Kaiser Permanente QUEST Integration

Provider Manual
This Provider Manual is available to all Kaiser Permanente QUEST Integration providers in electronic version, unless the provider requests a hard copy. The Provider Manual is available at no charge.

The electronic version of the Provider Manual will be updated within five days of any changes. Kaiser Permanente QUEST Integration providers will be notified of changes made via email broadcast. Providers, and network providers making a request, will be notified in writing. Providers may also be notified of updates in the provider newsletter. All notifications will be available at no charge.
Aloha & Welcome

As a Practitioner with Kaiser Permanente Hawaii, you are part of a unique organization within the community. Our size and experience enable Kaiser Permanente to attract outstanding physicians and professional staff who provide our members with quality and compassionate care.

Kaiser Permanente is committed to preventing disease, promoting health, and serving our members by Caring for Hawaii’s People like Family. We take pride in the skills, experience and caring that our physicians and staff offer our members. Working as a team, our medical staff provides comprehensive, high quality medical care to more than 253,000 members statewide.

Our relationship with you is very important to us. Our goal is to provide you with the best quality support and communication as we continue our partnership. To help the relationship run smoothly, we present this manual to provide information about Kaiser Permanente. This manual is designed as a reference guide for you and your staff. The contents will be periodically updated as we continue to move forward to improve best practices in alignment with the National Committee for Quality Assurance (NCQA), and Federal and State regulatory agencies. In addition, we welcome your suggestions to support your needs. Please share this manual with your Admissions, Quality Assurance, Business Offices and any other appropriate staff. Feel free to place this manual on your computer systems for access by your departments. However, because it is copyrighted, please do not reproduce it.

Kaiser Permanente appreciates your willingness to work with Kaiser Permanente and looks forward to a continued valuable relationship. Thank you for your participation and should you need additional information or have any questions, please do not hesitate to contact the Provider Contracting and Relations staff at (808) 432-5429.
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Chapter 1: The Kaiser Permanente Medical Care Program

We hope the following overview of the Kaiser Permanente Medical Care Program will help you to understand the Kaiser Health Plan. We would like you to know some of Kaiser's history and philosophy and what makes them different.

Who Are We?

The Kaiser Permanente Medical Care Program is the nation's preeminent pre-paid health care plan. The program was formed as a non-profit health plan in response to the needs of the post-World War II San Francisco Bay Area community. Kaiser Permanente health plans provide and arrange health care services for more than 8.3 million* members nationwide.

Central to the program's philosophy is the independent role of Medical Group physicians. Physicians belong to one of the 8 Permanente Medical Groups plus 1 Group throughout the country. 12,012 full-time physicians representing all specialties and over 141,909 nonphysician employees serve members through dozens of Kaiser Permanente hospital centers, other community hospitals, and hundreds of medical office facilities. Kaiser Permanente differs from health insurance plans in that it actually provides or arranges the health care services it covers.

Kaiser Permanente's health benefits coverage, quality assurance programs, and pricing methods meet the standards and requirements of the federal HMO Act. Over 97% of Kaiser Permanente's revenues are applied directly to patient care and to building and expanding health care facilities.

Our Service Areas

Kaiser Permanente evolved from private industrial medical care programs during the 1930's and 1940's and opened enrollment to the public on the West Coast in 1945. Today, Kaiser Permanente serves the following eight states and the District of Columbia:

- California
- Colorado
- Georgia
- Hawaii
- Maryland
- Oregon
- Virginia
- Washington

Kaiser Permanente service areas are subject to change at any time.
**Our Medicaid Members**

Beginning in 1971, with 500 public assistance families under a contract with the Hawaii Department of Human Services called X5, Kaiser continued to provide services to families with low-to-moderate income not eligible for public assistance through federal and state contracts. In August 1994, Kaiser was one of the first health plans to participate in the Hawaii QUEST program. Effective January 2015, Kaiser became one of five health plans participating in the QUEST Integration program, which integrates the aged, blind, and disabled population into the prior QUEST program. The goal of the QUEST Integration program is to improve health outcomes by integrating programs and benefits, streamline care for members when health status changes, and to minimize the administrative burden on providers.

At Kaiser, we aim to not only increase access to care for the undeserved, but also to ensure these populations are afforded high-quality care. This is especially relevant for members whose multiple or high-risk conditions account for a larger share of medical services. We take pride in knowing that our members in these programs will have the same access and quality standards as commercial members.

**Our Structure**

Kaiser Permanente is a collaborative organization of three contractually linked organizations briefly described below. Joint decision-making by the professions of medicine and business management, including all significant Program policy, planning, and resource allocation decisions, enables Kaiser Permanente to continue its pursuit of excellence in care and services for its members.

The Kaiser Foundation Health Plan, Inc. (KFHP) is a nonprofit corporation with the responsibilities of marketing, benefit plan design, computation of rate structures, data collection and enrollment. It contracts with the Hawaii Permanente Medical Group, Inc. and Kaiser Foundation Hospitals to provide health care services to members.

Hawaii Permanente Medical Group, Inc. (HPMG) is a for-profit corporation of board-eligible and board-certified physicians representing all major specialties and most subspecialties. It contracts with Kaiser Foundation Health Plan, Inc. to provide care to members at Kaiser Permanente facilities. The contract with Kaiser Foundation Health Plan, Inc. helps physicians to focus their attention on the practice of medicine rather than devoting energy to administrative tasks and the acquisition of facilities and equipment.

Kaiser Foundation Hospitals (KFH) is the third component of the Kaiser Permanente Medical Care Program. It is a nonprofit corporation which provides hospital care, including room and board, nursing care and other standard services provided by a large community hospital.

Kaiser Permanente QUEST Integration: (808) 432-5330 or 1 (800) 651-2237 toll-free  
TTY: 1 (877) 447-5990/5991 toll-free  providers.kaiserpermanente.org

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Our Hawaii Service Area

The Hawaii Service Area of the Kaiser Permanente Medical Care Program began in 1958. It introduced the concept of a group practice prepayment plan to Hawaii's residents. Beginning with one medical center and 5,000 members, the Program now features the Moanalua Medical Center in addition to 19 convenient medical office locations on the islands of Oahu, Maui, Hawaii and Kauai. Services provided on the island of Kauai consist of contracts with independent primary and specialty practitioners including specialty care at the Kauai Medical Clinic. Kaiser Permanente currently owns and operates a 275+ bed inpatient facility, and a skilled nursing care facility at the Moanalua Medical Center on Oahu.

Our Medical Group’s Values Statement

The Hawaii Permanente Medical Group ("HPMG") seeks associate physicians who support and promote Kaiser Permanente's mission of providing quality care and comprehensive medical services in an accessible, cost-effective manner for members. In addition, the HPMG Board of Directors has identified professional and personal values that enhance individual and collective medical practice. The following are our core values.

The characteristics of professional competency, integrity, flexibility, reliability, compassionate caring, and a striving for excellence are core values necessary for our associates. Furthermore, we value good-natured team players who are approachable by colleagues and staff. We expect our associates to be hardworking professionals capable of an innovative approach to solving problems, who make efficient use of time and resources. We expect our associates to maintain a professionally appropriate appearance. And we expect a professionally appropriate attitude that embraces and accepts cultural diversity, excluding bigotry and prejudice.

We value individuals who are responsive to constructive criticism and demonstrate courtesy and respect to fellow workers as well as patients. We place value on quality work with consistent standards. It is important for Kaiser Permanente to recognize professional limitations in forming the boundaries of work, matching competence with confidence.

We seek associates who will actively assist the organization to function efficiently and effectively. Our strength comes from a shared sense of responsibility for the Medical Group and from our collective talents as medical professionals. Finally, we believe that along with hard work, we seek to achieve a balance between a satisfying career and a fulfilling personal life.
Chapter 2: Contact Information

Kaiser Permanente appreciates your willingness to work with Kaiser Permanente in providing quality care to our Members. The Hawaii Kaiser Permanente Provider Contracting and Relations Department is committed to providing support to you and your staff which includes contractual and operational questions.

Should you need additional information or have any questions, please do not hesitate to contact the Provider Contracting and Relations department. Other contact numbers are listed below:

<table>
<thead>
<tr>
<th>Contact Numbers</th>
<th>Mon- Fri., except State holidays 7:45am-4:30pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information/ assistance (Facilities &amp; non-Physicians)</td>
<td>(808) 432-5658  (808) 432-5777, ext. 1369, ext. 1365 or ext. 1373</td>
</tr>
<tr>
<td>General information/ assistance (Physicians)</td>
<td>(808) 432-5897</td>
</tr>
<tr>
<td>Assistance with QUEST Integration Service Coordination</td>
<td>Kaiser Permanente QUEST Integration Provider Call Center (808)432-5330 (Oahu)/ 1-800-651-2237 (toll-free) or by TTY 1-877-447-5990</td>
</tr>
<tr>
<td>Questions regarding bills or payment status</td>
<td>Community Medical Services Representative (808) 432-5330 (Oahu) (800) 651-2237 (toll-free) (808) 432-5433 (facsimile)</td>
</tr>
<tr>
<td>Routine transfers</td>
<td>Transfer Coordinators (808) 432-7252 (808) 432-7250 – after hours Fax: (808) 432-7251</td>
</tr>
<tr>
<td>Emergency transfers to Kaiser Permanente Moanalua Medical Center &amp; routine transfers after clinic hours</td>
<td>Emergency Hotline (808) 432-7038</td>
</tr>
<tr>
<td>Questions regarding out of plan services and authorization</td>
<td>Authorization and Referrals Management (808) 432-5687 (808) 432-5691 (facsimile)</td>
</tr>
<tr>
<td>Questions regarding the QUEST Integration program</td>
<td>Kaiser Permanente QUEST Integration Call Center (808) 432-5330 or toll-free at 1-800-651-2237</td>
</tr>
</tbody>
</table>
Chapter 3: Membership Identification Card

When enrollment forms have been processed, the Kaiser Foundation Health Plan sends each new member a permanent membership card (example below). The card displays the member's medical record number which is used for identification.

The QUEST Integration identification card has additional information required by DHS:

- Member’s Kaiser Permanente Member Identification Number
- Member’s name
- Effective date of member’s Kaiser Permanente QUEST Integration coverage
- Primary clinic name and telephone number
- Third Party Liability (TPL) information
- QUEST Integration Call Center telephone number
- After Hours Advice Line telephone number

How to use the identification cards:

Members should show their Kaiser Permanente identification card and photo ID when they need medical care or services. Even if they do not have their card, we can still verify coverage in our membership system as long as they bring a photo ID. Members should only use their cards when they have maintained their Kaiser Permanente membership, and they should never let anyone else use their cards.
Chapter 4: Member Rights and Responsibilities

All Kaiser Permanente QUEST Integration members are sent a handbook with information about their rights and responsibilities.

Member Rights and Responsibilities

Member Rights

As a person using our services, a member has specific rights regardless of age, cultural background, gender, gender identity, sexual orientation, financial status, national origin, race, religion, or disability.

For detailed information about member rights to privacy, please refer to Notice of Privacy Practices. A member can find the Notice of Privacy Practices on our Web site at [kaiserpermanente.org](http://kaiserpermanente.org), or contact our Customer Service Center at 432-5955 (Oahu) or 1-800966-5955 (Neighbor Islands).

A member has the right to:

- Receive information about Kaiser Permanente, our services, our health care practitioners and providers, and his/her rights and responsibilities.
- Get information about the people who provide health care including their names, professional status, and board certification.
- Be treated with consideration, compassion, and respect taking into account his/her dignity and individuality, including privacy in treatment and care.
- Be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.
- Make decisions about his/her medical care. This includes advance directives to have life-prolonging medical or surgical treatment given, ended, or stopped, withholding resuscitative services, and care at the end of life. The member has the right to assign another person to make health care decisions for him/her, to the extent allowed by law.
- Discuss all medically necessary treatment options, regardless of cost or benefit coverage.
- Voice his/her complaints freely without fear of discrimination or retaliation. If the member is not satisfied with how his/her complaint was handled, the member may have us reconsider his/her complaint.
- Make recommendations regarding Kaiser Permanente's Member Rights and Responsibilities statement.
• Be involved and include his/her family in the planning of his/her medical care. The member has the right to be informed of the risks, benefits, and consequences of his/her actions.

• The member may refuse to participate in research, investigation and clinical trials.

• Refuse care, treatment and services.

• Choose his/her primary care physician, change his/her primary care physician, or obtain a second opinion within Kaiser Permanente. The member also has the right to consult with a non-Plan doctor at his/her own expense.

• Have direct access to a practitioner of women’s health services to ensure continuing care.

• Find out about his/her care. Have the right to talk it over with his/her doctor. Talk with the doctor about his/her medical condition. Discuss the diagnosis. Discuss what kind of treatment is available. The member may discuss alternatives to treatment. The member have a right to have these presented in a way that is appropriate to his/her condition and ability to understand.

• Have an interpreter for his/her language. The member have a right to have an interpreter when needed to understand his/her care and services.

• Be involved in considering ethical issues. The member has the right to contact our Bioethics Committee for help in resolving ethical, legal, and moral matters relating to his/her care

• Be informed of the relationship between Kaiser Permanente and other health care programs, providers, and schools.

• Be informed about how new technologies are evaluated in relation to benefit coverage.

• Receive the medical information and education he/she needs to participate in his/her health care.

• Give informed consent before the start of any procedure or treatment.

• Give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his / her own care.

• Have access to medically necessary services and treatment, including emergency treatment, and covered benefits, in a timely and fair way. Services should not be arbitrarily denied or reduced in amount, duration or scope because of diagnosis, type of illness, or condition.

• Receive services in a coordinated manner. The PCP is in charge of the member’s medical care. He or she treats the member, refers the member to specialists when needed, and connects the member to all of his/her services. The doctor will work with the member to help the member meet his/her health goals so that the member can live well.
- Have Kaiser Permanente consider and respect the member’s needs. We respect the member’s cultural and spiritual needs. We respect the member’s psychological and social needs.

- Have privacy and confidentiality for all discussion and records of the member’s care. We will protect the member’s confidentiality. The member or a person the member choose can ask for the member’s medical records. The member can see the records or get a copy. The member can ask to amend or correct them, within the limits of the law. In addition, the member have the right to limit, restrict or prevent disclosure of protected health information.

- Be treated in a safe, secure, and clean environment. Be free from physical and chemical restraints. Exception: these can only be used when ordered by a doctor, or in the case of an emergency. Even then, they can only be used when needed to protect the member or others from injury.

- Get appropriate and effective pain management. Get it as an important part of the member’s care plan.

- Get an explanation of the member’s bill and benefits. The member have this right regardless of how the member pay. The member have the right to know about our available services, referral procedures, and costs.

- Get other information and services. These are things required by various state or federal programs.

- When appropriate, be told about the outcomes of care. That includes outcomes that were not expected.

- Discuss “do not resuscitate” wishes or advance directive instructions for health care with the member’s surgeon and anesthesiologist prior to an operative procedure when the member wish to have the “do not resuscitate” honored in the event of a life-threatening emergency during an operative procedure.

- Medicaid patients receiving services, including in the Ambulatory Surgery Center, who wish to file a complaint or voice a concern may contact the Medicaid Ombudsman, our Ombudsman Hotline at 808-692-8101. Medicare patients may contact the Office of the Medicare Beneficiary Ombudsman at www.medicare.gov.

- The patient receiving services in the Ambulatory Surgery Center may also contact Accreditation Association for Ambulatory Health Care; 5250 Old Orchard Road, Suite 200, Skokie, IL 60077. Tel: 847-853-6060, Fax: 847-853-9028, or by email: info@aaahc.org.

- Be informed about 432E HRS Patient’s Bill of Rights and Responsibilities.

- Be included in development of a service/treatment plan.

- Only be responsible for cost sharing in accordance with 42CFR Section 447.50.
Member Responsibilities

As a partner in his/her health care, the member has the following responsibilities:

- **Give Kaiser Permanente correct and complete information** about the member’s health. Tell Kaiser Permanente about the medical conditions the member have now. Tell Kaiser Permanente about the medical conditions the member had in the past.

- **Follow the treatment plan. The member** and the member’s health care practitioner agreed on the plan. Tell them if the member do not understand or cannot follow through with the member’s treatment.

- **Understand his/her health problems.** As much as possible, work with the practitioner to come up with treatment goals the member and they can agree on.

- **Tell Kaiser Permanente who the member are.** Use his/her Kaiser Permanente identification card the way it’s supposed to be used.

- **Cooperate with our staff.** Help Kaiser Permanente diagnose and treat his/her illness or condition properly.

- **Keep appointments.** If the member cannot keep them, cancel them in a timely manner.

- **Know the plan benefits.** Know the member’s plan. Know the member’s plan limits.

- **Sign a release form.** If the member choose not to follow the recommended treatment or procedures, we will provide the member with adequate information to make an informed decision and will ask the member to sign a release form.

- **Realize the effects lifestyle has on health.** Understand that decisions the member make in his/her daily life, such as smoking, can affect his/her health.

- **Be considerate of others.** Respect the rights and feelings of the staff. Respect the privacy of other patients.

- **Don’t make a disturbance.** Don’t disrupt our operations and administration. Cooperate with staff. That way we can continue what we’re doing for other patients.

- **Follow all hospital, clinic, and health plan rules and regulations.** Respect hospital visiting hours.

- **Cooperate** in the proper processing of third-party payments.

- **Tell Kaiser Permanente** when the member or his/her covered dependents change addresses.

- **Be responsible for his/her actions.** If the member refuse treatment, do not follow instructions, and if his/her actions or behavior interfere with facility and/or patient care, his/her care may be rescheduled. Should his/her medical condition change, the treatment plan may be modified.
• **For Ambulatory Surgery Center (ASC) patients**: Arrange for a responsible adult to take the member home and stay with the member for 24 hours, if required by his/her doctor.

**Hospital patient rights and responsibilities**

As a person using our services, the member have specific rights. These rights are the members’, regardless of:

- age
- cultural background
- gender
- gender identity
- sexual orientation
- financial status
- national origin
- race
- religion
- disability

As a patient in the Moanalua Medical Center members have the right to:

- **Know his/her rights and responsibilities.** We’ll give the member the information when the member become a hospital patient.

- **Have proper discharge from the hospital or transfer to another.** This may be for his/her welfare. It may be for another patients’ welfare. It may be for other causes as determined by his/her doctor. The member have a right to have reasonable advance notice. The member have a right to have discharge planning. Qualified hospital staff will make sure the member get the right care in the right place when the member get out of the hospital.

- **Ask for a visit by clergy** at any time. The member have a right to take part in social and religious activities. The member may do this unless it harms the rights of other patients or would hurt his/her medical care.

- **Get and use his/her own clothes and things** as space permits. The member may do this unless it harms the rights of other patients, violates our safety practices, or would hurt his/her medical care.

- **Give informed consent** before the start of any recording, films, or other images for purposes of nonpatient care.

- **Access protective and advocacy services.**

- **Get appropriate educational services.** The member need these when a child or adolescent patient’s treatment requires a significant absence from school.
- Be protected from requests to perform services for Kaiser Foundation Hospital. The member don’t need to do things that are not included for therapeutic purposes in his/her plan of care.

- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation. Federal regulations limit the use of restraints and seclusion.

- Receive visitors of his/her choice including a spouse, domestic partner, family member, or friend. All or certain visits may be excluded at his/her request or discretion of staff, physicians, or administration to allow for his/her and other’s rights, safety or well-being.

- File a complaint in the hospital, either verbally or in writing with the department manager or supervisor. If the member are not satisfied with the response, please contact Hospital Administration. They are located on the first floor of the hospital. Or call the operator at 808-432-0000 and ask for them. If the concern cannot be resolved by the hospital, the member may contact The Joint Commission by phone, mail, fax, or email. Phone: Toll free U.S., weekdays 8:30 a.m.–5 p.m. Central time, 1-800-994-6610. Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Fax: 630-792-5636. Email: complaint@jointcommission.org.

As a QUEST Integration member, the member have the following additional rights and responsibilities.

You have a right:

- Not to pay for our debts if we go broke.
- Not to pay for services if the state doesn’t pay us.
- Not to pay for covered services if we or the state do not pay the doctor or the person who gave the member the service.
- To receive covered services outside of Kaiser Permanente (under a contract, referral or other arrangement) if we are unable to provide the service for the member and for as long as we are unable to provide it. The member will not have to pay more than if we provided the services directly.
- To get direct access to a specialist through a standing referral for the same condition, if the specialist treated the member before and the member have special health care needs. Special health care needs are determined by an appropriate health care professional.
- To receive information on available treatment options and alternatives in a way that the member can easily understand and in a manner that takes into consideration his/her special needs.
- Freely exercise his/her rights, including those related to filing a grievance or appeal. Exercising those rights do not negatively affect the way we treat the member.
• To receive all written materials in an easily understood language and format.
• Receive services according to appointment waiting time standards.
• Receive services in a culturally competent manner.
• Receive services in a coordinated manner.

