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INTRODUCTION

It is our pleasure to welcome you as a contracted provider with Kaiser Permanente (KP). We want this business relationship to work well for you, your medical support staff, and our Health Plan members.

This Provider Manual was created to help guide your staff in working with KP’s various systems and procedures. It is intended to supplement, and not to replace or supersede, the Agreement between you and KP. Updates to the Provider Manual will be provided on a periodic basis in accordance with the Agreement and in response to changes in operational systems and regulatory requirements.

There are attachments, exhibits and forms appearing throughout this Provider Manual, so please feel free to reproduce them as necessary. In the event of any discrepancy between the terms of this Provider Manual and your Agreement, the terms of the Agreement shall govern.
SECTION I: HOW THIS PROVIDER MANUAL IS ORGANIZED

This Provider Manual has been developed to assist you with understanding the administrative processes related to accessing and providing comprehensive, effective and quality medical services to KP members. Kaiser Permanente’s goal is to make this Provider Manual as helpful and easy to use as possible.

The contents of this Provider Manual have been organized according to similar topics and functions. A complete “Table of Contents” is located at the beginning of the Provider Manual and includes the subheadings of topics included within each section. The “Key Contacts” section includes names, departments, and telephone numbers that will assist you in obtaining answers to questions or rendering services under KP procedures.

You may wish to make copies of specific pages or reference tables that are used frequently and place them in the front of the Provider Manual.

1.1 YOUR RESPONSIBILITIES

This Manual, including all updates, shall remain the property of Kaiser Permanente. While you have the Provider Manual, you are responsible for maintaining it and its updates and also for providing copies of the Provider Manual to all subcontractors who provide services to Health Plan members.

1.2 PROVIDER CHANGES THAT MUST BE REPORTED

Please remember to send written notification to KP’s Network Development and Administration department when you have important changes to report.

Relocations:
Notify Provider Relations at least ninety (90) days prior to relocation to allow for the transition of Members to other Providers, if necessary.

Adding/Deleting New Practice Site or Location:
Notify Provider Relations at least ninety (90) days prior to opening an additional practice site or closing an existing service location.

Changes in Telephone Numbers:
Notify Provider Relations at least thirty (30) days prior to the implementation of a change in telephone number. If the initial notification is given verbally, you must send written confirmation of what was verbally conveyed.

Federal Tax ID Number and Name Changes:
If your Federal Tax ID Number or name should change, please notify us immediately so that appropriate corrections can be made to KP’s files.
**Mergers and Other Changes in Legal Structure:**
Please notify us in advance and as early as possible of any planned changes to your legal structure, including pending merger or acquisition in writing.

**Contractor Initiated Termination (Voluntary):**
Your Agreement requires that you give advance written notice if you plan on terminating your contractual relationship with KP. The written notice must be sent in accordance with the terms of your Agreement.

When you give notice of termination, you must immediately advise Provider Relations of any Members who will be in the course of treatment during the termination period.

Provider Relations may contact you to review the termination process, which may include transferring Members and their medical records to other providers designated by KP.

KP will make every effort to notify all affected Members of the change in providers at least sixty (60) days prior to the termination, so that the Members can be given information related to their continuity of care rights, and to assure appropriate transition to ensure that they will have appropriate access to care. KP will implement a transition plan to move the Members to a provider designated by KP, respecting each Member’s legal continuity of care rights, and making every effort to minimize any disruption to medical treatment. You are expected to cooperate and facilitate the transition process. You will remain obligated to care for the affected Members in accordance with the written terms of the Agreement, state and federal law.

**Other Required Notices:**
You are required to give KP notice of a variety of other events, including changes in your insurance, ownership, adverse actions involving your license, participation in Medicare or Medicare certification, and other occurrences that may affect the provision of services under your Agreement. Your Agreement describes the required notices and manner in which notice should be provided.
SECTION II. KAISER PERMANENTE MEDICAL CARE PROGRAM

The KP Medical Care Program is a cooperative endeavor among representatives of medicine and management, sharing responsibilities for organizing, financing, and delivering high quality health care services to its members. Three separate entities comprise the KP Medical Care Program: Kaiser Foundation Health Plan, Inc. (KFHP); Kaiser Foundation Hospitals. (KFH); and Southern California Permanente Medical Group (SCPMG). For purposes of this Provider Manual, the terms Kaiser Permanente or KP mean KFHP, KFH, and SCPMG, collectively.

1.1 HISTORY

Kaiser Permanente was founded in the late 1930’s by an innovative physician, Sidney R. Garfield, MD, and an industrialist, Henry J. Kaiser, as a comprehensive affordable alternative to “fee-for-service” medical care. Initially, the health care program was only available to construction, shipyard, and steel mill workers employed by the Kaiser industrial companies during the late 1930’s and 1940’s. The program was opened for enrollment to the general public in 1945.

Today, Kaiser Foundation Health Plan is one of the country’s largest nonprofit, independent, prepaid group practice health maintenance organizations. We are proud of our over 60-year history of providing quality health care services to our members and of the positive regard we’ve earned from our members, peers, and others within the health care industry.

1.2 ORGANIZATIONAL STRUCTURE

Kaiser Permanente’s Southern California Region is comprised of three separate entities that share responsibility for providing medical, hospital and business management services. These groups of entities are referred to in this Provider Manual as Kaiser Permanente. The entities are:

- Kaiser Foundation Health Plan, Inc. (Health Plan) Health Plan is a California nonprofit, public benefit corporation that is licensed as a health care service plan under the Knox-Keene Act. Health Plan contracts with Kaiser Foundation Hospitals and Southern California Permanente Medical Group to provide or arrange for the provision of medical services.
- Kaiser Foundation Hospitals (KFH) KFH is a California nonprofit public benefit corporation that owns and operates community hospitals and outpatient facilities. KFH provides and arranges for hospital and other facility services, and sponsors charitable, educational, and research activities.
- Southern California Permanente Medical Group (SCPMG) is a professional corporation of providers in the Kaiser Permanente Southern California Region. SCPMG provides and arranges for professional medical services.
1.3 SOUTHERN CALIFORNIA REGION

The Southern California Region is one of Kaiser Permanente’s eight regions within the United States. Covering an area from Bakersfield to San Diego, the Kaiser Permanente Southern California Region spans more than six counties.

1.4 INTEGRATION

Kaiser Permanente is unique. We integrate the elements of health care providers, hospitals, home health, support functions and healthcare coverage into a cohesive healthcare delivery system. Our integrated structure enables us to coordinate care to our members across the continuum of care settings.

1.5 PREVENTIVE HEALTH CARE

Kaiser Permanente continues to influence the practice of medicine by focusing on keeping the member healthy and on treating illness and injuries. We encourage members to seek care on a regular and preventive basis.

SECTION III. CONTRACTING FOR MEDICAL SERVICES

In Southern California, the Network Development and Administration Department (ND&A) contracts with community-based hospitals, skilled nursing facilities and other community-based health care providers, to provide services for our members. Network Development and Administration is responsible for the day-to-day operational maintenance of the contracts.

In Southern California, the Affiliated Provider Services (APS), contracts with community-based physicians and professional providers, to provide services for our members. Affiliated Provider Services is responsible for the day-to-day operational maintenance of the contracts.

For more information regarding this section, please contact us at the number listed in the Key Contacts section of this Provider Manual.

SECTION IV. KEY CONTACTS

1.1 INTRODUCTION

At Kaiser Permanente, we believe in clear, open, and frequent communication with our contracted providers. The following are the key departments and individuals available to assist you with questions or clarification of any issues regarding your association with Kaiser Permanente. Please feel free to call them as the need may arise.
For clarification, questions or comments about your role as a contracted provider for Kaiser Permanente, please contact Network Development and Administration at 1-626-405-3240.

