MEDI-CAL MANAGED CARE LONG-TERM SERVICES AND SUPPORT

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PROVIDER TRAINING OBJECTIVES

By the end of today's presentation participants will:

- Have a comprehensive understanding of the unique benefits or processes related to serving Kaiser Permanente's (KP) Medi-Cal Members
- Understand the administrative process related to claim submissions and payment
- Identify resources/contacts for specific Medi-Cal services

This training covers specific Medi-Cal regulations. This presentation is a supplement to the HMO Provider Manual for institutional providers serving Kaiser Permanente's Medi-Cal members.

- Please refer to the Table of Contents beginning on slide 2 to locate a specific topic

About Kaiser Permanente

Kaiser Permanente is committed to helping shape the future of health care. We are recognized as one of America’s leading health care providers and not-for-profit health plans.

Founded in 1945, Kaiser Permanente has a mission to provide high-quality, affordable health care services, and to improve the health of our members and the communities we serve. We currently provide services to more than 12.5 million members in eight regions - CA,CO,GA HI,OR,WA, Mid-Atlantic, and the District of Columbia.

Kaiser Permanente Mission

Kaiser Permanente exists to provide affordable, high-quality health care services to improve the health of our members and the communities we serve.

Kaiser Permanente Promise

Is our commitment to our members and patients to provide high-quality, convenient, and affordable care with a personal touch.

LONG-TERM SERVICES AND SUPPORT (LTSS)

MEMBER PLACEMENT SCENARIOS

Placement Scenarios	Authorization Request
Skilled short-term placements	*KP case manager manages referral*
Skilled placement from KP hospital that extends to long-term care Member admits from home as long-term care Member was placed under another Medi-Cal health plan and transitioned to KP Medi-Cal Member was previously Medi-Cal Fee-For-Service (FFS) and is now KP Medi-Cal	**SNF faxes requests to KP Regional Long-Term Care (LTSS)** **Fax: (866) 473-0344** Number for authorizations follow-up / questions: (626) 405-7988
Member placed in a noncontracted facility	A letter of agreement (LOA) is required for both skilled and long-term care (contact local LTC dept.)

long-term care = custodial

INITIAL LONG-TERM CARE AUTHORIZATION

- **Fax the following documentation:**
  - KP Admission and Discharge Notification
  - Nursing Face Sheet
  - Current Minimal Data Sheets (MDS)
  - Pre-Admission Screening (PAS)/Pre-Admission Screening Resident Review (PASARR)
- Referral process is typically 5 to 10 business days (timeframe may be longer if documentation is incomplete)

**This does not replace the facility's responsibility to submit the MC 171 with the state*

Fax: (866) 473-0344

Regional Long-Term Care
393 E. Walnut Street
Pasadena, CA 91188
Department line: 626-405-7988

KAISER PERMANENTE
Long Term Care Secure FAX: (866) 473-0344

This form is to be used only for Kaiser Permanente (KP) Medi-CAL Members where KP has the financial risk for the Medi-CAL benefit. This form should not be used for any other KP Member, i.e. Fee-For-Service

KAISER PERMANENTE MEDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION

Patient's Name (Last) (First) (MI)		Name of Facility	
Kaiser Permanente MRN	Date of Birth	Address (Number and Street)	
Medi-Cal ID Number (Taken from Medi-Cal card)		City	State / Zip

DOES FACILITY HAVE A CURRENT LTSS CONTRACT WITH KAISER FOUNDATION HEALTH PLAN

☐ Yes ☐ No If No, has a Letter of Agreement (LOA) been obtained ☐ Yes ☐ No

ADMISSION FROM

☐ Hospital ☐ Home ☐ Skilled Nursing Facility ☐ Other ______________________

TYPE OF AUTHORIZATION BEING REQUESTED

☐ Initial Long Term Care Authorization ☐ Reauthorization ☐ Bed Hold ☐ Discharge

INITIAL LONG TERM CARE AUTHORIZATION OR LONG-TERM CARE REAUTHORIZATION

Admission Date: ___/___/___ Requested Date of Service: ___/___/___ ☐ Stay anticipated to be less than 90 days

Level of Care: ☐ SNF (NFB) ☐ SNF (NFA) ☐ Sub Acute Vent ☐ Sub Acute Non-Vent

Attending Physician: ______________________ ICD10: ________

BED HOLD AUTHORIZATION

☐ Hospitalization – unplanned ☐ Hospitalization – planned ☐ Therapeutic Leave of Absence

Requested Dates of Service: ___/___/___ to ___/___/___ Total # of Days: ________

Level of Care: ☐ SNF (NFB) ☐ SNF (NFA) ☐ Sub Acute Vent ☐ Sub Acute Non-Vent

Peds Level of Care: ☐ Sub Acute Vent ☐ Sub Acute Non-Vent ☐ Ventilator Weaning

Attending Physician: ______________________ ICD10: ________

(A Long Term Care Re- Authorization must be requested when resident returns to the facility)

DISCHARGE NOTIFICATION

Date of Discharge: ___/___/___

Discharge Disposition: ☐ Home ☐ SNF ☐ RCFE ☐ Death ☐ Other________________

Facility Representative (please print)	Title
Facility Representative (signature)	Date
Representative or Department Email	Phone Number

BED HOLDS AND THERAPEUTIC LEAVES OF ABSENCE

- Bed holds are granted for a maximum of 7 days per admission
- Bed holds and leaves of absence can only be requested once **BOTH** the start and end dates are known (or after the 7th day)
- **Fax the following documentation:**
  - KP Admission and Discharge Notification form
  - Either the SNF Transfer Order for Hospitalizations for bed hold, or the SNF physician order for Therapeutic Leaves of Absence
- A new Initial Long-Term Care authorization is needed once the member returns to the facility (follow Initial Long-Term Care Authorization process)

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Peds Level of Care: ☐ Sub Acute Vent ☐ Sub Acute Non-Vent ☐ Ventilator Weaning

Attending Physician: ____________ ICD10: ______

(A Long Term Care Re- Authorization must be requested when resident returns to the facility)

DISCHARGE NOTIFICATION

Date of Discharge: __/__/__

Discharge Disposition: ☐ Home ☐ SNF ☐ RCFE ☐ Death ☐ Other____________

Facility Representative (please print)	Title
Facility Representative (signature)	Date
Representative or Department Email	Phone Number

LONG-TERM CARE EXTENSION OF SERVICES

- **Fax the following documentation:**
  - KP Admission and Discharge Notification
  - Nursing Face Sheet
  - Most recent Minimal Data Sheets (MDS)

- Facilities should submit renewal request no sooner than two weeks before the expiration date

- Extension of services are not processed until eligibility is updated on the Medi-Cal website on the first of each month
  - *Example: July renewals will not be processed until after July 1*
  - *Referrals are authorized 6 months at a time. An authorization number will be valid for up to a year. After a year, a new authorization number will be provided*

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Peds Level of Care: ☐ Sub Acute Vent ☐ Sub Acute Non-Vent ☐ Ventilator Weaning

Attending Physician: ____________________ ICD10: ________

(A Long Term Care Re- Authorization must be requested when resident returns to the facility)

DISCHARGE NOTIFICATION

Date of Discharge: ___/___/___

Discharge Disposition: ☐ Home ☐ SNF ☐ RCFE ☐ Death ☐ Other____________________

Facility Representative (please print)	Title
Facility Representative (signature)	Date
Representative or Department Email	Phone Number

DISCHARGE NOTIFICATION

- Nursing facilities are to notify KP of member changes as soon as known/possible

- **Fax the following documentation:**
  - KP Admission and Discharge Notification

- Discharges include:
  - Discharge to home
  - Change to hospice
  - SNF to SNF transfer
  - Member expiration

Fax: (866) 473-0344

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☐ Yes ☐ No If No, has a Letter of Agreement (LOA) been obtained ☐ Yes ☐ No

ADMISSION FROM

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☐ Hospitalization – unplanned ☐ Hospitalization – planned ☐ Therapeutic Leave of Absence

Requested Dates of Service: ___/___/___ to ___/___/___ Total # of Days: ________

Level of Care: ☐ SNF (NFB) ☐ SNF (NFA) ☐ Sub Acute Vent ☐ Sub Acute Non-Vent

Peds Level of Care: ☐ Sub Acute Vent ☐ Sub Acute Non-Vent ☐ Ventilator Weaning

Attending Physician: ______________________________ ICD10: _______

(A Long Term Care Re- Authorization must be requested when resident returns to the facility)

DISCHARGE NOTIFICATION

Date of Discharge: ___/___/___

Discharge Disposition: ☐ Home ☐ SNF ☐ RCFE ☐ Death ☐ Other__________________

Facility Representative (please print)	Title
Facility Representative (signature)	Date
Representative or Department Email	Phone Number

NOTICE OF REFERRED SERVICES

- **A hard copy of the notice is mailed or faxed to the nursing facility by the Outside Referral Department (ORD)**
- A new initial LTC referral will be provided with all (skilled, custodial, hospice, and hospitalization) level care transitions
- If you are having issues with receiving the notice, validate your facility's profile with ORD to ensure that your fax number and/or mailing address are correct
- The nursing facility is to confirm patients' Share of Cost (SOC) as the amount or eligibility status is subject to change

KAISER PERMANENTE®
Kaiser Foundation Health Plan, Inc.
10800 Magnolia Avenue, Riverside, CA, 92505
1-800-390-3510 (TTY/ TDD 1-800-777-1370)

NOTICE OF REFERRED SERVICES

June 16, 2021

ABC SKILLED NURSING FACILITY
1234 5th ST
Los Angeles, CA 90028

Dear ABC SKILLED NURSING FACILITY NAME:

The member identified below was referred to you for the services described herein. This notice confirms that the referral has been entered into our claims system for the purposes of payment, pursuant to the terms and conditions set forth below.