You must tell DHS and Kaiser Permanente when there are any of these changes in his/her family:
• Death in the family (recipient, spouse, dependent)
• Birth
• Adoption
• Marriage
• Divorce
• Change in health condition (such as pregnancy or permanent disability)
• Change of address
• Institutionalization (such as nursing home, state mental health hospital or prison)

Also, the member must notify Kaiser Permanente if:
• Some other person, organization or program needs to pay for his/her care (such as no-fault insurance for a car accident, or workers’ compensation for an injury on the job)
• You will need continuing medical care while visiting another island
• You are going to be away from home for more than 90 calendar days
• Please report the above information to Kaiser Permanente at 808-432-5330 or toll free at 1-800-651-2237 or 711 (TTY).

**Member Inquiry and Grievances Process**

Definitions

• **Action:**
  1. The denial or limited authorization of a requested service, including the type or level of service.
  2. The reduction, suspension, or termination of a previously authorized service.
  3. The denial, in whole or in part, of payment for a service.
  4. The failure to provide services in a timely manner as defined by the State of Hawaii.
  5. The failure of the health plan to act within prescribed timeframes

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6. For a rural area member or for islands with only one contractor or limited providers, the denial of a member’s request to obtain services outside the network:

   a) From any other provider (in terms of training, experience, and specialization) not available within the network.
   
   b) From a provider not part of the network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days; however, KP is still responsible for reimbursement for the services the provider rendered.
   
   c) Because the only plan or provider available does not provide the service because of moral or religious objections.
   
   d) Because the member’s provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network.
   

- **Authorized Customer Feedback System (CFS) User**: Staff members who are granted access to and authorized to use the CFS system.

- **Clinical Urgency**: A situation which could jeopardize the life or health of the member or the member’s ability to regain maximum function.

- **Customer Feedback System**: The electronic database system used for the recording, documentation, and tracking of customer concerns and denials.

- **Grievance**: An expression of dissatisfaction from a member, member’s representative, or a provider, with written consent, on behalf of member, about any matter other than an action, as “action” is defined above. Examples of issues that will be resolved through the grievance process include quality of care issues, waiting times in physician offices and rude or unresponsive physician or staff and failure to respect enrollee’s rights. Standard disposition of a grievance and notice to the affected parties may not exceed 30 days from the date the grievance is received.

- **Inquiry**: A question regarding any aspect of the Health Plan’s or Provider’s operations, activities or behavior or to request disenrollment but does not express dissatisfaction.

- **Local Accountable Group**: The organizational entity responsible for the delivery of quality patient care and member service and response to any customer concerns with that care and service.

- **Organization determination**: an initial decision by Health Plan to pay or deny a request for payment or coverage of a service or item.

- **Sentinel Event**: an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. The phrase “or the risk thereof” includes any process

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variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response. The terms sentinel event and medical error are not synonymous; not all sentinel events occur because of error and not all errors result in sentinel events. A distinction is made between an adverse outcome that is primarily related to the natural course of the patient’s illness or underlying condition, and a death or major permanent loss of function that is associated with the treatment or lack of treatment of that condition, or otherwise not primarily related to the natural course of the patient’s illness or underlying condition. Kaiser Permanente sentinel events are inclusive of all Joint Commission Sentinel Events.

General Requirements for Member Inquiries and Grievances

- Members may designate a representative or provider to make an inquiry or file a grievance on their behalf and may request a State administrative hearing.
- Members may provide verbal consent for Kaiser Permanente staff to interact with the authorized representative or provider. The member’s designation will be documented in the applicable Kaiser Permanente system when consent from the member is provided verbally.
- Members will be provided with any reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers with TTD and interpreter capability.
- The Kaiser Permanente systems used to record, and track inquiry and grievance information contain protected member demographic and medical care information. System users will handle this information in strictest confidentiality in accordance with Regional Policy 6226-06-01 “Regional Confidentiality and Security of Information” and MQD-RFP-2014-005.
- Members may submit an inquiry or file a grievance by calling 432-5955 or toll-free at 1-800-966-5955, or by TTY at 1-877-447-5990. Members may also write to Kaiser Permanente at:

  Kaiser Foundation Health Plan, Inc.
  Customer Service Center
  711 Kapiolani Blvd.,
  Honolulu, HI  96813

Member Inquiry Process

All member oral or written inquiries will be addressed and provided a response in a timely manner.

- All member inquiries will be entered into the MACESS tracking system.
- If at any time during the inquiry process (written or telephone request), the member expresses a complaint of any kind, the inquiry then becomes a grievance or appeal and the member will be given his/her grievance and/or appeal rights, as applicable.

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Member Grievance Process

If members are unhappy with Kaiser Permanente, they may file a grievance or have a representative or a provider file the grievance for them. They can ask anyone at Kaiser Permanente to send it to Member Services or mail it to: Member Services, Kaiser Permanente, 711 Kapiolani Boulevard, Honolulu, HI 96813. If they would like someone to help write the grievance, or they want to file their grievance by telephone, call the QUEST Integration Call Center at 808-432-5330, toll free at 1-800-651-2237, or 711 (TTY).

A letter will be sent to the member within five business days to let them know that we have received the member’s grievance. We will send it to the supervisor of the area they wrote or called about. That person will answer the grievance within 30 calendar days from when it was received.

If the member received KP’s answer, but they are still not satisfied, the member may ask for a state grievance review from the State of Hawaii’s Department of Human Services Med-QUEST Division. The member must call or write to Med-QUEST within 30 days of getting the member’s answer from Kaiser Permanente. If the member do not do this, the member’s complaint will be considered resolved.

To ask for a State grievance review, call the Med-QUEST Division at 808-692-8094. Or mail a request to:

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190

Med-QUEST will review the member’s complaint. They will decide on it within 90 calendar days from getting the member’s request. Their decision will be final.

Filing a claim

How to file a claim for payment

If the member receive medical care outside of Kaiser Permanente, the member may submit a claim with us. We review each claim to decide if we will pay. We look to see if the member’s care was referred by us. We will see whether it was medically needed emergency care or urgent care. If we approve the member’s claim, we will pay according to the member’s plan benefits.
If the member have questions relating to filing a claim, please contact the QUEST Integration Call Center at 432-5330 or toll free at 1-800-651-2237. If the member have questions about a claim already submitted, please call Claims Administration toll free at 1-877-875-3805.

The member may have someone file the claim on their behalf. If the member chooses to do this, the member must name this person in writing and state who is authorized to file the claim for the member. Both the member and the member’s representative must sign this statement, unless the person is the member’s attorney. When necessary, the member’s representative will have access to medical information about the member that relates to the request. If the member prefer, the member may call our QUEST Integration Call Center at 432-5330 or toll free at 1-800-651-2237 to request a form.

**Appeals**

Did Kaiser Permanente health plan or the member’s doctor refuse an item or service the member asked for? If the member do not agree with a decision that was made about the services the member are getting, or want to get, the member may ask for a review of an adverse benefit determination taken by Kaiser Permanente for the member’s medical care. Some of the other reasons the member may want to file an appeal are if we stopped care that we already approved; if the member don’t get care when the member need it; if we don’t give the member an answer to a grievance or an appeal that the member already filed by the time we’re supposed to; or if we can’t provide the member with a medically necessary covered service within Kaiser Permanente and we don’t authorize coverage for that service outside Kaiser Permanente. If the member provide the member’s written consent, providers may file an appeal on the member’s behalf if we deny coverage of a service.

After the member get a denial notice or Notice of Adverse Benefit Determination, the member have 60 calendar days to make the member’s appeal. Appeals must be made in writing. The member may make an appeal orally, but if the member file an oral appeal, then the member must follow up in writing with a signed appeal. The member may ask Kaiser Permanente or someone else to help the member write the member’s appeal. If the member would like help to write the member’s appeal, call the QUEST Integration Call Center at 808-432-5330, toll free at 1-800-651-2237, or 711 (TTY). The member may also request an interpreter to help the member through this process.

Only the member or someone with the member’s permission may make an appeal. If the member gives someone else permission to make an appeal on their behalf, the member can let Kaiser Permanente know by sending Kaiser Permanente a letter or by calling 808-432-5330, toll-free at 1-800-651-2237 or 711 (TTY). If the member lets Kaiser Permanente know by phone, the member must also send a letter confirming that the member is giving another person permission to make an appeal for them. The member’s letter must have the name of the person authorization for that person to file an appeal for the member. The member and authorized person must both
sign and date the letter. When necessary, the member’s representative may have access to medical information about the member that relates to the request.

Send the member’s appeal to:

Kaiser Foundation Health Plan Inc.
Attn: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813

You may fax the member’s appeal to 808-432-5260 or send it by email at KPHawaii.Appeals@kp.org. The member may also contact the QUEST Integration Call Center at 808-432-5330, toll free at 1-800-651-2237 or 711 (TTY).

We will write to the member within five business days to say we got the member’s appeal. The member will have a chance to present evidence and to argue facts or law if the member want to. The member may do this in person or in writing. The member or the member’s representative may examine the case file. The case file may have medical records and any other papers and records that we will look at during the appeals process. The member may give Kaiser Permanente written comments, papers, medical records, or other information to consider. We will review the case and give the member a written decision within 30 calendar days. We may take up to 14 more calendar days if the member ask Kaiser Permanente to or if we need more information and it would be in the member’s best interest if we had more time before deciding. If the member didn’t ask for the delay, we will make reasonable efforts to give the member prompt oral notice of the delay. We will also send the member a letter to explain why we need extra time within 2 calendar days. Then we will inform the member of the member’s right to file a grievance if the member disagree with our decision.

**Expedited review**

Sometimes we must review the member’s appeal more quickly. When we receive the member’s appeal, we will decide if taking the regular amount of time to review it could mean a danger to the member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function. If we or the person who treats the member finds that it could, we will use a faster process. We call it an expedited review of the member’s appeal. It’s the same as the regular one except:

If the member ask for it orally the member don’t have to follow it up in writing

We must ensure that the person who treats the member won’t be punished for helping the member ask for the faster appeal

We must decide the member’s appeal as fast as needed for the member’s condition. We can’t take more than 72 hours from when we receive the member’s appeal. We may take up to 14 more calendar days if the member ask Kaiser Permanente to or if we show that we need more information and that it would help the member if we waited for it. If the member didn’t ask for
the delay, we will make reasonable efforts to give the member prompt oral notice of the delay. We will also send the member a letter explaining why the delay is needed within 2 calendar days.

If we say no to the member’s request for an expedited review, here is what we must do:

Transfer the member’s appeal to the regular appeal process

Make reasonable efforts to tell the member orally what we have done

Tell the member in writing within two calendar days from when we received the member’s appeal the reason the decision to extend the timeframe or deny a request for expedited resolution of an appeal

Resolve the appeal as expeditiously as the member’s health condition requires and no later than the date the extension expires.

If we said no to the member’s request for an expedited appeal, and the member is unhappy about it, the member may file a grievance with us.

**External review**

**DHS administrative hearing**

If the member have gone through Kaiser Permanente’s appeal process and are not happy with the decision, we made about the member’s appeal the member can ask DHS for an administrative hearing. Write to the Administrative Appeals Office (AAO) of DHS. The AAO must receive the member’s letter within 120 calendar days from when the member got Kaiser Permanente’s answer about the member’s appeal. Include information: any statements of fact or laws to support the member’s request. Send the member’s appeal to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

There is no cost to receive copies of the appeal file. The member have the right to name someone to file the appeal for the member. The member must name that person in writing when the member send the member’s appeal. The member may represent himself/herself at the hearing or the member may have a lawyer, a relative, a friend, or someone else there to speak on their behalf. The member will receive a decision within 90 calendar days from the date they received the member’s request. We must follow the decision of the DHS administrative hearing. The member must go through Kaiser Permanente’s appeal process first before asking for a DHS administrative hearing.

The member or the member’s approved representative, is considered to have used up Kaiser Permanente’s grievance and appeal process if Kaiser Permanente does not follow the notice and
timing requirements set by Med-QUEST Division of DHS. When this happens, the member have the right to file for a State administrative hearing.

**Expedited DHS administrative hearing**

If the member had an expedited review of the member’s appeal with us, and it didn’t go the way the member wanted it to, then the member may ask DHS for an expedited administrative hearing. The member must submit the member’s letter to the AAO within 120 calendar days of getting the member’s answer from Kaiser Permanente about the member’s appeal. An expedited administrative hearing needs to be reviewed and decided upon within three business days from when the member’s request was filed.

**Receiving benefits during the appeals process or DHS administrative hearing**

If we told the member that we are going to reduce, delay or stop anything that we already approved, the member have the right to still get those services during the appeals process or state administrative hearing process. For that to happen the member must file the member’s appeal and ask Kaiser Permanente to continue the member’s benefits in a timely manner. This means within 10 calendar days of getting the denial notice or Notice of Adverse Benefit Determination, or before the date that the service is going to be reduced, delayed, or stopped. The services the member are asking to be continued must have been approved by an authorized provider within the time period covered by the original authorization.

If the member’s benefits are continued during the appeal or administrative hearing process, it will be provided until one of the following happens:

- You withdraw the member’s appeal
- You don’t request a DHS administrative hearing within 10 calendar days of getting the denial notice or Notice of Adverse Benefit Determination from us
- The DHS administrative hearing does not decide in the member’s favor

If Kaiser Permanente or DHS do not decide in the member’s favor, the member will have to pay for the services that the member requested to be continued during the appeal process.
Medicaid ombudsman program

The State of Hawaii Department of Human Services (DHS) oversees the Medicaid ombudsman program. our Ombudsman Hotline at 808-692-8101

Access to Care Standards

Kaiser Permanente consistently maintains a sufficient number of providers to service our members. Our providers must adhere to the following QUEST Integration program wait time standards and geo access standards to ensure timely access to care and services:

- Immediate care without prior approval for emergencies
- Within 24 hours for urgent care
- Within 24 hours for PCP pediatric sick visits
- Within 72 hours for PCP adult sick visits
- Within 21 days for PCP routine visits
- Within 21 days for routine behavioral health visits
- Within 4 weeks for visits with a specialist
- Within 4 weeks for non-emergency hospital stays

Interpreter/translation services

Kaiser Permanente offers interpreter services at no charge. If a member needs an interpreter during a doctor visit, let Kaiser Permanente know by calling our Customer Service Center at 808-432-5955 (Oahu) or (toll-free) 1-800-966-5955 (Neighbor Islands). A Customer Service representative may provide an interpreter over the phone or arrange for one in person. Members who are deaf, hard of hearing, or speech impaired may call toll free 1-877-447-5990 (TTY).

If members need information in a different language or format (including large print or Braille), call the QUEST Integration Call Center at 432-5330 or toll-free at 1-800-651-2237 for assistance.

Advance Directives for Health Care

Practitioners are encouraged to inform each adult member of his/her right to make advance medical decisions according to the Federal Patient Self-Determination Act of 1990, and Hawaii Revised Statutes, Section 327D. The purpose of the Act is to protect each adult patient's right to participate in health care decision-making to the maximum extent of his/her ability and to prevent discrimination based on whether the member has executed an advance directive for health care.
When a member provides an advance directive, an entry should be made in the medical record.

**Cultural Competency Plan**

Kaiser Permanente Hawaii Region’s mission is to provide high quality affordable health care services and to improve the health of our members and the communities we serve. Delivering on this mission includes providing care in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Kaiser members have the right to receive information in a language and manner that can be easily understood. Communicating effectively with limited English speaking patients or non-English speaking patients plays a large role in ensuring the quality of and compliance with care provided to members.

The Kaiser Permanente Hawaii Region’s Cultural Competency Plan is available to providers upon request at no charge.

**Chapter 5: Provider Rights and Responsibilities**

**Provider Requirements**

**Role and responsibility**

- To be employed by Kaiser Permanente, these practitioners are required to have active licensure in the State of Hawaii. Licensure status is reviewed by the Credentials and Privileges committee. PCPs have the responsibility for supervising, coordinating, and providing initial and primary care to the member, initiating and coordinating both internal and outside referrals for specialty care and maintaining the continuity of the member’s health care and medical record.

Kaiser defines a PCP as a MD or DO who is a board certified/eligible internist, family practitioner, or pediatrician. The definition does not include the other providers (general practitioner, OB/Gyn, APRN, PA) in the QUEST Integration RFP, in part because there are no access issues preventing each QUEST Integration member from linking with an internist, family practitioner, geriatrician, or pediatrician. In addition, women (pregnant or non-pregnant) also have open access to an obstetrician/gynecologist and to see their OB/Gyn regularly. However, each member also has access to primary care services.
• Certain members may also have regular specialty care, linked to a specialist for a particular chronic condition. However, in addition, the member would also have a primary care physician who would work closely with the specialist. Kaiser’s physician assistants and nurse practitioners generally work in specialty areas, so do not provide primary care.

**PCP Selection and Change**

• In the event that a member does not choose a PCP within 10 calendar days, or chooses to give up an existing assigned PCP, or chooses not to have a person as a PCP, they are linked to a clinic, which may then serve as a PCP for the patient. This is made possible by the group practice nature of Kaiser Permanente. Since staffing models at Kaiser Permanente are applied at a clinic and area level, adequate coverage for clinic assigned patients is assured. Primary care physicians in the particular clinic will serve the needs of the member and ensure individual treatment plans are developed and carried out.

• The member can select a PCP and change PCP at any time and for any reason. They may notify any staff member at any clinic in person for assistance. They may contact the QUEST Integration office, notify Kaiser Permanente in person, by regular mail, by email, or may also change their PCP online. A message is sent to the business office to initiate the change of PCP process. This may be done by email or directly through Health Connect. PCP changes become effective the following business day.

• Biography cards with information about PCPs accepting new patients help members make more informed PCP choices. These cards are available at all clinic check-in locations. These biographies are also available online.

• In the event that a PCP is unable to fulfill their responsibilities to the member, the physician, patient or QUEST Integration staff member/manager will inform the QUEST Integration Medical Director, who will assess the situation, and if necessary, develop an action plan to transition the member to another PCP. If the original PCP is unable to provide continued care to the member during the transition period, medical staff at the clinic of record will provide care for the member until the transition to the new PCP is complete. At any time, if the member’s health or safety is in jeopardy, the member will be immediately transferred to another PCP, health plan, or provider.

• On Maui and Oahu, all PCPs are members of Hawaii Permanente Medical Group. When a PCP terminates from Kaiser, a letter is sent to the member and the member is assigned to another physician taking over the PCP’s panel or to a new PCP of the member’s choosing. However, during the interim, the member is automatically cared for by the other physicians in the health care team and/or the clinic to ensure of care.
PCP Monitoring

- PCP performance is monitored and supported at many levels: (1) QUEST Integration reporting criteria, (2) teams of practitioners monitoring high risk or high volume concerns like abnormal mammograms, positive fecal occult blood, diabetic foot screening, etc., (3) periodic monitoring of patient and peer surveys, and (4) direct observation by the clinic and professional chiefs.

- Health Connect, our electronic medical record also supports PCPs and assists in monitoring their performance by: (1) the Panel Support Tool and “How Are We Doing” – data bases addressing issues of prevention, monitoring, and efficacy of care – that are directly accessible from the patients file, (2) the record itself is formatted to automatically document the necessary and appropriate medical information, assuring a complete, clear and compliant document that meets appropriate medical record standards, (3) internal and external referrals may be placed real time to minimize barriers to referral, and (4) allowing all providers access to the complete medical record, simplifying continuity of care.

- Aside from the routine monitoring of PCP performance through the professional chiefs and clinic chiefs, the QUEST Integration program also monitors performance through regular reports on utilization, quality, and grievances/complaints, among others.

Provider Access

- As with any Kaiser member, QUEST Integration female members have direct access to Kaiser Permanente gynecology services without the need for a referral.