1.2 KEY CONTACTS

**SOUTHERN CALIFORNIA REGION – KEY CONTACT**

<table>
<thead>
<tr>
<th>Department</th>
<th>Area of Interest</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Prospective Review Program (EPRP)</td>
<td>Emergency Notification</td>
<td>1-800-447-3777</td>
</tr>
<tr>
<td>Outside Utilization Resource Services (OURS)</td>
<td>Authorizations for Post Stabilization Management after Emergency Medical Services</td>
<td>1-800-225-8883 Available 24 hours a day 7 days a week</td>
</tr>
<tr>
<td>California Claims Administration Department</td>
<td>Billing Questions Claims Inquiries</td>
<td>1-800-390-3510</td>
</tr>
<tr>
<td>KP Member Services</td>
<td>General Enrollment Questions</td>
<td>1-800-464-4000 (English)</td>
</tr>
<tr>
<td></td>
<td>Eligibility and Benefit Verification</td>
<td>1-800-788-0616 (Spanish)</td>
</tr>
<tr>
<td></td>
<td>Co-pay, Deductible and Co-insurance Information</td>
<td>1-800-757-7585 (Cantonese &amp; Mandarin)</td>
</tr>
<tr>
<td></td>
<td>Members presenting without KP identification number</td>
<td>1-800-777-1370 (TTY)</td>
</tr>
<tr>
<td></td>
<td>Member grievance and appeals</td>
<td>Monday – Friday 7 a.m. to 7 p.m. Saturday –Sunday 7 a.m. to 3 p.m.</td>
</tr>
</tbody>
</table>

Send Claims: Claims Administration Department
P.O. Box 7004
Downey, CA 90242-7004
<table>
<thead>
<tr>
<th>Department</th>
<th>Area of Interest</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Member Service</td>
<td></td>
<td>1-800-443-0815 Monday – Sunday 7 a.m. to 8 p.m.</td>
</tr>
<tr>
<td>Outside Referral Department</td>
<td>Authorizations/Referrals</td>
<td>See Section V</td>
</tr>
<tr>
<td>Network Development and Administration</td>
<td>Contract Interpretation</td>
<td>1-626-405-3240 Regional Office Monday – Friday 8:30 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>(Provider Contract Management and Provider Relations)</td>
<td>Updates to provider demographics (such as Tax ID and ownership changes, address changes)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide Education and Training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Form Request</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Billing Dispute Issues</td>
<td></td>
</tr>
<tr>
<td>Medical Transportation Non Emergent &quot;The Hub&quot;</td>
<td>Coordinate / Schedule Non-Emergency Transportation</td>
<td>1-877-227-8799 Available 24 hours a day Seven Days a Week</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Care Coordination</td>
<td>1-800-464-4000 Monday – Friday 7 a.m. to 7 p.m. Saturday – Sunday 7 a.m. to 3 p.m.</td>
</tr>
<tr>
<td>Care Coordination &amp; Discharge Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72 hour Expedited Appeals</td>
<td>Expedited Review</td>
<td>1-888-987-7247 Monday – Saturday 8:30 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>Behavioral Health Services</td>
<td>1-866-465-7296 7 a.m. – 5:30 p.m. Monday - Sunday</td>
</tr>
<tr>
<td>Behavioral Health Utilization Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION V: OUTSIDE REFERRAL DEPARTMENTS

The Outside Referral Department (ORD) is responsible for coordinating and tracking authorized referrals. Prior authorization is a prerequisite before payment can be made for any inpatient or outpatient services which would otherwise be covered by a member’s benefit plan, except for emergency services and other situations expressly allowed by your Agreement or this Provider Manual.

Referral Coordinators
- Process and distribute the authorization document(s)
- Verify status of authorizations

If you have not received an authorization document from us and are unsure about the appropriate Referral Coordinator, please contact the Outside Referral Services Department in your Service Area.

Referral Coordinators are centralized in KP Medical Centers and may be reached at the following telephone numbers:

<table>
<thead>
<tr>
<th>OUTSIDE REFERRAL DEPARTMENTS</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope Valley</td>
<td>1-661-729-7108</td>
</tr>
<tr>
<td>Baldwin Park</td>
<td>1-562-622-3880</td>
</tr>
<tr>
<td>Downey</td>
<td>1-562-622-3880</td>
</tr>
<tr>
<td>Coachella and Yucca Valley</td>
<td>1-951-602-4294</td>
</tr>
<tr>
<td>Fontana</td>
<td>1-909-609-3262</td>
</tr>
<tr>
<td>Kern County/Bakersfield</td>
<td>1-661-852-3482</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>1-323-783-7799</td>
</tr>
<tr>
<td>Orange County</td>
<td>1-714-564-4150</td>
</tr>
<tr>
<td>Panorama City</td>
<td>1-818-375-2806</td>
</tr>
<tr>
<td>Riverside</td>
<td>1-951-602-4294</td>
</tr>
<tr>
<td>San Diego</td>
<td>1-619-589-3360</td>
</tr>
<tr>
<td>South Bay/Harbor City</td>
<td>1-310-816-5324</td>
</tr>
<tr>
<td>West Ventura</td>
<td>1-805-223-2120</td>
</tr>
<tr>
<td>West Los Angeles</td>
<td>1-323-783-7799</td>
</tr>
<tr>
<td>Woodland Hills</td>
<td>1-805-223-2120</td>
</tr>
</tbody>
</table>
SECTION VI: MEMBER ELIGIBILITY AND BENEFITS

1.1 INTRODUCTION

This section describes the requirements for verifying member eligibility and Kaiser Permanente benefit coverage.

You are required to verify eligibility each time a member presents for services so that services are only provided to someone who is eligible and so that you can be compensated by Kaiser Permanente for services you provide to our Health Plan members. Members are issued identification cards, but the card alone is not sufficient verification of eligibility.

You are also responsible for confirming that services provided to a member are covered benefits.

Both requirements and verification tools are described in more detail in this section.

For specific questions regarding eligibility or a member’s benefit plan and coverage for services, please call Member Services. The Member Services telephone number is located in the “Key Contacts” section of this Provider Manual.
## 1.2 Kaiser Permanente Membership Type

<table>
<thead>
<tr>
<th>Membership Type</th>
<th>Membership Defined</th>
<th>Covered Benefits Defined By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>Members* who purchase Health Plan coverage on an individual basis (other than Medicare and Medicaid) Members who are covered as part of an employer group and are not Medicare-eligible or Medicaid-eligible</td>
<td>Membership Agreement/ Evidence of Coverage Membership Agreement</td>
</tr>
<tr>
<td>Medicare Advantage (formerly Medicare + Choice) (Senior Advantage)</td>
<td>Individual Medicare beneficiaries who have assigned their Medicare benefits to Kaiser Permanente by enrolling in the Kaiser Permanente Senior Advantage Program Employer group retirees or otherwise Medicare-eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to Kaiser Permanente by enrolling the Kaiser Permanente Senior Advantage Program</td>
<td>Medicare, with additional benefits provided by Kaiser Permanente Medicare and Membership Agreement</td>
</tr>
<tr>
<td>Medicare Cost Regular Medicare (Medicare unassigned)</td>
<td>Member who is enrolled under a Medicare Cost contract between Health Plan (or subsidiary or affiliated health plan) and CMS and for whom Medicare is the primary payor for purposes of this Agreement Members (i) entitled to coverage under Part A only or Part B only or Parts A and B of Medicare but (a) are not enrolled under a Medicare Advantage contract or a Medicare Cost contract between Health Plan (or another Kaiser Payor) and CMS and (b) for whom the</td>
<td>Medicare Dual Coverage: Two separate plans – the primary Medicare benefits are defined by Medicare; the Health Plan benefits are defined by the</td>
</tr>
</tbody>
</table>

* In each case, “member” includes the subscriber and any eligible dependents, in accordance with the terms of the applicable membership agreement.
<table>
<thead>
<tr>
<th>MEMBERSHIP TYPE</th>
<th>MEMBERSHIP DEFINED</th>
<th>COVERED BENEFITS DEFINED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>Medicare program is the primary payor for Medicare-covered services under Medicare reimbursement rules, or (ii) enrolled under a Medicare Advantage contract and are hospice patients receiving care from Provider for services unrelated to the hospice patient's terminal condition.</td>
<td>Membership Agreement (and the Employer Group if applicable).</td>
</tr>
<tr>
<td>State Programs</td>
<td>Contact Member Services for detailed information specific to your geographic area.</td>
<td>Contact Member Services for detailed information specific to your geographic area.</td>
</tr>
<tr>
<td>Added Choice</td>
<td>Members who are working and part of an employer group</td>
<td>Health Plan (HMO) benefits determined by the Membership Agreement. Allows members to choose from three provider options to obtain health care coverage that best meets their needs. Your Agreement and this Provider Manual apply only to services that are Health Plan covered benefits.</td>
</tr>
</tbody>
</table>
1.3 MEDICAL RECORD NUMBER

A unique Medical Record Number (MRN) is assigned to each member and is also listed on the front of the member’s identification card. The MRN is used by Kaiser Permanente to identify the member’s medical record, eligibility, and benefit level. If a member’s enrollment terminates and the member re-enrolls at a later date, the member retains the same MRN although employer or other information may change. The MRN enables medical records/history to be tracked for all periods of enrollment.

Note: The MRN should be used as the “Member ID” when submitting bills or encounter data. Please refer to the “Billing and Payment” section of this Provider Manual for additional information.

1.4 MEMBER IDENTIFICATION CARDS

Kaiser Permanente issues a Health Plan Member Identification (ID) card to each member. The ID card for the appropriate benefit plan/type of coverage is included in the New Member Enrollment Packet sent to members. Members are instructed to present their ID card and Photo Identification each time they access services.

All Kaiser Permanente ID cards include:

- Member name
- Medical Record Number (MRN)
- Emergency information for non-Kaiser Permanente facilities

For record-keeping purposes, your business office may wish to photocopy the front and back of a member’s ID card and place it in the member’s medical records file.