Important Plan Information

Referral Priority: Routine
Referring Provider: John Smith MD
Referring Provider NPI: 123456789
Medical Record Number: 123456789
Member Name: Jane Doe
DOB: 01/23/45
Gender: Female
Member Address: 1234 5th St
Member Phone Number: 123-456-7890 (home)
Language Assistance Required: No
Primary Spoken Language: English
Coverage Type: Medi-CAL
Diagnoses:
I73.9 (ICD-10-CM) – Peripheral Vascular Disease
M81.0 (ICS-10-CM) - Osteoporosis

Referral Authorization Number: 9874561230
Authorization Valid From/To: 04/01/2021 to 9/30/2021
Estimated Member Liability: Patient Share of Cost: Verify with state Medi-CAL
CMS Place of Service Code: 33 – Custodial Care Facility
Place of Service Location: Skilled Nursing Facility

Authorized Service(s):

Code	Procedure Name	Modifiers	Revenue Code	Approved Quantity
--	--	--	0198	1
--	--	--	0195	5

NOTICE OF EXTENSION OF SERVICES

- **A hard copy of the notice is mailed or faxed to the nursing facility by the Outside Referral Department (ORD)**

- If you are having issues with receiving the authorizations, validate your facility's profile with ORD to ensure that your fax number and/or mailing address are correct

- The nursing facility is to confirm patients' Share of Cost (SOC) as the amount or eligibility status is subject to change

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June 16, 2021

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1234 5th ST
Los Angeles, CA 90028

Dear ABC SKILLED NURSING FACILITY NAME:

The member identified below was referred to you for the services described herein. This notice confirms that the referral has been entered into our claims system for the purposes of payment, pursuant to the terms and conditions set forth below.

Important Plan Information

Initial Notification Sent On: 4/1/2021
Referral Priority: Routine
Referring Provider: John Smith MD
Referring Provider NPI: 123456789
Medical Record Number: 123456789
Member Name: Jane Doe
DOB: 01/23/45
Gender: Female
Member Address: 1234 5th St
Member Phone Number: 123-456-7890 (home)
Language Assistance Required: No
Primary Spoken Language: English
Coverage Type: Medi-CAL
Diagnoses:
I73.9 (ICD-10-CM) – Peripheral Vascular Disease
M81.0 (ICS-10-CM) - Osteoporosis

Referral Authorization Number: 9874561230
Authorization Valid From/To: 10/1/2021 to 3/31/2022
Estimated Member Liability: Patient Share of Cost: Verify with state Medi-CAL
CMS Place of Service Code: 33 – Custodial Care Facility
Place of Service Location: Skilled Nursing Facility

Authorized Service(s):

Code	Procedure Name	Modifiers	Revenue Code	Quantity Approved in Previous Notice	Quantity Approved to Date
--	--	--	0198	1	1

KP Custodial Referral Process Reference Guide

Scenario*	KP Process	Provider Process	Provider Notification Received
Skilled patient transitions to a custodial level of care	Existing skilled referral will be closed. An Initial custodial referral is entered	Send a request to Regional LTC for an Initial Long-Term Care referral	"Notice of Referred Services" letter
Direct admission at a custodial level of care	Initial custodial referral is entered	Send a request to Regional LTC for an Initial Long-Term Care referral	"Notice of Referred Services" letter
Custodial referral expires; patient's stay is uninterrupted	Additional 6 months will be authorized.	Send a request to Regional LTC for a Long-Term Care Extension of services referral	Provider will receive either a "Referred Service" notification if a new referral ID is issued, or "Extension of Service" notification if an existing referral ID is used.
Custodial patient returns from hospital stay after any length**	Existing custodial referral is closed. A new custodial referral will be created upon readmission to custodial level if care	Send one request to Regional LTC for both the bed hold and new initial referral upon readmission	Two separate "Notice of Referred Services" letters, one for the bed hold and one for the initial referral
Custodial patient transitions to a skilled level of care	Existing custodial referral is closed. A new custodial referral will be created when patient transitions back to a custodial level of care	Send a request to Regional LTC for a new initial referral upon transition back to a custodial level of care	"Notice of Referred Services" letter
Coverage loss	Existing referral is closed at loss of coverage. New referral may be entered when KP coverage is reinstated	Send a request to Regional LTC for an Initial referral when coverage is reinstated	"Notice of Referred Services" letter
Custodial patient discharges	Existing custodial referral will be closed	Send Discharge Notification to Regional LTC	Updated version of most recent letter
Hospice transitions	Existing custodial referral is closed. A new custodial referral will be created if patient transitions back to a custodial level of care	Send a request to Regional LTC for a new initial referral if patient transitions back to a custodial level of care	"Notice of Referred Services" letter

**all scenarios apply to members with Medi-Cal assigned to KP*
***if a patient is transferred and returned to the SNF on the same day, no new referral is required*

OUTSIDE REFERRAL DEPARTMENT (ORD)

- Responsible for coordinating and tracking authorized referrals.
- Authorization is required for payment of covered services.
- Kaiser Permanente will compensate according to the scope and duration of the authorization.
- Authorization/Referral Contact information for:

Service Area	Telephone	Service Area	Telephone
Antelope Valley	(661) 729-7108	Orange County	(714) 564-4150
Baldwin Park	(562) 622-3880	Panorama City	(818) 375-2806
Downey	(562) 622-3880	Riverside	(951) 602-4294
Coachella and Yucca Valley	(951) 602-4294	San Diego	(619) 589-3360
San Bernardino County	(909) 609-3262	South Bay	(310) 816-5324
Kern County	(661) 852-3482	West Los Angeles	(323) 783-4401
Los Angeles	(323) 783-4401	Woodland Hills and West Ventura	(844) 424-1869

- If it’s been 15 business days since authorization was requested, provide follow-up with details to ORD and confirm your fax or mailing address.
- If there is a trend of ongoing issues, then call provider support because ORD phone number may have changed or other changes may have occurred.

KP MEDICAL CENTER LONG-TERM CARE DEPARTMENTS

Medical Center	Telephone	Medical Center	Telephone
Antelope Valley	(661) 729-7213	Panorama City	(818) 815-6370
Baldwin Park	(626) 480-5210	Riverside	(951) 602-4230
Downey	(562) 622-3823	San Bernardino County	(909) 609-3500
Hawaii	(808) 432-7100	San Diego	(619) 528-1245
Kern County	(661) 337-7285	South Bay	(424) 251-7875
Los Angeles	(323) 783-4600	West Los Angeles	(323) 857-3606
Orange County	(714) 734-5500	Woodland Hills	(818) 592-2400

- If you have any questions, please contact KP's Regional LTSS Department at (626) 405-5218, Monday through Friday, from 9 a.m. to 5 p.m.
- Email address: LTSS-SNF@kp.org

RECOMMENDED BILLING

BILLING GUIDELINES

- Provider shall bill the normal, usual, and customary charges for **authorized** services.
  - KP does not encourage providers to bill at the expected reimbursement rate
- Provider should inform our Medi-Cal members, in writing, that Kaiser Permanente may not cover, or continue to cover, the cost of a specific service or services, that may not be covered under their benefits.
- Members **should not be billed** for services that are **pending** payment from Kaiser Permanente.

COPAYMENTS, CO-INSURANCE, AND DEDUCTIBLES

- Contracted providers are responsible for collecting copayments, coinsurance and deductibles (collectively, "Copays") in accordance with member benefits unless explicitly stated otherwise in your contract.
- Invoices submitted by providers who are responsible for collecting copays will be paid at the applicable rate(s) under your contract less the applicable copay amount due from the Member.
- You must not waive copays you are required to collect, except as expressly permitted under applicable law and your contract.
- Please verify applicable copays at the time of service. You may do this via Kaiser Permanente Online Affiliate (see page 29 on how to enroll) or by contacting Member Services at (888) 576-6789.

CLAIM SUBMISSION AND INQUIRIES

Claim Submission

Providers must submit itemized claims for covered services on an appropriate billing form, as follows:

- **Timely Claim Submission:**
  - Claims must be submitted with reasonably relevant supporting information required **within 90 calendar days after the date of service**, or as noted in your contract.
  - Untimely billing can result in the denial of a claim and/or payment reduction.
- **Claim Submission Method**
  - **Electronic Data Interchange (EDI):**
    - We urge you to submit claims electronically utilizing EDI, following all HIPAA standards and appropriate coding and regulatory requirements. Please see appendix for EDI information.
  - **Paper Claim Submission:**
    - If a paper claim must be submitted, institutional charges must be submitted on a preprinted OCR red-lined UB-04 (or successor) Claim form
    - Entries must be completed in accordance with National Uniform Billing Committee (NUBC) directions and contain all mandatory entries.
- **KP Authorization Number is Required**
  - The KP authorization number is required in box 63 of the paper UB claim, or the Ref*9F segment of Loop 2300 on the 8371 EDI claim. This is the referral number given by the Utilization Management department.
- **Supporting Documentation:**
  - You can submit supporting information required for the payment of your claim proactively (i.e.: invoice or requested records) and/or respond to a Request for Information (RFI) through the Online Affiliate Link self-service tool, see appendix for more information.

