondary** payer, you can submit claims **either**

electronically or on one of the standard paper claim forms.

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

- 837P claim transaction Enter amount paid
- 837I claim transaction Enter prior payments

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

- CMS-1500 claim form: Complete Field 29 (Amount Paid)
- CMS-1450 claim form: Complete Field 54 (Prior Payments)

5.35.4 Self-Funded Members Enrolled in Two Kaiser Permanente Plans

Some Self-Funded members may be enrolled under two separate plans offered through Kaiser Permanente (dual coverage). In these situations, providers need only submit **one** claim under the primary plan and send to either Harrington Health (for Self-Funded plan) or Kaiser Permanente (for fully insured plan) depending on which plan is primary.

5.35.5 COB Claims Submission Timeframes

If a Self-Funded plan is the secondary payer, any Coordination of Benefits (COB) claims must be submitted for processing within the timely filing period according to the standard claims submission timeframe.

5.35.6 COB Fields on the UB-04 Claim Form

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

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

8371 Loop #	Field #	Field Name	Instructions/Examples
2300 H1	**32-35** (UB-92) **31-36** (UB-04)	Occurrence Code/Date	Enter the appropriate occurrence code and date defining the specific event(s) relating to the claim billing period. **Note**: If the injuries are a result of an accident, please complete **Field 77 (E-Code)**.

8371 Loop #	Field #	Field Name	Instructions/Examples
2330B NM	**50**	Payer *(Payer Identification)*	Enter the **name** and **number** *(if known)* for each **payer organization** from whom the provider expects (or has received) payment towards the bill. List payers in the **following order** on the claim form:
2320 AMT	**54**	Prior Payments *(Payers and Patient)*	Enter the **amount(s)**, if any, that the provider has received **toward payment of the bill** PRIOR to the billing date, by the indicated payer(s). List prior payments in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2330A NM	**58**	Insured's name	Enter the **name** *(Last Name, First Name)* of the individual in whose name insurance is being carried. List entries in the **following order** on the claim form: A = **primary** payer B = **secondary** payer C = **tertiary** payer **Note:** For each entry in ***Field 58*****,** there MUST be corresponding entries in ***Fields 59*** *through* ***62*** (UB-92 and UB-04) **and** ***64*** *through* ***65 (Field 65 only on the UB-04)*****.**
2320 SBR	**59**	Patient's relationship to insured	Enter the **code** indicating the **relationship** of the patient to the insured individual(s) listed in **Field 58** *(Insured's Name).* List entries in the **following order:** A = **primary** payer B = **secondary** payer C = **tertiary** payer
2330A NM	**60**	CERT. – SSN – HIC – ID no. *(Certificate/Social Security Number/Health Insurance Claim/Identification Number)*	Enter the insured person's *(listed in Field 58)* unique **individual member identification number** (medical/health record number), as assigned by the payer organization. List entries in the **following order:** A = **primary** payer B = **secondary** payer

8371 Loop #	Field #	Field Name	Instructions/Examples
			C = **tertiary** paper
2320 SBR	**61**	Group name *(Insured Group Name)*	Enter the **name** of the **group or plan** through which the insurance is being provided to the insured individual *(listed in Field 58)*. Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper
2320 SBR	**62**	Insurance group no.	Enter the **identification number**, **control number**, or **code** assigned by the carrier or administrator to identify the **group** under which the individual *(listed in Field 58)* is covered. List entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper
2320 SBR	**64**	ESC *(Employment Status Code of the Insured)* ***Note:*** *This field has been deleted from the UB-04.*	Enter the code used to define the **employment status** of the insured individual *(listed in Field 58)*. Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper
2320 SBR	**65**	Employer name *(Employer name of the insured)*	Enter the **name of the employer** who provides health care coverage for the insured individual *(listed in Field 58)*. Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** paper

8371 Loop #	Field #	Field Name	Instructions/Examples
2300 H1	**67-76 (UB-92) 67 A-Q (UB-04)**	Diagnosis code	The **primary diagnosis** code should be reported in **Field 67**. Additional diagnosis code can be entered in **Field 68-76.**
2300H1	**77(UB-92) 72 (UB-04)**	External cause of injury code (e-code)	If applicable, enter an ICD-9-CM "Ecode" in this field.

5.35.7 COB Fields on the CMS-1500 Claim Form

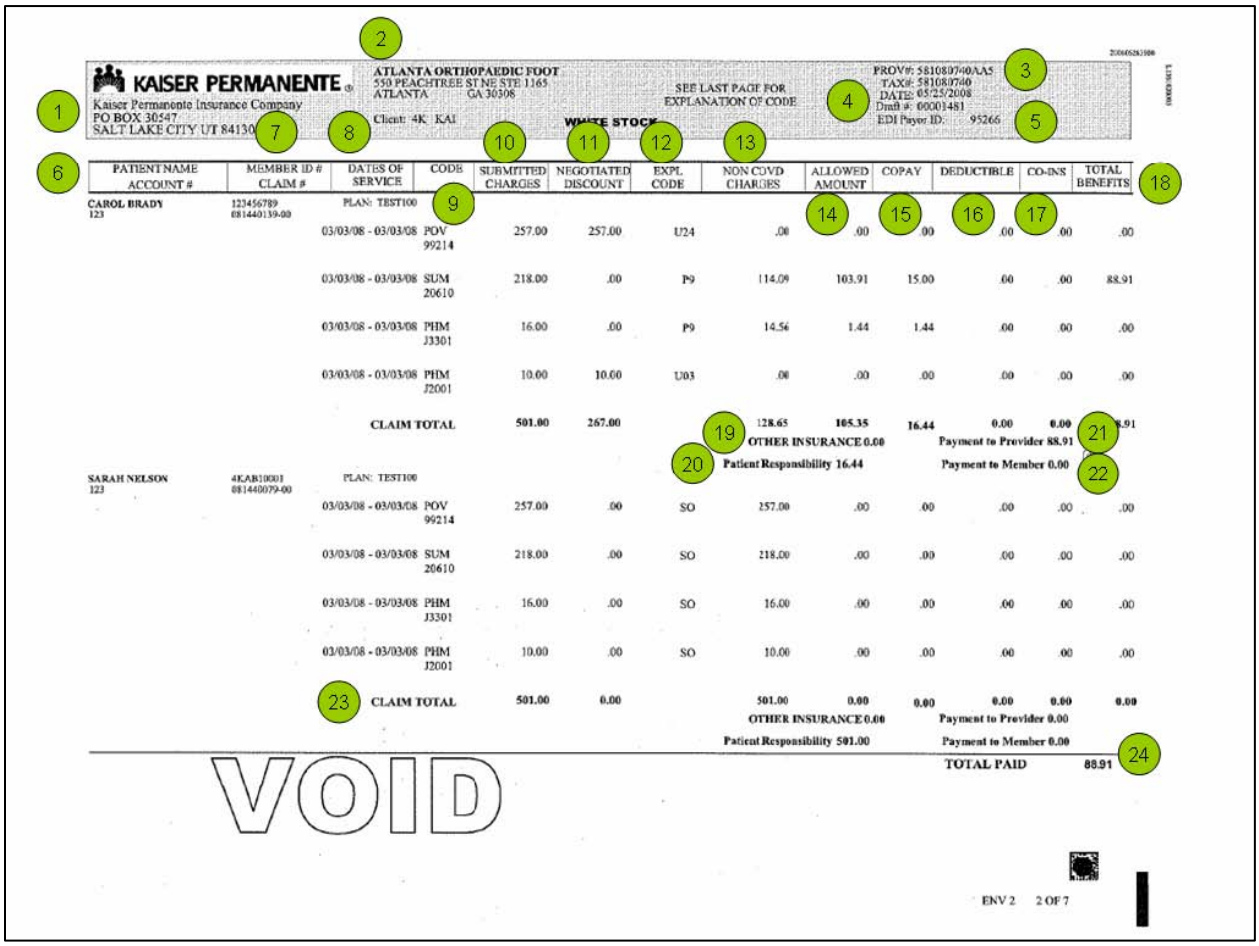
Complete the following fields on the CMS-1500 claim form, to ensure timely and efficient claims processing. Incomplete, missing, or erroneous COB information in these fields may cause claims to be denied or pended and reimbursements delayed.