1.5 VERIFICATION OF ELIGIBILITY

You must verify the member’s eligibility each time a member presents for services. After receiving the health plan identification card, members may lose their eligibility or change health plans. Unless a referral and/or authorization have been received, you must verify the member’s eligibility before rendering the service prior to the member presenting for services.

Please do not assume that because a person has a Kaiser Permanente ID Card that coverage is in effect. Please check a form of photo identification to verify the identity of the member. Member Services can always be contacted to verify the validity of the ID card/number; otherwise, you provide services at your own financial risk.

Verification of eligibility may be done quickly and easily by contacting Member Services:
1.6 AFTER HOUR ELIGIBILITY REQUESTS

Members who require medical care after normal business hours must have their eligibility verified during the next business day. During the interim, you must request that the member complete a financial responsibility form that places payment responsibility on the member in the event that the member is found to be ineligible. Eligibility verification or a financial responsibility form is not required for provision of emergency services; however Kaiser Permanente will not pay for services provided if the person is not a Health Plan member.

1.7 BENEFIT COVERAGE DETERMINATION

In addition to eligibility, you must determine that the member has coverage for services prior to providing such services to a member, usually by an authorization or referral from Kaiser Permanente. The “Utilization Management” and “Billing and Payment” sections of this Provider Manual provide information regarding authorizations and referrals.

1.8 BENEFIT EXCLUSIONS AND LIMITATIONS

KP benefit plans may be subject to limitations and exclusions. It is important to verify the availability of benefits for services before rendering the service so the member can be informed of any potential payment responsibility.

Contact KP Member Services to verify and obtain information on member benefits.

If services are provided to a member and the service is not a benefit, or the benefit has been exhausted, denied or not authorized, KP will not be obligated to pay for those services, except to the extent required by law.
SECTION VII: MEMBER RIGHTS AND RESPONSIBILITIES

1.1 INTRODUCTION

Kaiser Permanente recognizes that its members have both rights and responsibilities in the management of their health care.

Individuals enrolled in Kaiser Permanente Health Plans have certain rights that are protected during their encounters with Kaiser Permanente representatives who consist of participating providers, contracted providers, and their employees, as well as Kaiser Permanente employees.

By the same token, members are expected to assume responsibility for their knowledge, attitudes, and behavior related to the health care services they receive while enrolled in a Kaiser Permanente Health Plan.

This section addresses a member’s rights and responsibilities; in addition to avenues available to remedy any situation the member feels they have not received appropriate services, care, or treatment.

1.2 MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

Kaiser Permanente has developed a statement which addresses a member’s right to participate in their medical care decisions. These decisions range from selecting a primary care provider to being provided with all information needed to making decisions regarding recommended treatment plans.

This statement also addresses their responsibilities which include understanding the extent and limitations of their health care benefits, following established procedures for accessing care, recognizing the impact their lifestyle has on their physical conditions, providing accurate information to their caregivers, and following agreed treatment plans.

Kaiser Permanente provides each member with the Member Rights and Responsibilities Statement upon enrollment in the Health Plan. A copy of the statement is included in the Kaiser Permanente Rights and Responsibilities Handbook, the Disclosure Form and Evidence of Coverage booklet, and in New Member materials. Members may call Member Services to obtain additional copies of the above information.

Kaiser Permanente members have the right to:

- Receive information about Kaiser Permanente, our services, our practitioners and providers, and their rights and responsibilities
- Participate in a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage
• Participate with practitioners and providers in making decisions about their health care
• Have ethical issues considered
• Receive personal medical records
• Receive care with respect and recognition of their dignity
• Use interpreter services
• Be assured of privacy and confidentiality
• Participate in physician selection without interference
• Receive a second opinion from an appropriately qualified medical practitioner
• Receive and use member satisfaction resources including the right to voice complaints or make appeals about Kaiser Permanente or the care we provide
• Make recommendations regarding Kaiser Permanente’s member rights and responsibilities policies

Kaiser Permanente Members are responsible for:

• Knowing the extent and limitations of their health care benefits
• Notifying the Health Plan if they are hospitalized in a non-Kaiser Permanente Hospital
• Identifying themselves
• Keeping appointments
• Providing accurate and complete information (to the extent possible) that Kaiser Permanente and its practitioners and providers need in order to provide care
• Participating in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible
• Following the plans and instructions for care they have agreed on with their practitioners
• Recognizing the effect of their lifestyle on their health
• Being considerate of others
• Fulfilling financial obligations

• Knowing about and using the member satisfaction resources available to them, including the dispute resolution process

Providers and their staff are expected to review and abide by the statement. If you have any question regarding its contents, please contact us at the phone number included in the Key Contacts Section of this Provider Manual.

1.3 NON-COMPLIANCE WITH MEMBER RIGHTS AND RESPONSIBILITIES

Failure to meet the requirements of Kaiser Permanente’s Rights and Responsibilities Statement may result in action against the member, provider, or Kaiser Permanente, as appropriate.

• Members

In the event a member feels the member’s rights have not been upheld, they are instructed in the Member Handbook to discuss the situation with the provider.

If the member is not comfortable discussing concerns or the member feels the provider cannot resolve the issue to the member’s satisfaction, the member may contact Member Services directly via telephone at 1-800-464-4000 or via the web at www.KP.org to file a complaint against the provider and/or staff.

Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.

If you receive a complaint from or on behalf of a Kaiser Permanente member which, in your reasonable judgment, is not resolved within two working days, please notify Network Development and Administration at the phone number included in the Key Contacts Section of this Provider Manual.

• Providers

If a member fails to meet his/her obligations as outlined in Kaiser Permanente’s Rights and Responsibilities Statement and you have attempted to resolve the issue, please contact Member Services. The phone number is located in the Key Contacts section of this Provider Manual.

Provider should advise Member Services, if a member:

• Displays disruptive behavior or is not able to develop a provider/member relationship
• Unreasonably and persistently refuses to follow provider’s instructions to the extent that the member’s health is considered jeopardized

• Commits belligerent act or threatens bodily harm to physicians and hospital personnel

• Purposely conceals or misrepresents their medical history or treatment in order to subvert proper treatment planning

• Uses documents with the provider’s signature without proper authorization or forges/falsifies a provider’s name to documents

• Allows someone to misrepresent him/herself as a Kaiser Permanente member

Kaiser Permanente reserves the right to:

• Conduct informal mediation to resolve a relationship issue,

• Move the member to another hospital or provider,

• Pursue termination of the member’s coverage with the Health Plan, as allowed by the applicable Member “Disclosure Form and Evidence of Coverage.”

1.4 ACCESS TO CARE DECISIONS

Kaiser Permanente and affiliated hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for member’s medical needs. Kaiser Permanente does not compensate anyone for denying coverage or service, and Kaiser Permanente does not use financial incentives to encourage denials. In order to maintain and improve the health of member, all providers should be especially vigilant in identifying any potential underutilization of care or service.

Kaiser Permanente allows open provider-member communication regarding appropriate treatment alternatives without penalizing providers for discussing medically necessary or appropriate care for members.

Kaiser Permanente members have the right to choose treatment or service options regardless of benefit coverage limitations. Providers are encouraged to communicate appropriate treatment options, even when the options are not covered by the member’s benefit plan. If the provider and the member decide upon a course of treatment that is not covered under the member’s Health Plan, the member should be advised to contact Member Services for an explanation of his/her benefits plan. If the member persists in requesting non-covered services, the hospital business office should make payment arrangements with the member in advance of any treatment provided.
Kaiser Permanente’s Utilization Management program and procedures are:

- To establish whether services are covered under the member’s benefit plan
- Based on objective guidelines adopted by Kaiser Permanente, and
- Used to determine medical necessity and appropriateness of care

The decision to proceed with treatment rests with the Provider and the member.

1.5 ADVANCE DIRECTIVES

An Advance Directive is a written instruction, such as a living will or durable power of attorney for healthcare, recognized under California State and Federal law.

Kaiser Permanente requires that all contracted providers comply with the Federal Patient Self-Determination Act of 1990 which mandates that a member must have the opportunity to participate in determining the course of his/her medical care, even when s/he are unable to speak for themselves. The Federal Law applies to emancipated minors, but does not apply to all other minors.

To ensure compliance with the law, an Advance Directive should be documented in a prominent place in the medical record. The Provider shall provide written information regarding Advance Directives to all members admitted to the hospital, and provide staff and member education regarding Advance Directives.

If a member requests to formulate or change an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss the decision with the member. The attending physician will write a progress note in the member’s medical chart to reflect the formulation or change of an Advance Directive. An Advance Directive may be revoked by the member at any time, orally or in writing, as long as the member is capable of doing so. An Advance Directive is automatically invalidated by divorce if the spouse was designated as the surrogate decision-maker.

Members are provided with information regarding Advance Directives in the Disclosure Form and Evidence of Coverage booklet, as well as New Member materials. Members may also contact Member Services for an informational brochure and appropriate forms.

