HIPAA 5010

HIPAA 5010 is a new set of standards that regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims and remittances. Covered entities, such as health plans, healthcare clearinghouses, and healthcare providers, are required to conform to HIPAA 5010 standards as required by federal law. The compliance date for use of these standards in January 1, 2012.

These transactions are specified in the HIPAA 5010 standards:
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 276/277 Health Care Claim Status Request and Response
- 278 Health Care Services, Request for Review and Response; Health Care Services Notification and Acknowledgment
- 820 Payroll Deducted and Other Group Premium Payment for Insurance Products
- 834 Benefit Enrollment and Maintenance
- 835 Health Care Claim Payment/Advice
- 837 Health Care Claim (Professional, Institutional, and Dental), including coordination of benefits (COB) and subrogation claims
- NCPDP D.0 Pharmacy Claim

In order to prepare for the transition, an organization should coordinate testing with their clearinghouse. Alternatively direct testing is available to trading partners that transmit directly to Kaiser Permanente. It is highly recommended that you make the transition early so the transactions may process smoothly and timely.
Benefits of referring your patients to Kaiser Permanente for specialty care

As a Kaiser Permanente Participating, you play an integral role in the care coordination of our members. Referring your patients to Kaiser Permanente brings the advantages of the integrated care experience to our members as well as to you - the Participating Provider. Members referred to Kaiser Permanente for specialty care are seen by Mid-Atlantic Permanente Medical Group. P.C. physicians at our area Medical Centers. Additionally, all services rendered at a Kaiser Permanente Medical Center including lab, pharmacy, and radiology orders are documented within KP HealthConnect, our state-of-the-art electronic medical record and care management system. The electronic capabilities and technology available through KP HealthConnect allow us to keep you and the patient connected with all aspects of the care that he/she receives within Kaiser Permanente. Members may access health information related to their Kaiser Permanente care at kp.org. Participating Providers with access to KP HealthConnect AffiliateLink have real-time access to their patient’s encounters/visits, charts, lab results, and more via the web at providers.kp.org/mas.

If you do not have access to KP HealthConnect AffiliateLink and would like to enroll, you may download an enrollment package at providers.kp.org/mas or contact Provider Relations at 1 (877) 806-7470 for assistance.

Thank you for participating with Kaiser Permanente to provide quality care services to our members. Should you have any questions, please contact Provider Relations at 1 (877) 806-7470.

Emergency room notification process

As a Participating Provider, a Member may be directed and/or self-direct to your facility for emergency care. While prior authorization or referral approval is not required for reimbursement of covered emergency care services provided to Member, we nevertheless request notification when a Member presents to the Emergency Department for urgent and/or emergent care services. This notification will ensure that our Members are being given the best coordination and follow-up care possible.

There are two (2) quick and convenient options for providing notification to Kaiser Permanente:

Option 1: Fax Option: Complete the Emergency Department Visit Notification Form and fax to the Utilization Management Operations Center at 301-388-1639.

Option 2: Contact the Utilization Management Operations Center (UMOC) at 301-879-6143, or 1-800-810-4766, select option 1 and follow the prompts to report the Emergency Department visit.

All emergency room notifications should include the following information:
- Member Name
- Member Medical Record Number (MRN)
- Name of the Referring Physician (if applicable)
- Name of Hospital or Facility
- Complaint/Diagnosis
- Date of Service

The Utilization Management Operations Center (UMOC) is available to receive notification 24 hours a day, 7 days a week.

This information can be located in Section 9.0 –Utilization Management and Subsection 9.15 – Hospital and Facility Admissions of the Participating Provider Manual. You can download a copy of the Participating Provider Manual from our community provider website at providers.kp.org/mas, or request a hard-copy by contacting Provider Relations at 1-877-806-7470.
Kaiser Permanente Provider Relations

The Kaiser Permanente Provider Relations Department provides comprehensive and personalized support services to Kaiser Permanente Participating Practitioners and Providers that care for our members. This support includes:

- Responding to Participating Provider inquiries, payment disputes, and/or concern resolution
- Management of Participating Provider demographic and credentialing correspondence
- Assisting Participating Providers in identifying appropriate Kaiser Permanente Medical Center locations and other network resources available for patient care
- Provider communication, education, and training regarding Kaiser Permanente products, medical management procedures, compensation methodologies, and referral processes
- Alerting and assisting Kaiser Permanente Participating Providers with legislative changes, updates, and or other health care regulations

You can reach the Provider Relations Department at 1-877-806-7470 Monday thru Friday, 9:00 a.m. to 5:00 p.m.