- The QUEST Integration Manager monitors the number of QUEST Integration members assigned to each PCP through a regularly produced report to maintain an overall ratio of less than or equal to 1 PCP to 300 QUEST Integration members. This information is also directly provided to DHS as described in QUEST Integration RFP Section 51.520.3. If the average PCP to member ratio exceeds 1:300, the QUEST Integration Manager will inform the QUEST Integration Medical Director who will assess and, if necessary, develop corrective action which shall include discontinuation of auto assignment of new QUEST Integration members who have exceeded the 1:300 ratio. Members, however, may continue to select PCPs who have exceeded the 1 to 300 ratio as long as their absolute panel size recommendations are not exceeded. No restrictions of auto-assignment are applied to clinics serving as PCPs.
Hospitalists

- Most Kaiser Permanente PCPs do not hospitalize their own patients. When admitted to the hospital, the member is automatically transferred to the care of an appropriate hospitalist or specialist that is with Kaiser Permanente at either Moanalua Medical Center on Oahu or Maui Memorial Hospital. The staff is hired specifically to provide these services. The PCP is notified of both the admission and the discharge and has immediate access to the information about the hospital stay through the Health Connect medical record. Members are scheduled for an outpatient follow-up with the PCP post hospital discharge within a week. Members at contracted hospitals are also managed by the facility’s hospitalist.

In the event that a PCP is unable to fulfill their responsibilities to the member, the physician, patient or QUEST Integration staff member/manger will inform the QUEST Integration Medical Director, who will assess the situation, and if necessary, develop an action plan to transition the member to another PCP. If the original PCP is unable to provide continued care to the member during the transition period, medical staff at the clinic of record will provide care for the member until the transition to the new PCP is complete.

Provider Grievances & Appeals

Grievances and appeals filed by all providers will be proactively managed and resolved within 60 days of the day following the date of submission to the health plan. Providers are allowed 30 days from the decision of a grievance to file an appeal.

Providers may file a grievance to resolve issues and problems with the health plan (this includes problems regarding a member). This policy is not for filing a grievance or appeal on behalf of a member. Grievances and appeals filed on behalf of a member will be managed through the established regional member policies and procedures. Providers may ask for review of their grievance by the Provider Grievance/Appeals medical director.

Some examples of items that may be filed as a grievance are:

- Issues related to availability of health services from the health plan to a member, for example delays in obtaining or inability to obtain emergent/urgent services; medications; specialty care; ancillary services such as transportation; medical supplies, etc.;
- Issues related to the delivery of health services, for example, the PCP did not make a referral to a specialist; medication was not provided by a pharmacy; the member did not receive services the provider believed were needed; provider is unable to treat member appropriately because the member is verbally abusive or threatens physical behavior;
- Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the member; the provider reports that another provider has issues with cleanliness of office, instruments;
or other aseptic technique was used; the provider reports that another provider did not render services or items which the member needed; or the provider reports that the plan’s specialty network cannot provide adequate care for a member.

- Benefits and limitations, for example, limits on behavioral health services or formulary;
- Enrollment and eligibility, for example long wait times or inability to confirm enrollment or identify the PCP;
- Member issues, including members who fail to meet appointments or do not call for cancellations, instances in which the interaction with the member is not satisfactory; instances in which the member is rude or unfriendly; or other member-related concerns; and
- Health Plan issues, including difficulty contacting the health plan or its subcontractors due to long wait times, busy lines, etc; problems with the health plan’s staff behavior; delays in claims payments; denial of claims; claims not paid correctly; or other health plan issues.

An appeal is a request for review of an action. An action is defined as any one of the following:

- the denial or restriction of a requested service, including the type or level or service;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or part, of payment for a service;
- the failure to provide services in a timely manner as found in the access to care standards on pg. xx;
- the failure of the health plan to act within prescribed timeframes;
- for a rural area member or for islands with only one health plan or limited providers, the denial of a member’s request to obtain services outside the network:
- from any other provider (in terms of training, experience, and specialization) not available within the network;
- from a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;
- If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.
- because the only health plan or provider does not provide the service because of moral or religious objections;
• because the member’s provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and
• the State determines that other circumstances warrant out-of-network treatment.

You may file a grievance or appeal by calling the Manager of Provider Contracting & Resource Planning at 432-5897. You may also file in writing by writing to:

Hawaii Permanente Medical Group, Inc.
Provider Contracting & Resource Planning
2828 Paa St., Suite 2055
Honolulu, HI 96819

With written consent from the member or the member’s authorized representative, providers may also file grievances and appeals on behalf of a member. To do so, the provider may call 432-5955 or toll-free at 1-800-966-5955, or by TTY at 1-877-447-5990. Members may also write to Kaiser Permanente at:

Kaiser Foundation Health Plan, Inc.
Customer Service Center
711 Kapiolani Blvd.,
Honolulu, HI 96813

If a grievance is filed by a provider on behalf of a member or the member's authorized representative and there is no documentation of a written form of authorization, such as an appointment of representative form, then the provider will be advised about the written consent requirement in a manner to facilitate timely review of the concern.

Out-of-Plan/Network Referrals

All physicians have at times found the need to consult with another physician regarding their patient’s care. At Kaiser Permanente, we value the services of our Network Practitioners who, in partnership with our own physicians, provide our members with the highest quality of care available. This section contains the policies and procedures regarding how to refer Kaiser Permanente members to another practitioner.

Kaiser Permanente provides most services through its own hospital and clinics; through physicians of HPMG; and to a much lesser extent, through providers contracted through Health Plan’s Provider Contracting & Relations Department. The Health Plan has entered into an agreement with HPMG to provide or arrange for physician services for Kaiser Permanente members, including QUEST Integration. Services provided through contracted providers accounts for only 2% of all services provided for Kaiser Permanente members.

Kaiser Permanente QUEST Integration:(808) 432-5330 or 1 (800) 651-2237 toll-free
TTY: 1 (877) 447-5990/5991 toll-free providers.kaiserpermanente.org

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When services or items from an outside provider are needed, an authorization request is submitted and processed through Kaiser Permanente’s Authorization and Referral Management Department (ARM). Staff consults with the referring physician to ensure all prior authorization criteria are met. If the requested services meet benefit guidelines, the QUEST Integration Member will be sent to the appropriate non-Kaiser Permanente medical provider. A relatively small volume of prior authorizations allows for manual tracking of performance from medical review, through the authorization decision, and ending with the notification to the member and provider. Each step of the prior authorization process is monitored to ensure compliance within the allowable timeframes as described in the QUEST Integration contract. In the rare occasion that timeframes aren’t met, counseling and education are provided to the staff.

For LTSS services, QI service coordinators will be reviewing and authorizing services. The authorization will be tracked electronically via our electronic claim system. Referrals for services provided by non-Plan/non-Network providers must be reviewed and authorized through the established Plan referral authorization process. This process assures that Members are:

- Referred to the appropriate specialty provider;
- Referred to the providers who have met our service, quality, and credentialing requirements;
- Eligible for the requested medical service.

The Kaiser Physician-in-Charge is responsible for the final review and authorization of out-of-plan/network requests, including Behavioral Health and Chemical Dependency requests.

Referrals are authorized for specific services, including frequency and duration of treatment. Services or care beyond the scope of the initial authorization need additional authorization.

For contracted and credentialed professional and facility information, please contact the Community Medical Services at (808) 432-7529.

**Prior Authorizations**

Prior authorization is required as indicated in the ‘QUEST Integration Covered Benefits and Services’ starting on page 68. Most services within Kaiser Permanente require no prior authorizations. External referrals are generated in Kaiser’s electronic medical record for the Authorizations and Referrals Department to review and make a determination. Prior authorization is required for LTSS/HCBS services and the “at-risk” population.
Call the Kaiser QUEST Integration office at 432-5330 for:

- Ground transportation when medically necessary (see section below)
- Air and ground transportation, meals andlodgings for medically necessary care on another island or on the mainland
- Any member needing LTSS / HCBS
- Any member considered ‘At Risk’ (see page 82)

Follow Kaiser’s Prior Authorization process:

- Prior authorization must be obtained before service is rendered
- No retroactive requests will be processed, except for newborns, state-generated retroactive enrollments, weekend/holiday/evening discharges, and when members transition to Kaiser from another QUEST Integration health plan.

Prior Authorizations for Non-Emergency Transportation Services

The QUEST Integration transportation benefit is for medically necessary appointments for members who have no other means of transportation, who reside in areas not served by public transportation, or cannot access public transportation due to their disability. The health plan may use whatever mode of transportation which can be safely utilized by the member.

The most cost-effective means of transportation that best meets the needs of the member’s specific circumstances will be used when medically necessary as indicated by the Service Coordinator or PCP as documented in the care plan. Free transportation available to the member (e.g., friends, relatives, volunteer services, own vehicle, facility serving the member, consolidation of appointments, etc.) should be explored before other means of paid transportation are considered unless medically prohibited. Bus tickets may be provided for individual trips. Bus passes will be considered when the cost of multiple bus tickets exceeds or is expected to exceed the cost of a bus pass.

Taxi services shall be authorized when a recipient is unable to utilize public transportation or curb to curb services (Handi-Van) and only between the home of a recipient and to the nearest appropriate medical facility and back. Side trips are not allowed and will not be paid. In addition, payment will not be made for waiting time. Taxi services will only be provided after all other personal transportation options, such as family and friends, have been explored.

To be authorized, only licensed physicians are allowed to assess and justify the need for taxi services. Physical and/or mental impairment must be verified by a physician that travel by bus or Handi-Van would be either hazardous to the patient's health or would compromise his/her medical condition.

Kaiser Permanente QUEST Integration:(808) 432-5330 or 1 (800) 651-2237 toll-free
TTY: 1 (877) 447-5990/5991 toll-free providers.kaiserpermanente.org

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Contact the QUEST Integration Call Center at 432-5330 or 1-800-651-2237 (toll-free) for more information.

**How to Submit a Prior Authorization**

Submit a prior authorization/referral form contact the following respective department listed below. You may also submit online via the following link:  

**Examples of prior authorizations/referrals:**

Prior Authorization: Call the Kaiser QUEST Integration Service Coordinator at:  
432-5330 or 1-800-651-2237 (toll-free). Fax: 432-5260

- Adult Day Care Center (ADC)
- Adult Day Health Center (ADH)
- Assisted Living Facility (ALF) Community Care Management Agency (CCMA)
- Community Care Foster Family Home (CCFFH)
- Counseling and Training
- Environmental Accessibility Adaptations (EAA)
- Residential Care Services or Type 1 or Type II Expanded Adult Residential Care Home (E-ARCH)
- Home Delivered Meals
- Home Maintenance
- Moving Assistance
- Non-Emergent Only Transportation
- Personal Assistance Service Level I (PA1)
- Personal Assistance Service Level II (PA2)
- Personal Emergency Response Systems (PERS)
- Skilled (or Private Duty) Nursing
- Respite Care
- Specialized Medical Equipment and Supplies (SMES)
- Nursing facility
- Lactation counseling beyond six months
Kaiser Authorization Dept. for Plan Referral Phone at:
Phone: (808) 432-5687
Fax: (808) 432-5691
Alt Fax: (808) 432-5667

- Durable medical equipment (DME) and medical
- Hearing aid
- Breast pump (rental beyond six months and all purchases)
- Radiology/lab/other diagnostic services: Specialty procedures require prior authorization
- Dialysis
- Prior authorization is required for all rehabilitation services except for the initial evaluation
- Referral External Sleep Study
- Transplant
- Contact lenses
- Hospice

Transition of Care

Members transitioning to Kaiser:

If the member is receiving medically necessary covered services one day prior to enrollment to the health plan, Kaiser Permanente will be responsible for the cost of continuing these medically necessary services provided by contracted or non-contracted providers without prior approval. The period of coverage will include the prior period coverage (which is the period from the eligibility effective date to the data of enrollment into Kaiser QI), as well as any retroactive enrollment periods. Kaiser Permanente will provide continuation of services for individuals with SHCN and LTSS for at least ninety (90) days or until the member has received a health and functional assessment (HFA) by their service coordinator. Claims submitted by non-Kaiser Permanente providers for medically necessary care during the 45-day transition period will be reviewed and authorized for payment. Kaiser will reimburse PCP services that a member may have accessed during a 45-day period prior to transitioning to a Kaiser PCP, even if the prior PCP is not in the Kaiser’s network.

If the member transitioning into Kaiser is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal services the day before enrollment, Kaiser will be responsible for providing continued access to the prenatal provider, even if the provider is not
part of Kaiser’s network. Kaiser will continue covering prenatal services through the postpartum period.

Members transitioning from Kaiser:
Kaiser Permanente will assist the new health plan with obtaining the member’s medical records and/or other vital information as requested. A release of protected health information form will be completed before information is sent to the new plan. Kaiser will cooperate with the member and the new health plan in transitioning the member into the new health plan.

The Primary Care Physician may be consulted for medical input and a collaborative decision by the interdisciplinary team will be made to initiate case coordination/management while assisting a member with the transition of care. Once transition of care is established with the new plan, no further case coordination will be necessary from the Kaiser QI plan.

Kaiser Permanente will be responsible for the care and cost of inpatient services for members who moves to a different service area in the middle of a month and enrolls in a different health plan. Responsibility will continue until discharge or level of care change, whichever is first. For non-hospitalized members, the new health plan is responsible from the date of enrollment. Kaiser will be responsible for the care and cost of services provided to members who move to a different service area and remain with Kaiser QUEST Integration.

Pregnant members who are in their second or third trimester and are receiving medically necessary prenatal services the day before enrollment will be allowed to continue to receive care from their existing OB/GYN through the post-partum period, even if the provider is not in the new plan’s network.

Newborns whose mother elects to change health plans after the first 30 days of the newborn’s auto-assignment into the mother’s health plan (at the time of delivery) will have care coordination and continuity of care until the newborn is transitioned into the new plan’s network.

Members transitioning when provider terminates from Kaiser:
When a provider terminates from Kaiser, a letter is sent to the member who is assigned to another physician taking over the PCP’s panel or to a new PCP of the member’s choosing. However, during the interim, the member is automatically cared for by the other physicians in the health care team and/or the clinic to ensure continuity of care. The letter is sent to the member 30 days prior to the effective date of termination or relocation.

Fraud, Waste and Abuse
Like all of Kaiser Permanente in Hawaii, Kaiser Permanente recognizes that acting responsibly with our resources is critical to our success. In addition, the Deficit Reduction Act of 2005

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requires Kaiser Permanente to formally show our resolve in combating fraud, waste and abuse, especially in the administration of Federal and State health care programs such as Medicare and Medicaid. Therefore, Kaiser has revised the three policies described below. The Deficit Reduction Act requires that we make these policies available for all physicians, employees and you, our outside network partners.

Providing Information for Combating Fraud, Waste and Abuse, The Ability of Employees to Report Wrongdoing: This policy serves as a compendium of the existing tools that we, along with federal and state agencies and individuals, use to fight fraud, waste and abuse in the administration of federal and state health programs in our region. Examples of these tools include summaries of federal and state laws on false claims, and protection of employees who report suspected violations. It also includes our own existing policies and procedures for detecting and preventing fraud.

Prevention, Detection, and Correction of Fraud, Waste and Abuse: This policy articulates our commitment to control fraud, waste and abuse through prevention, detection and correction of any violation of a Federal or State law, regulatory requirement, contractual obligation or organizational policy or procedure.

Responsible Reporting of and Responding To Compliance / Ethics Concerns: This policy provides guidance regarding the internal reporting of compliance and ethics concerns, highlighting expectations of individuals who report concerns, and for the organization in responding to them. Additionally, it outlines our standards for investigation and corrective actions regarding violations of state or federal law, regulatory requirement, contractual obligation or organizational policy or procedure. Any retaliation can seriously undermine the reporting process; therefore, this policy also aims to protect employees and staff from retaliation when they make a good faith report.

Please contact Community Medical Services at (808) 432-7529 if you have any questions.

Chapter 6: Quality Management Program

Integrated Quality Program

Quality assurance and systems improvement are shared responsibilities of KFHP, KFH, a Hawaii Permanente Medical Group (HPMG), and affiliates. HPMG delivers medical care in an exclusive provider relationship in mutual collaboration with the KFHP and KFH. At all levels of the organization, Health Plan managers partner with physician managers to design, deliver, measure, and monitor quality care and service across the continuum of care – clinics, hospital, skilled and intermediate nursing facilities, home health care, affiliated services, and membership business and support services. The activities summarized in this Regional Quality Program Description serves to inform internal and external audiences about how the Hawaii Region is organized to
support the organization’s commitment to assessing and improving performance on a continuous systematic and outcome-oriented basis.

The Hawaii Region Quality Program is a systematic, integrated, widely deployed approach to planning, implementing, assessing, and improving clinical quality, patient safety, health outcomes, resource management/stewardship, clinical risk management, outside services, and service performance. All plans, goals, and initiatives are aligned with the Kaiser Permanente National Strategy, guided by the Hawaii Region’s mission and vision. Assessing group and member needs, responding to the voice of the customer, and monitoring quality of care and service are integrated into the Hawaii Region Quality Program. Also described are the responsibilities and relationship within the organization including the relationship between the Kaiser Foundation Health Plan/Hospitals (KFHP/H) Boards of Directors and the Quality and Health Improvement Committee (QHIC), which oversees quality KP program-wide, and our affiliates.

See link – 2019 Quality Program Description Hawaii Region

**Utilization Management Program**

For care delivered by HPMG and Kaiser Foundation Hospital-Moanalua staff, Utilization Management is based on an approach of advisory Utilization Management. HPMG physicians work collaboratively with their peers to ensure appropriate treatment plans and utilization of resources. In most cases, the final decision regarding a member’s treatment plan rests with the HPMG attending physician. Utilization Management / Continuing Care staff is available to support physicians in the management of member’s health care needs throughout the care continuum and provide a variety of services, such as discharge planning, utilization review, care management and ensuring compliance with internal and external regulatory requirements related to Utilization Management.

For care delivered by Contract Providers and Practitioners, the approach to Utilization Management includes an authorization process. For services not available within the HPMG / KFH system, procedures are developed for referrals to Contract Providers to ensure that referrals are appropriate. Contracted Providers are expected to comply with the Utilization Management procedures, to continue treatment plans, and to ensure appropriateness of care and resource management. In cases where Contracted Providers do not comply with HPMG / KFH procedures, reimbursement for services may be at risk.

See link – 2016 Integrated Quality Management Program Description Kaiser Permanent Hawaii Region
Guidelines for Patient Medical Records

The medical record shall reflect an accurate, comprehensive record of care planned and/or provided to a patient. The medical record serves as primary documentation of the health care process for patients. Health care Providers document clinical data and observations, develop and communicate plans of care, and record patient and family responses to planned or provided care. Any Provider who documents health care information in the medical record shall adhere to the guidelines defined by scope of practice, security classification and job description in providing care for patients.

DHS personnel or personnel contracted by the DHS shall have access to all records, as long as access to the records is needed to perform the duties of the contract and to administer the QUEST Integration program for information released or exchanged pursuant to 42 CFR Section 431.300. Practitioners shall provide DHS or its designee(s) with prompt access to members’ medical records; provide members with the right to request and receive a copy of his or her medical records, and to request that they be amended, as specified in 45 CFR Part 164, and allow for paper and electronic record keeping.

All access use and disclosure of member protected health information must be in accordance with state and federal regulations regarding privacy and confidentiality. Without fail, physicians and employees are expected to follow the requirements of HIPAA, other laws and KP policies on confidentiality, privacy and security.

Providers are required to adhere to the following requirements:

- All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
- All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
- All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
- All medical records shall be legible, signed and dated;
- Each page of the paper or electronic record includes the patient’s name or ID number;
- All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
- All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;
- All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;

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All medical records contain the patient’s past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;

All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;

All medical records include the provisional and confirmed diagnosis(es);

All medical records contain medication information;

All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);

All medical records contain information about consultations, referrals, and specialist reports;

All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;

All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;

All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;

All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and All medical records shall contain documented patient visits, which includes, but is not limited to:

- A history and physical exam;
- Treatment plan, progress and changes in treatment plan;
- Laboratory and other studies ordered, as appropriate;
- Working diagnosis(es) consistent with findings;
- Treatment, therapies, and other prescribed regimens;
- Documentation concerning follow-up care, telephone calls, emails, other electronic communication, or visits, when indicated;
- Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
- Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;
- Hospitalizations and/or emergency department visits, if applicable; and
All other aspects of patient care, including ancillary services.

See Attachment 3 – Ambulatory Electronic Medical Records Management

See Attachment 4 – Release of Protected Health Information

Chapter 7: Pharmaceutical Management Procedures and Drug Formulary

The Kaiser Hawaii Drug Formulary lists medications approved through a scientific review process by the Pharmacy and Therapeutics (P&T) Committee. Its intent is to enhance the quality of patient care by promoting safe, effective, and economical drug therapy. The Kaiser Hawaii Region’s drug formulary is considered a closed formulary, in which listed medications are usually covered under plan benefits. However, listing of a medication in our drug formulary does not necessarily mean it is covered under your patient’s prescription drug benefit plan since prescription benefit coverage varies depending on your patient’s plan.