1.6 MEMBER COMPLAINT AND GRIEVANCE PROCESS

Kaiser Permanente members are assured a fair and equitable process for addressing their complaints and grievances against contracted providers, provider staff, and Kaiser Permanente employees. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the member,
the provider and Kaiser Permanente. Members are notified of the processes available for resolving complaints in the Evidence of Coverage, and “Your Guidebook.”

A member complaint or grievance may relate to quality of care, access to services, provider or Kaiser Permanente staff attitude, operational policies and procedures, benefits, eligibility, or related issues.

Valid member complaints and grievances against a provider are included in the providers quality file at Kaiser Permanente and reviewed as part of the re-credentialing process. Complaints and grievances are tracked and trended on an ongoing basis to identify potential problems with a provider or Kaiser Permanente policies and procedures.

1.7 PROVIDER PARTICIPATION IN MEMBER COMPLAINT RESOLUTION

The established procedures for resolving member complaints may require the provider's participation under certain circumstances. Kaiser Permanente will advise the provider of the involvement required or information that must be provided. Complaints about clinical issues will be reviewed by at least one practitioner provided by Kaiser Permanente and practicing in the same or a similar specialty that typically manages the related medical condition, procedure or treatment who was not previously involved in the patient's care. As a result of this review, you may be asked as part of the investigation to respond by email or by an Investigative Review Form to Member Services with your clinical opinion regarding the member's concern or request. For additional information regarding provider appeal process, please refer to the Provider Rights and Responsibilities section of this Provider Manual.

1.8 MEMBER COMPLAINT AND GRIEVANCE RESOLUTION PROCEDURE

One of the rights that Members are apprised of in “Your Guidebook” is that they have the right to participate in a candid discussion with the provider of all available options regardless of cost or benefit coverage. Members are told, “You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they seem silly. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you do not agree with it or if it conflicts with your beliefs.” If the issue cannot be resolved in this manner, we encourage the member to contact the Member Services Department at the local Kaiser Permanente facility or the Member Service Contact Center for assistance.

If the member or provider feels that the issue is urgent in nature, the member or provider may call the Expedited Review Unit (ERU). More information regarding Expedited Review may be found in the Utilization Management section of this Provider Manual.
1.9 COMPLAINT PROCEDURES

If the problem/issue is not amenable to immediate resolution at the point of service, the member may submit a written complaint or grievance with the local Member Services Department, or by calling the Member Services Center at (800) 464-4000 or (800) 777-1370 (TTY). Our representatives will advise the Member about our resolution process and ensure that the appropriate parties review the complaint.

1.10 GRIEVANCE PROCEDURES

If a member is requesting care or service that is not amenable to immediate resolution at the point of service or the request is monetary in nature, he/she should be advised to contact the Member Service Department at the local Kaiser Permanente facility or to call the Member Service Contact Center to file a formal grievance. This may be done verbally or in writing. The request will be researched and presented to the appropriate decision-makers, and a decision will be rendered within fourteen (14) to thirty (30) days, depending on the type of request and membership. The member will receive the resolution in writing, and if denied, will be informed of any applicable appeal rights.

1.11 72 HOUR EXPEDITED REVIEW

Members and providers who believe that the member’s health status would be seriously jeopardized by submitting an issue through the standard process may request an expedited review. If the issue is accepted for processing through this procedure, upon receipt of all necessary information, Kaiser Permanente must make a determination as expeditiously as required by the member's medical condition, not to exceed 72 hours. If the request is denied, the member will be informed of any applicable appeal rights. If it is determined that there is no serious threat to life or limb, the request will be processed under the standard timeframes, fourteen (14) to thirty (30) days depending on the type of request and membership.

1.12 FRIDMAN-KNOWLES EXPERIMENTAL TREATMENT ACT

This Act is the California state law that mandates the right to external review by qualified experts when a terminally ill member has been denied coverage for a drug, device, procedure or other therapy generally considered experimental or investigational, including new technologies.

The request for this review can be requested by the Health Plan physician, a Non-Plan Physician, or the member. In any case, Member Services will initiate the process for review including facilitating the transfer of information to the independent review entity or internally in accordance with designated resolution timeframes.
1.13 DEMAND FOR ARBITRATION

A member may file a demand for arbitration after he/she has received the appeal decision or at any earlier step in the process. For more information on arbitration procedures, advise the member to contact the local facility Member Services Department.

NOTE: The complaint and appeals information provided may not address the rights and remedies of each category of member, for example, Medicare, Medi-Cal, as well as members who are employed and/or retired from the State of California and/or the Federal Government may have different rights and remedies. Members in these categories should be directed to contact Member Services for applicable grievance and appeal provisions, or they may refer to their “Disclosure Form and Evidence of Coverage” brochure for more information.

SECTION VIII: PROVIDER RIGHTS AND RESPONSIBILITIES

- Providers are responsible for the following:

  - Provide health care services without discriminating on the basis of health status or any other unlawful category.

  - Uphold all applicable responsibilities outlined in the Kaiser Permanente Member Rights & Responsibilities Statement in this Provider Manual.

  - Maintain open communication with a member to discuss treatment needs and recommended alternatives, without regard to any covered benefit limitations or Kaiser Permanente administrative policies and procedures. Kaiser Permanente encourages open provider-member communication regarding appropriate treatment alternatives and does not restrict providers from discussing all medically necessary or appropriate care with members.

  - Provide all services in a culturally competent manner.

  - Provide for timely transfer of member medical records when care is to be transitioned to a new provider, or if your Agreement terminates.

  - Participate in Kaiser Permanente Utilization Management and Quality Improvement Programs. Kaiser Permanente Quality Improvement and Utilization Management Programs are designed to identify opportunities for improving health care provided to members.

  - These programs may interact with various functions, including, but not limited to, the complaint or grievance process, disease management, preventive health, or clinical studies. Kaiser Permanente will communicate information about the programs and extent of provider participation through special mailings, and updates to the Provider Manual.
• Collect applicable copayments, deductibles, and coinsurance from members as required by your Agreement.
• Comply with this Provider Manual and the terms of your Agreement.
• Verify eligibility of members prior to providing covered services.
• Cooperate with and participate in the member complaint and grievance process, as necessary.
• Secure authorization or referral from a Medical Group physician prior to providing any non-emergency services.
• Encourage all practitioners and provider staff to include members as part of the member safety team by requesting members to speak up when they have questions or concerns about the safety of their care.
• Discuss adverse outcomes related to errors with the member and/or family.
• Ensure members' continuity of care including coordination with systems and personnel throughout the care delivery system.
• Foster an environment which encourages all practitioners and provider staff to report errors and near misses.
• Pursue improvements in member safety including incorporating member safety initiatives into daily activities.
• Ensure compliance with member safety accreditation standards, legislation, and regulations.

• Providers also have the following rights:

• Receive payment in accord with applicable laws and applicable provisions of your Agreement.

• File a provider dispute.

• Participate in the dispute resolution processes established by Kaiser Permanente in accord with your Agreement and applicable law.

• Rely on eligibility information provided by Kaiser Permanente about any particular member.

SECTION IX: COMPLAINT AND MEMBER CARE PROBLEMS

Kaiser Permanente will work with a contracted provider to resolve complaints regarding administrative or contractual issues, or problems encountered while providing health care to Health Plan members.
For Referral Related Issues:

- For assistance with referral or authorization issues, please contact a Referral Coordinator from the referring Kaiser Permanente facility. The telephone number is listed in the "Key Contacts" section of this Provider Manual.

For Contractual Concerns:

- For assistance in resolving contractual issues, please contact your Network Development and Administration Representative. The telephone number is listed noted in the Key Contacts section of this Provider Manual.

- For additional information, please refer to the "Member Rights and Responsibilities" section of this Provider Manual.

For Claim Issues:

- For assistance in resolving claim-related issues, please refer to the Billing and Payment section of this Provider Manual. The telephone number is listed in the "Key Contacts" Section of this Provider Manual.

For All Other Issues:

- If any issue remains unresolved, please contact Provider Relations. The telephone number is listed in the "Key Contacts" Section of this Provider Manual.

- For assistance in filing a Provider Dispute, please refer to the "Provider Appeals Process" section of this Provider Manual.
SECTION X: BILLING AND PAYMENT

1.1 INTRODUCTION

The applicable payor identified in your Agreement is responsible for payment of authorized services and emergency services in accordance with your Agreement and applicable law. It is your responsibility to submit itemized claims for those services provided to members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. The terms “bill”, “claim” and “invoice” are used interchangeably in this section, and should not be interpreted to differ in meaning.

1.2 BILLING REQUIREMENTS

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

- Institutional charges must be submitted on a form UB-04 (or successor form) with appropriate coding. Entries must be completed in accordance with National Uniform Billing Committee (NUBC) directions and contain all mandatory entries, and as required by federal statutes and regulations.

- Professional charges must be submitted on a CMS -1500 form (or successor form) with current ICD-10 diagnostic and CPT-4 procedure coding (or successor coding accepted commonly in the industry).