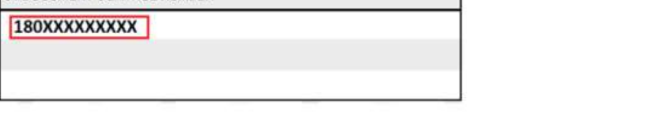
Claim Submission

Billing the correct KP entity:

- It is important to bill the Kaiser Permanente entity associated with the member receiving services
  - For example, if the member is self-funded, bill the Kaiser Permanente self-funded entity for payment
- Kaiser Permanente membership cards include claim submission details on the back of the card for reference
- Claims submitted to the wrong Kaiser Permanente entity are not processed and must be resubmitted to the correct entity

Corrected and Replacement Claims:

- If you should need to correct a claim that has already been adjudicated, you are required to follow the appropriate process for correcting/replacing a UB04 claim. This includes entering BOTH:
  - Frequency code 7 in the 837I EDI claim Loop 2300 CLM05-3 segment, or in box 4 (Type of Bill) on the UB04 paper claim
  - Original claim number (claim you are replacing) in the 837I EDI claim Loop 2300 REF02*F8, or in box 64 on the UB04 paper claim **(Document Control Number)**



- If you submit a correction or changes to a claim without indicating both the appropriate frequency code **and** original claim number, the claim will either reject or deny as duplicate to the original claim

LTSS Claim Submission

- For LTSS claims, Kaiser Permanente requires the following value codes to ensure timely and accurate processing:

Share of Cost	Accommodation Code	Units
• Value code 23 indicates the members share of cost and should ALWAYS be included in box 39 • If the share of cost is $0, please include "0" and do not leave blank	• Value code 24 represents the accommodation code and should always be included in box 40	• Value code 80 represents the # of units billed, and should always be included in box 41

39 Value Codes	
Code	Amount
23	730.00

40 Value Codes	
Code	Amount
24	0.01

41 Value Codes	
Code	Amount
80	5.00

LTSS COMMON PROVIDER ISSUES

Category	Issue	Resolution
Rx Exclusions	Billed with Rev 250 instead of 636	Provider to be rebill with Rev 636
Rx Exclusions	Invoice required for payment, but no Invoice Submitted	Provider to submit copy of invoice through online portal
Corrected/ Replacement claim	Incorrect frequency code. Denied as duplicate.	Provider to send with bill type '217'
Corrected/ Replacement claim	No reference to original KP claim number	Provider to send original KP claim number in box 63.
Share of Cost Required	Share of Cost (SOC) not included in box 39 per LTSS requirements (claim denied as Medicare Primary)	Provider to send SOC in box 39, even if $0. Provider to file a dispute.
Authorizations	Not matching – additional dates/services may have been added to authorization	Provider to verify and update authorization from KP when appropriate so dates/services match the claim.

For LTSS specific Claims FAQs please click **here** to access:

Process for EDI Claim Submissions

Submit Claims Electronically!

- **Reduce Costs**: Eliminate expenses associated with paper claim submission: Paper Claim Forms, Ink, Envelopes & Postage.
- **Save Time**: Receive verification of Claim Receipt within 48 hours of submission. Submit claims and check claims status online 24/7 by using Kaiser Permanente Online Affiliate (see page 29 on how to enroll)

Check member's ID card for Payer ID, if no Payer ID use the Regional Clearinghouse information below:

Clearinghouse	Northern CA	Southern CA	Hawaii	Georgia	Northwest	Mid-Atlantic	Colorado
ChangeHealthcare (CHC) www.changehealthcare.com	94135	94134	94123	21313	93079	52095	91617
OptimumInsight/Ingenix www.optum.com/solutions/provider	N/A	N/A	N/A	NG010**	NG009**	NG008**	COKSR
Navicure www.waystar.com/	N/A	N/A	N/A	21313	N/A	N/A	N/A
Office Ally https://cms.officeally.com	94135	94134	94123	21313	NW002	52095	91617
Availity (formerly REALMED) www.availity.com	N/A	N/A	N/A	N/A	N/A	54294	N/A
Relay Health www.changehealthcare.com/	RH009	94134	RH0011	RH008	RH002	RH010	RH003
SSI http://thessigroup.com	NKAISERCA	SKAISERCA	N/A	21313	SS002	N/A	999990273

**Providers may send EDI through one of Kaiser's direct clearinghouses; or any clearinghouse that can reroute through a Kaiser direct clearinghouse.

Go Paperless!

Getting Started with EDI/EFT/ERA
Questions? Submit a case to EDI:
kpnationalclaims.my.site.com/EDI/s/

If you are pending EDI set up, submit claims via **PAPER** to Kaiser Permanente for payment:

Kaiser Permanente Claims Administration Department
Post Office Box 7004
Downey, CA 90242-7004

Claim Status and Determinations

Claim Payment timeframe:

- Payment for covered services shall be made within 45 working days of the date of receipt by Kaiser Permanente of all necessary documents

Claim Status/Inquiries:

- Claim status can be obtained 24/7 by utilizing KP Online Affiliate
  - To register for access to KP Online Affiliate Link, visit: kp.org/providers/scal and select **Online Provider Tools**
  - Registering for the Online Affiliate portal allows you to check member benefits, eligibility, submit claim inquiries and provider disputes
  - For questions, submit an Online Affiliate Support Case via: kpnationalclaims.my.site.com/support/s/
- You can also check your claim status as a guest user without registering for KP Online Affiliate
  - Navigate to kp.org/providers/scal
- If you are unable to resolve your questions through KP Online Affiliate Link, call the Member Services Contact Center (MSCC) at (800) 390-3510

See Appendix for the KP Online Affiliate Fact Sheet

Electronic Fund Transfers (EFT) & Electronic Remittance Advice (ERA)

Providers seeking to register or manage account changes for EFT and ERA will need to use the **Citi Payment Exchange** Enrollment tool. Visit the Community Provider Portal website for information on how to register or manage your account

https://healthy.kaiserpermanente.org/southern-california/community-providers/claims

This secure electronic tool will:

- Eliminate the need for paper registration
- Reduce time and costs
- Allow you to register with multiple payers at one time!

For more information, please contact the **National Claims Administration-Provider Data Management and Contracting** Team by submitting a case to:

kpnationalclaims.my.site.com/support

Or visit your **Community Provider Portal (CPP) website** for additional information: kp.org/providers/scal

Provider Self-Service Tools

As a Kaiser Permanente contracted provider, you're eligible to access **Online Affiliate** to view your patients'…

- Benefits and Eligibility
- Claims details and status
- Referrals
- Explanation of Payments (EOPs)

Register today by following the steps outlined on the Southern California (SCAL) Community Provider Portal (CPP) site: **kp.org/providers/scal**

For questions or additional information, please contact the **KP Online Affiliate Support** Team:

Web form: kpnationalclaims.my.site.com/support/s/

Refunds to KP

If you have identified an overpayment (including Share of Cost), please forward your refund to:

Kaiser Permanente
Attention: Regional Claims Recovery
PO Box 741639
Los Angeles, CA 90074-1639

Please include the following information with your refund:

- Provider Name
- Provider Tax Identification Number
- Member Name
- KP Medical Record Number
- Kaiser Claim Number
- Dates of Service
- Copy of each applicable remittance advice
- Refund Reason, e.g., Member Share of Cost
- Authorization number(s) for all applicable non-emergency

PROVIDER DISPUTES

Provider Disputes

Types of Disputes

- **Claims disputes**:
  - Challenging, appealing, or requesting reconsideration of a claim (or bundled group of claims) that has been denied or paid incorrectly (e.g.denied for timely filing, pharmacy exclusions, etc.)
- **Responding to requests for overpayment reimbursement:**
  - Disputing a request by Kaiser Permanente of reimbursement by provider of overpayment of a claim.
- **Billing determinations disputes:**
  - Seeking resolution of a billing determination (or bundled group of billing determinations) by Kaiser Permanente.
- **Other contract disputes**:
  - Seeking resolution of a contract dispute.

Provider Dispute Requests

- **Provider disputes must contain the following information:**
  - Kaiser Permanente Claim Number
  - Tax ID Number (TIN)
  - Medical Record Number (MRN)
  - Date of Service (DOS)
  - Dispute Reason (detailed description of your dispute and expected payment or reimbursement)
  - Documentation to support your dispute

Time Period for Submitting Disputes

- Disputes must be received within 365 calendar days from the date the claim was finalized (pay or denied).

You may now submit your claim disputes and appeals online via KP Online Affiliate. With online submissions, you will receive an electronic acknowledgement and resolution letter to your Online Affiliate in-basket. Visit the Community Provider Portal website to sign up and start using Online Affiliate today – providers.kp.org/scal

If you are pending access to KP Online Affiliate, you may submit your disputes in writing to:

Kaiser Permanente Claims Administration Department
P.O. Box 7006
Downey, CA 90242-7006

Timely Filing Denials

In the event that you receive a denial for untimely submission, you must:

1. Submit Provider Dispute Request.
2. Attach the appropriate proof as outlined below.

Proof of timely filing:
1) A copy of the billing system with proof of when claim was mailed, and Kaiser Permanente is listed as the payor with a date prior to timely filing cutoff.
2) Clearinghouse report of acceptance from Kaiser Permanente with a date prior to the timely filing cutoff (EDI submissions).
3) A claim may be denied if the request for additional information (RFI) is not received prior to timely filing cutoff.
4) Date claim denial letter. EOB or EOMB from Kaiser Permanente with date prior to timely filing cutoff.
5) Denial letter from other insurance carrier dated and printed on letterhead with date prior to timely filing cutoff.
6) Dated EOB from another insurance company matching claim in dispute with a date prior to timely filing cutoff.
7) Proof of mailing: certified mail receipt, Fed express receipt, Express mail receipt, or other mail service receipt that shows both the date mailed and the address of the receipt with a date prior to the timely filing cutoff. Reference contents on original receipt and include copies of documents submitted within packet.
8) Proof of hand delivery with the date delivered.