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

837P Loop #	Field #	Field Name	Instructions/Examples
2330A NM	**9**	Other Insured's Name	When **additional** insurance coverage exists (through a spouse, parent, etc.) enter the LAST NAME, FIRST NAME, and MIDDLE INITIAL of the insured. **Note:** You must complete this field when there's an entry in Field 11d (Is There Another Health Benefit Plan?).
2330A NM	**9a**	Other Insured's Policy Or Group Number	Enter the policy and/or group number of the insured individual named in **Field 9**. If you do not know the policy number, enter the Social Security number of the insured individual. **Note:** You must complete Field 9a when there's an entry in Field 11d (Is There Another Health Benefit Plan?). **Note:** For each entry in this field, there must be a corresponding Entry in 9d (Insurance Plan Name or Program Name).
2320 DMG	**9b**	Other Insured's Date Of Birth/Sex	Enter date of birth and sex of the insured named in **Field 9**. The date of birth must include the month, day, and **four digits** for the year (MM/DD/YYYY). **Example:** 01/05/1971 **Note:** You must complete this field when there's an entry in Field 11d (Is There Another Health Benefit Plan?).

837P Loop #	Field #	Field Name	Instructions/Examples
N/A	**9c**	Employer's Name Or School Name	Enter the name of the employer or school name (if a student), of the insured named in **Field 9**. **Note:** You must complete this field when there's an entry in Field 11d (Is There Another Health Benefit Plan?).
2330B NM	**9d**	Insurance Plan Name Or Program Name	Enter the name of the insurance plan or program, of the insured individual named in **Field 9**. **Note:** You must complete this field when there's an entry in Field 11d (Is There Another Health Benefit Plan?).
2300 CLM	**10**	Is Patient's Condition Related To: a. Employment? b. Auto Accident? c. Other Accident? Place (State)	Check "yes" or "no" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in **Field 24**. **NOTE:** If yes, there must be a corresponding entry in Field 14 (Date of Current Illness/ Injury) and in Field 21 (Diagnosis). Place (State) Enter the state the auto accident occurred in.
N/A	**11d**	Is There Another Health Benefit Plan?	Check "yes" or "no" to indicate if there is another health benefit plan. (For example, the patient may be covered under insurance held by a spouse, parent, or some other person). **Note**: If "yes," then complete Fields 9 and 9a-d.
2300 DTP	**14**	Date Of Current -Illness (First symptom) -- Injury (Accident) -- Pregnancy (LMP)	Enter the date of the current illness or injury. The date must include the month, day, and **four digits** for the year (MM/DD/YYYY). **Example:** 01/05/2004
2300 H1	**21**	Diagnosis Or Nature Of Illness Or Injury	Enter the diagnosis and if applicable enter the Supplementary Classification of External Cause of Injury and Poisoning Code. **Note:** You must complete this field when there's an entry in Field 10 (Is The Patient's Condition Related To).
2320 AMT	**29**	Amount Paid	Enter the amount paid by the primary insurance carrier.

5.35.8 Explanation of Payment (EOP)



KAISER PERMANENTE®
Kaiser Permanente Insurance Company
PO BOX 30547
SALT LAKE CITY UT 84130

ATLANTA ORTHOPAEDIC FOOT
550 PEACHTREE ST NE STE 1165
ATLANTA GA 30308
Client: 4K KAI

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PROV#: 581080740AA5
TAX#: 581080740
DATE: 05/25/2008
Draft #: 00001481
EDI Payor ID: 95266

WHITE STOCK

PATIENT NAME / ACCOUNT #	MEMBER ID # / CLAIM #	DATES OF SERVICE	CODE	SUBMITTED CHARGES	NEGOTIATED DISCOUNT	EXPL CODE	NON COVD CHARGES	ALLOWED AMOUNT	COPAY	DEDUCTIBLE	CO-INS	TOTAL BENEFITS
CAROL BRADY 123	123456789 081440139-00	PLAN: TEST100										
		03/03/08 - 03/03/08	POV 99214	257.00	257.00	U24	.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	SUM 20610	218.00	.00	P9	114.09	103.91	15.00	.00	.00	88.91
		03/03/08 - 03/03/08	PHM J3301	16.00	.00	P9	14.56	1.44	1.44	.00	.00	.00
		03/03/08 - 03/03/08	PHM J2001	10.00	10.00	U03	.00	.00	.00	.00	.00	.00
		CLAIM TOTAL		501.00	267.00		128.65	105.35	16.44	0.00	0.00	88.91
							OTHER INSURANCE 0.00			Payment to Provider 88.91		
							Patient Responsibility 16.44			Payment to Member 0.00		
SARAH NELSON 123	4KAB10001 081440079-00	PLAN: TEST100										
		03/03/08 - 03/03/08	POV 99214	257.00	.00	SO	257.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	SUM 20610	218.00	.00	SO	218.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	PHM J3301	16.00	.00	SO	16.00	.00	.00	.00	.00	.00
		03/03/08 - 03/03/08	PHM J2001	10.00	.00	SO	10.00	.00	.00	.00	.00	.00
		CLAIM TOTAL		501.00	0.00		501.00	0.00	0.00	0.00	0.00	0.00
							OTHER INSURANCE 0.00			Payment to Provider 0.00		
							Patient Responsibility 501.00			Payment to Member 0.00		
										TOTAL PAID		88.91