Form UB-04 fields that require information regarding the “insured” should be completed based on the member’s data. The member’s Kaiser Permanente medical record number (MRN), as well as the authorization number from the authorization document(s) for non-emergency services, must be included in the appropriate fields of the billing form, as well as all other required information. (For services following stabilization of an emergency medical condition, refer to the “Emergency Services” section of this Provider Manual, for information regarding how to obtain an authorization for such services. Note that you must obtain an authorization as a condition to payment for all non-emergency services.) All other fields on the applicable form should be completed by your billing office for services provided.

You are also required under your Agreement and/or applicable law to submit certain encounter data for covered services provided to members. Encounter data must be provided on the applicable billing form.
1.3 SUPPORTING DOCUMENTATION

In general, you must submit, in addition to the applicable billing form, all supporting documentation that is reasonably relevant information and that is information necessary to determine our payment to you. At a minimum, the supporting documentation that may be reasonably relevant includes the following, to the extent applicable to the services provided:

- Admitting face sheet;
- Discharge summary;
- Operative report(s);
- Emergency room records with respect to all emergency services; and
- Treatment notes as reasonably relevant and necessary to determine payor payment to you, including 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.

If additional documentation is deemed to be reasonably relevant information and/or information necessary to determine our payment to you, we will notify you in writing.

1.4 STANDARD BILLING CODES

Standard codes, (and any commonly accepted successor codes), including the following, must be used on all billing forms:

- **REVENUE CODE:** Code used to identify specific accommodation, ancillary service or billing calculation
- **CPT–4:** Physicians Current Procedural Terminology
- **HCPCS:** Health Care Procedure Coding System
- **ICD-10-CM:** Medical Index, for medical diagnostic coding
- **DSM-IV-R:** Codes for mental health diagnostic coding
1.5 FORM UB-04 REQUIRED FIELDS

The fields identified in the table below as “Required” must be completed when submitting a CMS-1450 (UB-04), or successor form.

<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. IMPORTANT: This field aids in patient identification by the Provider.</td>
</tr>
<tr>
<td>3b</td>
<td>MEDICAL/HEALTH RECORD NUMBER</td>
<td>Required if Applicable</td>
<td>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)</td>
</tr>
<tr>
<td>4</td>
<td>TYPE OF BILL</td>
<td>Required</td>
<td>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.</td>
</tr>
<tr>
<td>5</td>
<td>FEDERAL TAX NUMBER</td>
<td>Required</td>
<td>Enter the federal tax ID of the hospital or person entitled to reimbursement in NN-NNNNNNNN format.</td>
</tr>
<tr>
<td>6</td>
<td>STATEMENT COVERS PERIOD</td>
<td>Required</td>
<td>Enter the beginning and ending date of service included in the claim.</td>
</tr>
<tr>
<td>7</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>8a, b</td>
<td>PATIENT NAME/ID</td>
<td>Required</td>
<td>Enter the patient’s name, together with the patient ID (if different than the insured’s ID).</td>
</tr>
<tr>
<td>9</td>
<td>PATIENT ADDRESS</td>
<td>Required</td>
<td>Enter the patient’s mailing address.</td>
</tr>
<tr>
<td>10</td>
<td>PATIENT BIRTH DATE</td>
<td>Required</td>
<td>Enter the patient’s birth date in MM/DD/YYYY format.</td>
</tr>
<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>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>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>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: 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.</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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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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><strong>Multiple/Different Dates of Service:</strong> 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>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 KP national health plan 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>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>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 KP 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>63</td>
<td>TREATMENT AUTHORIZATION CODE</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>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>Not Required</td>
<td>Enter the document control number related to the patient or the claim as assigned by KP.</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>65</td>
<td>EMPLOYER NAME</td>
<td>Required if Applicable</td>
<td>Enter the name of the insured’s (Field 58) employer.</td>
</tr>
<tr>
<td>66</td>
<td>DX VERSION QUALIFIER</td>
<td>Not Required</td>
<td>Indicate the ICD version indicator of codes being reported. \</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NOTE: At the time of printing, Kaiser only accepts ICD-10-CM diagnosis codes on the UB-04.</td>
</tr>
<tr>
<td>67</td>
<td>PRINCIPAL DIAGNOSIS CODE</td>
<td>Required</td>
<td>Enter the principal diagnosis code, on all inpatient and outpatient claims. The diagnosis code must be carried to its highest degree of detail, including the Present on Admission (POA) indicator, if applicable.</td>
</tr>
<tr>
<td>67A-Q</td>
<td>OTHER DIAGNOSES CODES</td>
<td>Required if Applicable</td>
<td>Enter other diagnosis codes corresponding to additional conditions that coexist or develop subsequently during treatment. Diagnosis codes must be carried to their highest degree of detail, including the POA indicator, if applicable.</td>
</tr>
<tr>
<td>68</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>69</td>
<td>ADMITTING DIAGNOSIS</td>
<td>Required</td>
<td>Enter the admitting diagnosis code on all inpatient claims.</td>
</tr>
<tr>
<td>70a-c</td>
<td>REASON FOR VISIT (PATIENT REASON DX)</td>
<td>Required if Applicable</td>
<td>Enter the diagnosis codes indicating the patient’s reason for outpatient visit at the time of registration.</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE</td>
<td>Required if Applicable</td>
<td>Enter the DRG number to which the procedures group, even if you are being reimbursed under a different payment methodology.</td>
</tr>
<tr>
<td>72</td>
<td>EXTERNAL CAUSE OF INJURY CODE (ECI)</td>
<td>Required if Applicable</td>
<td>Enter an ICD-10-CM “ECI-code” in this field <em>(if applicable).</em></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>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-10-CM 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-10-CM 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 individual NPI number 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><strong>Inpatient Claims—Attending Physician</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enter the full name (<em>first and last name</em>) of the physician who is responsible for the care of the patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Outpatient Claims—Referring Physician</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ALL outpatient claims, enter the full name (<em>first and last name</em>) 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 individual NPI number and the name of the lead surgeon who performed the surgical procedure.</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>78–79</td>
<td>OTHER PHYSICIAN/ NPI/ QUAL/ ID</td>
<td>Required if Applicable</td>
<td>Enter the individual NPI numbers and names 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>

**Note:** Fields must be completed in accordance with the National Uniform Billing Committee (NUBC) requirements for mandatory data fields, and as required by federal and state statutes and regulations.
1.6 CLAIM SUBMISSION REQUIREMENTS

• Authorized or Emergency Services

Bills for authorized or emergency services should be mailed to the address located on the authorization document(s), or, to:

Kaiser Foundation Health Plan, Inc.  
Claims Administration Department  
Post Office Box 7004  
Downey, CA 90242-7004  
1-800-390-3510

1.7 ELECTRONIC SUBMISSION OF CLAIMS DATA

Kaiser Permanente encourages (and your Agreement may require) electronic submission of claims and encounter data. If you have questions about electronic submission of bills and encounter data, please contact the Southern California Kaiser Permanente EDI Helpline at 866.285.0361.

EDI is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI transactions replace the submission of paper claims. Required data elements (for example: claims data elements) are entered into the computer only ONCE—typically at the Provider’s office, or at another location where services were rendered or billed.

Benefits of EDI Submission

• Reduced Overhead Expenses: Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated.

• Improved Data Accuracy: Because the claims data submitted by the Provider is sent electronically, data accuracy is improved, as there is no need for re-keying or re-entry of data.

• Low Error Rate: Additionally, “up-front” edits applied to the claims data while information is being entered at the Provider’s office, and additional payor-specific edits applied to the data by the clearinghouse before the data is transmitted to the appropriate payor for processing, increase the percentage of clean claim submissions.
• **Bypass U.S. Mail Delivery**: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system. **Standardized Transaction Formats**: Industry-accepted standardized medical claim formats may reduce the number of “exceptions”.

**Where to Submit Electronic Claims:**

Each clearinghouse assigns a unique identifier for Kaiser Permanente’s Southern California Region. The payer ID numbers for KP’s approved clearinghouses are indicated in the following chart.

<table>
<thead>
<tr>
<th>CLEARINGHOUSE</th>
<th>KP PAYER ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Ally</td>
<td>94135</td>
</tr>
<tr>
<td>SSI</td>
<td>94135</td>
</tr>
<tr>
<td>RelayHealth</td>
<td>94135</td>
</tr>
<tr>
<td>Emdeon</td>
<td>94135</td>
</tr>
<tr>
<td>Capario</td>
<td>KS003</td>
</tr>
</tbody>
</table>

**EDI Submission Process:**

Provider sends claims via EDI: Once a Provider has entered all of the required data elements (i.e., all of the required data for a particular claim) into its claims processing system, the Provider then electronically “sends” all of this information to a clearinghouse for further data sorting and distribution.