ADDITIONAL INFORMATION

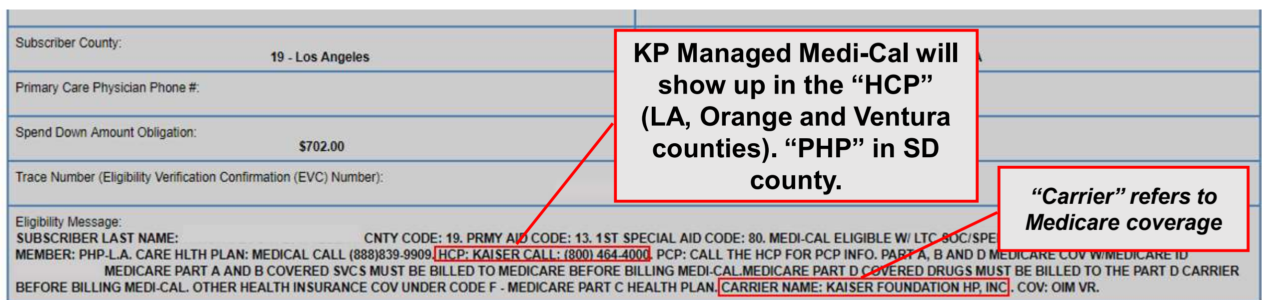
- Kaiser Permanente Medi-Cal Plan
- Eligibility and Benefits
- Language Assistance Program
- Long Term Care Pharmacy
- Community-Base Adult Services
- Hospice
- Medi-Cal Non-Medical Transportation

KAISER PERMANENTE MEDI-CAL PLAN

MEDI-CAL ASSIGNED TO KAISER PERMANENTE

Checking eligibility:

- Medi-Cal website: assignment will show as the HCP (for Los Angeles, Ventura and Orange Counties) or as the PHP in San Diego.



- IEHP website: assignment will show as PCP for Riverside and San Bernardino counties

MEDI-CAL ELIGIBILITY AND BENEFITS

Medi-Cal Eligibility and Benefits

- We encourage you to verify and confirm Member eligibility and benefits **prior** to services being rendered.
- Also verify at the beginning of the month, if continuing care from the previous month.

KP Online Affiliate

You can verify patient eligibility and benefits 24 hours a day 7 days a week via Online Affiliate (see page 29 on how to enroll)

TELEPHONE SYSTEM

Member Services Call Center - Provider Call Flow - 1-888-576-6789 *(toll free)*
You will be asked to provider either the Member Record Number (MRN) or the last four digits of the Social Security Number (SSN), the complete date of birth (month/day/year) and the Member's zip code to obtain:

- Eligibility
- Benefits
- Claims
- Deductible Status

PROVIDER CONTACT INFORMATION

Contact information	Type of Help or Information from this Department
Member Service Call Center Information is available: 24 hours a day, 7 days a week (888) 576-6789	• Copayments/Deductibles
KP Online Affiliate or Guest Access 24 hours a day, 7 days a week Go to kp.org/providers/scal and select **Online Provider Tools**	• Eligibility, Benefits and Demographics • Copayment/Deductibles • Claims Status and Payment Details • Online Claim Status Inquiries, Disputes, Appeals and respond to Kaiser Request for Information

LANGUAGE ASSISTANCE PROGRAM

Language Assistance – California Law

California Law Knox Keene Act: **§1300.67.04.** **"Language Assistance Programs"** **(formerly, SB-853)**	Effective January 1, 2009, Kaiser Foundation Health Plan, Inc. (or "Kaiser Permanente" or "KP") and its contracted providers are required to comply with the Language Assistance Program ("LAP") regulations for health plan enrollees who are Limited English Proficient ("LEP"), including enrollees who require sign language services. The California legislature in 2003 amended the Knox-Keene Health Care Services Plan Act of 1975 ("Knox-Keene Act") by enacting Senate Bill 853, which mandates that all California health plans provide language translation and interpretation services to their LEP enrollees. This legislation was deemed necessary to address the significant and growing language barriers encountered in the health care system by limited English proficient enrollees, defined as "enrollee[s] who [have] an inability or limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees."

Language Assistance – Phone and Sign

Our expectation is that you will provide interpreter services in-person using your own qualified bilingual staff if you have them. If you do not have qualified staff, utilize KP Language Assistance.

When accessing KP Language Assistance, contracted providers must have the following data elements* available before placing the call:

- KP Client ID number
- KP referral or authorization number
- Enrollee's KP Medical Record Number

** This information will be provided to you on the document shown to the right. This document is normally the last page of the referral packet.*

Interpreter Instructions and Documentation Form for Non-Kaiser Permanente (KP) Providers

In compliance with the Department of Managed Health Care (DMHC) Language Assistance Regulations under California Senate Bill 853 (SB 853)* this communication serves as notification that the referred Kaiser Permanente member is limited English language proficient (LEP) and will require interpreter services when receiving medical care at your facility. You must offer and document the use/refusal of interpretation services for this KP member.

If qualified bilingual staff are not available at your facility to provide interpreter services or you need American Sign Language support for the referred Kaiser Permanente member, you may obtain these language assistance services as follows:

Telephone Interpreter

- Call this telephone number to obtain interpreter services: **1-855-701-8100**;
- Provide this Kaiser Permanente **client identification number**:
- Enter the patient's **language of services** needed for interpretation;
- Enrollee's KP **Medical Record Number (MRN)**:
- Enter the **Referral Authorization Number** found on the "Notice of Authorization of Services":

Sign Language interpreter services (in-person interpreter)

- In-person interpreter requires a minimum of 24 hours lead time for scheduling.
- Interpreters are available 24 hours per day, 7 days a week.
- Call Interpreters Unlimited's telephone number, **1-800-726-9891**, press 3, then 1, 24 hours per day, 7 days a week.
- Multiple dates of an in-person interpreter service can be arranged with one call.
- Provide the following data elements to schedule:
  - Provide this Kaiser Permanente **client identification number**:
  - Enrollee's KP **Medical Record Number (MRN)**:
  - Enter the **Referral Authorization Number** found on the "Notice of Authorization of Services":
  - Date(s) of **enrollee's appointment**(s);
  - Time and **duration** of each appointment;
  - Specific **address** and location of appointment(s);
  - Any access or **security measures** the interpreter will need to know to gain entry to the place of service.
- When the interpreter arrives at the appointment, the interpreter will request your staff to sign a Verification of Service form. Please sign and complete this form to confirm services were rendered in order to facilitate KP payment.

Language Assistance – Phone and Sign

PHONE

- We have contracted with United Language Group, with the capability to provide telephonic interpreter services in 200 different languages.
- Phone interpreter services are available 24 hours a day, 7 days a week. United Language Group: 1-855-701-8100. This phone number is dedicated to the interpreter needs of KFHP enrollees.

SIGN LANGUAGE

- KP has contracted the services of Interpreters Unlimited, with the capability to provide in-person interpreter services for enrollees requiring Sign Language (SL)
- Two week's advance notification of need for a Sign Language interpreter is recommended to help ensure an interpreter is available.
- Interpreters Unlimited: 1-844-855-0249, 24 hours a day, 7 days a week.

LONG-TERM CARE PHARMACY

LONG TERM CARE (LTC) PHARMACY BACKGROUND

- In 2014, DHCS implemented the Care Coordination Initiative (CCI) which means many members in LTC are no longer disenrolled from Medi-Cal Managed Care into Fee For Service. They continue to be assigned to KP for their Medi-Cal benefit which includes medications.
    - CCI shifted the responsibility for LTC from Medi-Cal Fee for Service to Medi-Cal managed care plans and eliminated the need for disenrollment of those 21 years old and over in LTC in the SCAL CCI counties [Los Angeles, Riverside, San Bernardino, and San Diego].
    - Requires mandatory assignment of Medi-Cal to managed care for those dually eligible for Medicare and Medi-Cal.
- KP Medi-Cal only and partial dual managed care members in LTC may have their medications provided through the nursing facility pharmacy in their nursing facility. Includes select over the counter (OTC) medications when ordered by prescription.
- What does not change: KP Medi-Cal managed care members in LTC who are also eligible for Medicare Part D have access to their Medicare covered medications in their nursing facility through their Part D LTC pharmacy benefit.

KP MEDI-CAL ONLY MEMBERS CAN OBTAIN MEDICATIONS THROUGH THE NURSING FACILITY PHARMACY

In the Los Angeles,Orange,Riverside San Bernardino and San Diego counties the Nursing Facility Pharmacy can obtain new or refill medication for members with Medi-Cal only or Partial Duals without Medicare Part D.

The PBM now receives member information on eligibility file and allows nursing facility's pharmacy to fill the prescription.