Drugs covered by QUEST Integration are those prescribed by a physician or other health care provider licensed for prescription privileges and is on the list of approved drugs, and includes over-the-counter drugs. Drugs must be medically necessary to optimize the member’s medical condition (including children receiving CAMHD services).

The QUEST Integration benefit also includes:

- Medication management and patient counseling is also included.
- Drugs required to be covered by statute, including antipsychotic medication and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for a U. S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder,
- Drugs approved by the FDA that are eligible pursuant to the Omnibus Budget Reconciliation Rebates Act and necessary to treat members for human immunodeficiency virus, acquired immune deficiency syndrome, or Hepatitis C, or a member needing transplant immunosuppressive (without the need for a prior authorization).

Practitioners and providers who have questions regarding Kaiser’s Pharmaceutical Management procedures may call the Pharmacy Administration Department at (808) 432-5549.

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The formulary approval process ensures that available drugs meet established quality standards and that adequate information for their optimal use is provided, while limiting the availability of unsafe, "less than effective," or "ineffective" drugs, and drugs with a high potential for toxicity or abuse.

The drug formulary also supports cost management by promoting the use of effective but less costly therapeutic equivalents, reducing the number of therapeutically redundant drugs, optimizing pharmacy management or drug inventories, and maximizing leverage through the drug purchasing and bid process.

Non-formulary drugs are drugs not officially accepted for inclusion into our drug formulary. This includes new drugs not yet reviewed for addition, drugs that have been reviewed but denied admission to the formulary, or a brand, strength, or dosage form of a formulary drug not stocked in Kaiser pharmacies.

Non-formulary drugs are excluded from drug plan coverage unless your patient is allergic to a formulary drug, fails to respond to formulary drug therapy at maximum doses, or has special circumstances requiring the use of a non-formulary drug. If your patient meets any or all of these “medically necessary” conditions for use of a formulary drug, as documented in the patient’s medical record, your patient may obtain his/her prescription at his/her usually supplemental charge or receive a refund on a prescription for which they initially paid full price. Non-formulary drugs are not usually stocked in our pharmacies, therefore, there may be a delay before such a medication is dispensed or administered.

The following are three methods in which you may access the drug formulary:

1. Access the formulary online via the internet. See instructions for accessing the Lexi-Comp FormuLink™ Online site below.

   Consumer Drug Formulary

2. Access the formulary via downloads to PDA or Pocket PC. See download instructions by PDA type below.

   Consumer Drug Formulary for Palm OS
   Consumer Drug Formulary for Pocket PC

3. Accessing the formulary via the kp.org website.

   Formulary (list of covered drugs)

We will notify you of any changes to the formulary before the change takes effect. If you do not have access to the internet or have difficulties in accessing the formulary, you may email the call

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Chapter 8: Credentialing

This section highlights procedures and policies, such as those regarding credentialing, bioethics, regulatory reporting, quality of care reporting, and other related information.

Credentialing

As an important part of Kaiser Permanente’s Quality Management Program, all credentialing and recredentialing activities are structured to assure all practitioners are qualified to meet Kaiser Permanente’s standards for the delivery of quality healthcare and service to its members.

As stated in the facility services agreements, all providers will remain in compliance with all applicable facility, local, State and Federal laws, rules and regulations including, but not limited to, those (a) regarding licensure, certification and accreditation of acute care hospitals; (b) necessary for participation in the Medicare and Medicaid programs; and (c) regulating the operations and safety of acute care hospitals (including all laws, rules and regulations regarding hazardous substances), and (2) accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") or any successor and any other accreditation organization reasonably requested by Kaiser Foundation Hospitals.

The credentialing/recredentialing policies and procedures approved by Kaiser Permanente are intended to meet the standards outlined by NCQA.

All practitioners wishing to participate in Kaiser Permanente must successfully complete the credentialing process and must demonstrate their on-going ability to meet credentialing standards through a biennial recredentialing process. Practitioners are required to provide Kaiser Permanente with the information needed to review and verify their credentials.

The Professional Competency Department is responsible for collecting and verifying credentialing information while the Credentials and Privileges Committee reviews the completed credentialing or recredentialing files to determine if the practitioner will be approved for new or continuing participation in Kaiser Permanente.

Credentialing/Recredentialing Requirements

Each practitioner must provide/demonstrate that all the criteria noted below are met:
A completed application which includes practitioner demographics, practice information, work history, educational background, and a personal attestation to the practitioner’s physical and mental well-being and the accuracy of the information provided.

A current valid license to practice.

The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility, as applicable.

A valid DEA or CDS certificate, as applicable to the specialty.

Appropriate education and training for the practice specialty.

Explanations for any gaps in work history (initial credentialing only).

Evidence of current, adequate professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate with exceptions only granted upon complete review.

Acceptable history of malpractice claims experience.

Compliance with medical record and facility site reviews (see attached Care Practitioner Site Visit Tool). The requirement is applicable to:

Primary care practitioners (defined as Internal Medicine, Family Practice, and Pediatrics) and OB/GYNs at the time of initial credentialing and recredentialing. Credentialing and re-credentialing requirements noted above apply to practitioners who provide health care services on behalf of Kaiser Permanente. These include, but are not limited to MDs, DOs, DPMs, DDSs, NPs, CNMs, PAs, PhDs, PSYs, CRNAs, LCSWs, ODs, and CNSs for Behavioral Health.

- High Volume Specialists at the time of recredentialing.

Acceptable performance as recorded in all practice information related to Kaiser Permanente members.

Full disclosure requirements as identified in accordance with 42 CFR Part 455, Subpart B.

Credentials and Privileges Committee

When all credentialing or recredentialing requirements have been collected and verified, they are presented to the Credentials and Privileges Committee for review and approval of the practitioner’s new or continued participation as a contracted practitioner.

Approvals

Practitioners who have been approved for new or continued participation in Kaiser Permanente are notified by letters within one month of approval.

Denial as Termination of Participation

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Practitioners are notified by certified or registered mail when they are denied participation with Kaiser Permanente. If a practitioner wishes to appeal the decision, please refer to the attached Notice and Fair Hearing Procedure.

**Practitioner Rights to Review and Correct Erroneous Credentialing Information**

Kaiser Permanente notifies a practitioner when a credentialing verification conflicts with information provided on the initial or recredentialing application. The practitioner then has the right to:

- review the conflicting verification documentation provided such disclosure is not prohibited by law, and
- submit documentation supporting or clarifying the information provided on the application.

The conflicting information and the practitioner’s supporting documentation are included in the practitioner’s credentials file for review by the Credentials and Privileges Committee.

**Confidentiality of Credentialing Information**

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

**Chapter 9: Claim and Invoice Submission**

**How to send Claims and Invoices to Kaiser Permanente**

Send your completed claim, invoice or direct inquiries to the appropriate locations:

**For Claim Submission:**

Kaiser Foundation Health Plan, Inc.
Hawaii Claims Administration
PO Box 378021
Denver, Colorado 80237

**Contact Numbers to Call for Billing Questions:**

(877) 875-3805 (Toll-free) or KP Hawaii Customer Service for Q1 Claims (808)432-5330 or 1-800-651-2237 (toll-free) 7:45am – 4:30 Monday -Friday

**For Invoice Submissions:**

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It is your responsibility to submit itemized claims for services provided to QUEST Integration Members in a complete and timely manner and based on chart documentation, in accordance with your Agreement, this Provider Manual and applicable law.

Methods of Claims Submission

Claims may be submitted by mail or electronically. Whether submitting claims on paper or electronically, only the UB-04 form will be accepted for facility services billing and only the CMS-1500 form, which will accommodate reporting of the individual (Type 1) NPI, will be accepted for professional services billing. Submitting claims that are handwritten, faxed or photocopied will be subject to processing delay and/or rejection.

When CMS-1500 or UB-04 forms are updated by NUCC/CMS, KP will notify Provider when the KP systems are ready to accept the updated form(s) and Provider must submit claims using the updated form(s).

Supporting Documentation for Paper Claims

In general, the Provider must submit, in addition to the applicable billing form, all supporting documentation and information that is reasonably relevant and necessary to determine payment.

At a minimum, supporting documentation that may be reasonably relevant may include the following, to the extent applicable to the services provided:

- Authorization
- Admitting face sheet
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment and visit notes as reasonably relevant and necessary to determine payment
- A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier
• A physician report relating to any claim under which a physician is billing an “Unlisted Procedure”, a procedure or service that is not listed in the current edition of the CPT codebook
• Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
• Therapy logs showing frequency and duration of therapies provided for SNF services

Electronic Data Interchange (EDI)
KP encourages Providers to submit electronic claims (837I/P transaction). Electronic claim transactions eliminate the need for paper claims. Electronic Data Interchange (EDI) is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. KP requires all EDI claims be HIPAA compliant.

HIPAA Requirements
All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and electronic loops and segments. HIPAA Implementation Guides can also be ordered by calling Washington Publishing Company (WPC) at (301) 949-9740 www.dhhs.gov www.wedi.org www.wpc-edi.com

Claims Submission Timeframes
Claims for services provided to Members should be submitted for payment within ninety (90) days of such service. However, all claims and encounter data must be sent to the appropriate address no later than 365 days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge, as applicable.

Member Cost Share
Please verify applicable Member Cost Share at the time of service by contacting Member Services. Members may be responsible to share some cost of the services provided. Member Cost Share are the fees a Member is responsible to pay a Provider for certain covered services.

CMS-1500 Field Descriptions
The fields identified in the table below as “Required” must be completed when submitting a CMS-1500 (02/12) claim form for processing:
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MEDICARE/ MEDICAID/ TRICARE/ CHAMPVA/ GROUP HEALTH PLAN/FECA BLK LUNG/OTHER</td>
<td>Not Required</td>
<td>Check the type of health insurance coverage applicable to this claim by checking the appropriate box.</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER</td>
<td>Required</td>
<td>Enter the patient’s Kaiser Permanente Medical Record Number (MRN)</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME</td>
<td>Required</td>
<td>Enter the patient’s name. When submitting newborn claims, enter the newborn’s first and last name.</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE AND SEX</td>
<td>Required</td>
<td>Enter the patient’s date of birth and gender. The date of birth must include the month, day and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME</td>
<td>Required</td>
<td>Enter the name of the insured, i.e., policyholder (Last Name, First Name, and Middle Initial), unless the insured and the patient are the same—then the word “SAME” may be entered. If this field is completed with an identity different than that of the patient, also complete Field 11.</td>
</tr>
<tr>
<td>5</td>
<td>PATIENT’S ADDRESS</td>
<td>Required</td>
<td>Enter the patient’s mailing address and telephone number. On the first line, enter the STREET ADDRESS; the second line is for the CITY and STATE; the third line is for the nine digits ZIP CODE and PHONE NUMBER.</td>
</tr>
<tr>
<td>6</td>
<td>PATIENT’S RELATIONSHIP TO INSURED</td>
<td>Required</td>
<td>Check the appropriate box for the patient’s relationship to the insured.</td>
</tr>
<tr>
<td>7</td>
<td>INSURED’S ADDRESS</td>
<td>Required if Applicable</td>
<td>Enter the insured’s address (STREET ADDRESS, CITY, STATE, and nine digits ZIP CODE) and telephone number. When the address is the same as the patient’s—the word “SAME” may be entered.</td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED’S NAME</td>
<td>Required if Applicable</td>
<td>When additional insurance coverage exists, enter the last name, first name and middle initial of the insured.</td>
</tr>
<tr>
<td>9a</td>
<td>OTHER INSURED’S POLICY OR GROUP NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the policy and/or group number of the insured individual named in Field 9 (Other Insured’s Name) above. NOTE: For each entry in Field 9a, there must be a corresponding entry in Field 9d.</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>Required if Applicable</td>
<td>Enter the name of the “other” insured’s INSURANCE PLAN or program.</td>
</tr>
<tr>
<td>10a-c</td>
<td>IS PATIENT’S CONDITION RELATED TO</td>
<td>Required</td>
<td>Check “Yes” or “No” to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. NOTE: If “yes” there must be a corresponding entry in Field 14 (Date of Current Illness/Injury). Place (State) - enter the State postal code.</td>
</tr>
<tr>
<td>10d</td>
<td>CLAIM CODES (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>11</td>
<td>INSURED’S POLICY NUMBER OR FECA NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the insured’s policy or group number.</td>
</tr>
<tr>
<td>11a</td>
<td>INSURED’S DATE OF BIRTH</td>
<td>Required if Applicable</td>
<td>Enter the insured’s date of birth and sex, if different from Field 3. The date of birth must include the month, day, and FOUR digits for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>11c</td>
<td>INSURANCE PLAN OR PROGRAM NAME</td>
<td>Required if Applicable</td>
<td>Enter the insured’s insurance plan or program name.</td>
</tr>
<tr>
<td>11d</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN?</td>
<td>Required</td>
<td>Check “yes” or “no” to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If “yes” then fields 9 and 9a-d must be completed.</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Required if Applicable</td>
<td>Have the patient or an authorized representative SIGN and DATE this block, unless the signature is on file. If the patient’s representative signs, then the relationship to the patient must be indicated.</td>
</tr>
<tr>
<td>13</td>
<td>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Required</td>
<td>Have the patient or an authorized representative SIGN this block, unless the signature is on file.</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP)</td>
<td>Required if Applicable</td>
<td>Enter the date of the current illness or injury. If pregnancy, enter the date of the patient’s last menstrual period. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>15</td>
<td>OTHER DATE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>Not Required</td>
<td>Enter the “from” and “to” dates that the patient is unable to work. The dates must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2003</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>Required if Applicable</td>
<td>Enter the FIRST and LAST NAME of the KP referring or KP ordering physician.</td>
</tr>
<tr>
<td>17a</td>
<td>OTHER ID #</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI NUMBER</td>
<td>Required</td>
<td>Enter the NPI number of the KP referring provider</td>
</tr>
<tr>
<td>18</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>Required if Applicable</td>
<td>Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.</td>
</tr>
<tr>
<td>19</td>
<td>ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>20</td>
<td>OUTSIDE LAB CHARGES</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>Required</td>
<td>Enter the diagnosis/condition of the patient, indicated by an ICD-9-CM (or its successor, ICD-10) code number. Enter up to 4 diagnostic codes, in PRIORITY order (primary, secondary condition).</td>
</tr>
<tr>
<td>22</td>
<td>RESUBMISSION</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
<td>Required if Applicable</td>
<td>For ALL inpatient and outpatient claims, enter the KP referral number, if applicable, for the episode of care being billed. NOTE: this is a 10-digit alphanumeric identifier</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
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<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24A-J</td>
<td>SUPPLEMENTAL INFORMATION</td>
<td>Required</td>
<td>Supplemental information can only be entered with a corresponding, completed service line. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. When reporting additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP – HIBCC codes, OZ – GTIN codes or contract rate, enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/information. The following qualifiers are to be used when reporting these services. 7 – Anesthesia information ZZ – Narrative description of unspecified code N4 – National Drug Codes (NDC) VP – Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard OZ – Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) CTR – Contract rate</td>
</tr>
<tr>
<td>24A</td>
<td>DATE(S) OF SERVICE</td>
<td>Required</td>
<td>Enter the month, day, and year (MM/DD/YY) for each procedure, service, or supply. Services must be entered chronologically (starting with the oldest date first). For each service date listed/billed, the following fields must also be entered: Units, Charges/Amount/Fee, Place of Service, Procedure Code, and corresponding Diagnosis Code. <strong>IMPORTANT:</strong> Do not submit a claim with a future date of service. Claims can only be submitted once the service has been rendered (for example: durable medical equipment).</td>
</tr>
<tr>
<td>24B</td>
<td>PLACE OF SERVICE</td>
<td>Required</td>
<td>Enter the place of service code for each item used or service performed.</td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td>Required if Applicable</td>
<td>Enter Y for &quot;YES&quot; or leave blank if &quot;NO&quot; to indicate an EMERGENCY as defined in the electronic 837 Professional 4010A1 implementation guide.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
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<td>----------------------</td>
</tr>
</tbody>
</table>
| 24D          | PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER | Required | Enter the CPT/HCPCS codes and MODIFIERS (if applicable) reflecting the procedures performed, services rendered, or supplies used.  
**IMPORTANT:** Enter the anesthesia time, reported as the “beginning” and “end” times of anesthesia in military time above the appropriate procedure code. |
| 24E          | DIAGNOSIS POINTER | Required | Enter the diagnosis code reference number (pointer) as it relates the date of service and the procedures shown in Field 21. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained.  
**IMPORTANT:** (ICD-9-CM, (or its successor, ICD-10) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.) |
| 24F          | $ CHARGES   | Required | Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc).  
Do not use commas when reporting dollar amounts.  
Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. |
| 24G          | DAYS OR UNITS | Required | Enter the number of days or units in this block. (For example: units of supplies, etc.)  
When entering the NDC units in addition to the HCPCS units, enter the applicable NDC ‘units’ qualifier and related units in the shaded line. The following qualifiers are to be used:  
F2 - International Unit  
ML - Milliliter  
GR - Gram UN Unit |
| 24H          | EPSDT FAMILY PLAN | Not Required | |

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TTY: 1 (877) 447-5990/5991 toll-free providers.kaiserpermanente.org

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<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>24I</td>
<td>ID. QUAL</td>
<td>Required, if Applicable</td>
<td>Enter the qualifier of the non-NPI identifier. The Other ID# of the rendering provider is reported in 24j in the shaded area. The NUCC defines the following qualifiers: 0B - State License Number 1B - Blue Shield Provider Number 1C - Medicare Provider Number 1D - Medicaid Provider Number 1G - Provider UPIN Number 1H - CHAMPUS Identification Number EI - Employer’s Identification Number G2 - Provider Commercial Number LU - Location Number N5 - Provider Plan Network Identification Number SY - Social Security Number (The social security number may not be used for Medicare.) X5 - State Industrial Accident Provider Number ZZ - Provider Taxonomy</td>
</tr>
<tr>
<td>24J</td>
<td>RENDERING PROVIDER ID #</td>
<td>Required if Applicable</td>
<td>Enter the non-NPI identifier in the shaded area of the field, if applicable. Enter the NPI number in the non-shaded area of the field, if applicable. Report the Identification Number in Items 24i and 24j only when different from data recorded in Fields 33a and 33b.</td>
</tr>
<tr>
<td>25</td>
<td>FEDERAL TAX ID NUMBER</td>
<td>Required</td>
<td>Enter the physician/supplier federal tax I.D. number or Social Security number of the billing provider identified in Field 33. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. <strong>IMPORTANT:</strong> The Federal Tax ID Number in this field must match the information on file with the IRS.</td>
</tr>
<tr>
<td>26</td>
<td>PATIENT’S ACCOUNT NO.</td>
<td>Required</td>
<td>Enter the patient’s account number assigned by the Provider’s accounting system, i.e., patient control number. <strong>IMPORTANT:</strong> This field aids in patient identification by the Provider.</td>
</tr>
<tr>
<td>27</td>
<td>ACCEPT ASSIGNMENT</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
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<td>Instructions/Examples</td>
</tr>
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<td>--------------</td>
<td>------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>28</td>
<td>TOTAL CHARGE</td>
<td>Required</td>
<td>Enter the total charges for the services rendered (total of all the charges listed in Field 24f).</td>
</tr>
<tr>
<td>29</td>
<td>AMOUNT PAID</td>
<td>Required if Applicable</td>
<td>Enter amount paid by other payer. Do not report collections of patient cost share.</td>
</tr>
<tr>
<td>30</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td>Required</td>
<td>Enter the signature of the physician/supplier or his/her representative, and the date the form was signed. For claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.</td>
</tr>
<tr>
<td>32</td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
<td>Required if Applicable</td>
<td>The name and address of the facility where services were rendered (if other than patient’s home or physician’s office). Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code. Do not use commas, periods, or other punctuation in the address (e.g., “123 N Main Street 101” instead of “123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9 digit zip code, include the hyphen.</td>
</tr>
<tr>
<td>32a</td>
<td>NPI #</td>
<td>Required if Applicable</td>
<td>Enter the NPI number of the service facility if it is an entity external to the billing provider.</td>
</tr>
<tr>
<td>32b</td>
<td>OTHER ID #</td>
<td>Required if Applicable</td>
<td>Enter the two-digit qualifier identifying the non-NPI identifier followed by the ID number of the service facility. Do not enter a space, hyphen, or other separator between the qualifier and number.</td>
</tr>
<tr>
<td>33</td>
<td>BILLING PROVIDER INFO &amp; PH #</td>
<td>Required</td>
<td>Enter the name, address and phone number of the billing entity.</td>
</tr>
<tr>
<td>33a</td>
<td>NPI #</td>
<td>Required if Applicable</td>
<td>Enter the NPI number of the billing provider.</td>
</tr>
<tr>
<td>33b</td>
<td>OTHER ID #</td>
<td>Required if Applicable</td>
<td>Enter the two-digit qualifier identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. If available, please enter your unique provider or vendor number assigned by KP.</td>
</tr>
</tbody>
</table>
UB-04 (CMS-1450) Field Descriptions