Clearinghouse receives electronic claims and sends to KP: Providers should work with their EDI vendors to route their electronic claims to the clearinghouse. The clearinghouse “batches” all of the information it has received, sorts the information, and then electronically “sends” the information to KP for processing. Data content required by HIPAA Transaction Implementation Guides is the responsibility of the Provider and the clearinghouse. The clearinghouse should ensure HIPAA Transaction Set Format compliance with HIPAA rules.

In addition, clearinghouses:
- Frequently supply the required PC software to enable direct data entry in the Provider’s office.
- May edit the data which is electronically submitted to the clearinghouse by the Provider’s office, so that the data submission may be accepted by KP for processing.
- Transmit the data to KP in a format easily understood by KP’s computer system.
- Transmit electronic claim status reports from KP to providers.

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

**Electronic Claims Disposition:**

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

**NOTE:** If you are not receiving electronic claim receipts from the clearinghouse, you should contact your clearinghouse to request them.

**Detailed Error Report:** The electronic claim acknowledgement reports include reject reports that identify specific errors on non-accepted claims. Once the claims listed on the reject report are corrected, the Provider may re-submit these claims electronically through the clearinghouse. Providers are responsible for reviewing and updating their reject reports from the clearinghouse. In the event claims errors cannot be resolved, Providers should submit claims on paper to KP.

**Supporting Documentation for Electronic Claims:**
If submitting claims electronically, the 837 transaction contains data fields to house supporting documentation through free-text format (exact system data field within your billing application varies). If supporting documentation is required, KP will request the supporting documentation and let you know where to send the information.

**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 425-562-2245.


1.8 **PROHIBITED BILLING PRACTICES**

Balance billing members for services covered by Health Plan is prohibited by California and Federal law and under your Agreement. Except for applicable copayments, coinsurance and deductibles, and as otherwise expressly permitted in your Agreement and under applicable law, providers must look solely to KFH or other responsible payor (e.g., Medicare) for compensation of covered services provided to members.
1.9 CLAIMS PROCESSING GUIDELINES

Kaiser Permanente will follow the applicable Knox-Keene Act or Medicare requirements for claim processing.

- All claims for services provided to Kaiser Permanente members must be submitted within ninety (90) days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge if applicable.
- To the extent required by law, claims that are denied because they are filed beyond the applicable claims filing deadline shall, upon a provider’s submission of a provider dispute notice as described in the Provider Dispute Resolution Process section of this Provider Manual and the demonstration of good cause for the delay, be accepted and adjudicated in accordance with the applicable claims adjudication process.

1.10 CLAIMS PAYMENT POLICY

- Except for emergency services, the member’s eligibility and benefits coverage must have been verified at prior to the time of service, in accordance with your Agreement and applicable law.
- All non-emergency services must be authorized, and the authorization number must be included on field 63 of the form UB-04 (or successor form). In most cases, bills for non-emergency services will be denied for payment if an authorization was not obtained in accordance with the requirements of your Agreement.
- Invoices for emergency services are subject to retrospective review for medical necessity, using the prudent layperson standard, in accordance with your Agreement and applicable law.
- Contracted providers will be compensated for covered services based on the compensation arrangement set forth in your Agreement.

1.11 CLAIMS ADJUSTMENTS

Kaiser Permanente reviews codes and adjusts claims in accordance with your Agreement and the provisions below, and in accordance with applicable law.

Claims adjustments are made in connection with claims review, as described in more detail below and as otherwise set forth in your Agreement.

If you believe we have made an incorrect adjustment to a claim that has been paid, please refer to the Provider Dispute Resolution Process section of this Provider Manual for information on how to dispute such adjustment. When submitting the dispute resolution documentation, please clearly state the reason(s) you believe the claim adjustment was incorrect.
1.12 CLAIMS REVIEW

Billed items will be reviewed and/or corrected as described in your Agreement and as permitted by applicable law. Final payment will be based on such reviewed (and, if necessary, corrected) information.

Code Review:

The terms of your Agreement govern the amount of payment for services provided under your Agreement. The following general rules apply to our payment policies.

Kaiser Permanente’s claims policies for provider services follow industry standards as defined by the AMA and CMS. Routinely updated code editing software from a leading national vendor is used for processing all relevant bills in a manner consistent with the Medicare Correct Coding Initiative and CPT guidelines. Our claims adjudication systems accept and identify all active CPT and HCPCS Codes as well as all coding modifiers. Payment for services such as multiple procedures, bilateral procedures, assistant surgeons, co-surgeons and application of modifiers are paid in accordance with Medicare guidelines. When applicable, we request supportive documentation for “unlisted” procedure codes and the application of Modifier 26.

We do not allow code unbundling for procedures for which Medicare requires all-inclusive codes and we will re-bundle the procedures and pay according to Medicare’s all-inclusive codes for all members.

If your agreement so provides, Kaiser Permanente uses reasonable and customary rates to pay for those services that are not subject to contracted rates. Reasonable and Customary rates are determined using a statistically credible database updated at least annually.

Clinical Review:

In addition to code review, invoices may be reviewed by a physician or other appropriate clinician.

1.13 DO NOT BILL EVENTS (DNBE)

Depending on the terms of your Agreement, you may not be compensated for services directly related to any Do Not Bill Event (as defined below) and may be required to waive applicable Copays (as defined in Section X.1.16 below) associated with, and hold members harmless from, any liability for services directly related to any DNBE. KP expects you to report every DNBE as set forth in Section XIV.1.3 of this Provider Manual and as may be further required by your Agreement. KP may reduce compensation for services directly related to a DNBE when the value of such services can be separately quantified in accordance with the applicable payment methodology.
DNBE shall mean the following:

In any care setting, the following surgical errors identified by CMS in its National Coverage Determination issued June 12, 2009¹ (SE):

- Wrong surgery or invasive procedure² on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part

Specifically in an acute care hospital setting, the following hospital acquired conditions identified by CMS on August 19, 2008³ (together, with RFO-HAC, as defined below (HACs)) if not present upon admission:

- Intravascular air embolism
- Blood incompatibility (hemolytic reaction due to administration of ABO/HLA incompatible blood or blood products)
- Pressure ulcer (stage three or four)
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Catheter associated urinary tract infection
- Vascular catheter associated infection
- Manifestation of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following orthopedic procedures (spine, neck, shoulder, elbow)
- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
- Deep vein thrombosis or pulmonary embolism following orthopedic procedures (total knee or hip replacement)
- Any new Medicare fee-for-service HAC later added by CMS

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² ‘Surgical and other invasive procedures’ is defined by CMS as ‘operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. ‘Invasive procedures’ include a ‘range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through needle or trocar.’”

In any care setting, the following HAC if not present on admission for inpatient services or if not present prior to provision of other services (RFO-HAC):

- Removal (if medically indicated) of foreign object retained after surgery

Claims for Do Not Bill Events:

- You must submit claims for services directly related to a DNBE according to the following requirements and in accordance with the other terms of your Agreement and this Provider Manual related to claims.

- UB04 – If you submit a UB-04 Claim (or its successor) for inpatient or outpatient facility services provided to a member wherein a HAC (Including a RFO-HAC) has occurred, you must include the following information:

- DRG. If, under the terms of your Agreement, such services are reimbursed on a DRG basis, you must include the applicable ICD-9 (or its successor, ICD-10) codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.

- Other Payment Methodologies. If, under the terms of your Agreement, such services are reimbursed on a payment methodology other than a DRG and the terms of your Agreement state that you will not be compensated for services directly related to a DNBE, you must split the Claim and submit both a Type of Bill (TOB) ‘110’ (no-pay bill) setting forth all services directly related to the DNBE including the applicable ICD-9 (or its successor, ICD-10) codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program, and a TOB ‘11X (with the exception of 110)’ setting forth all covered services not directly related to the DNBE.

1.14 COORDINATION OF BENEFITS (COB)

When a member is enrolled in more than one group benefit plan (e.g., a person who has Kaiser Permanente coverage also is covered by another health plan), it is necessary to coordinate the benefits between the two plans so that you will receive from both plans no more than 100% of what Kaiser Permanente would have been required to pay if it were the only payor.

- Determining Primary Coverage

Primary coverage is determined using the guidelines established under California law, including Title 28 of CCR Section 1300.67.13.
• Between spouses, the plan that covers the member as an employee is the primary plan. The spouse of the employee is a dependent under that plan (and that plan is secondary for that spouse).

• You determine primary coverage for dependent children based on their parents’ birthdays. The plan of the parent whose birthday occurs earlier in the year (without regard to the year of the parent’s birth) is the primary plan.

• If a provider invoice is submitted to Kaiser Permanente when another carrier is primary, Kaiser Permanente will deny payment of the invoice. The provider will need to submit an invoice to the other (primary) carrier. Within 90 Business days (or longer period if required under applicable law or expressly permitted under your Agreement) after the primary carrier has paid its benefit, please resubmit the invoice and include the EOB that accompanied payment by the primary carrier to Kaiser Permanente. The invoice will be reviewed and the amount of payment due, if any, will be determined.