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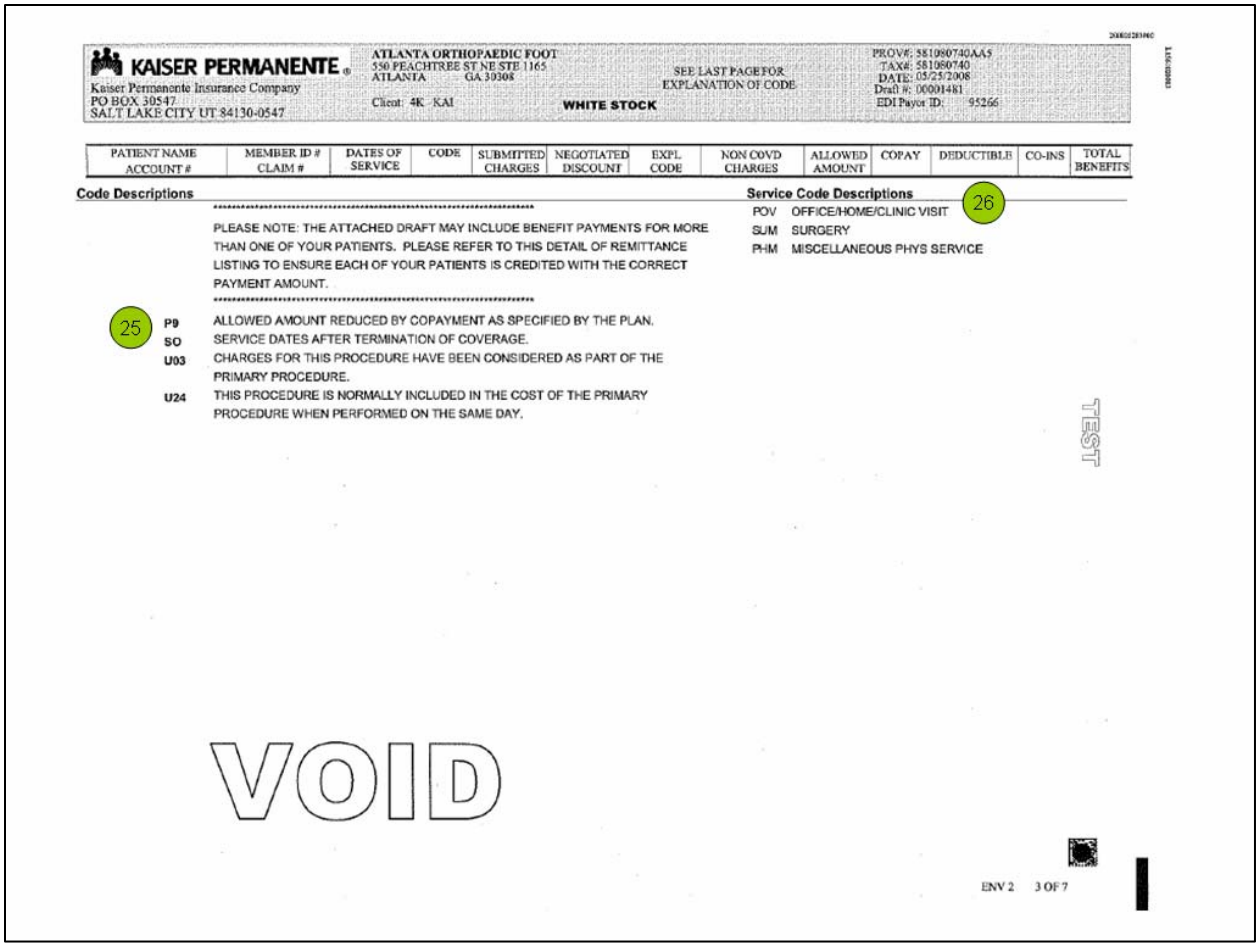
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Kaiser Permanente Insurance Company
PO BOX 30547
SALT LAKE CITY UT 84130-0547

ATLANTA ORTHOPAEDIC FOOT
550 PEACHTREE ST NE STE 1165
ATLANTA GA 30308
Client: 4K KAI

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PROV#: 581080740AA5
TAX#: 581080740
DATE: 05/25/2008
Draft #: 00001481
EDI Payor ID: 95266

PATIENT NAME ACCOUNT #	MEMBER ID # CLAIM #	DATES OF SERVICE	CODE	SUBMITTED CHARGES	NEGOTIATED DISCOUNT	EXPL CODE	NON COVD CHARGES	ALLOWED AMOUNT	COPAY	DEDUCTIBLE	CO-INS	TOTAL BENEFITS

Code Descriptions

PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.

25

P9 ALLOWED AMOUNT REDUCED BY COPAYMENT AS SPECIFIED BY THE PLAN.
SO SERVICE DATES AFTER TERMINATION OF COVERAGE.
U03 CHARGES FOR THIS PROCEDURE HAVE BEEN CONSIDERED AS PART OF THE PRIMARY PROCEDURE.
U24 THIS PROCEDURE IS NORMALLY INCLUDED IN THE COST OF THE PRIMARY PROCEDURE WHEN PERFORMED ON THE SAME DAY.

Service Code Descriptions

26

POV OFFICE/HOME/CLINIC VISIT
SUM SURGERY
PHM MISCELLANEOUS PHYS SERVICE

TEST

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ENV 2 3 OF 7

Number	Field Name	Explanation
1	Payer Name & Address	Name of payer issuing the EOP, along with address to send applicable claims resubmission, supporting documentation, or overpayment refund check
2	Provider Name & Address	Name and address of the servicing provider
3	Provider Number & TIN	Provider number noted on claim and provider tax ID
4	Payment # & Date	Check or electronic funding transfer (EFT) draft number and date of payment
5	EDI Payer ID	EDI ID for payer issuing the EOP
6	Patient Name	Name of patient to whom services were provided
7	Self-Funded Member ID & Claim #	Patient's medical record number (MRN) and the unique claim number assigned to this claim
8	Date of Service	Date(s) in which services billed were rendered
9	Code	Code for the services rendered
10	Submitted Charges	Amount billed by the provider for a given service

Number	Field Name	Explanation
11	Negotiated Discount	Write-off amount based on claims adjudication outcome
12	Explanation Code	Reason code describing how the claim was processed
13	Non-Covered Charges	Amount billed by the provider for services not covered due to limitations or exclusions defined by the patient's plan benefits
14	Allowed Amount	Amount allowed by contract or plan specification for the given service
15	Copay	Specific dollar amount that is the responsibility of the patient for a given service
16	Deductible	Specific dollar amount that is the responsibility of the patient for a given service; must be met before benefits for a given service can be paid
17	Co-Insurance	Percentage of the allowed amount that is the responsibility of the patient for a given service
18	Total Benefits	Amount paid by the payer for a given service
19	Other Insurance	Amount paid by another insurance under coordination of benefits
20	Patient Responsibility	Dollar amount that is the responsibility of the patient for an episode of care; total amount of copay + deductible + co-insurance
21	Payment To Provider	Amount paid by the plan sponsor to the servicing provider for a given claim
22	Payment To Self-Funded Member	Amount paid by the plan sponsor to the Self-Funded member for a given claim
23	Claim Total	Total amount of a given claim; sum of all submitted charges for an episode of care for a given patient
24	Total Paid	Total amount paid by the payer for all claims submitted and identified on the EOP
25	Explanation Code Description	Description of the reason code
26	Service Code Descriptions	Description of the code denoted for the services rendered

5.36 Provider Claims Payment Disputes

For disputes of claims payment, contact Self-Funded Customer Service. The TPA will review

the claim, to verify if the claim(s) were adjudicated correctly, according to the Self-Funded member's benefits. If the TPA determines the correct payment was made and the dispute remains, the call will be transferred to the Regional Provider Relations Department.

Section 6: Provider Rights and Responsibilities

As a contracted provider for Kaiser Permanente, you must understand and comply with terms of your Agreement and this manual. If you have questions about your rights and responsibilities under the Agreement and the manual, call our Provider Relations Department at 503-813-3376.

While this manual is not intended to provide specific instructions on how to comply with these responsibilities, you're responsible for doing or ensuring the following.

6.1 Primary Care Providers' (PCP) Responsibilities

All PCPs who have contracted with Kaiser Permanente are held to the same standards of care.

Qualifications:

- Each PCP must be a family practitioner, internal medicine practitioner, pediatrician or general practitioner.
- PCPs must be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association. PCPs must be boarded in the specialty for which they are applying for credentialing. Any exceptions must be approved by the Credentialing Committee.
- PCPs must complete the Kaiser Permanente credentialing process, including completion of a credentialing application, and supply copies of all applicable supporting documentation.
- All physicians in the practice must be participating with Kaiser Permanente, or in the process of becoming active. If any physicians in the practice are not participating, the practice may be terminated from the network.
- Appropriate licensure and malpractice insurance must be current and remain current throughout the duration of the Agreement.
- Annually submit certificates of insurance to the credentialing department:

  Kaiser Permanente
  Credentialing Department
  500 NE Multnomah St
  Portland, OR 97232

Scope of Services:

- PCP care within the scope of the PCP's license, using applicable standards of care
- PCP designation, by age, members to whom the physician will provide care (e.g., pediatrics up to age 18)
- A way to notify members if an allied health practitioner (e.g., PA, CNP) will provide care
- Office visits during regular visit hours to evaluate and manage common medical conditions (patient education functions can be delegated to trained staff under the PCP's supervision)