The fields identified in the table below as “Required” must be completed when submitting a UB-04 claim form for processing:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PROVIDER NAME and ADDRESS</td>
<td>Required</td>
<td>Enter the name and address of the billing provider which rendered the services being billed.</td>
</tr>
<tr>
<td>2</td>
<td>PAY-TO NAME, ADDRESS, CITY/STATE, ID #</td>
<td>Required if Applicable</td>
<td>Enter the name and address of the billing provider’s designated pay-to entity.</td>
</tr>
<tr>
<td>3a</td>
<td>PATIENT CONTROL NUMBER</td>
<td>Required</td>
<td>Enter the patient’s account number assigned by the Provider’s accounting system, i.e., patient control number. <strong>IMPORTANT:</strong> This field aids in patient identification by the Provider.</td>
</tr>
</tbody>
</table>
| 3b           | MEDICAL / HEALTH RECORD NUMBER      | Required if Applicable                | Enter the number assigned to the patient’s medical/health record by the Provider.  
Note: this is not the same as either Field 3a or Field 60. |
<p>| 4            | TYPE OF BILL                        | Required                              | Enter the appropriate code to identify the specific type of bill being submitted.  This code is required for the correct identification of inpatient vs. outpatient claims, voids, etc. |
| 5            | FEDERAL TAX NUMBER                  | Required                              | Enter the federal tax ID of the hospital or person entitled to reimbursement in NN-NNNNNNNN format. |
| 6            | STATEMENT COVERS PERIOD             | Required                              | Enter the beginning and ending date of service included in the claim.                 |
| 7            | BLANK                               | Not Required                          | Leave blank.                                                                          |
| 8            | PATIENT NAME / ID                   | Required                              | Enter the patient’s name, together with the patient ID (if different than the insured’s ID). |
| 9            | PATIENT ADDRESS                     | Required                              | Enter the patient’s mailing address.                                                   |
| 10           | PATIENT BIRTH DATE                  | Required                              | Enter the patient’s birth date in MM/DD/YYYY format.                                  |</p>
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>PATIENT SEX</td>
<td>Required</td>
<td>Enter the patient’s gender.</td>
</tr>
<tr>
<td>12</td>
<td>ADMISSION DATE</td>
<td>Required if Applicable</td>
<td>For inpatient and Home Health claims only, enter the date of admission in MM/DD/YYYY format.</td>
</tr>
<tr>
<td>13</td>
<td>ADMISSION HOUR</td>
<td>Required</td>
<td>For either inpatient OR outpatient care, enter the 2-digit code for the hour during which the patient was admitted or seen.</td>
</tr>
<tr>
<td>14</td>
<td>ADMISSION TYPE</td>
<td>Required</td>
<td>Indicate the type of admission (e.g. emergency, urgent, elective, and newborn).</td>
</tr>
<tr>
<td>15</td>
<td>ADMISSION SOURCE</td>
<td>Required</td>
<td>Enter the code for the point of origin of the admission or visit.</td>
</tr>
<tr>
<td>16</td>
<td>DISCHARGE HOUR (DHR)</td>
<td>Required if Applicable</td>
<td>Enter the two-digit code for the hour during which the patient was discharged.</td>
</tr>
<tr>
<td>17</td>
<td>PATIENT STATUS</td>
<td>Required</td>
<td>Enter the discharge status code as of the “Through” date of the billing period.</td>
</tr>
<tr>
<td>18-28</td>
<td>CONDITION CODES</td>
<td>Required if Applicable</td>
<td>Enter any applicable codes which identify conditions relating to the claim that may affect claims processing.</td>
</tr>
<tr>
<td>29</td>
<td>ACCIDENT (ACDT) STATE</td>
<td>Not Required</td>
<td>Enter the two-character code indicating the state in which the accident occurred which necessitated medical treatment.</td>
</tr>
<tr>
<td>30</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>31-34</td>
<td>OCCURRENCE CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter the code and the associated date (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.</td>
</tr>
<tr>
<td>35-36</td>
<td>OCCURRENCE SPAN CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter the occurrence span code and associated dates (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.</td>
</tr>
<tr>
<td>37</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>38</td>
<td>RESPONSIBLE PARTY</td>
<td>Not Required</td>
<td>Enter the name and address of the financially responsible party.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>39-41</td>
<td>VALUE CODES and AMOUNT</td>
<td>Required if Applicable</td>
<td>Enter the code and related amount/value which is necessary to process the claim.</td>
</tr>
<tr>
<td>42</td>
<td>REVENUE CODE</td>
<td>Required</td>
<td>Identify the specific accommodation, ancillary service, or billing calculation, by assigning an appropriate revenue code to each charge.</td>
</tr>
<tr>
<td>43</td>
<td>REVENUE DESCRIPTION</td>
<td>Required if Applicable</td>
<td>Enter the narrative revenue description or standard abbreviation to assist clerical bill review.</td>
</tr>
<tr>
<td>44</td>
<td>PROCEDURE CODE AND MODIFIER</td>
<td>Required if Applicable</td>
<td>For ALL outpatient claims, enter BOTH a revenue code in Field 42 (Rev. CD.), and the corresponding CPT/HCPCS procedure code in this field.</td>
</tr>
<tr>
<td>45</td>
<td>SERVICE DATE</td>
<td>Required</td>
<td>Outpatient Series Bills:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A service date must be entered for all outpatient series bills whenever the “from” and “through” dates in Field 6 (Statement Covers Period: From/Through) are not the same. Submissions that are received without the required service date(s) will be rejected with a request for itemization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Multiple/Different Dates of Service:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Multiple/different dates of service can be listed on ONE claim form. List each date on a separate line on the form, along with the corresponding revenue code (Field 42), procedure code (Field 44), and total charges (Field 47).</td>
</tr>
<tr>
<td>46</td>
<td>UNITS OF SERVICE</td>
<td>Required</td>
<td>Enter the units of service to quantify each revenue code category.</td>
</tr>
<tr>
<td>47</td>
<td>TOTAL CHARGES</td>
<td>Required</td>
<td>Indicate the total charges pertaining to each related revenue code for the current billing period, as listed in Field 6.</td>
</tr>
<tr>
<td>48</td>
<td>NON-COVERED CHARGES</td>
<td>Required if Applicable</td>
<td>Enter any non-covered charges.</td>
</tr>
<tr>
<td>49</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------</td>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>50</td>
<td>PAYER NAME</td>
<td>Required</td>
<td>Enter (in appropriate ORDER on lines A, B, and C) the NAME and NUMBER of each payer organization from which you are expecting payment towards the claim.</td>
</tr>
<tr>
<td>51</td>
<td>HEALTH PLAN ID</td>
<td>Not Required</td>
<td>Enter the Plan Sponsor identification number.</td>
</tr>
<tr>
<td>52</td>
<td>RELEASE OF INFORMATION (RLS INFO)</td>
<td>Required if Applicable</td>
<td>Enter the release of information certification indicator(s).</td>
</tr>
<tr>
<td>53</td>
<td>ASSIGNMENT OF BENEFITS (ASG BEN)</td>
<td>Required</td>
<td>Enter the assignment of benefits certification indicator.</td>
</tr>
<tr>
<td>54A-C</td>
<td>PRIOR PAYMENTS</td>
<td>Required if Applicable</td>
<td>If payment has already been received toward the claim by one of the payers listed in Field 50 (Payer) prior to the billing date, enter the amounts here.</td>
</tr>
<tr>
<td>55</td>
<td>ESTIMATED AMOUNT DUE</td>
<td>Required if Applicable</td>
<td>Enter the estimated amount due from patient. Do not report collection of patient’s cost share.</td>
</tr>
<tr>
<td>56</td>
<td>NATIONAL PROVIDER IDENTIFIER (NPI)</td>
<td>Required</td>
<td>Enter the billing provider’s NPI.</td>
</tr>
<tr>
<td>57</td>
<td>OTHER PROVIDER ID</td>
<td>Required</td>
<td>Enter the service Provider’s Kaiser-assigned Provider ID, if any</td>
</tr>
<tr>
<td>58</td>
<td>INSURED’S NAME</td>
<td>Required</td>
<td>Enter the insured’s name, i.e. policyholder.</td>
</tr>
<tr>
<td>59</td>
<td>PATIENT’S RELATION TO INSURED</td>
<td>Required</td>
<td>Enter the patient’s relationship to the insured.</td>
</tr>
<tr>
<td>60</td>
<td>INSURED’S UNIQUE ID</td>
<td>Required</td>
<td>Enter the patient’s Kaiser Medical Record Number (MRN).</td>
</tr>
<tr>
<td>61</td>
<td>INSURED’S GROUP NAME</td>
<td>Required if Applicable</td>
<td>Enter the insured’s group name.</td>
</tr>
<tr>
<td>62</td>
<td>INSURED’S GROUP NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the insured’s group number. For Prepaid Services claims enter &quot;PPS&quot;.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------</td>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 63           | TREATMENT AUTHORIZATION CODE        | Required if Applicable                | For ALL inpatient and outpatient claims, enter the KP referral number, if applicable, for the episode of care being billed.  
NOTE: this is a 10-digit alphanumeric identifier |
| 64           | DOCUMENT CONTROL NUMBER             | Not Required                          | Enter the document control number related to the patient or the claim as assigned by KP. |
| 65           | EMPLOYER NAME                       | Required if Applicable                | Enter the name of the insured’s (Field 58) employer.                                  |
| 66           | DX VERSION QUALIFIER                | Not Required                          | Indicate the ICD version indicator of codes being reported.  
At the time of printing, Kaiser only accepts ICD-9-CM diagnosis codes on the UB-04.  ICD-10 standards for paper and EDI claims will be implemented by KP for outpatient dates of service and inpatient discharge dates on/after October 1, 2014. |
<p>| 67           | PRINCIPAL DIAGNOSIS CODE            | Required                              | Enter the principal diagnosis code, on all inpatient and outpatient claims.            |
| 67A-Q        | OTHER DIAGNOSES CODES               | Required if Applicable                | Enter other diagnoses codes corresponding to additional conditions that coexist or develop subsequently during treatment. Diagnosis codes must be carried to their highest degree of detail. |
| 68           | BLANK                               | Not Required                          | Leave blank.                                                                         |
| 69           | ADMITTING DIAGNOSIS                 | Required                              | Enter the admitting diagnosis code on all inpatient claims.                           |
| 70a-c        | REASON FOR VISIT (PATIENT REASON DX)| Required if Applicable                | Enter the diagnosis codes indicating the patient’s reason for outpatient visit at the time of registration. |
| 71           | PPS CODE                            | Required if Applicable                | Enter the DRG number to which the procedures group, even if you are being reimbursed under a different payment methodology. |
| 72           | EXTERNAL CAUSE OF INJURY CODE (ECI) | Required if Applicable                | Enter an ICD-9-CM “E-code” (or its successor, ICD-10 code) in this field (if applicable). |</p>
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>73</td>
<td>BLANK</td>
<td>Not required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>74</td>
<td>PRINCIPAL PROCEDURE CODE AND DATE</td>
<td>Required if Applicable</td>
<td>Enter the ICD-9-CM (or its successor, ICD-10) procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed (if applicable).</td>
</tr>
<tr>
<td>74a-e</td>
<td>OTHER PROCEDURE CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter other ICD-9-CM (or its successor, ICD-10) procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims (in fields “A” through “E”) for any additional surgical and/or obstetrical procedures which were performed (if applicable).</td>
</tr>
<tr>
<td>75</td>
<td>BLANK</td>
<td>Not required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>76</td>
<td>ATTENDING PHYSICIAN / NPI / QUAL / ID</td>
<td>Required</td>
<td>Enter the NPI and the name of the attending physician for inpatient bills or the KP physician that requested the outpatient services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inpatient Claims—Attending Physician</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enter the full name (first and last name) of the physician who is responsible for the care of the patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Outpatient Claims—Referring Physician</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ALL outpatient claims, enter the full name (first and last name) of the KP physician who referred the Patient for the outpatient services billed on the claim.</td>
</tr>
<tr>
<td>77</td>
<td>OPERATING PHYSICIAN / NPI / QUAL / ID</td>
<td>Required If Applicable</td>
<td>Enter the NPI and the name of the lead surgeon who performed the surgical procedure.</td>
</tr>
<tr>
<td>78-79</td>
<td>OTHER PHYSICIAN/ NPI/ QUAL/ ID</td>
<td>Required if Applicable</td>
<td>Enter the NPI and name of any other physicians.</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>Not Required</td>
<td>Special annotations may be entered in this field.</td>
</tr>
<tr>
<td>81</td>
<td>CODE-CODE</td>
<td>Required if Applicable</td>
<td>Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate.</td>
</tr>
</tbody>
</table>

Kaiser Permanente QUEST Integration:(808) 432-5330 or 1 (800) 651-2237 toll-free
TTY: 1 (877) 447-5990/5991 toll-free providers.kaiserpermanente.org

Provider Manual_rev7.15.2020
### Form UB-04

<table>
<thead>
<tr>
<th>Page</th>
<th>Creation Date</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Name**: [Enter name]

**Health Plan**: [Enter health plan]

**Provider Name**: [Enter provider name]

**Service Date**: [Enter date]

**Type of Bill**: [Enter type]

**Patient Identification**: [Enter identification]

**Procedure**: [Enter procedure]

**Code**: [Enter code]

**Amount**: [Enter amount]

**Value Codes**: [Enter value codes]

**The formula for the UB-04**:

The UB-04 form is used to submit insurance claims to health insurance companies. It contains various sections for entering patient information, service details, and payment information. The form includes spaces for entering codes and amounts, which are used to calculate the total charges and payments.
Members with Other Insurance

When a member has other health care coverage that is primary to Kaiser Permanente Health Plan coverage, (such as No-Fault, Worker's Compensation, Medicare), the Practitioner needs to bill that primary insurance carrier directly.

Kaiser Permanente will review for payment consideration any remaining balance and may reimburse applicable co-payments and deductibles, if any, of the contractually eligible charges for the member’s covered benefits.

Remittance Advice

The Remittance Advice Details (RAD) is designed for line-by-line reconciliation of transactions. Reconciliation of the RAD to providers’ records will help determine which claims are paid or denied.

Refer to the Remittance Advice Details (RAD) example form for a completed sample of RA. (See legend below)

1.1 Remittance Advice Details

A. Patient Name
B. Line of Business (LOB)
C. Service Dates
D. Claim Number (Claims System Number)
E. Code
F. Description
G. Billed
H. Contract (Amount Paid)
P. Interest Owed
I. Adjust (Adjustment Amount)
J. Pt share
K. Provider Name (Vendor#)
L. Provider Address
M. Check#
N. Check Amount
O. Total for Provider
## Remittance Advice Report

### Remittance Advice

**Vendor:** K  
**Provider Address**  
City, State Zip code  
**Vendor:** K  
Provider ID#: 12724188  
**Vendor ID:** K  
Provider Name:  
**Check #:** M  
Check Date: 07/01/2015  
**Check Amount:** N

---

**Ins. Co. Name:** KAISER FOUNDATION HEALTH PLAN [1]  
**Check #:** M  
**Claim #:** D

**Patient Name:** Last name, First Name - A  
**Date of Birth:** Month/Day/Year  
**Patient Acct#:**  
**Member ID:** xxxxxx  
**Group:**

<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Service</th>
<th>Procedure</th>
<th>Before Ben</th>
<th>Not</th>
<th>Copay/ Exc Ben</th>
<th>Patient Adj After Ben</th>
<th>Net</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>90999</td>
<td>05/18/15</td>
<td>5885.00</td>
<td>0.00</td>
<td>0.00</td>
<td>4707.76</td>
<td>0.00</td>
<td>15.00</td>
<td>0.00</td>
</tr>
<tr>
<td>90999</td>
<td>05/18/15</td>
<td>5885.00</td>
<td>0.00</td>
<td>0.00</td>
<td>4707.76</td>
<td>0.00</td>
<td>15.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Kaiser Permanente QUEST Integration:(808) 432-5330 or 1 (800) 651-2237 toll-free  
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Provider Manual_rev7.15.2020
**CLAIM EOB SUMMARY**

Claim Level Code: [23] Payment adjusted, due to impact of prior payor adjudication (Use only with Group Code OA): Generated by adjudicator Added by retro adjudication process.

**Interest Amount:** 17.36  
**Penalty Amount:** 0.00

Total for Processed Claims:

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>17655.00</td>
<td>0.00</td>
<td>0.00</td>
<td>14124.00</td>
<td>0.00</td>
<td>0.00</td>
<td>45.00</td>
<td>0.00</td>
</tr>
<tr>
<td>3531.00</td>
<td>14079.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total for HMO B**

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>17655.00</td>
<td>0.00</td>
<td>0.00</td>
<td>14124.00</td>
<td>0.00</td>
<td>0.00</td>
<td>45.00</td>
<td>0.00</td>
</tr>
<tr>
<td>3531.00</td>
<td>14079.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Remittance Advice

Remittance Detail Report

**Vendor: Vendor Name**

**Address**

**City, State Zip Code**

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure</th>
<th>Before Ben</th>
<th>Not</th>
<th>Copay/Exc Ben</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adj After Ben</td>
<td>Net</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date /DRG</td>
<td>Billed Disallow Penalty Allowed Covered Deduct Coins Amt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Adjust</td>
<td>RSN Penalty Withhold Discount</td>
<td>H Paymnt Codes Ins</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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========== ========= ========= =========

Total for **Vendor Name**: *

---------- --------- --------- --------- --------- -------- -------- -------- -------- --------- --- ----
---- -------- ---------- --------- -------- ---------
17655.00      0.00      0.00  14124.00      0.00     0.00  45.00     0.00  45.00  0.00  0.00
0.00  0.00     3531.00  14079.00               0.00

Remittance Advice

Remittance Detail Report

**Vendor: Name**

**Address**

**City, State Zip Code**

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure</th>
<th>Before Ben</th>
<th>Not</th>
<th>Copay/Exc Ben</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adj After Ben</td>
<td>Net</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Kaiser Permanente QUEST Integration:(808) 432-5330 or 1 (800) 651-2237 toll-free TTY: 1 (877) 447-5990/5991 toll-free providers.kaiserpermanente.org
<table>
<thead>
<tr>
<th>Date</th>
<th>DRG</th>
<th>Billed</th>
<th>Disallow Penalty</th>
<th>Allowed</th>
<th>Covered</th>
<th>Deduct</th>
<th>Coins</th>
<th>Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Adjust</td>
<td>RSN Penalty</td>
<td>Withhold</td>
<td>Discount</td>
<td>Paymnt</td>
<td>Codes</td>
<td>Ins</td>
<td></td>
</tr>
<tr>
<td>======</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
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</tr>
<tr>
<td>========</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
<td>=========</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total for payee Vendor Name - [Check # M]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17655.00</td>
<td>0.00</td>
<td>0.00</td>
<td>14124.00</td>
<td>0.00</td>
<td>0.00</td>
<td>45.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Total Interest Amount: 298.75
Total Penalty Amount: 0.00

CODES SUMMARY

-------------------

**E** Reason Code: [ 3] **E** Co-payment Amount

Reason Code: [ C] Contracted Rate Payment

Reason Code: [ 45] Chg exceeds fee sched/max allowbl or contrctd/legisltd fee, use only with Group Codes PR/CO

*** End of Report ***
**Claims Adjudication Overview**

This topic provides a high-level description of the first-pass adjudication business process. Details of how to perform individual tasks are found in the desk level procedures (DLPs) in this repository.

Most first pass adjudication for KPClaimsConnect is auto-adjudicated, meaning that the claim is reviewed and priced by the system without manual claim adjudicator intervention.

Once the claim comes into the system either electronically, through Electronic Data Interchange (EDI), or manually, through mail room receipts of paper claims, a series of data checks are performed on the claim to determine whether to pay or deny the claim. See [Paper Intake](#).

The system looks at many different elements of the claim during auto-adjudication: authorization exclusions, matching referrals, membership coverage/eligibility, provider selection, contract pricing, CPT/HCPCS/revenue codes, modifier placement, service dates, claim billed/allowed/insurance/net amounts.

- If there are no questions about these claim elements, the claim will automatically pay or deny and be released to AP.
- If there are questions about one or more of these elements, the system applies a code to hold or pend the claim for manual review. There could be specific claim types that will always require review, for example high dollar claims, or there can be combinations of factors that cause the claim to hold/pend for review.

