SECTION 12

PROVIDER APPEALS

12.1 INTRODUCTION

Kaiser Permanente provides all providers with a fast, fair and cost-effective dispute resolution mechanism under which a provider may submit all disputes/appeals regarding invoices, billing determinations, or other contract issues. Kaiser Permanente will handle disputes/appeals and this dispute resolution mechanism in accordance with applicable law.

This section of the Provider Manual gives the provider information regarding our dispute resolution process, but is not intended to be a complete description of the law or the provisions of the Agreement. Please make sure that you review the Agreement and the applicable law for a complete description of the dispute resolution process.

12.2 DISPUTES

If a provider has a dispute pertaining to a Kaiser Permanente claims decision, they must submit a written notice to the applicable Kaiser Permanente region.

For Claims: Challenging, appealing or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted or contested by Kaiser Permanente please follow the procedures notes below.

Colorado:

- The provider must call Customer Service to inquire about the claim(s) in dispute. The telephone number is listed in the “Key Contacts” section of this Provider Manual for specific telephone numbers. In most cases they should be able to answer and resolve any issues you may have.
- Pursuant to the Division of Insurance criteria of regulation 4-2-23, when a provider disagrees with a claim determination, a request for reconsideration on the claim must be forwarded in writing to Kaiser Permanente within 60 days from the date of the statement of remittance. A provider’s failure to do so shall result in the request being denied with no further action being allowed by the provider.
- A Provider Appeals Committee reviews written appeals submitted by providers. The Committee reviews appeals submitted for provider liability issues only. The Committee reviews the circumstances and determines the disposition of the following types of appeals:
  - Timely Filing
  - Other Carrier
  - No Referral or Authorization
Date of Authorization Different Than Date of Service
Contract Dispute
Coding Issues
Other

To access the Provider Appeals Committee the provider must submit requests, in writing, along with supporting documentation, within 60 days of statement of remittance to:

Kaiser Permanente Provider Appeals
P.O. Box 372970
Denver, CO 80237

Denials Overturned – The provider will be notified via telephone, fax, or in writing of the outcome of the appeal and action taken by the Kaiser Permanente Appeals Unit.

Please contact the National Provider Contracting and Network Management department at the telephone number listed in the “Key Contacts” section of this Provider manual for examples of the Provider Appeal Form and the Provider Reconsideration Form.

Georgia:

The provider must first call Claims Services. In most cases they will be able to answer and resolve any issues you may have. The telephone number is listed in the “Key Contacts” section of this Provider Manual for specific telephone numbers.

If resubmission or reconsideration is being requested, the provider must send the claim(s) in dispute with either “resubmission” or “reconsideration” stamped or written on them.

If Customer Service is unable to resolve the dispute, a formal appeal must be submitted in writing within 60 calendar days from the date of payment or notice. They must include all necessary information and all supporting documentation. After submission the provider has the option of presenting the appeal in person, by teleconference, or videoconference. You may also designate a representative to act on your behalf.

The formal appeal must be sent to the Kaiser Permanente Appeals Unit. The submission of supporting clinical documentation is strongly encouraged. Provider appeal should be sent to:

Kaiser Permanente Appeals Unit
Claims Administration/GA
P.O. Box 190849 Atlanta, GA 31119-0849

A decision will be made within 180 days of receipt of the appeal request. You will be notified, in writing, by the Appeals Unit of their decision. Appeals that involve Medicare members will be resolved within 60 days.
Denials Upheld – The provider will be notified, in writing, by the Kaiser Permanente Appeals Unit with the rationale for the decision. If the Member is to be held financially liable, they will also receive a copy of the letter and instruction on any further appeal rights.

Denials Overturned – The provider will be notified, in writing, of the outcome of the appeal and action taken by the Kaiser Permanente Appeals Unit.

Once a decision has been made the provider’s appeal rights are exhausted unless additional documentation to support the appeal is supplied to Kaiser Permanente subsequent to the Appeal Unit’s decision.

Hawaii:

Disputes related to levels of payment, as well as timeliness of claims filing with Kaiser Permanente can be filed with Kaiser Permanente Hawaii Region Community Medical Services.

Disputes related to denials of coverage or payments are filed with the Regional Appeals Office. The dispute will be reviewed and resolved through the member appeals process following the rules defined by the member’s Kaiser Permanente plan. Specific filing and processing rules that apply to each plan type are described below. An appeal may not be filed unless a written initial denial notice has been issued by Kaiser Permanente. Instructions and contact information for filing an appeal are stated in the denial notice. Appeals that are not properly filed will be returned with filing instruction and not opened for review. A provider may bill a member directly once Kaiser Permanente has issued its denial.

The Customer Service Center (CSC) is the contact for questions regarding the appeals process before an appeal is filed. The CSC can be reached during normal business hours at the telephone number listed in the ‘Key Contacts’ section of this Provider Manual. Once an appeal has been filed, the Regional Appeals Office can be reached at the telephone number listed in the ‘Key Contacts’ section of this Provider Manual for assistance with questions.

Commercial (employer group and individual) Plan Members:

Appeals from providers must be filed in writing within 180 days of the date of the initial denial notice. Cases related to claims for payment (post-service appeals) are reviewed within 30 days from receipt of the request as a First Level appeal. Appeal rights to a Second Level review will be provided if payment continues to be denied.

Cases related to requests for a service or item not yet received (preservice appeals) are reviewed as quickly as the patient’s health requires but not longer than within 30 days from the date the appeal was received. Pre-service requests are processed through one internal level of review. Pre-service appeals submitted on behalf must be filed with the patient’s written authorization.