In collaboration with KP Pharmacy and MedImpact a process has been developed using MedImpact:

- **Members may obtain medications from their LTC facility's pharmacy**
- A network of pharmacies attached to LTC facilities can be associated to KP Medi-Cal members
- Medi-Cal members are identified using enrollment units (EU) from KP's membership system
- KP sends an automated file to MedImpact each month to allow the identified members to access the identified pharmacies

SNF MEMBER PHARMACY NEEDS

How to obtain member prescriptions by type of coverage

Member Coverage	LTC with KP (LA, OC, Riv, SB, SD, Vta)	LTC in FFS (member disenrolled – Kern, Member <21 YO in LA, Riv, SB, SD)
KP Full Dual (KP Medicare) Eligible and any Medi-Cal	**Medications are covered by Medicare Part D – Catamaran**	
PARTIAL Dual Eligible with KP Part D and any Medi-Cal		
KP Medi-Cal Only and Partial Dual Eligible without Part D	**MedImpact:** LTC Pharmacy processes order or refill and submit claim to MedImpact. MedImpact approves and provides to the Member via Pharmacy in facility	Meds covered by Medi-Cal FFS
KP Medi-Cal only		

To set up with MedImpact: (800) 788-2949

COMMUNITY-BASED ADULT SERVICES (CBAS)

NEW REQUEST FOR CBAS SERVICES

1. CBAS provider completes Benefit Inquiry Form with health and physical attached and TB clearance and submits to KP Complex Case Management (CCM) via fax at (877) 515-6591
2. CCM reviews inquiry and applies pre-screen eligibility and criteria:
   - Medi-Cal eligible and assigned to KP
   - 18 years or older
3. If *not eligible*, CCM sends to the member and requestor notification of ineligible status
4. If *eligible*, KP sends acknowledgment letter to outside requester within *5 business days* from receipt of inquiry
5. KP schedules the Face-to-Face assessment within *5 business days* from receipt of Inquiry and completes the DHCS-approved CBAS eligibility determination tool (CEDT). If possible, KP will complete the DHCS-approved CBAS eligibility determination tool (CEDT) through a Kaiser Permanente medical record chart review and if needed a phone call with member/member's caregiver
6. Two additional attempts are made via the telephone to schedule Face-to-face assessment *between 5 and 8 business days* of receipt of request
7. KP mails letter to member to inform that she/he has until the 14th day from receipt of inquiry to schedule the Face-to-Face assessment
8. If KP member does not schedule the Face-to-Face within the 14 days of receipt of inquiry, KP sends a letter to both the member and the requestor stating that if services are still needed a new inquiry needs to be submitted to start the process again

NEW REQUEST FOR CBAS SERVICES (cont.)

9. The face-to-face must be completed using CEDT tool within 30 days from initial inquiry
10. Approval or denial of eligibility for CBAS to conduct 3-day Comprehensive Multidisciplinary Evaluation will be faxed to the CBAS provider within 1 business day of decision; the authorization is valid for 3 months
    - **HCPCS Code for 3-day assessment: H2000**
11. CBAS provider must conduct the 3-day evaluation within 3 months of receipt of the approved authorization to develop the Individual Plan of Care (IPC); once completed, the CBAS provider sends in a prior authorization request, including the IPC with level of service recommendations and duration of services
    - **HCPCS Code for CBAS Services: S5102**
12. KP will authorize, modify, or deny prior authorization *within 5 business days.* If approved this authorization is valid for 6 months
13. KP will notify the CBAS provider *within 24 hours*, and the member *within 48 hours, via phone call, of the decision*
14. The written notification of the authorization, modification, or denial will go to the member, the CBAS provider and the requesting provider
15. If unable to make a decision within 5 business days, a 14-day delay letter will be sent to the member and CBAS provider
16. CBAS provider must reassess member and re-submit the new IPC before the expiration of the current authorization
17. When a member is discharged from services, the CBAS provider should fax a discharge summary to KP Permanente CCM at (877) 515-6591
18. Member has the right to choose a CBAS center

KAISER PERMANENTE CBAS FORMS

Benefit Inquiry Form

KAISER PERMANENTE
393 E. Walnut Street
Complex Case Management - PE
Pasadena, CA 91188
Phone (866) 551-9619
Complex-Case-Management@kp.org

For Kaiser Use Only REFERENCE NO:	For Kaiser Use Only Status: ☐Approved as Requested ☐Denied ☐Approved as Modified ☐Deferred

Benefit Inquiry for Community Based Adult Services (CBAS)

☐Expedited: (877) 515-6591 FAX ☐Routine: (877) 515-6591 FAX

SECTION I
Patient Name:______________ ☐M ☐F D.O.B.________ Age:______
Last First

Mailing Address:____________ City:__________ Zip:______ Phone No:__________

Social Security #:__________ CIN#:______________

SECTION II
Requestor Name:______________

Telephone Number:____________ Email:______________

Address:______________

Relationship to Patient:______________

SECTION III
Information Regarding Patients Need for Service:

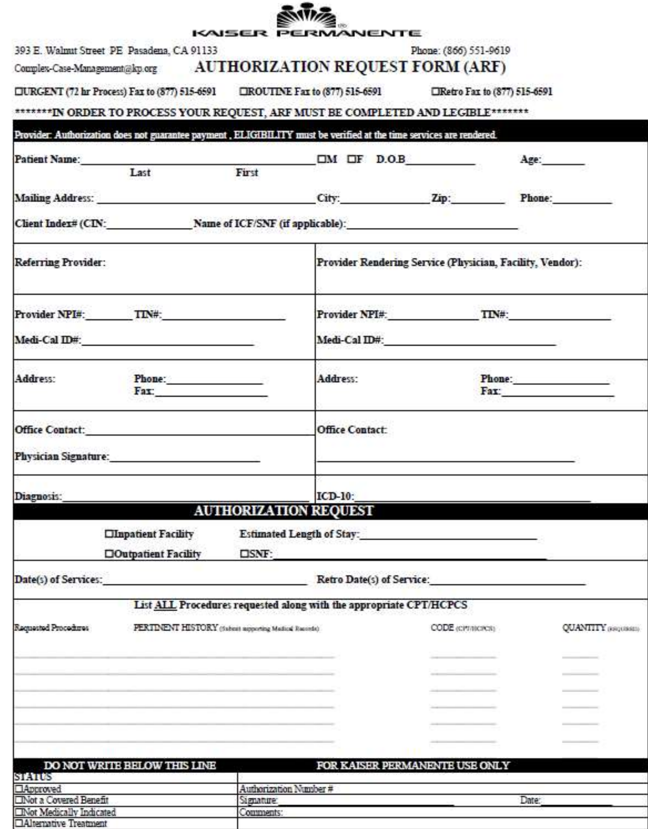
SECTION IV
Additional Comments:

DO NOT WRITE BELOW THIS LINE

For Kaiser Permanente Use Only:

Signature: Date: Phone Number:

Authorization Request Form



KAISER PERMANENTE

393 E. Walnut Street PE Pasadena, CA 91133 Phone: (866) 551-9619
Complex-Case-Management@kp.org

AUTHORIZATION REQUEST FORM (ARF)

☐URGENT (72 hr Process) Fax to (877) 515-6591 ☐ROUTINE Fax to (877) 515-6591 ☐Retro Fax to (877) 515-6591

*******IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE*******

Provider: Authorization does not guarantee payment , ELIGIBILITY must be verified at the time services are rendered.

Patient Name:______________ ☐M ☐F D.O.B________ Age:______
Last First

Mailing Address:____________ City:__________ Zip:______ Phone:________

Client Index# (CIN:__________ Name of ICF/SNF (if applicable):______________

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#:______ TIN#:________ Medi-Cal ID#:__________	Provider NPI#:______ TIN#:________ Medi-Cal ID#:__________
Address: Phone:________ Fax:________	Address: Phone:________ Fax:________
Office Contact:__________ Physician Signature:__________	Office Contact: __________
Diagnosis:__________	ICD-10:__________

AUTHORIZATION REQUEST

☐Inpatient Facility Estimated Length of Stay:__________
☐Outpatient Facility ☐SNF:__________

Date(s) of Services:__________ Retro Date(s) of Service:__________

List ALL Procedures requested along with the appropriate CPT/HCPCS

Requested Procedures	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT/HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE	FOR KAISER PERMANENTE USE ONLY
STATUS	
☐Approved	Authorization Number #
☐Not a Covered Benefit	Signature:__________ Date:______
☐Not Medically Indicated	Comments:
☐Alternative Treatment	
☐Modified	
Affiliated Health Plan:__________	Phone:__________

CBAS FORMS: Additional Information

- CBAS providers may download the following forms directly from the California Department of Aging website:
- https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/Eligibility_and_Service_Authorization/
  - CBAS Eligibility Determination Tool (CEDT)
  - Individual Plan of Care (IPC)
- To request a copy of the authorization, please contact the ORD department in your area (refer to slide 17)
- For additional questions, please contact Kaiser Permanente's CCM department at
- (866) 551-9619 or Complex-Case-Management@kp.org

KAISER PERMANENTE MANAGED CARE HOSPICE

HOSPICE

- Authorization for hospice services is based on some of the following information:
- A Medical Group physician must order and direct the requests for hospice services
- The Kaiser Permanente Continuing Care staff review referral requests from Medical Group
- The member is a Health Plan member
- The member requires the care in the member's place of residence within the Kaiser Permanente Service Area. Any place that the member is using as a home is considered the member's residence
- The member has a terminal illness that has a prognosis of six months or less, as certified by a hospice physician. In addition, the member understands and is in agreement with hospice philosophy, which is comfort-focused care and no longer seeking curative/aggressive treatment
- The home environment is a safe and appropriate setting to meet the member's needs and provide Hospice Services.
- There is a reasonable expectation that the needs of the member can be met by the provider

HOSPICE (Continued

- Medically necessary care must be provided by a registered nurse. The core hospice team includes physician, registered nurse, social worker, clinical chaplain, home care aide, and volunteer.
- The member and caregiver(s) are willing to participate in the plan of care and work toward specific end of life goals.
- Services are provided under Health Plan coverage and benefit guidelines.
- Such Hospice services are authorized for a member only if the services are appropriate for the member's clinical condition. The member must have a terminal illness with a prognosis of six months or less, as certified by a hospice physician.
- Hospice attending physician and Hospice Medical Director develop a plan of care in collaboration with the member, family and Hospice interdisciplinary team.
- Hospice staff coordinates with the Hospice provider and conduct concurrent telephone or on-site review to assess the member's progress toward achieving goals in the plan of care. Ongoing team discussion and collaboration regarding member's progress towards goals is discussed with entire team at least every 14 days during Interdisciplinary Team meetings. In addition, the Hospice attending physician conducts at least one face-to-face visit with the member before each new certification period (every 60 or 90 days depending on certification number)
- Eligibility for Hospice services is ongoing as the member's condition changes. A member will most often stay on Hospice services until death, but in some instances their condition improves to the point they no longer meet criteria. In these instances, the member is discharged from hospice for extended prognosis, and they are often referred to another service along the continuum, such as Palliative Care, Home Health of back to Primary Care

LONG TERM CARE MEDI-CAL MEMBERS IN HOSPICE

Hospice room and board in a SNF is a covered Medi-Cal benefit under hospice. The hospice agency pays the SNF directly for Room and Board and is reimbursed from Medi-Cal or the Medi-Cal payor.