If the system cannot automatically determine whether to pay or deny the claim based on the data available, or if there are Federal, State, or regional policy rules that require the claim is reviewed before it is paid or denied, then the system applies a claim code on the claim to stop the claim from auto-adjudicating, and routes it to a person to perform an action.

**Claim Codes**

There are four types of claim codes that are applied to a claim or a line on a claim: pend, hold, denial, and/or informational. More than one claim code can be applied to a claim or claim service line. The following table gives a description of the claim code types and their effects on the claim depending on whether the claim code is applied at the claim level or service line level.

For specific claim codes and applicable DLPs, refer to the [Pend/Hold Code Matrix](#).

<table>
<thead>
<tr>
<th>Claim Code</th>
<th>Applied to Claim</th>
<th>Applied to Service Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pend/Hold</td>
<td>Pends/holds the claim for manual review. <strong>Note:</strong> The difference between a pend code and a hold code is on whether they hold a claim when</td>
<td>Pends/holds the claim for manual review.</td>
</tr>
</tbody>
</table>
| Deny | Denies the claim.  
Note: If the claim has a hold code, it will not auto-deny. Instead, the claim will hold for review to determine if the denial stays or will be overwritten. | Denies the service.  
Note: A service line may be denied, but the claim is still payable with a status of Clean. These are sometimes referred to as Clean Denials. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Informational</td>
<td>No effect. Claim code and description may be set up to print on RA and/or EOB to provide payment explanation.</td>
<td>No effect. Claim code and description may be set up to print on RA and/or EOB to provide payment explanation.</td>
</tr>
</tbody>
</table>

Note: A claim can have a combination of pend/hold and denial codes applied at the service line level.

**Claim Code Distribution**

The claim is assigned to the applicable In Basket pool based on the claim code(s) and will be reviewed and cleared by users assigned to that pool. The following documents lists provide reference to how pools are mapped for distribution for each region.

- Hawaii Distribution Scheme
- Northwest Distribution Scheme
- See Resolving Claim Codes.

**CRM Process**

The person or department receiving the claim may require additional information or may need to assign a task to a different person or department before they can finalize claims processing. CRMs can be sent to request action and/or additional information. See Completing Tasks and Resolving CRM Records.
When Can Members be Billed?

Members do not have any co-payments for covered services.

You cannot bill a member in the following situations:

- **You** fail to follow Kaiser Permanente’s procedures which results in our non-payment to you.
- Member is a no-show for a scheduled appointment for covered services.

You may bill a member in the following situations:

- **Member** self-refers to a specialist or other provider within our network without following Kaiser Permanente’s procedures which results in our non-payment to you.
- When the member requests and agrees to pay for a non-covered service or self-referrals, and you obtain prior agreement from the member regarding the cost of the services and payment terms at the time of service.

Reporting Requirements

As a Medicaid Health Plan, Kaiser QUEST Integration is required to submit a variety of reports to the State on a schedule.

Some examples include:

- Timely access
- Over and under utilization
- Quality and satisfaction, e.g. HEDIS, CAHPS
- Drug utilization
- Interpretative services
- Member and provider grievances
- Suspected fraud and abuse, including child abuse and adult abuse

As a provider, you are required to comply with all requests for information necessary for Kaiser QUEST Integration that do meet state reporting requirements. This information will also provide Kaiser Permanente with information about your practice and patients gathered from claims for process improvement and quality and performance improvement initiatives.
Chapter 10: Kaiser Permanente QUEST Integration
Program Covered Benefits

For more than 35 years, Kaiser Permanente Hawaii Region has had a program of medical care and outreach service for persons with low income. The program began in 1971 with the enrollment of 500 public assistance families under a contract with the Hawaii Department of Human Services (DHS). It continued with federal and state contracts for medical care for families with low-to-moderate income who were not eligible for public assistance.

In 1994, in an effort to increase access to health care and control the rate of health care expenditures, the State of Hawaii implemented the Hawaii QUEST program (QUEST). QUEST Integration is a statewide program that provides medical and behavioral health services using capitated managed care delivery systems.

QUEST stands for:
- Quality Care
- Universal Access
- Efficient Utilization
- Stabilizing Cost
- Transforming provision of health benefits to public clients

Kaiser Permanente has participated in the QUEST program since its inception.

Kaiser Permanente is proud to be a participating health plan in the new QUEST Integration program serving member starting January 1, 2015. We provide services to Kaiser Permanente QUEST Integration members on the islands of Oahu and Maui.

How to reach us

The Kaiser Permanente QUEST Integration Call Center assists members and providers. Call Kaiser Permanente at 432-5330 or toll-free at 1-800-651-2237. We’re here from 7:45 a.m. to 4:30 p.m., Monday through Friday, except holidays. After normal business hours, you may leave a message on the voice mailbox and someone will call you back as soon as possible, but no later than 4:30pm the following business day. Members who are deaf, hard of hearing, or speech impaired may call toll free 1-877-447-5990 (TTY).
Kaiser Permanente identification cards

Kaiser Permanente QUEST Integration members have a **Kaiser Permanente Identification Card**

The QUEST Integration identification card has additional information required by DHS:

- Member’s Kaiser Permanente Member Identification Number
- Member’s name
- Effective date of member’s Kaiser Permanente QUEST Integration coverage
- Primary clinic name and telephone number
- Third-party liability (TPL) information (not Kaiser Permanente insurance)
- QUEST Integration Call Center telephone number
- After-hours advice line telephone number
## QUEST Integration Covered Benefits and Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary and Acute Care Services</strong> (in alphabetical order)</td>
<td></td>
</tr>
<tr>
<td><strong>Cornea Transplants and Bone Graft Services</strong></td>
<td>Cornea transplants and bone graft services are covered when medically necessary.</td>
</tr>
<tr>
<td><strong>Dialysis</strong></td>
<td>Settings where members can receive dialysis include:</td>
</tr>
<tr>
<td></td>
<td>• Hospital inpatient</td>
</tr>
<tr>
<td></td>
<td>• Hospital outpatient</td>
</tr>
<tr>
<td></td>
<td>• Non-hospital dialysis facility</td>
</tr>
<tr>
<td></td>
<td>• Member’s home</td>
</tr>
<tr>
<td></td>
<td>Dialysis services include:</td>
</tr>
<tr>
<td></td>
<td>• Lab tests</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B vaccines</td>
</tr>
<tr>
<td></td>
<td>• Alfa-Epoetin (EPO) provided during dialysis</td>
</tr>
<tr>
<td></td>
<td>• Drugs related to ESRD</td>
</tr>
<tr>
<td></td>
<td>• Home dialysis equipment</td>
</tr>
<tr>
<td></td>
<td>• Continuous ambulatory peritoneal dialysis (CAPD)</td>
</tr>
<tr>
<td></td>
<td>• Physician services</td>
</tr>
<tr>
<td></td>
<td>• Hospital stays</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME) and Medical Supplies</strong></td>
<td>Durable medical equipment needed to:</td>
</tr>
<tr>
<td></td>
<td>• Reduce a medical disability</td>
</tr>
<tr>
<td></td>
<td>• Restore or improve function</td>
</tr>
<tr>
<td></td>
<td>Supplies for rent or purchase include:</td>
</tr>
<tr>
<td></td>
<td>• Oxygen tanks and concentrators</td>
</tr>
<tr>
<td></td>
<td>• Ventilators</td>
</tr>
<tr>
<td></td>
<td>• Wheelchairs</td>
</tr>
<tr>
<td></td>
<td>• Crutches and canes</td>
</tr>
<tr>
<td></td>
<td>• Eyeglasses</td>
</tr>
<tr>
<td></td>
<td>• Orthotic devices</td>
</tr>
<tr>
<td></td>
<td>• Prosthetic devices</td>
</tr>
<tr>
<td></td>
<td>• Hearing aids</td>
</tr>
<tr>
<td></td>
<td>• Pacemakers</td>
</tr>
<tr>
<td></td>
<td>• Medical supplies (surgical dressings, continence and ostomy supplies)</td>
</tr>
<tr>
<td></td>
<td>• Foot appliances (orthoses, prostheses)</td>
</tr>
<tr>
<td></td>
<td>• Orthopedic shoes and casts</td>
</tr>
<tr>
<td></td>
<td>• Ortho digital prostheses and casts</td>
</tr>
<tr>
<td></td>
<td>• Other medically necessary durable medical equipment covered by</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Emergency and Post- Stabilization Services</td>
<td>Services in an emergency room for emergent conditions. If the condition is considered non-emergent, members may have to pay for charges related to the visit. Kaiser Permanente will not deny payment for emergency services sought by a prudent layperson, even if emergency services are determined not needed and regardless if the provider is in- or out-of-network. Members are also covered for care that keeps his/her condition stable after an emergency.</td>
</tr>
</tbody>
</table>
| Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | Routine checkups for children and youth under the age of 21 included (but are not limited to):  
• Medical and behavioral health screening  
• Diagnostic tests  
• Immunizations  
• Preventive care, etc.                                                                                                                                                                                                                                                        |
| Family Planning Services                    | Services for members who are sexually active and of childbearing age:  
• Education and counseling to make informed choices and understand contraceptive methods;  
• Emergency contraception and counseling, as indicated;  
• Follow up care and office visits (to help prevent unwanted pregnancies; to help plan the number of pregnancies; to help plan the time between pregnancies; or to confirm if members are pregnant);  
• Pregnancy testing;  
• Family planning drugs, supplies, and devices to prevent unwanted pregnancy (to include generic birth control pills and diaphragms);  
• Diagnosis and treatment of sexually transmitted diseases.  
You have the choice to get the above family planning services from Kaiser Permanente or from an out-of-network provider without a referral from us. Other family planning services available to you:  
• Office visits and diagnostic tests to diagnosis infertility;  
• Sterilization.                                                                                                                                                                                                                                                             |
| Fluoride Varnish                            | Application by a qualified primary care physician is covered for children between 1 and 6 years of age who have not received topical fluoride treatment by a dentist or qualified PCP within the past six months.                                                                                                                                                                    |
| Habilitation Services                       | Habilitative services and devices include:  
• Audiology services  
• Occupational therapy                                                                                                                                                                                                                                                                                                                  |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
|                         | • Physical therapy  
|                         | • Speech-language therapy  
|                         | • Vision services  
|                         | • Augmentative communication devices  
|                         | • Reading devices  
|                         | • Visual aids  
|                         | Devices used only for activities at school are not covered. |
| Hearing Services        | Services include:  
|                         | • Diagnostic services  
|                         | • Screening  
|                         | • Preventive care  
|                         | • Corrective services, equipment, and supplies |
| Service                 | Under age 21                                      | Age 21 and older                           | Prior approval required |
| Hearing exam            | One time a year                                   | One time a year                           | No                     |
| Hearing aid fitting and | Two times every three years                       | One time every three years                | Yes                    |
| orientation             |                                                       |                                           |                        |
| Hearing aids            | One hearing aid per ear every 24 months           | One hearing aid per ear every 24 months   | Yes                    |
| Home Health Services    | Services provided at home by qualified home health agencies:  
|                         | • Skilled nursing  
|                         | • Home health aides  
|                         | • Medical supplies and DME  
|                         | • Therapeutic rehab services (physical and occupational therapy)  
|                         | • Audiology and speech pathology                   |
| Immunizations           | Receive the following immunizations:  
|                         | • Influenza  
|                         | • Diphtheria  
|                         | • Tetanus  
|                         | • Pneumococcal vaccine  
|                         | • Other vaccines as needed | |
| Inpatient Hospital      | Includes the cost of room and board for inpatient stays.  
| Medical and Surgical    | The services include:  
| Services                | • Nursing care |

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<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| Medical supplies                       | - Medical supplies  
- Equipment and drugs  
- Diagnostic services  
- Physical therapy  
- Occupational therapy  
- Audiology and speech-language pathology |
| Inpatient Hospital Maternity/Newborn Care Services | Women in good health with deliveries that are not complex may stay in the hospital for up to:  
- 48 hours after a natural birth  
- 96 hours after a cesarean section  
The patient and physician may agree to an early discharge. |
| Medical Services Related to Dental Needs | Kaiser Permanente covers dental services to treat medical conditions done in a medical facility like a hospital. Med-QUEST, not Kaiser Permanente, covers dental services through the month of a member’s 21st birthday. Adults age 21 or older may receive emergency dental services. Also see “Covered by Med-QUEST but not by Kaiser Permanente” at the end of this section. |
| Nutrition Counseling                   | Types of services for members include:  
- Diabetes self-management training  
- Nutrition counseling for obesity  
- Nutrition counseling for other metabolic conditions (if medically necessary) |
| Outpatient Hospital Services            | Services to prevent, diagnose, or manage the pain of an illness or injury such as:  
- Family planning  
- Medical services related to dental needs  
- Imaging services  
- Laboratory studies  
- Oncology services  
- Diagnostic testing  
- Ambulatory surgery services  
- Physical therapy  
- Occupational therapy  
- Speech therapy  
- Blood storage and processing  
- Respiratory services  
- Audiology services  
- Cardiology services  
- Chemotherapy services  
- Radiation services |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>Services provided by or under the direct supervision of physicians include:</td>
</tr>
<tr>
<td></td>
<td>- Physical examinations</td>
</tr>
<tr>
<td></td>
<td>- Screening examinations</td>
</tr>
<tr>
<td></td>
<td>- EPSDT screenings for children and youth under age 21</td>
</tr>
<tr>
<td>Podiatry (foot disease) Services</td>
<td>Services for the foot and ankle such as:</td>
</tr>
<tr>
<td></td>
<td>- Professional services, not involving surgery</td>
</tr>
<tr>
<td></td>
<td>- Diabetic foot care (inpatient and outpatient)</td>
</tr>
<tr>
<td></td>
<td>- Diagnostic radiology procedures limited to ankle and below</td>
</tr>
<tr>
<td></td>
<td>- Surgical procedures limited to ankle and below</td>
</tr>
<tr>
<td></td>
<td>- Foot and ankle care for infection or injury</td>
</tr>
<tr>
<td>Pregnancy-Related Services for</td>
<td>Services provided for pregnancy and maternity care such as:</td>
</tr>
<tr>
<td>Pregnant Women and Expectant</td>
<td>- Prenatal visits</td>
</tr>
<tr>
<td>Parents</td>
<td>- Diagnostic tests (X-ray and laboratory)</td>
</tr>
<tr>
<td></td>
<td>- Treatment of missed or threatened abortions</td>
</tr>
<tr>
<td></td>
<td>- Postpartum care (up to 60 calendar days)</td>
</tr>
<tr>
<td></td>
<td>- Health education and screening for conditions that could make a pregnancy “high risk”</td>
</tr>
<tr>
<td></td>
<td>- Fetal development</td>
</tr>
<tr>
<td></td>
<td>- Labor and delivery of infant</td>
</tr>
<tr>
<td></td>
<td>- Diagnostic ultrasound</td>
</tr>
<tr>
<td></td>
<td>- Fetal stress and non-stress testing</td>
</tr>
<tr>
<td></td>
<td>- Prenatal vitamins</td>
</tr>
<tr>
<td></td>
<td>- Lactation counseling – up to six months*</td>
</tr>
<tr>
<td></td>
<td>- Breast pump rental – up to six months*</td>
</tr>
<tr>
<td></td>
<td>- Breast pump purchase – requires prior approval</td>
</tr>
<tr>
<td></td>
<td>*May be extended with prior approval.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>- Prescription drugs and certain over-the-counter drugs which are on the list of approved drugs and prescribed by a licensed doctor</td>
</tr>
<tr>
<td></td>
<td>- Medication management and counseling</td>
</tr>
<tr>
<td>Preventive Services – Adult</td>
<td>Includes:</td>
</tr>
<tr>
<td>(21 years or older)</td>
<td>- Blood pressure</td>
</tr>
<tr>
<td></td>
<td>- Breast cancer screening</td>
</tr>
<tr>
<td></td>
<td>- Cervical cancer screening</td>
</tr>
<tr>
<td></td>
<td>- Chemoprophylaxis</td>
</tr>
<tr>
<td></td>
<td>- Colorectal cancer screening</td>
</tr>
<tr>
<td></td>
<td>- Health education and counseling</td>
</tr>
<tr>
<td></td>
<td>- Immunizations</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Preventive Services – Children (Less than 21 years of age) | Includes:  
  - Age-appropriate dental referral and oral fluoride  
  - Age-appropriate health education  
  - EPSDT services  
  - Hospital stay for normal, term, and healthy newborn  
  - Immunizations  
  - Newborn screening  
  - Other age-appropriate laboratory screening tests  
  - Screening to assess health status  
  - Tuberculin skin testing |
| Preventive Services – Pregnant Women         | Includes:  
  - Diagnostic amniocentesis, diagnostic ultrasound, fetal stress and non-stress  
  - Diagnosis of premature labor  
  - Health education and screening  
  - Hospital stays  
  - Prenatal laboratory screening tests  
  - Prenatal visits  
  - Prenatal vitamins, including folic acid |
| Radiology/Laboratory/Other Diagnostic Services | Includes:  
  - Diagnostic and therapeutic radiology and imaging  
  - Screening and diagnostic laboratory test  
  - Other medically necessary diagnostic or therapeutic service Services may require a prior approval. |
| Rehabilitation Services                     | Provided to patients who are expected to improve in a reasonable period of time with therapy. Services include:  
  - Physical therapy  
  - Occupational therapy  
  - Audiology  
  - Speech-language pathology  
Prior approval is required for all rehabilitation services except for the initial evaluation. |
<p>| Sleep Laboratory                             | Diagnosis and treatment of sleep disorders by accredited sleep laboratories. |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Cessation Services</td>
<td>Services include:&lt;br&gt;  - In-person counseling sessions:&lt;br&gt;     - At least four in-person sessions&lt;br&gt;     - Limited to two quit attempts per benefit period&lt;br&gt;     - Medications&lt;br&gt;</td>
</tr>
<tr>
<td>Sterilizations and Hysterectomies</td>
<td>For both men and women when the following are met:&lt;br&gt;     - Age 21 years or older at time of consent&lt;br&gt;     - Mentally competent&lt;br&gt;     - Require consent at least 30 calendar days prior to the procedure&lt;br&gt;</td>
</tr>
<tr>
<td>Telehealth Services</td>
<td>Services include live consultation provided through video or web conferencing. Services are covered if referred by an in-network provider and if members have difficulty using transportation to the provider.</td>
</tr>
<tr>
<td>Transportation Services</td>
<td>Services include emergency and non-emergency ground and air transportation.&lt;br&gt;                                         Transportation to and from medically necessary covered medical appointments is covered for:&lt;br&gt;     - Members who have no means of transportation&lt;br&gt;     - Members who reside in areas not served by public transportation or who cannot access public transportation&lt;br&gt; Transportation is also covered when the medical condition requires treatment that is not available in the area where members are. Travel services include:&lt;br&gt;     - Ground and air transportation&lt;br&gt;     - Lodging&lt;br&gt;     - Meals&lt;br&gt; Prior approval is required. Includes travel services for the member and (if needed) an attendant.</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Care for a medical condition that is serious but not life threatening and needs to be treated within 24 hours.&lt;br&gt; Call any Kaiser Permanente clinic for an appointment. If the clinic is closed, call the after-hours advice line at 808-432-7700, toll free at 1-800-467-3011, or 711 (TTY).&lt;br&gt; Urgent care out of area is only covered for members under age 21.</td>
</tr>
</tbody>
</table>
## Vision Services

Routine eye exams and glasses:

<table>
<thead>
<tr>
<th>Service</th>
<th>Under age 21</th>
<th>Age 21 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Once in 12 months</td>
<td>Once in 24 months</td>
</tr>
<tr>
<td>Eyeglasses (includes lens, frames, fitting, and adjustment)</td>
<td>One every 24 months</td>
<td>One every 24 months</td>
</tr>
</tbody>
</table>

Contact lenses may be covered with prior approval.

Emergency eye medical-condition care is covered for all members without prior approval.

Vision services not included:
- Orthoptic training
- Prescription fee
- Progress exams
- Radial keratotomy
- Visual training
- Lasik procedure

## Other Facility Services

### Hospice Care

Provides care to terminally ill patients who are not expected to live more than six months. Hospice services will be covered in the home, nursing facility or inpatient settings.

Children under the age of 21 can receive treatment to manage or cure disease while in hospice care.