1.15 THIRD PARTY LIABILITY (TPL)

Unless and to the extent your Agreement expressly provides to the contrary, Kaiser Permanente has the exclusive right of recovery for third party liability claims. Third party liability (TPL) for health care costs arise from sickness or injury caused or alleged to be caused by a third party. In order to prevent duplicate payments for health care costs that are also paid by another responsible party, contracted providers are required to assist Kaiser Permanente in identifying all potential TPL situations and to provide Kaiser Permanente with information that supports Kaiser Permanente’s TPL inquiries.

Third Party Liability Guidelines

Providers are asked to assist and cooperate with Kaiser Permanente’s efforts to identify TPL situations by doing the following:

• Provide full information in fields 50A through 50C on the UB-04 billing form. If one or more payors is (are) named, Kaiser Permanente will contact the member for potential TPL information.

• Enter ICD-9 diagnosis data in fields 67 through 75 on the UB-04 form.

Kaiser Permanente retains the right to investigate TPL recoveries through retrospective review of ICD-9 and CPT-4 codes from your billing forms where a possible third party liability is indicated.
1.16 COPAYMENTS, COINSURANCE AND DEDUCTIBLES

- Contracted providers are responsible for collecting copayments, coinsurance and deductibles (collectively, “Copays”) in accordance with member benefits unless explicitly stated otherwise in your Agreement.
- Invoices submitted by providers who are responsible for collecting Copays will be paid at the applicable rate(s) under your Agreement less the applicable Copay amount due from the Health Plan member.
- You must not waive Copays you are required to collect, except as expressly permitted under applicable law and your Agreement.

Please verify applicable Copays at the time of service by contacting Member Services at the number listed in the Key Contacts section of this Provider Manual.

1.17 WORKERS' COMPENSATION

If a member indicates that his or her illness or injury occurred while the member was "on the job", payment for such health care services should be handled as follows:

If Kaiser Permanente is specified as the Workers’ Compensation carrier and you have received an authorization to provide such care to the member, you should submit your bill to Kaiser Permanente in the same manner as you submit other bills for services. Your Agreement may specify a different payment rate for these services.

If Kaiser Permanente is not specified as the Workers’ Compensation carrier, you should do the following:

- Document that the illness or injury occurred "on the job" on the bill;
- Complete fields 39-41 on the form UB-04; and
- Submit the bill to the member’s Workers' Compensation carrier.

If the member's Workers' Compensation carrier ultimately denies the member’s workers compensation claim, you should submit the bill for covered services to Kaiser Permanente in the same manner as you submit other bills for services.

Providers must comply with all state and federal laws applicable to Workers’ Compensation services.

1.18 OVERPAYMENT POLICY

- If you receive an overpayment directly from Kaiser Permanente or as a result of coordination of benefits, you must notify Kaiser Permanente promptly upon discovery and return the overpayment as soon as possible. In addition, you must return any overpayment identified by Kaiser Permanente within 30 working days after receipt from Kaiser Permanente of a notice of overpayment, unless you
contest such notice. If you contest all or any portion of the overpayment described in the Kaiser Permanente notice, you must send a written notice identifying the contested amount and the basis upon which you believe the claim(s) was (were) not overpaid, within 30 working days after receipt of the notice of overpayment. Such required written notice must be provided to Kaiser Permanente in accord with the terms of your Agreement or as described in the notice of overpayment. If your Agreement so provides, Kaiser Permanente may offset from future claims payments to you the amount of any uncontested overpayment not paid by you within the 30 working day repayment period.

Please include the following information when returning uncontested overpayments:

- Name of each Health Plan member who received care for which an overpayment was received
- Copy of each applicable remittance advice
- Each applicable member’s Kaiser Permanente medical record number (MRN)
- Authorization number (s) for all applicable non-emergency services

1.19 OFFSETS TO PAYMENTS

We will only offset an uncontested notice of overpayment of a claim against a Provider’s current claim submission when: (i) the Provider fails to reimburse KP within the timeframe set forth above, and (ii) KP’s contract with the Provider specifically authorizes KP to offset an uncontested overpayment of a claim from the provider’s current claims submissions or KP has obtained other written offset authorization from the provider. In the event that an overpayment of a claim or claims is offset, we will supply you with a detailed written explanation identifying the specific overpayment(s) that have been offset against the specific current claim(s).

1.20 DIRECT MEMBER BILLING

Health Plan members may be billed only for copayments, coinsurance and deductibles where applicable according to member benefit coverage and your Agreement, which payments may be subject to an out of pocket maximum.

The circumstances above are the only situations in which a Health Plan member can be billed for covered services.

1.21 MEMBER CLAIMS INQUIRIES

If you are presented with a Health Plan member complaint or inquiry regarding any direct member billing (including any billing for Copay or other member liability described above) you should direct the member to call:
SECTION XI: PROVIDER APPEALS PROCESS

1.1 INTRODUCTION

Health Plan provides all providers with a fast, fair and cost-effective dispute resolution mechanism under which you may submit all disputes regarding invoices, billing determinations, or other contract issues. We will handle disputes and this dispute resolution mechanism in accordance with applicable law. Please note that the process described in this section is applicable to disputes covered by the California Knox-Keene Act. While we expect to use this process for other types of disputes, we are not required to do so.

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

1.2 TYPES OF DISPUTES

If you have one of the following disputes, you must submit a written notice to us. Your written notice of a dispute is referred to in this Provider Manual as a Provider Dispute Notice.

- **For Claims:** challenging, appealing or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted or contested by us;
- **For Billing Determinations:** seeking resolution of a billing determination (or bundled group of billing determinations) by us;
- **For Other Contract Disputes:** seeking resolution of a contract dispute (or bundled group of contract disputes) between you and us;
- **For Responding to Requests for Overpayment Reimbursements:** disputing a request by us of reimbursement by you of overpayment of a claim.
1.3 INFORMATION THAT MUST BE SUBMITTED

Your Provider Dispute Notice must contain at least the information listed below, as applicable to your dispute. If your Provider Dispute Notice does not contain all of the applicable information listed below, we may return the Provider Dispute Notice to you and we will identify in writing the missing information necessary to resolve the dispute.

If you want to continue the dispute, you must submit an amended Provider Dispute Notice within 30 working days after the date that you received your Provider Dispute Notice back from us.

- Your name, Provider Identification Number (PIN), and your contact information
- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item using the same number assigned to the original claim, the date of service and a clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If the dispute is not about a claim, a clear explanation of the issue and your position on the issue
- If the dispute involves a member or a group of members, the name and Medical Record Number(s) of the member(s), a clear explanation of the disputed item, including the date of service and your position about the item.
- If you are submitting a batch of disputes, they must be substantially similar, and you must have a numbering system that identifies each dispute contained in the bundled notice.

1.4 THE PROVIDER DISPUTE NOTICE

You may submit your Provider Dispute Notice on our Provider Dispute Resolution Request form (PDRR), but you may also submit a dispute in writing in any format you prefer, so long as it includes the appropriate information.

1.5 WHO MAY SUBMIT A PROVIDER DISPUTE NOTICE

Your Provider Dispute Notice may be submitted by you or by your authorized representative (for example, a billing service, a collection agency, or an attorney) approved by you to perform this function.
If your authorized representative submits your Provider Dispute Notice, that representative will be required to provide confirmation that an executed business associate agreement that complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is in place between you and the representative.

1.6 CONFIRMATION OF RECEIPT/HOW TO GET INFORMATION

We will confirm receipt of your Provider Dispute Notice and any amended Provider Dispute Notice within 15 working days after our receipt of your complete Provider Dispute Notice.

For disputes related to our payment or denial of claims, send the Provider Dispute Notice by mail or personal delivery, to the address identified on the payment or denial remittance you are disputing, or, to the address identified when you were sent a PDRR. You may call the telephone number identified on the payment or denial remittance you are disputing for information about your Provider Dispute Notice or general information about filing provider disputes related to billings.

For disputes related to contract issues other than our payment or denials of claims, send the Provider Dispute Notice by mail or personal delivery, to the address listed below. You may call our Claims Call Center at (800) 390.3510 for information about your Provider Dispute Notice or information about filing such provider contract disputes.

Kaiser Foundation Health Plan, Inc.
Claims Administration Department
Provider Disputes
Post Office Box 7006
Downey, CA  90242-7006
1-800-390-3510

All PDRR’s must be submitted to the address specified in the initial denial letter/notification by the Provider or designee if related to a claim, or to the notification address identified in the contract for contract related issues.

1.7 PROVIDER DISPUTE PROCESS TIMELINE

Time Period for Submitting Disputes

We must receive your Provider Dispute Notice within 365 days after (i) our action which led to your dispute (e.g. a denial of a claim) or (ii) in the case of our inaction, 365 calendar days plus 45 additional working days after the date of our receipt of your claim, or such longer timeframe as may be specifically applicable to you (the Provider).
Time Period for Written Determination

We will issue our written determination of the dispute and the reasons for our determination within forty-five (45) working days of the receipt of the Dispute Notice by the Claims Administration Department, unless stated otherwise in the Provider Manual or the Agreement.