Members maintain the choice to select their preferred hospice. We are encouraged by the response of our SNFs in aiding our members to seek this service.

Whenever a Long Term Care member, residing in a SNF, transitions to hospice, the nursing home needs to:

- Obtain a physician order for hospice Service or have the KP MD place the order.
- FAX the physician order to the KP hospice intake.
- Contact the hospice agency to coordinate care and obtain bed payment.

For Hospice **Medi-Medi** Room and Board, the provider is to submit an invoice and/or UB-04 to Hospice-Medicare-Billing HOSPICE-MEDICARE-BILLING@kp.org

If the coverage is **Commercial** or **Medi-Cal only**, providers are to bill Claims, either electronically via their claims system or by regular mail.

KAISER PERMANENTE HOSPICE AGENCIES

Facility	Telephone	Fax
Antelope Valley Hospice	661-729-7250	661-729-7254
Baldwin Park Hospice	626-480-5176	626-480-5112
Metro LA Hospice	626-381-4290	626-381-3415
Orange County Hospice	714-734-5464	714-734-7590
Riverside Hospice	951-270-1250	951-270-1218
San Bernardino Hospice	909-609-3838	909-609-3865
San Diego Hospice	619-641-4100	619-641-4111
South Bay Hospice	888-215-4300	562-658-3848
Tri-Central Hospice	888-215-4300	562-658-3848
Valley Hospice	818-832-7422	818-832-7253

MEDI-CAL NON-MEDICAL TRANSPORTATION

Other Benefits | Transportation

Medi-Cal offers transportation benefits for **KP Medi-Cal members** who have no other way to get to their scheduled appointment or service.

	Non-Medical Transportation NMT	Non Emergency Transportation NEMT
Who is eligible?	• Members that **can** get **in and out of the vehicle** without any help from the driver	• Members that are **unable to get in and out the vehicle** due to a physical or mental disability and need help from the driver. Unable to use car, bus, train, or taxi.
How do you access services?	• Members or staff can **self- refer** by calling Kaiser Permanente Transportation Services to schedule a ride. • To schedule a ride, call 1-844-299-6230 Monday-Friday 5am-7pm *Urgent Requests can call 24 hours/day, 7 days/week	• Transportation **must be prescribed in writing** by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender*. • Once approved, members will receive a letter in the mail with details on how to schedule transportation.
What is the service?	• Private or public transportation, bus, or car to medical appointments to Medi-Cal covered services.	• Ambulance, wheelchair van, gurney/litter van to and from residence, vehicle or place of treatment for medical needs. Air transportation is necessary because clinical and practical considerations render ground transportation not feasible.

* A physician extender is: A physician extender includes Non-Physician Medical Practitioners, which includes Physician Assistants, Nurse Practitioners, and Certified Midwives.

Other Benefits | Transportation

Medi-Cal offers transportation benefits for **KP Medi-Cal members** who have no other way to get to their scheduled appointment or service.

	Non-Medical Transportation NMT	Non Emergency Transportation NEMT
Gas Mileage Reimbursement	• Members can arrange private conveyance (private vehicle) when no other methods of transportation are available. This can include personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft. • Members can attest that they had no other methods of transportation available over the phone, electronically, or in-person. • To receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include a valid driver's license, vehicle registration and insurance. Mileage reimbursement is based on the IRS medical mileage reimbursement rate.	

* A physician extender is: A physician extender includes Non-Physician Medical Practitioners, which includes Physician Assistants, Nurse Practitioners, and Certified Midwives.

Other Benefits | Non-Medical Transportation Services (NMT)

Non-Medical Transportation (NMT) through the vendor, Medical Transportation Management (MTM), is available by **private or public transportation.** KP Medi-Cal members may be able to get NMT **to/from a medical appointment or Medi-Cal Covered service, including pharmacy**.

Eligibility

- A Kaiser Permanente Medi-Cal member
- Able to get in and out of the vehicle without any help from the driver
- Traveling to and from an appointment for a Medi-Cal covered service
- Members using a collapsible wheelchair or walker and can walk short distances can use NMT.

Service

- Go to a Medi-Cal covered service
- Get medical services like lab work or X-rays
- Pick-up medicine that cannot be mailed
- Pick-up medical supplies or equipment

Referrals

- Members or staff can self-refer to access NMT services.

How to access services:

To schedule a NMT ride:

Call 1-844-299-6230
Prefer 3 days advance notice, available 24 hours a day, 7 days a week.

Urgent requests can call 24 hours a day, 7 days a week.

Other Benefits | Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) is transportation for KP Medi-Cal **members who cannot use public or private transportation** to/from Medi-Cal covered services, and who are **unable to ambulate.** This type of transportation can be scheduled through the **KP Regional Transportation Hub.** These services must be prescribed by a provider.

Eligibility

- A Kaiser Permanente Medi-Cal member
- Member is unable to physically or medically use a bus, taxi, car or van to get to your appointment
- They need help from the driver to and from their residence, vehicle or place of treatment due to physical or mental limitations

Service

- Medical Transportation for situations that are **NOT** emergencies
- Basic Life Support Ambulance
- Wheelchair Van Transportation
- Gurney/Litter Van
- Air Transportation

Referrals

- Prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender.
- The provider will determine the appropriate type of NEMT transportation that is needed.

Note: KP covers the lowest cost of medical transportation for medical needs prescribed by a physician to the closest provider where an appointment is available.

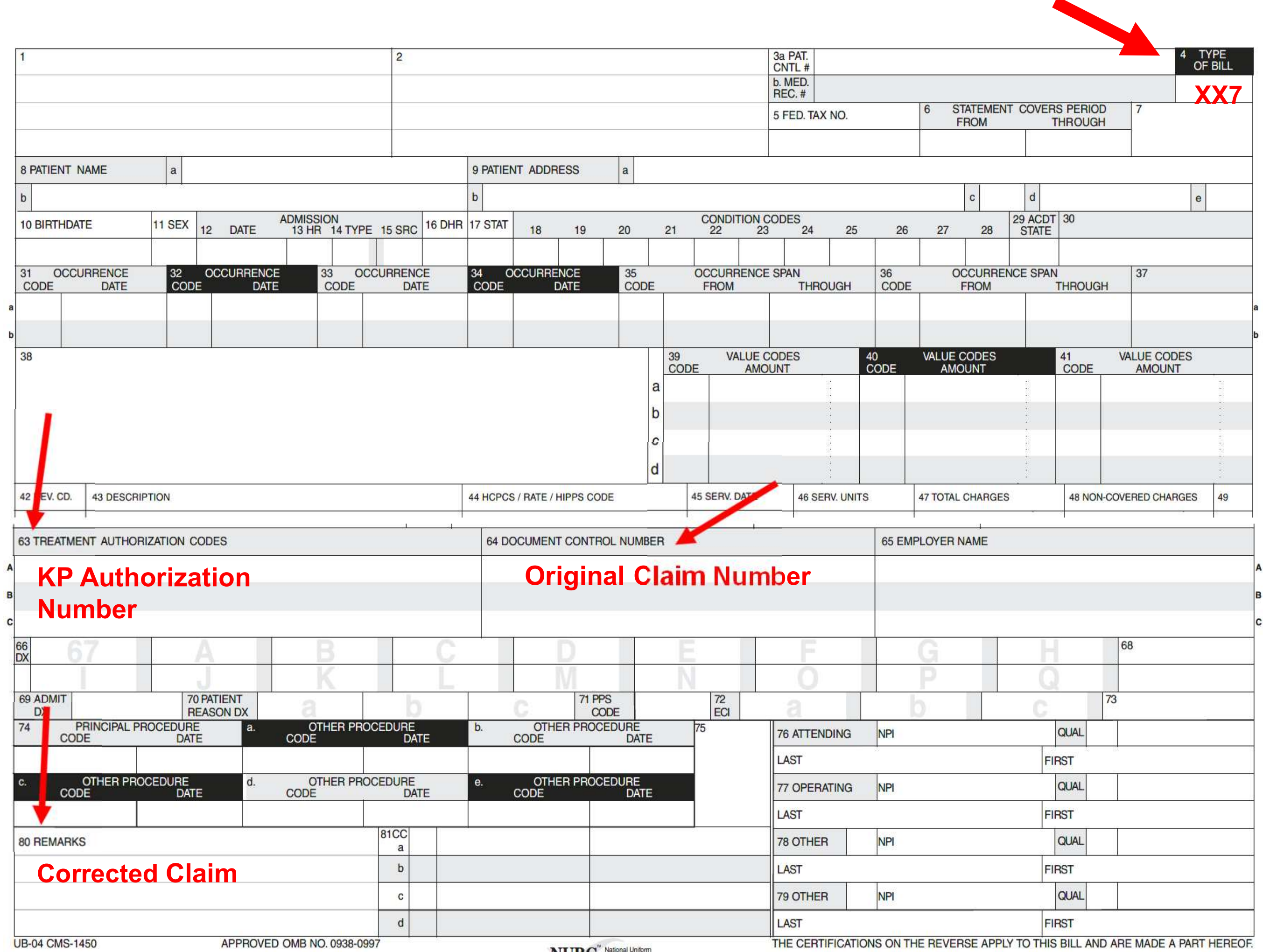
Appendix

Corrected Claims

TOB (Box 4) = XX7

Corrected or replacement of prior claim.