The Provider Relations Department is comprised of specialized staff to meet your support needs:

**Network Communications Specialists**
Candra Terry and Michelle Reid provide excellent customer service for general provider inquiries and network management questions from Participating Providers, assist providers with locating Kaiser Permanente resources available for patient care, provide general information on claim and referral processes, and submit requests for demographic updates. These representatives can be reached Monday thru Friday, 9:00 a.m. to 5:00 p.m.

**Candra Terry**
Network Communication Specialist
1-877-806-7470

**Michelle Reid**
Network Communication Specialist
1-877-806-7470
Field Operations Specialists
Ebony Staples and Linda Boyce serve as liaisons to Kaiser Permanente Providers by providing personalized issue support, issue resolution, on-site provider orientations and training.

Ebony Staples
Senior Field Operations Specialist
Phone 301-816-5684

Linda Boyce
Field Operations Specialist
Phone 301-816-6329

KP HealthConnect Security Analyst
Patricia Roberts-Bradley provides KP HealthConnect AffiliateLink support, troubleshooting, log-on access and navigation training.

Patricia Roberts–Bradley
KPHC AffiliateLink Security Analyst
Phone (301) 816-6554

Network Education and Media Specialist
Sirena Perkins coordinates quarterly service area meetings, group provider orientations, web-based training development and our community provider websites.

Sirena Perkins
Network Education & Media Specialist
Phone (301) 816-7193

Program Coordinator
Jennifer Bond monitors Participating Provider Network access and availability surveys, coordinates our Network News publications, assists providers with registering with CAQH, provides practitioner credentialing coordination, and assists with the development of our community provider website.

Jennifer Bond
Program Coordinator
Phone (301) 816 - 6709

Provider Reimbursement and Dispute Analysts
Review and respond to post service review request and payment disputes from Participating Providers.

Anthony Swinton, Joan Uhlig, & Melvin Margao,
Provider Reimbursement Specialists

Latarsha Wilson, Derrick Lampkins & Keisha Ballard, Provider Dispute Analysts
All payments disputes should be initiated in writing and submitted to:
Kaiser Permanente
Attention: Provider Relations
2101 East Jefferson Street
Rockville, Maryland 20852

Kenya Onley
Director, Provider Relations
Phone 301-816-6564 email Kenya.C.Onley@kp.org

Ese Elesinmogun
Supervisor, Provider Relations
Phone 301-816-6870 email Ese.Elesinmogun@kp.org

Note: For routine claims inquiries or claims status questions please contact our Member Services Department at 1-877-777-7902.

Coming Soon!
Provider Relations is working to create web-based training to make learning about Kaiser Permanente more convenient for you. Soon you will be able to get an overview of Kaiser Permanente, learn about our electronic capabilities, and have a guide on how to utilize our secure online medical record system right at your finger tips. These web-based trainings will allow providers and office staff members to receive training whenever they need it and from the comfort of their office or desk computer. So keep a look out for these web-based trainings!
Flexible Choice referral policy

As of September 1, 2011, there was a change to the Kaiser Permanente Flexible Choice referral policy and process for members who have visited an Option 2 participating MultiPlan or PHCS network provider or Option 3 out-of-network provider and want to see an Option 1 Mid-Atlantic Permanente Medical Group (Permanente) specialist for additional recommended care.

If you are seeing a Kaiser Permanente Flexible Choice member under their Option 2 or Option 3 benefits and you recommend that the member see a specialist, the member can call 301-879-6180, 8 a.m. to 4:30 p.m., Monday through Friday to request an appointment with an Option 1 Permanente physician:

When Kaiser Permanente Flexible Choice members call this number, a representative will ask for medical information (i.e. diagnosis, brief condition summary) that you as their Option 2 or Option 3 provider can provide. The representative will tell the member what information is needed, and the member can provide this information by phone, fax, or mail. You may also call directly to provide the requested information on a member’s behalf.

ICD-10 is Coming!

International Classification of Diseases (ICD) is a coding system used for inpatient and outpatient diagnoses and inpatient procedures. ICD-9 is the current version used in the United States when billing for health care services.

On January 16, 2009, the Department of Health and Human Services released the Final HIPAA Administrative Mandate to Adopt Version 10 (ICD-10.) The compliance date for implementation of the ICD-10 Coding System is October 1, 2013.

Why is this happening?
ICD-9 is running out of codes. Hundreds of new diagnosis codes are submitted annually. ICD-10 will allow not only for more codes, but also for greater specificity and thus better epidemiological tracking.

What this means for providers?
• Providers will not be able to continue to report ICD-9-CM codes for services provided on or after October 1, 2013
  • ICD-10-CM (diagnoses) will be used by all providers in every health care setting
  • ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures
  • ICD-10-PCS will not be used on physician claims, even those for inpatient visits
  • No impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes
  • CPT and HCPCS will continue to be used for physician and ambulatory services including physician visits to inpatients

For more information:
Visit the CMS ICD-10 website at www.cms.gov/ICD10 for the latest information and links to resources for providers to prepare for the ICD-10 implementation.
Keeping the provider directory up to date

Please use the sample letter format below to update us with any changes you may have throughout the year. It is very important that we have the most accurate information when we pull our data for the directory.