- Management of patient care in a hospital, skilled nursing facility, home, hospice, or acute rehabilitation unit
- Preventive care services, including well child, adolescent, and adult preventive medicine; nutrition; health counseling; and immunization
- Well-woman exams including breast exams and routine gynecological care with Pap and pelvic exams when the PCP is chosen by the female Member to render such services
- Therapeutic injections (including cost of medication)
- Allergy injections (including administration, excludes cost of serum)
- Standard testing and/or rhythm strip EKGs in adults
- Basic pulmonary function tests, including timed vital capacity and maximum capacity in adults, and peak flow studies in children
- Local treatment of first-degree and uncomplicated second-degree burns
- Minor surgical procedures (e.g., simple skin repair, incision and drainage, removal of foreign body, benign skin lesion removal or destruction, aspiration)
- Simple splinting and treatment of fractures
- Removal of foreign body or cerumen from external ear
- Rectal exams, anoscopy, and sigmoidoscopy
- Standard screening vision and hearing exams
- PPD skin tests
- Lab worked performed in the PCP's office that doesn't require CLIA certification (e.g., urinalysis by dipstick, blood sugar by dipstick, hemoglobin and/or hematocrit, stool occults blood)

Appointment Access/Office Hours:

- Provide, evaluate, triage, and arrange for member care 24 hours a day, 7 days a week, including evaluating the need for an arrangement of appropriate specialty referral or consultation
- On-call coverage, 24 hours a day, 7 days a week; member access to their PCP or his/her designee, who must be a Kaiser Permanente contracted, credentialed provider, by telephone after regular office hours.

Covering Services:

- PCPs are responsible for securing covering physician services.
- The covering physician must be a contracted and credentialed with privileges at the same Kaiser Permanente contracted hospital as the PCP.

- Payment to non-participating covering PCPs must be arranged by PCP. PCP will ensure covering specialists do not bill members, except for applicable co-payments, co-insurance and deductibles for any covered services.

Referrals and Authorizations/Utilization Management:

- PCPs must comply with all referral and authorization requirements outlined the Utilization Management section of this manual and are responsible for obtaining appropriate authorization for services.
- PCPs must use contracted vendors or provider may be liable for charges incurred at non-participating vendors (e.g., lab, radiology).

Claims Submission:

- Providers must submit claims electronically. For details, see the Billing and Payment section of this manual.

Office Requirements:

Offices must:

- Post a sign containing the names of all physicians practicing in the office.
- Be readily accessible to all patients (with handicapped accessibility), including but not limited to the entrance, parking, and bathroom facilities.
- Be clean and presentable and have a professional appearance.
- Provide clean, properly equipped patient toilet and hand-washing facilities.
- Have adequate waiting room space.
- Have an adequate number of clean, properly equipped exam rooms that provide privacy for the patient.
- Have a non-smoking policy.
- Have an assistant in the office during business hours.
- Require a medical assistant to attend specialized (e.g., gynecological) exams, unless the patient declines to allow the assistant to be present.
- Collect all applicable co-pays, deductibles, or coinsurance.
- Provide evidence that physicians have a copy of current licenses for all allied health practitioners (PAs, NPs, etc.) practicing in the office, including state professional license, FDA, and state controlled drug substance, where applicable.
- Keep on file and be able to produce any state-required practice protocols or supervising agreements for allied health practitioners practicing in the office.
- Pass a site evaluation, performed by a Provider Relations representative. Copies of the site evaluation are available in advance. We may also perform a site visit if we receive a complaint.

Medical Record Standards:

- PCPs must demonstrate at the time of application and throughout the term of the Agreement, that medical records are legible, reproducible, and otherwise meet applicable laws and standards for confidentiality, medical record keeping practices and that clinical documentation demonstrates comprehensive care.
- Members' medical records should include reports from referred and/or referring providers, discharge summaries, records of emergency care received, and other information Kaiser Permanente might ask for.
- Each member encounter must be documented in writing and signed or initialed by the PCP or as required by state law. Please include member's name, date of birth, and medical record number.
- PCPs must comply with the terms of your agreement regarding medical records and follow Kaiser Permanente's medical record documentation standards.
- PCPs should review HEDIS information via KP Online-Affiliate to submit information needed to support HEDIS measures for the year.

6.2 Specialty Care Providers' Responsibilities

All specialty care providers who have contracted with Kaiser Permanente are held to the same standards of care.

Qualifications:

- Each specialist physician must be an MD or DO who dedicates a significant portion (usually greater than 50 percent of his or her professional services) to non-primary care delivery.
- Specialists must be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association. Specialists must be boarded in the specialty for which they are applying for participation. Exceptions must be approved by the Credentialing Committee.
- Specialists must complete the Kaiser Permanente credentialing process (as applicable), including completion of a credentialing application, and supply copies of all applicable supporting documentation.
- Appropriate licensure must be current and remain current throughout the duration of the Agreement.
- All physicians in the practice must be participating with Kaiser Permanente, or in the process of becoming active. If any physicians in the practice are not participating, the practice may be terminated from the network.
- Annually submit certificates of insurance to the credentialing department:

  Kaiser Permanente
  Credentialing Department
  500 NE Multnomah St
  Portland, OR 97232

Scope of Services:

- Specialists should provide care within the scope of their license and pursuant to applicable standards of care.
- Specialist is responsible for communicating findings and recommended treatment to the member's PCP in a timely manner.
- Offices should have a way to notify members if an allied health practitioner (e.g., PA, NP, CNM) will provide care.

Accessibility/Office Hours

- Specialists must perform office visits during regular visit hours to evaluate and manage medical conditions. Patient education functions may be conducted by appropriately trained staff under the Kaiser Permanente contracted provider's supervision.
- Specialists must have on-call coverage, 24 hours a day, 7 days a week. Members are entitled to access their specialty physician or his/her designee, who must be a Kaiser Permanente contracted and approved credentialed provider, by phone after regular office hours. Specialist must have a reliable answering service or machine with beeping or paging system.
- Each specialist or their covering physician must respond to a member within 30 minutes after notification of an urgent call.
- Specialist must be available at least an average of eight hours a week for scheduling office appointments, as applicable.
- If a specialist's office has more than one physical location contracted with Kaiser Permanente, then the specialist must have, at minimum, eight hours of regularly scheduled office hours for patient treatment at each location.
- Each specialist must maintain the following standards for appointment access:
    - Emergency care: patient must be seen immediately or referred to ER, as appropriate
    - Urgent complaint: same day care, or within 24 hours of member's request
    - Regular or routine care: within 14 days of member's request
    - Preventive routine care: within four (4) weeks of member's request

Covering Services:

- Specialists are responsible for securing covering specialist services that are contracted with Kaiser Permanente.
- For inpatient services, the covering physician must be a contracted provider who has privileges at the same Kaiser Permanente contracted facility as the specialist.
- Approval of coverage by a non-contracted specialist physician is subject to Kaiser Permanente's sole discretion, and such approval must be in writing. Approved covering specialists must abide by the responsibilities included in this manual.

- Payment to non-participating covering specialists must be arranged by the specialist. Specialist will ensure covering specialists do not bill members, except for applicable co-payments, coinsurance, and deductibles for any covered services.

Hospital Privileges/Admissions:

- When applicable to relevant specialty, and based on the contractual obligation with Kaiser Permanente, specialists must maintain hospital privileges with a contracted hospital six months before applying with Kaiser Permanente, unless the specialist has more recently entered into clinical practice or completed their residency or fellowship training program. Hospital privileges must remain current and in good standing for the duration of the contractual relationship with Kaiser Permanente.
- If specialist provides specialty services at a contracted facility, they must also meet any additional criteria applicable as set forth in the participation responsibilities for facilities (see section 6.3 below) for the duration of the contract.