### Nursing Facility

Includes:
- Skilled Nursing Facility (SNF)
- Intermediate Care Facility (ICF)
- Subacute level of care in a hospital

## Behavioral Health Services

### Standard Behavioral Health Services

(includes psychiatric services and substance abuse treatment services)

Includes:
- Room and board
- Nursing care
- Medical supplies
- Equipment
- Medications
- Medication management
- Diagnostic services

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<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Mental Health Services</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>• 24-hour access line</td>
</tr>
<tr>
<td></td>
<td>• Mobile crisis response</td>
</tr>
<tr>
<td></td>
<td>• Crisis stabilization</td>
</tr>
<tr>
<td></td>
<td>• Crisis management</td>
</tr>
<tr>
<td></td>
<td>• Crisis residential services</td>
</tr>
<tr>
<td>Psychotropic Medications and Medication</td>
<td>Medications and medication management includes:</td>
</tr>
<tr>
<td>Management</td>
<td>• Evaluation, prescription and maintenance of psychotropic</td>
</tr>
<tr>
<td></td>
<td>medications</td>
</tr>
<tr>
<td></td>
<td>• Medication management</td>
</tr>
<tr>
<td></td>
<td>• Counseling</td>
</tr>
<tr>
<td></td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td>• Promotion of algorithms and guidelines</td>
</tr>
<tr>
<td>Psychiatric or Psychological Evaluation</td>
<td>Services to evaluate and provide treatment of behavioral</td>
</tr>
<tr>
<td>and Treatment</td>
<td>health include:</td>
</tr>
<tr>
<td></td>
<td>• Individual and group counseling and monitoring</td>
</tr>
<tr>
<td>Medically Necessary Alcohol and Chemical</td>
<td>Inpatient and outpatient substance abuse services. Provided</td>
</tr>
<tr>
<td>Dependency Services</td>
<td>in a setting accredited according to standards set by the</td>
</tr>
<tr>
<td></td>
<td>Alcohol and Drug Abuse Division (ADAD) of the Hawaii</td>
</tr>
<tr>
<td></td>
<td>State Department of Health.</td>
</tr>
<tr>
<td>Methadone Management Services</td>
<td>Methadone and levo-alpha-acetylmethadol (LAAM) services for</td>
</tr>
<tr>
<td></td>
<td>acute opiate detoxification and maintenance.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>Long-Term Services and Supports (LTSS)</td>
<td>Includes Institutional Care as well as Home and Community Based Services (HCBS). Individuals need to qualify for all LTSS services. Services may be determined based on a member’s functional assessment documented on the DHS 1147 form. Services may include:</td>
</tr>
</tbody>
</table>
| | • Home delivered meals  
| | • Personal Emergency Response System (PERS)  
| | • Personal care services  
| | • Adult day care  
| | • Adult day health  
| | • Skilled and private duty nursing  
| In addition, the At-Risk member seeking qualification for LTSS must: | |
| | • Live in his or her home  
| | • Not be homebound  
| | • Not meet criteria for ICF/DDD  
| | • Not be living in a care home/foster home or facility/institution  
| Acute Waitlisted SNF/ICF | Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF) level of care services provided in an acute care hospital in an acute care hospital bed.  
| Adult Day Care Center (ADC) | Supportive care for four or more disabled adults. Services include:  
| | • Observation/supervision  
| | • Coordination and use of behavioral, medical, and social care plans, and therapeutic, social, educational, recreational, and other activities  
| Adult Day Health Center (ADH) | Organized day program with nursing oversight. Provided to adults with physical and/or mental conditions. The purpose is to help members to stay in the community as much as possible.  
| Assisted Living Facility (ALF) | Services include:  
| | • Personal care  
| | • Supportive care (homemaker, chore and meal preparation)  
| | • Nursing  
| | • Help with medication  
| Community Care Management Agency (CCMA) | For members living in Community Care Foster Family Homes and other community settings, services by a CCMA include:  
| | • Nurse delegation to the caregiver  
| | • Identifying needed services, supplies, and equipment  
| | • Face-to-face monitoring  
| | • Use of the service plan  
| | • Assisting the caregiver with undesired effects and/or changes in condition of members  
| Community Care | For members living in Community Care Foster Family Homes (certified
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| Foster Family Home (CCFFH)                   | private home with care provider living in the home), services include:  
|                                              |   • Personal and supportive care  
|                                              |   • Homemaker  
|                                              |   • Chores  
|                                              |   • Companion services  
|                                              |   • Nursing  
|                                              |   • Medication oversight  |
| Counseling and Training                      | Counseling and training activities include:  
|                                              |   • Member care training for members, families, and caregivers regarding health conditions  
|                                              |   • Infection control  
|                                              |   • Treatment regimens  
|                                              |   • Equipment  
|                                              |   • Crisis intervention  
|                                              |   • Grief counseling  
|                                              |   • Substance abuse  
|                                              |   • Nutrition  
|                                              |   • Safety  |
| Companion Services                           | Non-medical care, supervision, and socialization prior approved by a service coordinator and documented in the service plan. |
| Environmental Accessibility Adaptations (EAA)| Changes to the home needed to ensure the health, welfare, and safety of the member, allowing the member to stay at home as much as possible. |
| Home Delivered Meals                         | For members who cannot prepare meals without help and need meal services to stay independent and at home.  
|                                              | Does not include residential or institutional settings. |
| Home Maintenance                             | Services to maintain a safe and clean environment may include:  
|                                              |   • Heavy-duty cleaning  
|                                              |   • Minor repairs to essential appliances  
|                                              |   • Fumigation or extermination services  |
| Moving Assistance                            | May be provided in rare cases for members who need to move to a new home. For example:  
|                                              |   • Unsafe deteriorating home  
|                                              |   • Member is evicted from current home  
|                                              |   • Member is not able to afford home due to a rent increase  
<p>|                                              |   • Wheelchair bound member living above the first floor of a multi-story building without elevator  |
| Non-Medical Transportation                   | May be authorized based on demonstrated need for member access to community services, activities, and resources in their service plan. This service does not replace medical transportation. |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF)</td>
<td>Services provided in a nursing facility licensed and certified to provide skilled nursing and rehabilitative services on a regular basis. Nursing facility members require assistance 24 hours a day with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).</td>
</tr>
<tr>
<td>Personal Assistance Service Level I (PA1)</td>
<td>For members who are not living with their family and may need help with their daily activities. Services include:</td>
</tr>
<tr>
<td></td>
<td>- Companion services (meal prep, laundry, errands)</td>
</tr>
<tr>
<td></td>
<td>- Homemaker/chore service (routine housecleaning, care of clothing and linen, shopping, yard work)</td>
</tr>
<tr>
<td>Personal Assistance Service Level II (PA2)</td>
<td>For members needing:</td>
</tr>
<tr>
<td></td>
<td>- Moderate to total assistance with activities of daily living</td>
</tr>
<tr>
<td></td>
<td>- Health maintenance activities</td>
</tr>
<tr>
<td></td>
<td>Provided by Home Health Aide, Personal Care Aide, Certified Nurse Aide or Nurse Aide.</td>
</tr>
<tr>
<td>Personal Emergency Response Systems (PERS)</td>
<td>Electronic device with a 24-hour emergency assistance service that helps members get immediate help in an emotional, physical, or environmental emergency.</td>
</tr>
<tr>
<td>Residential Care Services or Type I or Type II Expanded Adult Residential Care Home (E-ARCH)</td>
<td>Services include:</td>
</tr>
<tr>
<td></td>
<td>- Personal care</td>
</tr>
<tr>
<td></td>
<td>- Nursing</td>
</tr>
<tr>
<td></td>
<td>- Homemaker</td>
</tr>
<tr>
<td></td>
<td>- Chores</td>
</tr>
<tr>
<td></td>
<td>- Companion services</td>
</tr>
<tr>
<td></td>
<td>- Medication oversight (provided by a principle care provider who lives in the home)</td>
</tr>
<tr>
<td>Respite Care</td>
<td>May be provided on a short-term basis to individuals unable to care for themselves. Respite may be provided hourly, daily, or overnight in the following locations: individual’s home or place of residence; CCFFH; E-ARCH; NF; licensed respite day care facility; or other community care residential facility approved by the State.</td>
</tr>
<tr>
<td>Skilled (or Private Duty) Nursing</td>
<td>For members requiring ongoing nursing care, provided by licensed nurses.</td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies (SMES)</td>
<td>Refers to the purchase, rental, lease, warranty costs, installation, repairs, and removal of devices, controls, or appliances, as specified in the service plan. Services include but are not limited to:</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>Items necessary for life support</td>
<td></td>
</tr>
<tr>
<td>Specialized infant car seats</td>
<td></td>
</tr>
<tr>
<td>Modification of parent-owned motor vehicle to accommodate the child, e.g. wheelchair lifts</td>
<td></td>
</tr>
<tr>
<td>Shower seat</td>
<td></td>
</tr>
<tr>
<td>Portable humidifiers</td>
<td></td>
</tr>
<tr>
<td>Medical supplies</td>
<td></td>
</tr>
<tr>
<td>Heavy duty items</td>
<td></td>
</tr>
</tbody>
</table>

**Subacute Facility Services**

Members do not require acute care but need more intensive skilled nursing. Services provided in:
- A licensed nursing facility
- A licensed and certified hospital

**Community Integrated Services (CIS)**

To be eligible, members need to be eighteen (18) years of age or older to be eligible. Also, members must meet the following to qualify for CIS:

1. Be chronically homeless, or
2. Currently homeless and have one of the qualifying health conditions listed below, or
3. Living in an institution and cannot leave without stable housing and have one of the qualifying health conditions listed below, or
4. Living in public housing and at risk of being kicked out and have one of these qualifying health conditions:
   - A mental health disorder affecting one or more major life activities, or
   - Diagnosed with substance use disorder, or
   - Have a chronic physical or complex health needs, or
   - Go to the emergency department or inpatient hospital often.

CIS is divided into three categories: (1) pre-tenancy services, (2) tenancy services, and (3) other housing and tenancy support services.

**Pre-tenancy services**

Include:
- Screening and assessments
- Developing housing support assistance plan
- Searching for housing
- Preparing and submitting applications
- Identifying needs for start-up
- Identifying equipment, technology, and other changes needed
- Reviewing safety of housing
- Moving assistance
- Housing crisis plan

**Tenancy services**

Include:
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
|         | - Identifying and assisting with bad behaviors  
|         | - Educating members about roles and responsibilities of tenant/landlord  
|         | - Coaching members how to develop and maintain relationships with landlords/property managers  
|         | - Teaching members how to resolve disagreement with landlords/neighbors  
|         | - Connecting members with supportive groups to help prevent members from being kicked out of his/her home  
|         | - Housing recertification process  
|         | - Updating/maintaining housing assistance and crisis plans  
|         | - Developing skills for daily living and maintaining his/her home  
|         | - Coordinating Service care  
|         | - Managing housing crisis |

**Other Housing and Support services**

Include:

- Training for jobs and employment  
- Support (peers, groups, caregiver/family)  
- Non-medical transportation  
- Outreach and In-reach services  
- Managing health  
- Counseling and therapies  
- Assessing services  
- Developing Service plan  
- Teaching members skills for living alone and managing money  
- Equipment, technology and other modifications  
- Managing his/her home  
- Other supplemental services as needed
Covered by Med-QUEST but not by Kaiser Permanente

Some services are not covered by the member’s medical plan. He/she can get these services in other ways.

Dental care: The DHS, not Kaiser Permanente, covers dental services through the month of a member’s twenty-first (21st) birthday. For adult members twenty-one (21) years and older, Med-QUEST only covers emergency dental services to ease dental pain, remove infections, and treat serious injuries to teeth and supporting structures. Use the Medicaid card to obtain dental services. Members must get dental care from a dentist who sees Medicaid members. For help in finding a dentist, call Community Case Management Corp. at 808-792-1070 or 1-888-792-1070 (toll-free).

Elective abortions or intentional termination of pregnancy (ITOP): DHS, not Kaiser Permanente, covers procedures, medications, transportation, meals, and lodging for ITOPs. Members do not need a referral from us. Members must find a doctor who sees Medicaid patients and accepts Medicaid fee-for-service. Use the Medicaid card. The Member’s doctor will submit a claim to DHS. If member’s need help with arranging transportation, they may call 808-692-8124.

State of Hawaii Organ and Tissue Transplant (SHOTT) Program: DHS provides transplants through the SHOTT program. Covered transplants must be non-experimental, non-investigational for the specific organ/tissue and specific medical condition being treated. These transplants may include liver, heart, heart-lung, lung, kidney, kidney-pancreas, and allogenic and autologous bone marrow transplants. In addition, children may be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT program contractor.

Services from other agencies in the community:

Early Intervention Program (EIP) provides services for children 0 – 3 years of age with special needs. Services are provided in places where a child lives, learns and grows. Parents and/or caregivers are coached on how to help their child succeed in their environment. Services covered include: Assistive Technology, occupational therapy, physical therapy, psychology services, special instruction, speech-language pathology, and vision services. For more information, call 808-594-0066.

Honolulu Community Action Program (HCAP) – Head Start

This is a federal program to help prepare children ages 3 – 5 years old for school. Some of the programs offered are part-day or full-day centers, home-based, Head Start DOE combined classrooms, and family activities. To apply, or for more information, call 808-847-2400.
**Women, Infant and Children (WIC)** - This program helps low-income, nutritionally at-risk pregnant women, new moms, and children under age 5 with healthy foods, nutrition education, screening and referrals to other health, welfare and social programs. Some of the healthy foods are milk, eggs, cheese, cereal, peanut butter, fruits, vegetables and infant food. For more information, call 808-586-8175 on Oahu or 1-888-820-6425.

**Tuberculosis Control Program**: This program is for the diagnosis, treatment, identification, prevention, and appropriate therapy of tuberculosis. For more information, call the Tuberculosis Control Branch at 808-832-5731.

**Hansen's Disease Community Program**: This program is for patients with Hansen’s Disease. The program provides treatment, education, assistance to family members and health care providers, and helps patients obtain services. For more information, call the Hansen’s Disease Branch at 808-733-9831.

**Community Care Services (CCS) Behavioral Health Program (provided by Ohana Health Plan)**: Adult members 18 years or older with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) may be eligible for additional behavioral health service from the CCS program. Specialized behavioral health services include inpatient and outpatient therapy, tests to monitor the member’s response to therapy, and intensive case management. For more information, call 1-888-846-4262.

**Services for Individuals with Developmental Disabilities/Intellectual Disabilities (DD/ID)**: The DOH Developmental Disability Division (DOH/DDD) provides intermediate care facility/ID services to some individuals. Kaiser Permanente and DOH/DDD coordinate activities for people with DD/ID. For more information, call 808-586-5840.
Support for Emotional and Behavioral Development (SEBD) for children: Behavioral health services are available for children with emotional and behavioral development issues. The Department of Health, through its Child and Adolescent Mental Health Division (CAMHD) provides behavioral health services, including transportation, to children and adolescents ages 3 through 20 who need intensive behavioral health services. To find out more, call one of the Family Guidance Centers listed below.

<table>
<thead>
<tr>
<th>Family Guidance Center</th>
<th>Address</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Oahu</td>
<td>860 Fourth Street, 2nd Floor Pearl City, Hawaii 96782</td>
<td>808-453-5900</td>
<td>808-453-5940</td>
</tr>
<tr>
<td>Family Court Liaison Branch</td>
<td>Hawaii Youth Correctional Facility 42-477 Kalanianaole Hwy. Kailua, Hawaii 96732</td>
<td>808-266-9922</td>
<td>808-266-9933</td>
</tr>
<tr>
<td>Honolulu</td>
<td>3627 Kilauea Avenue, Room 401 Honolulu, Hawaii 96816</td>
<td>808-733-9393</td>
<td>808-733-9377</td>
</tr>
<tr>
<td>Leeward Oahu</td>
<td>601 Kamokila Blvd., Room 355 Kapolei, Hawaii 96707</td>
<td>808-692-7700</td>
<td>808-692-7712</td>
</tr>
<tr>
<td>Windward Oahu</td>
<td>45-691 Keaahala Road Kaneohe, Hawaii 96744</td>
<td>808-233-3770</td>
<td>808-233-5659</td>
</tr>
<tr>
<td>Maui</td>
<td>270 Waiehu Beach Road, Suite 213 Wailuku, Hawaii 96793</td>
<td>808-243-1252</td>
<td>808-243-1254</td>
</tr>
</tbody>
</table>

Services that are typically NOT covered under the QUEST Integration Program:

- Personal care items such as shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers, shoes, slippers, clothing, laundry services, baby oil, sanitary napkins, diapers for babies, soaps, lip balm, bandages, and contact lens solution
- Non-medical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items, motor vehicles or furnishings
- Experimental and/or investigative services, procedures, drugs, devices, and treatments; drugs not approved by the Federal Drug Administration (FDA)
- Treatment of complications resulting from previous cosmetic, experimental or investigative services, or other services that are not covered

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• Treatment of baldness, including hair transplants and topical medications, wigs, and hairpieces
• Treatment of persons confined to public institutions
• All medical and surgical procedures, therapies, supplies, drugs, and equipment for the treatment of sexual dysfunction or inadequacies
• Penile or testicular prostheses and related services
• Reversal of sterilization, in vitro fertilization, artificial insemination, sperm banking procedures, fertilization by artificial means, and all procedures and drugs to treat infertility or enhance fertilization
• Bereavement counseling, employment counseling, primal therapy, long-term character analysis, marathon group therapy, and/or consortium
• Routine foot care, treatment of flat feet
• Swimming lessons, summer camp, gym membership, and weight control classes
• Beds – lounge beds, bead beds, water beds, day beds, overbed tables, bed lifters, bed boards, bed side rails if not an integral part of a hospital bed
• Contact lenses for cosmetic purposes; bifocal contact lenses
• Oversized lenses, blended or progressive bifocal lenses, tinted or absorptive lenses (except for aphakia, albinism, glaucoma, medical photophobia) trifocal lenses (except as a specific job requirement), spare glasses
• Refractive eye surgery
• Physical exams and/or psychological evaluations as a requirement for employment or as a requirement for continuing employment (e.g., truck and taxi drivers’ licensing)
• Physical exams and/or psychological evaluations as a requirement for drivers’ licenses or for the purpose of securing life and other insurance policies or plans
• Organ transplants not meeting the guidelines established by the Medicaid program and organ transplants not specifically identified as benefits
• Biofeedback, acupuncture, chiropractic services, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment (by masseurs), and any other form of self-care or self-help training and any related diagnostic testing
• Ambulance wait time, physician wait time, standby services, telephone consultations, telephone calls, writing of prescriptions, stat charges
• Treatment of pulmonary tuberculosis that is covered by DOH
• Treatment of Hansen’s Disease that is covered by DOH
• Topical application of oxygen
• Orthoptic training
• Travel medicine
• OPTIFAST programs and supplements, bariatric classes and supplies

Emergency Services

Definitions:

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition shall not be defined based on lists of diagnoses or symptoms.

Emergency Services – Any covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish services and that are needed to evaluate or stabilize an emergency medical condition.

Emergency services from non-Kaiser Permanente practitioners are covered ONLY if the services meet the prudent layperson standard and the services were immediately required because it was an unforeseen illness or injury and the delay caused by coming to a Kaiser Permanente facility would have resulted in death, serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or placed the health of the individual in serious jeopardy. Continuing or follow up care from non-Kaiser Permanente providers is not covered, except for post-stabilization care while waiting to transfer care to Kaiser Permanente.

If a member is admitted to a non-Kaiser Permanente facility, the member or a family member must notify Kaiser Permanente within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of their Kaiser Permanente identification card.

Urgent Care: Urgent care is defined as care for a sudden and unforeseen illness or injury which is required to prevent serious deterioration of the member’s health and which cannot be delayed until the member is medically able to safely return to the Hawaii Service Area to receive care from a Kaiser Permanente practitioner (if outside the Hawaii Service Area), or to travel to a Kaiser Permanente facility.
When members are in need of urgent care, please contact the nearest clinic. After hours, call the Kaiser Permanente After Hours Advice Nurse (1-800-467-3011 from Neighbor Islands or 432-7700 from O'ahu).

**QUEST Integration Service Coordination**

Kaiser Permanente will identify those members who may be candidates for service coordination. For members new to KP and subject to initial assessment requirements and timeframes, the determination of need for LTSS will be included in that assessment.