- Timeliness rules apply as initial claim (e.g., 90 days or as noted in contract)
- Preference is for the corrected claim to be submitted via EDI
- Use frequency code of 7 to indicate replacement claim
- Original claim number is required in Field 64: Document Control Number.
- EDI Claims: Enter the original claim number in the 2300 Loop, REF*F8, and the Kaiser Permanente original claim number from your EPO/ERA.



Kaiser Permanente Online Affiliate and Claims Status Online Fact Sheet

What is Online Affiliate?

If you would like more information on accessing Online Affiliate, please navigate to kp.org/providers and select your region from the drop down.

On the home page, locate Online Provider Tools for instructions to set up access to Online Affiliate. You may also reach out to your regional Online Affiliate regional representative:

For more information or support:

Region	Contact
Northern California	Online Affiliate Support Webform
Southern California	
Colorado	
Georgia	
Hawaii	
Maryland/Virginia/DC	
Oregon/SW Washington	NW-Provider-Relations@kp.org

Keep ND&A Informed of Any Changes to the Following:

- Federal Tax Identification Number (TIN)
- Include copy of W-9 form/Copy of Letterhead Effective date of change
- National Provider Number (NPI)
- Information that may affect billing and payment

Notify ND&A by email at: NDANDA-PROVIDERRELATIONS@KP.ORG

or by US Mail at:

Kaiser Permanente

Network Development and Administration

393 E. Walnut Street – 7th Floor (S/W)

Pasadena, CA 91188-8116

Tel: 1-626-405-3240 Fax: 1-626-405-6774

RESOURCES

SUMMARY OF IMPORTANT TELEPHONE NUMBERS

Automated Telephone System (eligibility/benefits)
1-888-576-6789 *(toll free)*

Claim Denial Inquiry / Provider Disputes
1-800-390-3510 *(toll free)*

Complex Case Management Department
1-866-551-9619 *(toll free)*

Medical Transportation Management (MTM)
1-844-299-6230 *(toll free)*

Member Services (eligibility/benefits verification/complaints, grievances, inquiries)
1-800-464-4000 *(toll free)*

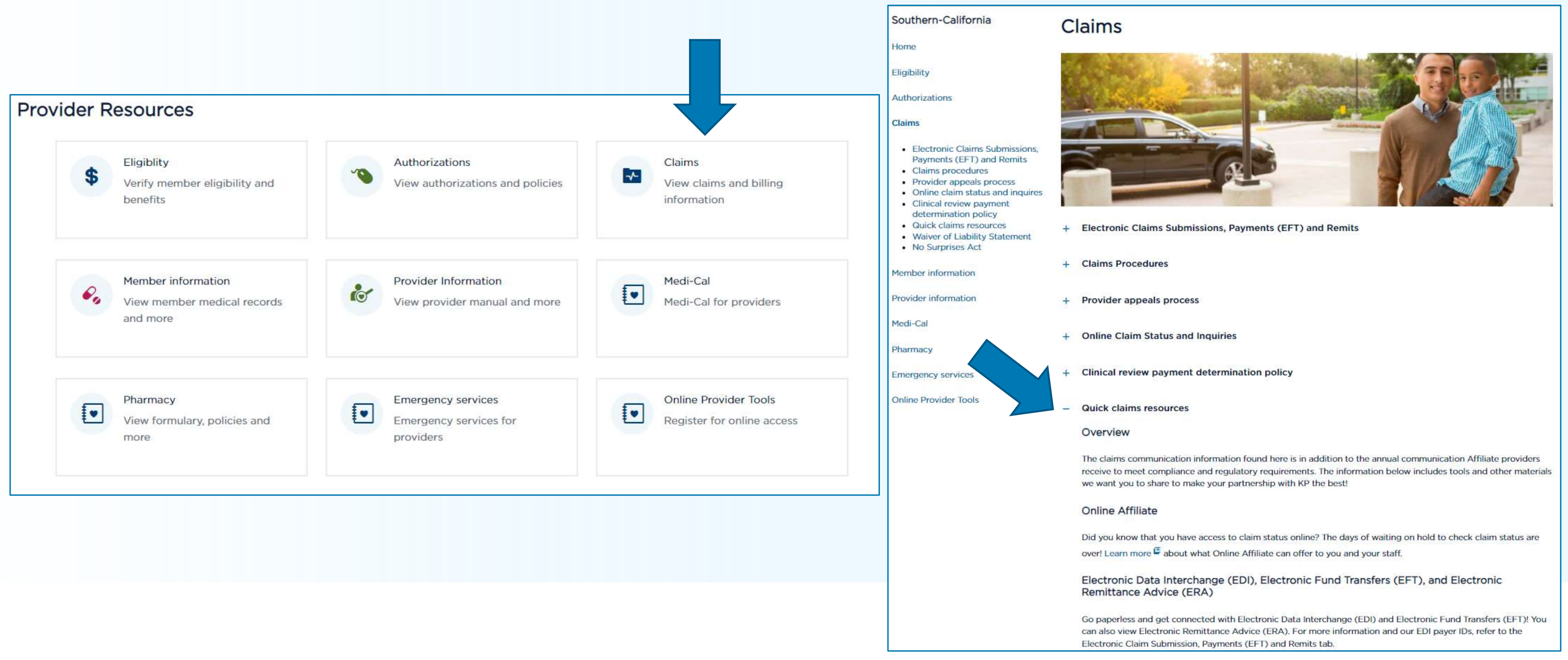
Provider Relations – Network Development and Administration (Contracting) Department
Tel: 626-405-3240 Fax: 626-405-6774

Regional Long-Term and Post Acute Care Department
Tel: 626-405-5218 Fax: 1-866-473-0344

Claims:

If you need additional information regarding billing or anything else specific for claims, here is the link to the to the SCAL-Kaiser Permanente Community Provider Portal:

[CPP Southern California - Claim procedures (kaiserpermanente.org)]



ADDITIONAL RESOURCES:

Additional resources and comprehensive presentation can be found in the SCAL-Kaiser Permanente Community Provider Portal:

institutionalmanualkaiserpermanente.org)
https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info

Welcome to the Community Provider Portal!

Southern California

Important Updates

- COVID-19

Announcements

- Register for Online Affiliate or sign-on to begin submitting online disputes, appeals, supplemental claim attachments or request for information (RFI). Learn more about our new Claim submission tools and partnership.
- Please note that Self-Funded, PPO, POS or OOA member claims may not be available in Online Affiliate. If your inquiry is about a Self-Funded member claim, please sign on to the Self-Funded plans online tool. If your inquiry is about a PPO, POS or OOA member claim, please call (800) 392-8649, Monday through Friday from 6am to 6pm.

Our online resources provide quick and easy access to the information you need to work effectively with Kaiser Permanente and to provide the best possible service to our members.

We are committed to promoting the total health of Kaiser Permanente members. We appreciate the services you provide to support that mission.

Kaiser Permanente members may access your account to message your doctor, fill prescriptions, and view your medical record by visiting kp.org.

Please be advised that Claims Status information can only be obtained through one of our self-service tools. Please use our Guest Access feature or sign up today for Online Affiliate.

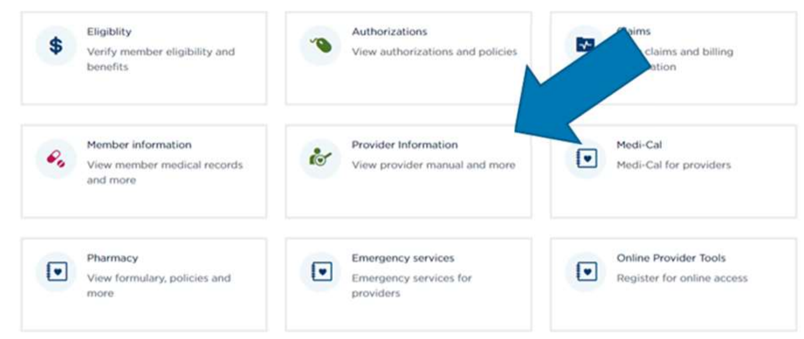
Quick Links

- KP ClaimsConnect Information
- Institutional provider manuals
- Institutional provider required training
- View claim status as a guest user