Referrals and Authorizations/Utilization Management:

- Specialists must comply with all referral and authorization requirements outlined in the Utilization Management section of this provider manual and must get authorization for services.
- Specialists must use contracted vendors or the provider may be liable for charges incurred at non-participating vendors (e.g., lab, radiology vendors). Certain radiology procedures must have an authorization if not performed in a Kaiser Permanente medical office.
- Specialists are responsible for getting authorizations and verifying before seeing the member that the needed authorization(s) are valid.

Claims Submission

- Providers must submit claims electronically. For details, see the “Billing and Payment” chapter of this provider manual.

Office Requirements:

Offices must:

- Have a sign containing names of all the physicians practicing at the office.
- Be readily accessible to all patients (with handicapped accessibility), including but not limited to the entrance, parking, and bathroom facilities.
- Be clean and presentable and have a professional appearance.
- Provide clean, properly equipped hand-washing and toilet facilities for members.
- Have adequate waiting room space.
- Have an adequate number of clean, properly equipped exam rooms that provide privacy for the patient.
- Have a non-smoking policy.
- Have an assistant on the premises during scheduled office hours.

- Require a medical assistant to attend specialized (e.g., gynecological) exams unless the patient declines to allow the assistant to be present.
- Collect all applicable co-pays, deductibles, or coinsurance.
- Provide evidence that physicians have a copy of current licenses for all allied health practitioners (PAs, NPs, etc.) practicing in the office, including state professional license, FDA, and state controlled drug substance, where applicable.
- Keep on file and be able to produce any state-required practice protocols or supervising agreements for allied health practitioners practicing in the office.
- Pass a site evaluation, performed by a Provider Relations representative, when applicable. Copies of the site evaluation are available in advance. We might also perform a site visit if we receive a complaint.

Medical Record Standards:

- Specialists must demonstrate at the time of application and throughout the term of the Agreement, that medical records are legible, reproducible, and otherwise meet Kaiser Permanente's standards for confidentiality, medical record-keeping practices, and that clinical documentation demonstrates comprehensive care.
- Members' medical records should include reports from referred and/or referring providers, discharge summaries, records of emergency care received, and other information Kaiser Permanente might ask for.
- Each member encounter must be documented in writing and signed or initialed by the specialist or as required by state law. Include the member's name, date of birth, and medical record number.
- Specialists must comply with the terms of your agreement regarding medical records and follow Kaiser Permanente's medical record documentation standards. See Quality & Patient Safety Policy V-1, *Medical Records Documentation Standards: Compliance and Intervention*.
- Specialists should review HEDIS information via KP Online-Affiliate, in order to submit information needed to support HEDIS measures for the year.
- Specialists must submit consultation reports to Kaiser Permanente within 30 days.

6.3 Hospitals' and Facilities' Responsibilities

All hospital and ancillary facilities that have contracted with Kaiser Permanente are held to the same standards of care.

- Hospitals and facilities must provide hospital or ancillary services, per the contractual agreement with Kaiser Permanente.
- Hospitals and facilities must cooperate and comply with Kaiser Permanente Utilization Management and Quality & Patient Safety programs.
- Hospitals and facilities must get authorization for services.
- Hospitals and facilities must collect all applicable co-pays, deductibles, or coinsurance.

- Hospitals and facilities must determine primary and secondary carriers for members to coordinate benefits for members.
- Hospitals must submit claims electronically.
- Hospitals and facilities must maintain appropriate licensure, insurance, and accreditation as appropriate and specified in the contracted terms, and per NCQA, CMS, state, and federal guidelines.
- Hospitals must ensure that hospital-based physicians (e.g., emergency medicine, radiologists, pathologists) are credentialed.
- Hospitals must submit discharge summaries to Kaiser Permanente. Please continue to use the specific fax number your facility was given.

6.4 Events that Require Notification

6.4.1 Closing and Opening Provider Panels

If you intend to close your practice to new patients, you must give Kaiser Permanente written notice 30 days before the effective date, mailing it to this address:

Kaiser Permanente
500 NE Multnomah St
Portland, OR 97232

6.4.2 Change of Information

If your office or facility changes any pertinent information such as tax identification number, phone or fax number, billing address, or practice address, please mail or fax a written notice, including the effective date of the change. For changes in federal tax ID numbers, include a W-9 form with the correct information. Mail them here:

Provider Contracting
Kaiser Permanente
500 NE Multnomah St
Portland, OR 97232

Or fax them to 503-813-2017.

Due to HIPAA regulations, keep your user information current for access to KP Online-Affiliate. User IDs and passwords are unique. New staff members must get their own individual user IDs and passwords, and we must be informed when change in staff occurs so we can appropriately terminate user IDs and passwords.

6.4.3 Adding a New Practitioner

If your office adds a physician or other professional practitioner to the practice, notify Kaiser Permanente at:

Provider Contracting
Kaiser Permanente
500 NE Multnomah St
Portland, OR 97232

A network associate will make sure you receive the proper documents and guide you and your

new physician through Kaiser Permanente's credentialing process. Please note that practitioners cannot see Kaiser Permanente members or bill for services until successfully completing the credentialing process.

6.4.4 Provider Retirement or Termination

If your office has a practitioner who's retiring or leaving the practice, please mail written notice, including the retirement or departure's effective date, as soon as possible or at minimum thirty (30) days before the date the practitioner is leaving to:

Provider Contracting
Kaiser Permanente
500 NE Multnomah St
Portland, OR 97232

6.4.5 Other Required Notices

You must notify Kaiser Permanente of other events, including changes in your insurance and ownership, adverse actions involving your practitioners' licenses, participation in Medicare, and other occurrences that may affect the provision of services under your Agreement. Article 8 of your Agreement describes the required notices and how they should be provided.

Section 7: Quality Assurance and Improvement (QI)

Overview

KPNW is co-managed by Kaiser Foundation Health Plan of the Northwest (KFHP-NW), Kaiser Foundation Hospitals (KFH), and Northwest Permanente, P.C. (NWP). These entities collaborate to systematically assess care and service.

The KFHP-NW regional president and NWP executive medical director assume ultimate responsibility and accountability for the program's direction, implementation, and success. The health plan's Vice President of Quality and Service and NWP's Vice President for Quality, Care Experience, and Patient Safety are accountable for implementing and maintaining an ongoing quality program and assign appropriate accountability to operations managers within the delivery system.

The KPNW quality program supports practitioners and providers to provide the highest quality care by using a systematic, integrated approach to plan, design, measure, assess, and improve clinical outcomes, operational processes, and member and provider satisfaction. All Northwest Permanente (NWP) and non-NWP contracted/affiliate practitioners and providers are expected to participate in Kaiser Permanente's Service, Quality, Safety, and Resource Stewardship programs.

Quality of care and service activities cross all sites, departments, disciplines, and committees that contribute to the continuum of care throughout the delivery system and network, including: primary care, specialty care, behavioral health services, ancillary services, nursing services, skilled and intermediate nursing care, clinical support services, health education services, member services, medical offices, hospitals, ambulatory surgery centers, home health/hospice agencies, and contracted care.

Kaiser Permanente may take corrective actions in accordance with your Agreement and applicable laws and regulations if we determine that your performance might adversely affect member care.

7.1 Contact Information

Leong Koh, MD; VP of Quality, Care Experience and Patient Safety, 503-422-9203

Nancy Lee; VP Quality and Service, 503-813-3123

Laura Duffey; Senior Director, Quality & Patient Safety, 503-813-3958

Mary Pohlman; Quality Resource Manager, Credentials, 503-813-2666

7.2 Compliance with Regulatory and Accrediting Body Standards

Kaiser Permanente participates in review activities by the National Committee for Quality Assurance (NCQA), Center for Medicare and Medicaid Services, internal audits, and Oregon and Washington regulatory bodies to demonstrate our compliance with regulatory and accrediting standards and requirements.