Changes may be made by fax to: 301-388-1700 or by mail:

Kaiser Foundation Health Plan of The Mid-Atlantic States, Inc.
Provider Affairs; Flr 2 East
2101 East Jefferson St.
Rockville, MD 20852

If you would like to request a provider directory please contact Member Services at:
• For Maryland (301) 468-6000
• All other areas outside of Maryland
  1-877-777-7902

<<DATE>>

Tax identification #:  
Requestor phone #:  
Effective date of change(s):  
Requestor:

Reason for the request:

• Address change (practice location or billing)  
  *identify whether adding or deleting demographic change 
• Adding a provider or practitioner to an existing group contract  
  *identify whether adding or deleting provider

If adding or deleting a provider please include:

• First and last name 
• Sex 
• Title or degree 
• NPI number 
• CAQH number 
• UPIN or social security number 
• Primary specialty with secondary specialty if applicable 
• Practice locations w/ phone and fax numbers 
• Foreign languages 
• If urgent care/ will the provider have a panel of Kaiser Permanente patients.
As a result of a recent probe audit, the following coding issues were identified with our external providers encounter visits.

**CVA versus “History of” with or without residual**
Acute CVA is only coded at the time of the initial onset of the CVA. Once the patient is discharged from acute care (including transfer to a SNF) you may no longer code the CVA as acute. Depending on whether or not any residual conditions still exist at the time of discharge from acute care, the code assignment for subsequent encounters would either be for late effect of CVA or history of CVA.

**Late effects**
A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes. The condition or nature of the late effect is sequenced first. The late effect code is sequenced second. An exception to the above guidelines is those instances where the code for late effect is followed by a manifestation code. The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

**CA versus “History of CA”**
It is important to name the primary cancer site when it originated in a solid organ or to be as specific as possible as to the name or cellular type when the cancer is a lymphoma or leukemia. Clarify whether the malignancy has been excised or treated otherwise and if it is still present. Identify whether the patient is still on radiation or chemotherapy for the primary site tumor. Regarding metastases name each site where the cancer metastasized or identify whether it is local, synchronous, or meta-chronous cancer. Do not forget significant manifestations such as nutritional deficits, anemia, hydration status, mental status, infection, etc, you use the “Personal History of” diagnosis code when the patient’s primary malignancy has been excised or eradicated from its site; there is no evidence of a remaining malignancy at the primary site; and the patient is currently NOT receiving long term therapy. You use the correct “cancer” code if the patient is undergoing active treatment for a cancer. Active treatment may include chemotherapy, radiation therapy, long term therapy or long term suppressive therapy (e.g., Tamoxifen for breast cancer, Lupron for prostate cancer). If the medication is for preventive treatment of cancer, then you would use “Personal History of” diagnosis codes.

**Documentation of non-systemic diseases**
There must be supporting documentation of evaluation or treatment of non-systemic conditions in your office note. If a non-systemic diagnosis is captured in your assessment, the progress note must support evaluation of the condition during the encounter visit.

**Coding guidelines for coding “suggestive,” “questionable”**
Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

**Authentication requirements**
Every office note must be signed and legible with the author’s full name, credentials and date of signature. Signatures without the author’s credentials are non-billable.
Coding Corner, continued

Documentation Requirements for Hemiplegia/Hemiparesis
There are two code sets that are used for hemiplegia/hemiparesis. There is one for the acute phase during the initial diagnosis of a CVA, and another for late effects secondary to the CVA following the initial hospital admission/stay (sometimes, but rarely, initial diagnosis may be in the outpatient or office setting). Both types require the provider to document whether or not the hemiplegia/hemiparesis is affecting the dominant or non-dominant side. In general, physicians usually indicate the side affected as either the right or left rather than dominant or nondominant. This can sometimes lead to the documentation and the diagnosis code selected by the provider not matching up. During the initial phase of the hemiplegia/hemiparesis the documentation should also indicate whether the hemiplegia/hemiparesis is flaccid or spastic. Once documented, the appropriate diagnosis can be selected from Healthconnect.

Example: Stroke - patient is right handed admitted for left hemisphere stroke with aphasia and flaccid right hemiparesis.

Code during the acute admission:
434.91I Stroke
342.01A Flaccid hemiplegia, affecting dominant side.
784.3 E Aphasia.

Code after the acute admission:
438.21A Hemiplegia affecting dominant side, late effects of cerebrovascular disease
438.11A Aphasia, late effects of cerebrovascular disease