Training Resources

- Video Overview of KP Online Tools
- Video Overview of Guest Access

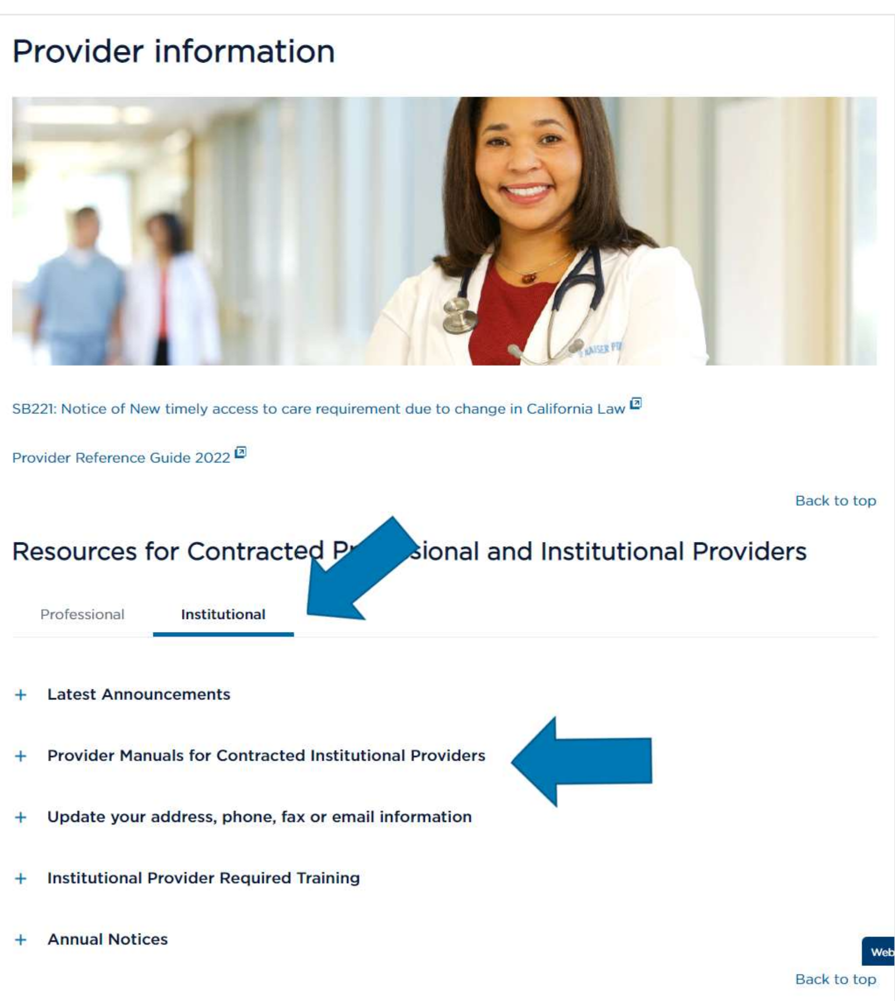
Provider Resources



SCAL-Kaiser Permanente Community Provider Portal Navigation

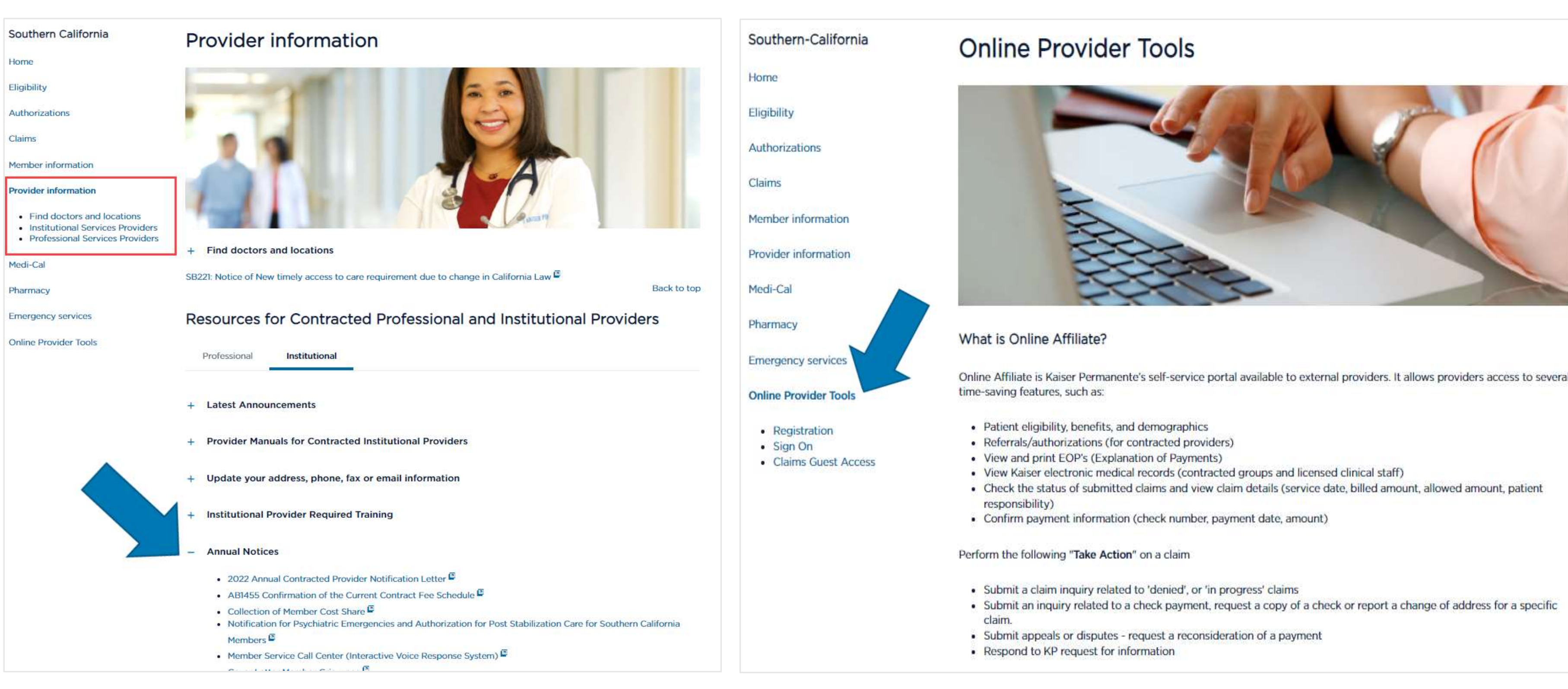
Provider Manuals can be found in the SCAL-Kaiser Permanente Community Provider Portal

institutionalmanualkaiserpermanente.org)
https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info

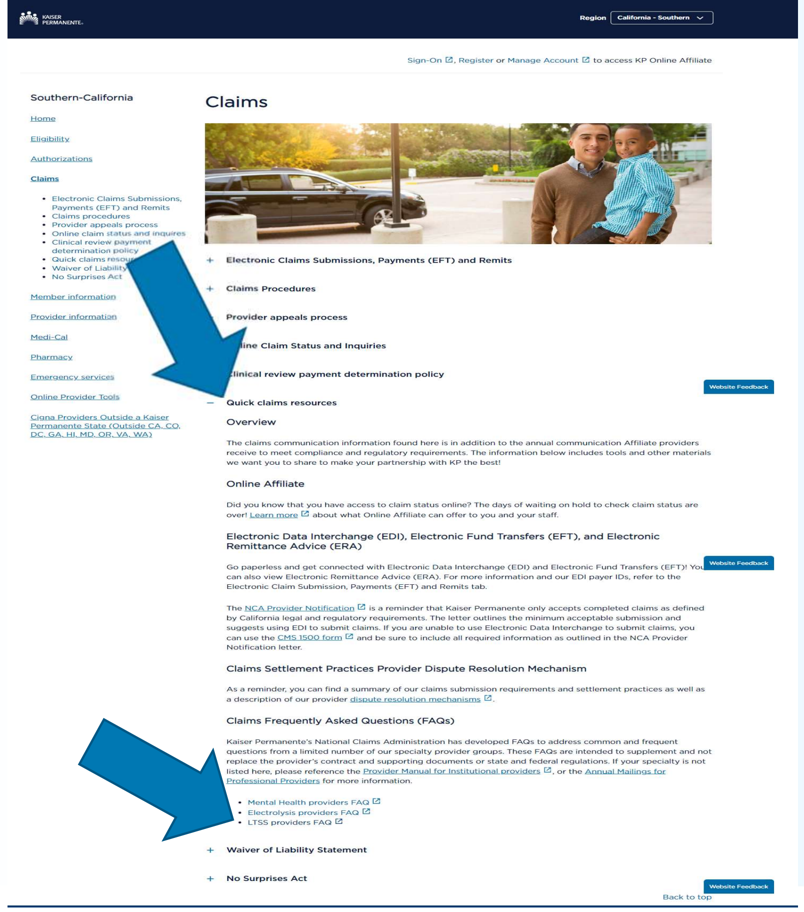


SCAL-Kaiser Permanente Community Provider Portal (CPP) Navigation

Educational materials can be found under Annual Notices and access claims guidelines and register for Online Affiliate Access to claims-benefits-referrals.

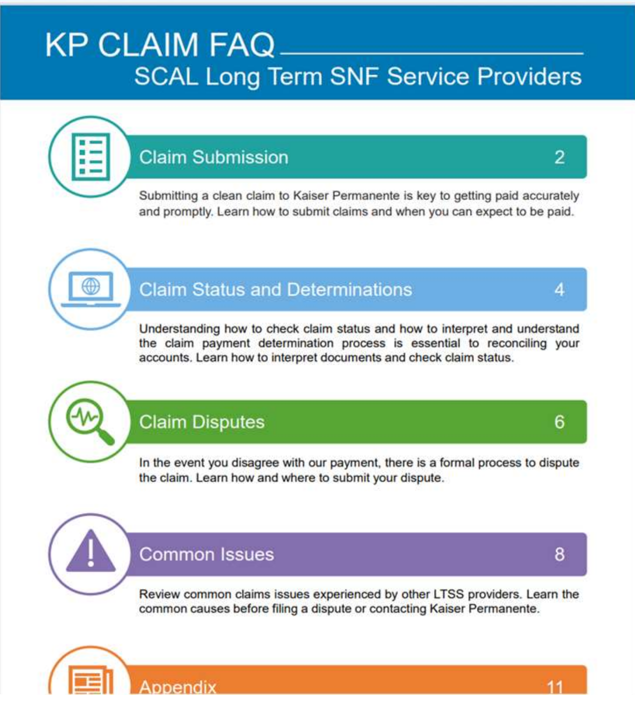


LTSS PROVIDERS FAQ:



Kaiser Permanente’s National Administration has developed Frequently Asked Questions to address common and frequent questions:

[Claims | Community Provider Portal | Kaiser Permanente]



THANK YOU!!!