In accordance with these standards, we require you to provide to Kaiser Permanente, and allow us to use data on, measures of clinical quality, access, and member satisfaction. This data is required annually at minimum, or more frequently if indicated based on an evaluation of performance.

Kaiser Permanente expects its hospitals to have and maintain Joint Commission accreditation and requires all providers and facilities to be in compliance with all regulatory requirements (e.g., CMS). Performance on quality indicators should be submitted per the agreed-upon contractual measures and requirements. All providers must maintain insurance as required by the Agreement. If you receive recommendations or notices of non-compliance from any accreditation or regulatory organizations, please provide Kaiser Permanente with the surveys' recommendations along with the action plan to resolve the identified issues. Email this information to NWQA@kp.org or mail it to:

Quality Resource Management
500 NE Multnomah St.
Ste. 100, Floor 5
Portland, OR 97232

Kaiser Permanente annually monitors the status of the above listed accreditations, licensures, certifications, etc.

7.3 Sentinel Events

The Joint Commission defines a sentinel event as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in death, permanent harm, or severe temporary harm. You must provide **immediate** notification to Kaiser Permanente in accordance with Kaiser Permanente's Sentinel Event Policy.

Report sentinel events to the Quality Resource Management Department at 503-813-3810. All sentinel event reports are considered confidential and privileged quality/peer review documents. A full copy of the policy is available through Kaiser Permanente's Quality Resource Management Department. To request a copy of this policy or to request a sentinel event summary brochure, call 503-813-3810.

7.4 Do Not Bill Events (DNBE)

Kaiser Permanente follows guidelines and policies established by the Centers for Medicare and

Medicaid Services (CMS).

The Health Plan's "Do Not Bill Event" policy is based on payment rules that waive fees for all or part of health care services directly related to the occurrence of certain adverse events as defined by the CMS National Coverage Determinations for surgical errors and the published listing of CMS Hospital Acquired Conditions. This policy applies to all claims for Health Plan members enrolled in the Kaiser Permanente Medicare Plus™ plan as well as members enrolled in Commercial Health Plan products such as the Kaiser Permanente Signature™ and Select™ plans.

Surgical "Do Not Bill Events" include an event in any care setting related to:

- Wrong surgical or invasive procedure(s) performed on a patient
- Surgical or other invasive procedure(s) performed on the wrong part of the body
- Surgical or other invasive procedure(s) performed on the wrong patient
- Unintended retention of a foreign object after surgery or procedure

Hospital-acquired conditions include a condition or event that occurs in a general hospital or acute care setting such as:

- Intravascular air embolism
- Hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
- Falls and trauma, including fractures, dislocations, intracranial injuries, crushing injuries, burns, or electric shock
- Manifestations of poor glycemic control: diabetic ketoacidosis, nonketotic hyperosmolar coma, hyperglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hypersomality
- Surgical site infections following certain elective procedures
- Deep vein thrombosis
- Vascular-catheter associated infection
- Catheter-associated urinary tract infection
- Mediastinitis after coronary artery bypass grafting

7.4.1 Notification of Adverse Event to Kaiser Permanente

After discovering an adverse "Do Not Bill Event" or condition affecting a member, providers should contact the KPNW Quality Department at 503-813-3810, or call Member Services at 503-813-2000.

7.4.2 Claims Submission and Adjustments Related to a "Do Not Bill Event"

Participating hospitals and facilities must include "Present on Admission" indicators on all member claims. Participating providers should make sure their billing staff are aware when a "Do Not Bill Event" involving a member's care has occurred before submitting the claim to

Kaiser Permanente.

When a “Do Not Bill Event” is recognized before claim submission, the UB-04 or CMS 1500 form should include:

- The applicable International Classification of Diseases (ICD) codes.
- All applicable standard modifiers, including CMS National Coverage Determination (“NCD”) modifiers for surgical errors.
- All services provided, including those related to a “Do Not Bill Event” with an adjustment in fee to reflect the waiver of fees directly related to the event(s).
- Any member cost share related to a “Do Not Bill Event” should be waived or reimbursed to the member. An affected member may not be balanced billed for any services related to a “Do Not Bill Event.”

7.5 Practitioner Credentialing

To ensure the quality of physicians who treat Kaiser Permanente members, we credential or oversee the credentialing function for all practitioners. All practitioners must be fully credentialed and approved to participate before treating Kaiser Permanente members.

7.5.1 Credentialing and Recredentialing Processes

The credentialing process follows applicable accreditation agency guidelines such as those set by the National Committee for Quality Assurance (NCQA). Credentialing and recredentialing are part of the provider contract process. Kaiser Permanente Quality Resource Management oversees all credentialing and/or recredentialing activities and ensures they’re conducted in a non-discriminatory manner.

You must provide the following information for the initial credentialing of each practitioner:

- A completed Kaiser Permanente application that includes provider demographics, practice information, work history, educational background, professional affiliations, attestation as to the accuracy of the information provided, and release.
- A copy of a current, valid, and unrestricted state license where your practice is located.
- An active clinical privilege in good standing at the hospital that is the provider’s primary admitting facility. This requirement may be waived if the practice specialty does not admit patients.
- A valid DEA or CDS certificate, as applicable to the specialty.
- Appropriate education and training for the practice specialty including board certification status, as appropriate.
- Evidence of current, adequate malpractice insurance.
- Acceptable history of malpractice claims experience.
- Compliance with medical record and facility and office site reviews.
- Additional verifications including a query of the National Practitioner Data Bank and a query for Medicare/Medicaid sanctions.

7.5.2 Practitioner Notification of Status of Credentialing Application

Upon request the Credentials staff will inform the practitioner of the status of his/her credentialing or recredentialing application. You can make requests by calling the Credentials Department at 503-813-3810.

7.5.3 Practitioner Right to Review and Correct Erroneous Information

Where appropriate, a practitioner has the right to review the information submitted in support of his/her application and will give Kaiser Permanente Northwest 24 hours' notice of intent to review. When notified by Kaiser Permanente Northwest of inconsistent or missing information, a practitioner must respond within 15 days with the correct or complete information.

Where appropriate, a practitioner can correct erroneous information. As a condition of making this application, a practitioner understands that any material misrepresentations, misstatements in, or omissions from this application, intentional or not, will be cause for automatic and immediate denial of participation. If participation has been granted before the discovery of misrepresentation, misstatement or omission, the discovery may result in immediate suspension or termination of participation.

7.5.4 Practitioners on Corrective Action Plan Status

To ensure quality and safety of care between recredentialing cycles, the KPNW Credentials Committee routinely monitors practitioner performance. The Committee acts on important quality or safety issues in a timely manner by taking appropriate action against a practitioner when occurrences of poor quality are identified and the practitioner is part of the root cause, and by reassessing the practitioner's ability to perform the services that he/she is under contract to perform. KPNW considers a full range of actions depending on the nature of adverse circumstances, including appropriate interventions. The Committee may request, at recredentialing or between recredentialing cycles, additional information or an action plan.

7.5.5 Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing process is considered confidential except as required by law.

7.6 Peer Review

The peer review process is a mechanism to evaluate potential quality of care concerns to determine if standards of care are met and 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.

Northwest Permanente physicians and contracted practitioners deliver services in many contract hospitals in the Northwest. Contract hospitals are required to have internal peer review processes that are separate and independent from those of KPNW given the legal protections regarding confidentiality and privilege. We provide a parallel process of review when there are concerns about one of our NWP physicians. Please notify the Quality Resource Management Department at 503-813-3810 to report concerns. Under state and federal laws and regulations, peer review activities are both confidential and privileged.