Kaiser Permanente Senior Advantage and Kaiser Permanente Medicare Cost Plan Members:
Appeals from provider must be filed with a signed appointment of representative statement from the member or the member’s authorized designee. Appeals must be filed in writing within 60 days of the date of the initial denial notice.

**Mid-Atlantic:**

- Providers who disagree with a decision may file a dispute notice. They must be filed within 180 days of the date of denial and/or the Explanation of Payment.
- A summary of the dispute(s), claim(s) number(s) at issue along with specific payment and/or adjustment information must accompany your dispute notice.
- The attachment of necessary supporting documentation, i.e., pertinent medical records, proof of timely filing, other insurance carrier explanation of payment and/or Medicare Summary Notice (MSN) is strongly recommended.
- All dispute requests must be received in writing and sent to:
  
  Kaiser Permanente  
  Attention: Provider Relations – Provider Dispute Resolution  
  Unit 2101 East Jefferson Street  
  Rockville, MD 20852

- Providers may also contact the Provider Relations department at the telephone number listed in the Key Contacts section of this Provider Manual.

**Northern California:**

- Providers who wish to file a written notice of dispute must submit it using a Provider Dispute Notice or any format preferred so long as it includes the appropriate information. All disputes must be received by Kaiser Permanente within 365 days after the action which led to the dispute. Please contact the National Provider Contracting and Network Management department at the telephone number listed in the “Key Contacts” section of this Provider Manual for a sample of the Provider Dispute Notice.
- The Provider Dispute Notice must contain the following information:
  
  - Provider’s name, National Provider Identifier (NPI) number, and contact information
  - If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item using the same number assigned to the original claim, the date of service and a clear explanation of the basis upon which the provider believes that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.
If the dispute is not about a claim, a clear explanation of the issue and the provider’s position on the issue.

If the dispute involves a member or a group of members, the name and Medical Record Number(s) of the member(s), a clear explanation of the disputed item, including the date of service and the provider’s position about the item.

If a provider is submitting a batch of disputes, they must be substantially similar, and they must have a numbering system that identifies each dispute contained in the bundled notice.

Kaiser Permanente will confirm receipt of the dispute within 15 working days after receipt.

Kaiser Permanente will issue a written determination of the dispute and the reasons for the determination within 45 working days of receipt of the Provider Dispute Notice by the Claims Administration Department, unless stated otherwise in this Provider Manual or the provider’s Agreement.

All written dispute notices must be sent to the address identified on the payment or denial remittance that is being disputed.

The provider may call the telephone number identified on the payment or denial remittance being disputed for information about the Provider Dispute Notice or general information regarding filing provider disputes related to billing issues.

Ohio:

If the provider office has questions or concerns regarding the way a particular claim was processed by Kaiser Permanente please contact the Network Development department (option #4) at the telephone numbers listed in the ‘Key Contacts section of this Provider Manual.

If the issue cannot be resolved through this initial contact the provider office will be instructed as follows:

Provider Appeals:

If the concern is determined to be a provider appeal issue, the provider will be advised to submit the concern in writing to:

Kaiser Permanente Appeals Unit
P.O. Box 93764
Cleveland, OH 44101-2884
Fax: 440 - 227- 4927

Appeal requests must be received within the same time frames as those that apply to the member appeals. The time frames are:
• Commercial Members (per the Department of Labor and the National Council for Quality Assurance [NCQA]) – within 180 calendar days of receipt of the initial adverse determination.
• Medicare Members (per the Center of Medicare and Medicaid Services [CMS]) – within 60 calendar days of receipt of the initial adverse determination.
• Federal Employee Members (per the Office of Personnel Management) – within 6 months of receipt of the initial adverse determination.

❖ All notifications will be in writing to the provider with a copy to the member when appropriate and will explain the basis for the claim payment appeals determination.

**Provider Payment Disputes**

❖ If the provider concern is determined to be a payment dispute issue the provider will be advised to submit their concern in writing to

  Kaiser Permanente  
P.O. Box 5316 Cleveland, OH 44111  
Attn: Payment Dispute Unit Fax #: 216 – 227 – 4927

❖ Payment disputes must be received within the same time frames as those that apply to appeals. The time frames are:

• Commercial Members (per the Department of Labor) and the National Council for Quality Assurance [NCQA]) – within 180 calendar days of receipt of the initial adverse determination.
• Medicare Members [per the Center of Medicare and Medicaid Services [CMS]) – within 60 calendar days of receipt of the initial adverse determination.
• Federal Employee Members (per the Office of Personnel Management) – within 6 months of receipt of the initial adverse determination.

❖ All notifications will be in writing to the provider with a copy to the member when appropriate, and will explain the basis for the provider payment dispute determination.

**Southern California:**

➢ Providers have 365 days from the date of the claim denial or payment to send Kaiser Permanente a written request for resolution for payment dispute. The request should include, at a minimum:

❖ Member name and Kaiser Permanente Medical Record Number
- Claim Number
- Kaiser Permanente Authorization Number
- Date of Service
- Explanation of What is Being Disputed
- Any Applicable Supporting Documentation
Please contact the National Provider Contracting and Network Management department at the telephone number listed in the “Key Contacts” section of this Provider Manual for a sample of the Provider Dispute Resolution Request form (single) and (multiple).

Completed forms should be sent to:
Kaiser Foundation Health Plan, Inc.
Provider Dispute Team
California Claims Administration
P.O. Box 7006
Downey, CA 90242

➢ Kaiser Permanente will send the provider a written acknowledgment of the dispute within 15 days of Kaiser Permanente’s receipt of the provider’s notification and will provide them with a written response to the dispute within 45 working days.

For Contract Disputes:

All disputes relating to the provider’s Agreement must be forwarded to the National Provider Contracting and Network Management department. Please find their telephone number in the “Key Contacts” section of this Provider Manual.