Service coordination assignments will be determined by the LTSS Manager or someone on his/her behalf when the cases are received. Specifically, those who qualify for Service Coordination fall into one of five (5) categories:

1. Adults with SHCN
2. Children with SHCN
3. Members receiving HCBS
4. Members choosing self-direction
5. Institutional LOC members residing in an institutional setting
6. Dual eligible

While Medical Group physicians have ultimate responsibility as the manager of his or her panel of patients, an additional service coordination support system is available for eligible QUEST Integration members. This system focuses on the use of licensed social workers, registered nurses, and para-professional staff to:

- Coordinate the timely access and use of medically necessary services.
- Direct and, as needed, assist QUEST Integration enrollees in their use of the Kaiser Permanente system to obtain services.
- Outreach to QUEST Integration new member enrollees to familiarize them with the Kaiser Permanente health plan, link them to a Primary provider, and inform them of their benefits (preventative care, EPSDT, SHCN, Chronic disease management, community resources, etc.).
- Assist with discharge planning for hospital patients.
- Track QUEST Integration enrollees' compliance with prescribed treatment and assist their compliance by coordinating necessary patient education.
- Assist the provider to outreach to the QUEST Integration enrollee for urgent matters in the clinic or at the enrollee's home.
- Refer members to other programs or agencies when care coordination services are not available at Kaiser

The PCP in conjunction with his or her support staff will be responsible for ensuring that recipients receive adequate information to permit them to make medically informed decisions about their health care needs.

QUEST Integration service coordinators and support staff are located in the “hub” Kaiser Permanente clinics on the islands of Oahu and Maui. Communication through the electronic medical record allows all providers and support staff to have immediate access to pertinent medical and social information. Physicians, QUEST Integration service coordinators and support staff are supported by established systems within Kaiser Permanente to direct the QUEST Integration member toward selected preventive services, track patients’ scheduled appointments and, when necessary, remind them about the need to fulfill the visit.

Referrals to QUEST Integration staff may be made by calling 432-5330 or 1-800-651-2237 (toll-free).

### Services for children

Regular medical visits are very important to keep children as healthy as possible and reduce the spread of disease. Children’s regular visits, examinations, immunizations (shots), and screening tests are included in well-child care at no cost.

For members under age 21, the QUEST Integration program provides these preventative services in a program called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Children will be examined periodically to check for any illness. Checkups are needed more often in the child’s first years and less often as he or she grows older (see examination and vaccine schedule on page 16). Some children look healthy but have hidden health problems. Screening tests, such as blood tests, give the doctor information about the child’s health. If any health problems are found, the doctor looks for the cause, makes a diagnosis, and orders treatment.

These medically necessary services, including behavioral therapy for children, are provided at no cost to you. The behavioral therapies include intensive behavioral therapy for children with autism spectrum disorder (ASD), including applied behavioral analysis (ABA) for the treatment of children with an ASD diagnosis.
Reminders of the next EPSDT appointment will be made by phone and email through kp.org.

Here is what to expect at the child’s EPSDT checkups:

- Height, weight, and blood pressure checks
- Eye exams
- Hearing tests
- Lab tests
- Immunizations
- Screening for lead, tuberculosis (TB) and other conditions
- Mental and physical assessment
- Screening for behavioral health issues or substance abuse
- Review of medications (including fluoride and multivitamins)
- Referrals to specialist or dentist, if needed
- Health education and guidance about the child’s health care
- Education and guidance for the child’s growth and development
- Information regarding accessing care, such as appointments, advice nurse, or after-hours care

The schedule on the next page may be used to remind parents when to make appointments for their child. Parents should let the child’s health care provider know if the child is ill or taking medicines (such as steroids) that may suppress their immunity. This schedule may change based on the child’s health care needs. Please check with the child’s health care provider.

Physical exams are advised once yearly from age 2 – 6 years, then once every other year. More exams may be needed depending on the child’s health care needs. Rotavirus vaccine for 2 and 4 months of ages only. TB risk assessment will be done with each physical exam starting from 2 years of age and annually up to 17 years of age. The TB skin test will only be done if the risk assessment is positive.
<table>
<thead>
<tr>
<th>AGE</th>
<th>APPOINTMENT TYPE</th>
<th>VACCINE TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3 days</td>
<td>Physical exam</td>
<td>Hepatitis B (HepB) administered at birth; catch up immunizations if needed</td>
</tr>
<tr>
<td>2–3 weeks</td>
<td>Physical exam</td>
<td>Catch up immunizations if needed</td>
</tr>
<tr>
<td>2 months</td>
<td>Physical exam with shots</td>
<td>Diphtheria-Tetanus-acellular Pertussis (DTaP), Haemophilus Influenza B (Hib), Polio, Pneumococcal Conjugate Vaccine (PCV), HepB, Rotavirus</td>
</tr>
<tr>
<td>4 months</td>
<td>Physical exam with shots</td>
<td>DTaP, Hib, Polio, PCV, Rotavirus</td>
</tr>
<tr>
<td>6 months</td>
<td>Physical exam with shots</td>
<td>DTaP, Hib, Polio, PCV, HepB</td>
</tr>
<tr>
<td>9 months</td>
<td>Physical exam</td>
<td>Catch up immunizations if needed</td>
</tr>
<tr>
<td>12–13 months</td>
<td>Physical exam with shots</td>
<td>TB risk assessment if indicated at 12 months of age (TB skin test done if risk assessment positive), Hepatitis A, Measles-Mumps-Rubella (MMR), Varicella</td>
</tr>
<tr>
<td>15 months</td>
<td>Physical exam with shots</td>
<td>DTaP, Hib, PCV</td>
</tr>
<tr>
<td>18 months</td>
<td>Physical exam with shots</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td>23–24 months</td>
<td>Physical exam</td>
<td>Catch up immunizations if needed</td>
</tr>
<tr>
<td>3 years</td>
<td>Physical exam with shots</td>
<td>MMR, Varicella</td>
</tr>
<tr>
<td>4 years</td>
<td>Physical exam with shots</td>
<td>DTaP, Polio</td>
</tr>
<tr>
<td>5 years</td>
<td>Physical exam with shots</td>
<td>DTaP, Polio (if not done at age 4 years)</td>
</tr>
<tr>
<td>6 years</td>
<td>Physical exam</td>
<td>Catch up immunizations if needed</td>
</tr>
<tr>
<td>7–13 years</td>
<td>Physical exam with shots</td>
<td>Done every other year, 11–12 years: Tetanus-Diptheria-acellular Pertussis (Tdap), then Tetanus (Td) every 10 years; Human Papillomavirus (HPV) series of two doses for both girls and boys; Meningococcal Conjugate</td>
</tr>
<tr>
<td>14–20 years</td>
<td>Physical exam with shots</td>
<td>Done every other year; catch-up on vaccines</td>
</tr>
</tbody>
</table>

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Definitions

Abuse — Any of the following:

- Practices (fiscal, business, or medical) that are not sound and cost more;
- Payments to providers for services not medically necessary;
- Payments to providers for services that do not meet professional standards for health care in a managed care setting;
- Payments to providers for services not in the contract for duties for health care in a setting;
- Events or medical practices of providers that are not sound.

Adverse Benefit Determination - Any one of the following:

- The denial or restriction of a requested service, including the type or level or service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or part, of payment for a service;
- The failure to provide services in a timely manner, as defined in Section 40.230 (availability of providers);
- The failure of the health plan to act within prescribed timeframes regarding the standard resolution of grievances and appeals;
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

For a rural area member or for islands with only one health plan or limited providers, the denial of a member’s request to obtain services outside the network:

- From any other provider (in terms of training, experience, and specialization) not available within the network;
- From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;
- If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days;
- Because the only health plan or provider does not provide the service because of moral or religious objections;
- Because the member’s provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and
Activities of Daily Living (ADLs) – Activities a person performs on a daily basis, for self-care, such as:
- feeding,
- grooming,
- bathing,
- dressing and
- toileting.

Acute Care – Medical care provided under the direction of a physician at a hospital for a condition requiring inpatient care and having a relatively short duration.

Adult - All members age of twenty-one (21) years or older for coverage benefit purposes only.

Adult Day Care Center – A licensed facility that is maintained and operated by an individual, organization, or agency for the purpose of providing regular care which includes supportive care to four (4) or more disabled adults.

Adult Day Health Center – A licensed facility that provides organized day programs of therapeutic, social, and health services for adults with physical or mental impairments, or both. Members requiring nursing oversight or care. For the purpose of restoring or maintaining, to the fullest extent possible, their ability for remaining in the community.

Adult group - Individuals who obtain Medicaid eligibility in accordance with Hawaii Administrative Rules, 17-1718.

Advance Directive - A written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to provision of health care when the individual is incapacitated.

Ambulatory Care - Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other PCPs.

Appeal - A review by the health plan of an adverse benefit determination.

Appointment – A face-to-face interaction between a provider and a member. This does include interactions made possible using telemedicine but does not include telephone or e-mail interaction.

Assisted Living Facility – A licensed facility that consists of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.
**Authorized Representative** – A person who can make care-related decisions for a member who is not able to make such decisions alone. A representative may, in the following order of priority, be a person who is:

- A court-appointed guardian of the person;
- A spouse or other family member (parent) as designated by the member or the State according to HRS 327 E-5; or
- Any other person who is not court-appointed, not a spouse or other family member who is designated as the member’s healthcare representative according to HRS 327 E-5.

**Benefits** - Those health services that the member is entitled to under the QUEST Integration program and that the health plan arranges to provide to its members.

**Child and Adolescent Mental Health Division (CAMHD)** - A division of the State of Hawaii Department of Health that provides behavioral health services to children ages three (3) through twenty (20) who require support for emotional or behavioral development.

**Children** - All members under the age of twenty-one (21) years of age for coverage benefit purposes only.

**Chronic Condition** – Any on-going physical, behavioral, or cognitive disorder. Including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms and service use or needs beyond what is normally considered routine.

**Claim** - A bill for services, a line item of services, or all services for one member within a bill.

**Community Care Foster Family Home (CCFFH)** - A certified home that provides twenty-four (24) hour living rooms, including personal care and homemaker services.

**Community Care Management Agency (CCMA)** - An agency that is involved with

- locating,
- coordinating and
- monitoring services to residents in community care family homes or members in E-ARCHs and assisted living facilities.

A health plan may be the owner of a community care management agency.

**Community Integration Services (CIS)** – Pre-tenancy supports and tenancy sustaining services that support individuals to be ready and successful tenants in housing that is owned, rented or leased to the individual.

- Pre-Tenancy services help to identify the individual’s needs and preferences. Also, assists in the housing search process, and provides help to arrange details of the move.
- Tenancy services help with independent living maintaining. Includes:
  - Kaiser Permanente QUEST Integration: (808) 432-5330 or 1 (800) 651-2237 toll-free
  - TTY: 1 (877) 447-5990/5991 toll-free providers.kaiserpermanente.org
- tenant/landlord education,
- tenant coaching and
- assistance with community integration and inclusion to help develop natural support networks.

**Complete Periodic Screens** - Screens that include, but are not limited to, age appropriate medical and behavioral health screening examinations, laboratory tests, and counseling.

**Covered Services** - Those services and benefits to which the member has a right to under Hawaii’s Medicaid programs.

**Cultural Competency** – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

**Days** - Unless otherwise specified, the term "days" refers to calendar days.

**Dental Emergency** - An oral condition that does not include services aimed at restoring or replacing teeth and shall include services for relief of dental pain, remove serious infection, treat serious injuries to teeth or supportive structures of the oral-facial complex.

**Department of Human Services (DHS)** – Department of Human Services, State of Hawaii.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** – A required program under Title XIX of the Social Security Act that provides. Provides services for children up to age 21 years. Emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely diagnosis and treatment of conditions that are detected. The State covers all services under Title XIX of the Social Security Act that are included in Section 1905 (a) of the Social Security Act, when medically needed, to correct or improve defects and physical and mental illness and conditions discovered as a result of EPSDT screening.

**Eligibility Determination** - A process of determining, upon receipt of a written request on the Department’s application form, whether an individual or family is eligible for medical assistance.

**Emergency Medical Condition** – A sudden medical condition with serious (including severe pain) that a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect that the without immediate medical attention could result in placing the health of the individual in
- serious risk,
- serious damage of bodily functions,
or serious dysfunction of any bodily organ or part not working.

An emergency medical condition shall not be defined based on lists of diagnoses or symptoms.

**Emergency Services** – Any covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish services and that are needed to evaluate or stabilize an emergency medical condition.

**Enrollment** - The process by which an individual, who has been determined eligible, becomes a member in a health plan, subject to the limitations specified in the DHS Rules.

**Enrollment fee** - The amount a member is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term services and supports.

**Expanded Adult Residential Care Home (E-ARCH)** – A licensed facility that provides twenty-four (24) hour living accommodations. There is a fee. For adults unrelated to the family. The member requires at least minimal assistance in the: activities of daily living, personal care services, protection, and healthcare services. And who may need the professional health services provided in an intermediate care or skilled nursing facility. There are two types of expanded care ARCHs in accordance with Section 321-15.62, HRS:

- **Type I** – home allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the department to live in a type I home, with no more than three (3) nursing facility level residents; and
- **Type II** – home allowing six (6) or more residents with no more than twenty percent (20%) of the home’s licensed capacity as nursing facility level residents.

**Fraud** - The planned deception or misrepresentation. Made by an entity or a person with the knowledge that the deception could result in some unauthorized benefit to the entity, her or himself, or to some other person in a managed care setting.

**Grievance** - An expression of dissatisfaction from a member, member’s representative, or a provider, with written consent, on behalf of member, about any matter other than an action, as “action” is defined above. Examples of issues that will be resolved through the grievance process include quality of care issues, waiting times in physician offices and rude or unresponsive physician or staff and failure to respect enrollee’s rights. Standard disposition of a grievance and notice to the affected parties may not exceed 30 days from the date the grievance is received.

**Grievance Review** - A State process for the review of a denied or unresolved (dissatisfaction from a member) grievance by a health plan.

**Health Care Professional** – A physician, podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or
practical nurse, licensed clinical social worker, nurse practitioner, or any other licensed or certified professional who meets the State requirements of a health care professional.

**Health Care Provider** – Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State.

**Health Plan** - Any health care organization, insurance company, accountable care organization, health maintenance organization, or managed care organization that provides covered services on a risk basis to enrollees in exchange for capitated payments.

**Home and Community Based Services (HCBS)**- Long-term services and supports provided to individuals who meet nursing facility level of care to allow those individuals to remain in their home or community.

**Hospital** - Any licensed acute care facility in the service area to which a member is admitted receiving inpatient services pursuant to arrangements made by a physician.

**Hospital Services** - Services that are medically necessary services for registered bed patients. Generally and usually provided by licensed acute care general hospitals in the service area and prescribed, directed or authorized by the attending physician or other provider.

**Independent Activities of Daily Living (IADLs)** – Activities related to independent living. Includes:
- preparing meals,
- running errands to pay bills or
- pick up medication,
- shopping for groceries or personal items, and
- performing light or heavy housework.

**Institutional or nursing facility level of care (NF LOC)**- The decision that a member needs the services of nurses in an setting to deliver the ‘s planned treatment for total care. These services can be provided in the home or in programs. And is cost-neutral. Also, it is the least limiting option to care in a hospital or nursing home.

**Long-Term Services and Supports (LTSS)** – A range of care and assistance. Including:
- in-home and community-based services for individuals 65 years or older and individuals with a disability or disabilities. For individuals who need help in maintaining keeping their independence,
- to institutional care for those who require that level of support.
Managed Care – A complete approach to the delivery of health care. Combines clinical services and administrative procedures. This is done in a combined, coordinated system to provide timely access to primary care and other necessary services in an efficient way.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the final rule of the BBA and that is: (1) a federally qualified HMO that meets the requirements under Section 1310(d) of the Public Health Service Act; (2) any public or private entity that meets the advance directives requirements and meets the following conditions: (a) makes the service it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services that are available to other non-Medicaid members within the area served by the entity and (b) meets the solvency standards of 42 CFR Section 438.116 and Section 432-D-8, HRS.

Medicaid - A federal/state program authorized by Title XIX of the Social Security Act, as amended, which provides federal matching funds for a Medicaid program for members of federally aided public assistance and Supplemental Security Income (SSI) benefits and other specified groups. Certain minimal populations and services must be included to receive FFP; however, states may choose to include certain additional populations and services at State expense or if CMS approved receive FFP.

Medical Facility – An inpatient hospital or outpatient surgical facility.

Medical Necessity – As defined in Section 432E-1.4, HRS.

Medical Services - Usually, those medical and behavioral health professional services of physicians, other health professionals and paramedical personnel that are generally and normally provided in the service area. Performed, given, or directed by the attending physician or other provider.

Medicare - A federal program authorized by Title XVIII of the Social Security Act, as amended, which provides health insurance for persons aged 65 years and older and for other specified groups. Part A of Medicare covers hospitalization; Part B of the program covers outpatient services and requires a premium; Part C which is an alternative to Parts A and B and offers managed care options, and Part D of the program which covers prescription drugs and may require a premium.

Member – An individual who has been designated by the Med-QUEST Division to receive medical services through the QUEST Integration program as defined in Section 30.300 and is currently enrolled in a QUEST Integration health plan. See also Enrollee.

Med-QUEST Division (MQD) – Under the State of Hawaii, Department of Human Services, the single state Medicaid agency responsible for administering Medicaid and other medical assistance programs, in Hawaii.

New Member - A member (as defined in this section) who has not been enrolled in a health plan during the prior six (6) month period.
Nursing Facility (NF) – A licensed facility that provides appropriate care to persons referred by a physician. Such persons are those who:

- Need twenty-four (24) hour a day assistance with the normal activities of daily living;
- Need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis; and
- May have a primary need for twenty-four (24) hours of skilled nursing care on an extended basis and regular rehabilitation services.

Participating -

1. A health plan that has signed a contract with the DHS to provide covered services to enrollees.
2. A provider who is employed by or who has signed a contract with a health plan to provide covered services to enrollees.
3. A facility means a facility that signed a contract with a health plan to provide covered services to members.

Personal Assistance – Care provided when a member, member’s parent, guardian or legal employs hires and oversees a personal assistant. The health plan will this person. This is based on watching of the member and the personal assistant during the actual delivery of care. The Documentation of this certification will be kept in the member’s individual plan of care.

Physician – A licensed Doctor of Medicine or doctor of osteopathy.

Post-Stabilization Services – Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member’s condition.

Primary Care – Outpatient care to include: prevention, treatment of acute conditions, and management of chronic conditions. Primary care is often first contact care of the same complaint. May result in diagnostic testing and treatment, appropriate consultation or referral and includes coordination and continuity of care.

Primary Care Provider (PCP) - A provider who is licensed in the State of Hawaii and is (1) a physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician/gynecologist (for women, especially pregnant women); or (2) an advanced practice registered nurse with prescriptive authority; or (3) a licensed physician assistant.

Protected Health Information (PHI) – As defined in the HIPAA Privacy Rule, 45 CFR Section 160.103.
**Provider** - An individual, clinic, or institution. Including, but not limited to allopathic and, nurses, referral specialists and hospitals, responsible. Responsible for the delivery of health services under a health plan. Providers are not a subset of subcontractors.

**QUEST Integration (QI)** - QUEST Integration is the capitated managed care program that provides health care benefits, including long-term services and supports, to individuals, families, and children. For both non-aged, blind, or disabled (non- ABD) individuals and ABD individuals, with household income up to a specified federal poverty level (FPL).

**Service Coordination** – The process that:
- assesses,
- plans,
- implements,
- coordinates,
- monitors and
- evaluates a member’s healthcare needs.

Includes options and services. Uses communication. Also, finds all available ways to help get quality results. The right care coordination occurs across a range of care. Focuses on the continuing individual needs instead of a single practice setting.

**Service Coordinator** – A person who helps manage the care of a member. Also, checks and makes sure the right and timely care is given to the member. This person may be chosen by the member or assigned by the health plan.

**Service Plan**– A written plan based on an evaluation. Includes, but is not limited to, the following:
- Goals, objectives or desired results; and
- A list of all services needed (Medicaid and non-Medicaid). Includes:
  - amount,
  - how often and how long, and
  - type of provider to give each service.

The service plan is reviewed on a schedule. The member or a person approved to represent the member and the member's service coordinator signs an agreement when the service plan is updated.

**State** - The State of Hawaii.

**Support for Emotional and Behavioral Development (SEBD)** – A program for behavioral health services for children and teenagers run by CAMHD.

**Third Party Liability (TPL)** – Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a member or to Medicaid.

Kaiser Permanente QUEST Integration:(808) 432-5330 or 1 (800) 651-2237 toll-free
TTY: 1 (877) 447-5990/5991 toll-free providers.kaiserpermanente.org

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**Urgent Care** - The diagnosis and treatment of medical conditions which are serious or acute but not an immediate threat to life or health. Requires medical care within 24 hours.

**Utilization Management Program (UMP)** - The requirements and processes established by a health plan to ensure members have equitable access to care, and to manage the use of limited resources for maximum effectiveness of care provided to members.