7.7 Compliance with Facility and Office Site Reviews

KPNW assures that the clinical offices of all primary care practitioners, OB/GYN, and high-volume behavioral health care practitioners meet KPNW standards for quality, safety,

accessibility, and medical/treatment recordkeeping practices. At the time of each initial credentialing site visit, we complete a standardized site visit review form/audit tool. The audit tool includes a set of criteria that assesses:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and exam room space
- Availability of appointments
- Adequacy of medical/treatment recordkeeping
- Standards and thresholds for acceptable performance against criteria

OFFICE SITE REVIEW STANDARDS

Category Description	
Access to Care	The practice site must demonstrate compliance with access to care and appointment guidelines outlined in Section 5, Access Standards to Medical Care.
Cultural Competence	The practice must ensure that key factors are in place to develop and provide programs and services that address the needs of the diverse Member population which it serves.
Waiting Area	The waiting area must have adequate space (i.e. at least 4 chairs per provider working at the same time)
Exam Room	The practice must have adequate space for patient scheduling (i.e., at least two private exam rooms for each provider working concurrently)
Office Site Safety	
Access for the Disabled To obtain: The Americans with Disabilities Act/Questions and Answers Contact: U.S. Equal Employment Opportunity Commission 1801 L Street NW Washington, D.C. 20507 Telephone: (800) 669-3362 – Voice: (800) 800-3302 - TDD	All office sites must comply with specifications included in the Americans with Disabilities Act unless the site qualifies for legal exceptions. These requirements include: • a designated handicapped parking space with wheelchair access (a ramp or other alternative) to the building • an elevator if there are two or more stories • a bathroom that is handicapped accessible or alternative access is available • access to drinking water by a water fountain at wheelchair level or other alternatives • office personnel are available to assist with handicapped patients as needed
CDS and/or DEA Certificate	A controlled drug/substance (CDS) or Drug Enforcement Agency (DEA) certificate must be available upon request.
Storage of Medical Records	• Medical records must be stored in a secure area away from patient access and in a manner that permits prompt retrieval. • Written policies and procedures exist on the

7.7.1 Frequency of Facility and Office Site Review

Initial office site visits occur before the credentialing decision.

7.7.2 Non-Compliance with Site Review Standards

KPNW established separate thresholds for office site standards and institutes actions for improvement with sites that don't meet thresholds. Sites that don't achieve a passing score in either or both sets of standards are reevaluated using the same standardized site visit review form/audit tool at least every six months until the performance standards have been met.

7.7 Accessibility Standards

Accessibility Standards for Medical Care	**Standard**
Preventive non-symptomatic care: including but not limited to well child visits, annual preventive screening visits, immunizations	30 calendar days
Routine, non-urgent symptomatic care for primary care: associated with the presentation of medical signs not requiring immediate attention	10 calendar days
Routine, non-urgent symptomatic care for specialty care: associated with the presentation of medical signs not requiring immediate attention	14 calendar days
Urgent medical care: associated with the presentation of medical signs that require immediate attention but are not life-threatening.	48 hours
Emergency medical care: services required for the immediate alleviation of acute pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Prudent layperson applies.	Immediate Available 24/7
After-hours care	Available 24/7 by answering services or direct pager
Accessibility Standards for Behavioral Health Care	**Standard**
Routine office visits	14 calendar days
Urgent care: severe crisis that isn't life-threatening, including impaired ability to function in normal roles due to symptoms	Within 48 hours
Emergency (non-life threatening): severe crisis not life-threatening but with potential to become so without intervention	Within 6 hours
Emergency: patient's perception of life-threatening	Immediate
After-hours care	Available 24/7 by answering services or direct pager

Section 8: Compliance

Kaiser Permanente (KP) strives to demonstrate high ethical standards in its business practices. Because contracting providers are an integral part of KP's business, it's important that we communicate and obtain your support for these standards. The Agreement details specific laws and contractual provisions we expect you to comply with.

8.1 Compliance with Law

Providers are expected to conduct their business activities in full compliance with applicable laws, including but not limited to the Healthcare Anti-Kickback Statute, False Claims Act, Stark Law, the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations ("HIPAA"), and any laws applicable to entities receiving federal funds.

8.2 Kaiser Permanente Principles of Responsibility and Compliance Hotline

The Kaiser Permanente *Principles of Responsibility* ("POR") is the code of conduct for Kaiser Permanente physicians, employees, and contractors working in KP facilities ("KP Personnel") in their daily work environment. You should report to Kaiser Permanente any suspected wrongdoing or compliance violations by KP Personnel under the POR. Use the Kaiser Permanente Compliance Hotline to report suspected wrongdoing without fear of retaliation. It's available 24 hours a day, 7 days a week, at 1-888-774-9100.

8.3 Gifts and Business Courtesies

You're expected to comply with all applicable state and federal laws governing remuneration for health care services, including anti-kickback and physician self-referral laws. Even if certain types of remuneration are permitted by law, Kaiser Permanente discourages providers from providing gifts, meals, entertainment, or other business courtesies to KP Personnel. KP staff have been advised that they cannot accept the following types of remunerations, and might be asked to return or reimburse the value of such gratuities if inadvertently received.

- Gifts or entertainment that exceed $25 in value
- Gifts or entertainment that are given 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 other attempt to gain advantage

Gifts or entertainment given to KP Personnel involved in Kaiser Permanente purchasing and contracting decisions.

8.4 Conflicts of Interest

Conflicts of interest between a provider and KP Personnel, or the appearance of it, should be avoided. There may be some circumstances when members of the same family or household may work for Kaiser Permanente 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 Kaiser Permanente (other than the person who has the relationship

with the provider). You can call the Compliance Hotline at 1-888-774-9100 for further guidance on potential conflicts of interest.

8.5 Fraud, Waste, and Abuse

Kaiser Permanente will investigate allegations of provider fraud, waste, or abuse related to services provided to members and, when appropriate, 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 sue on behalf of the government to recover fraudulently obtained funds (i.e., “whistleblower” or “qui tam” actions). KP Personnel may not be threatened, harassed, or in any way discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

8.6 Providers Ineligible for Participation in Government Health Care Programs

Under Kaiser Permanente policy, we will not do business with a provider if it or any of its officers, directors, or employees involved in Kaiser Permanente business is, or becomes excluded by, debarred from, or ineligible to participate in any federal health care program or is convicted of a criminal offense related to providing health care. Kaiser Permanente expects you to (a) disclose if any of its officers, directors, or employees becomes sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program or is convicted of a criminal offense related to providing health care and (b) assume responsibility for taking all necessary steps to ensure that your employees and agents directly or indirectly involved in Kaiser Permanente business haven’t been or aren’t currently excluded from participation in any federal program.

8.7 Visitation Policy

When visiting Kaiser Permanente facilities (if applicable), you’re expected to comply with the applicable visitation policy, which is available at Kaiser Permanente facilities upon request. You must wear a visitor badge provided by the Kaiser Permanente facility at all times during the visit.

8.8 Compliance Training

Kaiser Permanente requires certain providers, including those who provide services in a Kaiser Permanente facility, to complete Kaiser Permanente’s compliance training, as required by your Agreement, applicable law, or regulatory action. Where applicable, you must also ensure that your employees and agents involved in Kaiser Permanente business complete the relevant Kaiser Permanente compliance training. Please refer to your Kaiser Permanente contract manager for more guidance regarding these requirements.

8.9 Provider Resources

- Kaiser Permanente’s National Compliance Office: 510-271-4699
- Kaiser Permanente’s Compliance Hotline: 1-888-774-9100
- Regional Compliance Office: NW-RCO-KPNW@kp.org
- Provider Contracting Department 503-813-3376

Section 9: Glossary

A

Accumulator

A running total of the expenses that apply to the member's deductible and out-of-pocket expenses maximum. Determines how much the member cost share will be for current services or treatment.

Allowed amount

The maximum allowable benefits available under the plan. The allowed amount can be established by the practitioner/provider and Kaiser Permanente.

Appeal

A formal request by a practitioner or member to reconsider a decision made by the health plan. The appeal request may be related to a utilization management recommendation, benefit payment, administrative action against the practitioner or provider, or quality of care or service issue.

Authorization

A grant of approval to provide specific covered services.

B

Billed amount

Amount billed by the provider for a specific service.

Bundling

Occurs when two or more CPT-4 procedures are used to describe a procedure performed, when a single, more comprehensive, CPT-4 procedure code exists to accurately describe the entire procedure performed.

C

Capitation (CAP)

Capitation is a contracted per member per month (PMPM) dollar amount paid to a practitioner or provider to cover the cost of providing a specified scope of services. The provider is responsible for delivering (or arranging for the delivery of) all health services required by the covered person under the condition of the provider's contract.

Case management

Method of managing health care services for covered individuals with chronic, catastrophic, or ongoing health care needs, to develop and implement a plan that provides medically necessary quality care in a cost-effective environment.

Centers for Medicare & Medicaid Services

The federal agency responsible for administering Medicare and overseeing states' management of Medicaid. Formerly known as Health Care Financing Administration (HCFA).

Clean claim

A “clean” or “complete” claim is one with no defect or impropriety, including lack of required substantiating documentation from providers, suppliers, or members, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim.

Clearinghouse

A service bureau that handles electronic information routing.

Coinsurance

A form of cost-sharing where an insured individual pays a set percentage of the cost of covered health care services. The most common coinsurance involves the individual paying a fixed percentage (e.g., 20 percent) of the cost of a service.

Coordination of benefits (COB)

A way of determining the order in which benefits are paid and the amounts payable when a claimant is covered under more than one plan (individual or group). It’s intended to prevent duplication of benefits when someone is covered by multiple plans for medical, dental, or other care and treatment.

Covered services

Services covered under the terms of the contract between a carrier and a contract holder.

Copayments

A cost-sharing arrangement in which a member pays a specified charge for a specified service, such as $10 for an office visit. It’s usually due at the time the health care is rendered. Copayments are typically fixed or variable flat amounts for practitioner office visits, prescriptions, or hospital services.

Current Procedural Terminology (CPT)

A standard, universal medical procedures and services coding language developed and maintained by the American Medical Association (AMA). A CPT code usually consists of five digits that indicate a service or procedure. The AMA approves and updates CPT codes an

D

Deductible

A fixed amount of money a member must pay for certain services in a calendar year before Kaiser will cover those services. Not all services are subject to a deductible. Services not subject to a deductible will be provided, minus any copayments or coinsurance, whether or not the insured person has met their deductible.

Diagnosis related groups (DRG)

Statistical system of classifying any inpatient stays into groups for purpose of payment. DRGs may be primary or secondary. The Centers for Medicare & Medicaid Services (CMS) uses this form of reimbursement to pay hospitals for Medicare recipients. Also used by a few states for all payers and by many private health plans for contracting purposes.

Durable medical equipment (DME)

Equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples include hospital beds, wheelchairs, and oxygen equipment.

E

Effective/eligibility date

The date a member becomes eligible for covered services under their health plan.

Electronic data interchange (EDI)

The exchange of data through electronic means rather than by paper or the phone.

Employers Mutual Inc. (EMI)

The third party administrator (TPA) for ambulance claims.

Explanation of Benefits (EOB)

A written statement from an insurance company or third party payer that lists the amounts paid (or not paid/denied), based upon the member's benefit contract.

Explanation of Payment (EOP)

A written statement sent to the provider that lists the amounts paid (or not paid/denied), based upon the member's benefit contract.

F

Fee-for-service (FFS) reimbursement

The traditional health care payment system under which practitioners and other providers receive payment for services based on a contractually agreed-on fee schedule.

Formulary

A list of preferred drugs to be used as a guide for prescribing and dispensing pharmaceuticals.

G

Grievance procedure

The process by which a health plan member or participating provider can voice complaints and seek remedies.

H

Harrington Health

The third party administrator for the Self-Funded program.

Harrington Health Website

Online site where providers can check eligibility, benefit, and claims information for Self-Funded members. http://provider.kphealthservices.com

Health Care Financing Administration (HCFA)

See *Centers for Medicare & Medicaid Services*.

Health Care Financing Administration Common Procedure Coding System (HCPCS)

A uniform coding method for health care providers and medical suppliers to report professional services, procedures, and supplies.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A federal law dealing with a variety of issues, including standardizing electronic health care transactions and the privacy and security of protected health information (PHI).

I

In-Network

Refers to the most restrictive level of a HMO or POS plan or the only network in an EPO plan. Customers have limited choice among providers but receive richer benefits and pay less in out-of-pocket expenses than in the other tiers.

International Classification of Diseases, 9th Edition (ICD-9-CM)

A coding system used by providers and the insurance industry to succinctly describe a patient's medical condition/diagnosis. These codes are also used in claims payment and medical management activities to review the appropriateness of treatment provided for a specific diagnosis.

Incidental procedure

A procedure carried out at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. For these reasons, Kaiser Permanente won't reimburse an incidental procedure separately.

Integrated Voice Response System (IVR)

A phone-based voice response system used by the TPA to give Self-Funded-related support to providers.

IntelliClaim

A code editor software application designed to evaluate professional and facility outpatient claims data, including HCPCS and CPT codes and associated modifiers.

M

Medicare Summary Notice

A written statement from Medicare that lists amounts paid (or not paid/denied), based on the member's Medicare eligibility and coverage under the federal Medicare program. Also known as Explanation of Medicare Benefits (EOMB).

Member

A person who meets all eligibility requirements of the applicable Kaiser Foundation Health Plan, who is enrolled in the plan, and for whom all required premiums have been paid. Members include subscribers and their dependents as defined in the Evidence of Coverage (EOC).

Membership Services Department

Kaiser Permanente staff who serve as a liaison between members and the rest of Kaiser Permanente. This department addresses questions about benefits and claims and resolves members' issues and concerns.

N

National Provider Identifier (NPI)

A standard unique 10-digit numeric identifier for all health care providers.

The NPI was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Not covered amount

The amount billed by a provider for a service not covered due to limitations or exclusions from a member's benefit plan or provider reductions.

P

Patient responsibility

May include a portion of the amount listed in the "Not Covered Amount" column, any amount listed in "Applied to Deductible," and the "Copay/Coinsurance" columns on the Explanation of Payment.

Physical status modifiers

Should be appended to the CPT anesthesia code to distinguish between the various levels of complexity of anesthesia service(s) provided.

Preventive health services

Health care services designed for prevention and early detection of illnesses. These services generally include routine physical examinations, tests, and immunizations.

Provider Contracting & Relations

A department of internal and external representatives dedicated to serving Kaiser Permanente's provider networks. Responsibilities include provider contracting, reimbursement, provider office visits, training office staff, communicating Kaiser Permanente administrative policies and procedures, and resolving problems on behalf of providers.

U

Unbundling

The practice of a provider billing for multiple components of service previously included in a single fee.

Urgent care

Services needed to prevent serious deterioration of health from an unforeseen condition or injury (e.g., sore throats, fever, lacerations, and broken bones).

Utilization management

Evaluating the appropriateness of utilizing medical care services against the member's benefit plan, to ensure effective use of resources. Includes pre-authorization of services (before the service is obtained), concurrent review of services (while the service is being provided), retrospective review (after the service has been rendered), discharge planning, and case management.