SECTION XII: CREDENTIALING AND RE-CREDENTIALING

1.1  INTRODUCTION

Kaiser Permanente has developed and implemented credentialing and re-credentialing policies and procedures for Health Delivery Organizations.

As a contracted provider, your facility has already met the basic criteria for initial credentialing including insurance requirements, absence of Medicare and Medicaid sanctions, current state licensure, certificate of insurance and accreditation. If your facility is not accredited, then it met the Kaiser Permanente site survey criteria in the areas of appearance, safety, provider and staff availability, emergency preparedness, infection control, medical record, quality assessment and improvement, and utilization management. Your facility and all providers furnishing services to our members are required to meet applicable requirements and, unless your Agreement expressly provides otherwise, be properly enrolled in and certified under the Medicare and Medicaid programs.

1.2  CREDENTIALING AND RE-CREDENTIALING PROCESS

All staff, including employees, contractors and agents of your facility who provide Covered Services to members, will be at all times properly licensed by the state in which services are rendered, certified, qualified and in good standing in accord with all applicable local, state and federal laws.

During the period between initial credentialing and re-credentialing, your facility is required to continue to meet all initial credentialing criteria. This includes, but is not limited to submission of copies of current/renewed state license, accreditation and certificates of insurance to Regional Credentialing when requested. A copy of the credentialing application is included at the end of this section.

Re-credentialing will occur at least every thirty-six months and may occur more frequently if needed. In addition to the basic initial credentialing criteria, member grievances, member satisfaction, quality assurance/improvement, and utilization management data will be considered prior to re-credentialing. A copy of the credentialing application is included at the end of this section.
1.3 PROVIDERS ON CORRECTIVE ACTION PLAN STATUS

Based on a review of a provider’s credentialing/re-credentialing information, which includes a completed application, supporting documentation and site visit findings, the Kaiser Permanente Regional Credentialing Committee may accord a facility Corrective Action Plan Status (CAP). A provider on CAP is either:

a) newly opened and operational, or  
b) found to have deficiencies requiring corrective action

Newly operational facilities typically are monitored for at least six months. Such providers are required to provide monthly reports of applicable quality and/or clinical indicators for a minimum of the first 3 months of the Initial Credentialing.

Providers found to have deficiencies requiring corrective action such as:

- Regulatory non-compliance
- Member care or safety issues
- KP physician or staff member concern
- Member complaint

must complete a time-phased corrective plan of action that addresses the site visit findings and/or any applicable status of compliance (implemented action plan) with respect to all deficiencies identified in any Medicare Statement of Deficiencies and Plan of Correction (CMS Form 2567), usually within two weeks of notification.

Kaiser Permanente will review the corrective plan of action and determine whether it adequately addresses, in a reasonable time frame, identified issues. If the plan is not acceptable, Kaiser Permanente representatives will jointly work with the facility to make necessary revisions to the plan. Providers needing to submit corrective action plans are typically monitored for a year or less.

Facilities on CAP are notified in writing of the reason(s) for the designation, the time frames, and specific requirements applicable for the monitoring of their facilities.

1.4 CONFIDENTIALITY OF CREDENTIALING INFORMATION

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

For additional information regarding credentialing and re-credentialing requirements and policies, please contact the Regional Credentialing Department at the telephone number included in the Key Contacts section of this Provider Manual.
1.5 KAISER PERMANENTE SOUTHERN CALIFORNIA OUTSIDE PROVIDER CREDENTIALING APPLICATION

SCAL Network Development & Administration
Contract Documentation Form (CDF)
Contracted Non-KFH Facilities

Indicate reason for completing form:

[ ] requesting initial contract  [ ] contract re-credentialing  [ ] contract renewal  [ ] contract changes

Initial Contracting, contract renewal and contract changes, submit completed form and attachments to Director, Network Development & Administration, and the Contract Manager, Walnut Center, 7th Flr. Re-credentialing submit completed form and attachments to the Director, Regional Credentialing, Walnut Center – 3rd floor.

FROM:_____________________________ DATE: ______________________

Contract Liaison/Designee

Indicate Facility type:

Indicate Facility Type:  [ ] SNF    [ ] Home Health    [ ] Hospice    [ ] Acute Hospital    [ ] Psych
[ ] TRRS    [ ] Surgicenter    [ ] Other (specify)________________________

_______________________________ Medical Center hereby recommends the following, regarding:

_______________________________ (Facility)
_______________________________ (Address)
_______________________________ (City & Zip Code)
_______________________________ (Contact)
_______________________________ (Phone)

I. Contract Action Recommendation

( ) initial contract/initial credentialing

( ) re-credentialing

( ) renewal contract, [ ] with changes    [ ] without changes

( ) continue current status

( ) cancel initial contract request [initial request date: ___/___/___]

( ) contract with limitations as specified:

1. ________________________________________________________________
2. __________________________________________________________________________

( ) pend decision to contract due to operational/quality issues, until __/__/__.

( ) termination of existing contract due to ( ) quality considerations ( ) other considerations

II.A Contract Services Request
Contract requested by: ______________________________________________________

Services to be contracted IP OP Est. volume (visits/month, census

days, etc.)
1. ___________________________ ( ) ( )
2. ___________________________ ( ) ( )
3. ___________________________ ( ) ( )

• Professional services to be provided by [ ] SCPMG physicians [X] non-SCPMG physicians
  If non-SCPMG, provide name of group ______________________________
  [ ] combination of SCPMG and non-SCPMG physicians

• Is this service provided internally?
  ( ) NO
  ( ) YES Please identify need for contract: Difficult to provide adequately

• Is this service provided by another contracted facility?
  ( ) NO
  ( ) YES Which facility? ________________________________
  Please explain need for another contract:

• Other factors affecting decision to contract
  ( ) Geographic need
  ( ) Service need

II.B Complete for all initial and renewal Contract Requests

• Expected need date

• Estimated length of contract need: Indefinite.

• Any current issues to be considered when contracting?
  ( ) NO
  ( ) YES. Anesthesiologist contract also needed

• ( ) Limitations or “deal breakers” Specify: ________________________________

III. Complete for Contract/Credentialing & Re-Credentialing
(Check all that apply and attach required documentation)

( ) License Attached: Yes [ ] No [ ] NA [ ]
( ) JCAHO accreditation survey results Attached: Yes [ ] No [ ] NA [ ]
( ) DHS report Attached: Yes [ ] No [ ] NA [ ]
SECTION XIII: UTILIZATION MANAGEMENT

1.1 INTRODUCTION

Utilization Management (“UM”) is a shared responsibility of Health Plan, KFH, and Medical Group. These three entities work together to provide and coordinate UM for Health Plan members by reviewing and monitoring the full range of outpatient and inpatient services delivered by physicians, hospitals, and other health care providers. UM helps us to provide services that are appropriate to the members’ clinical conditions.

1.2 INVOLVEMENT OF CONTRACTED PROVIDERS

We expect our contracted providers to make medical decisions based on the appropriateness of care for a member’s medical needs and clinical condition. Kaiser Permanente does not reward or compensate anyone for denying services or coverage. Kaiser Permanente does not use financial incentives to encourage denials of care.

Kaiser Permanente expects our contracted providers to allow open provider-patient communication regarding appropriate treatment alternatives without regard for a member’s benefit plan. We do not penalize providers for discussing available care options with members.

Utilization management data collected by Kaiser Permanente is used to comply with regulatory and accreditation requirements, to identify areas for improvement in the delivery and management of care for both inpatient and outpatient services, for re-credentialing of providers and to coordinate the evaluation of resource utilization.
Kaiser Permanente conducts surveys of members and providers regularly. The results of the surveys are used in the UM program.

UM processes also collect evidence about medical necessity and medical appropriateness of health care services. Appropriate licensed health care professionals supervise all UM evaluations. A licensed physician reviews any denial of a health care service when that denial is based on medical appropriateness or medical necessity.

1.3 UTILIZATION MANAGEMENT AND DISCHARGE PLANNING PROGRAM

One of the principle goals of Kaiser Permanente’s Discharge Planning Program is to assure that members receive appropriate medical care, as needed, after an inpatient stay to facilitate the recovery process. Continuing Care Coordinators are registered nurses who coordinate ongoing medical care after discharge of members from inpatient settings, including home health services, rehabilitation services, and/or preventive services. Continuing Care Coordinators work with the provider’s staff and the member’s attending physician to facilitate discharge planning and post-inpatient care. This process may include making arrangements for and coordinating medically necessary transportation, DME, follow-up appointments, referrals to community services and any other services requested by Kaiser Permanente.

Unless the contracted provider has received prior authorization to furnish follow-up care, the provider must contact Kaiser Permanente to arrange for and to coordinate covered medically necessary care after discharge.

1.4 UTILIZATION MANAGEMENT INFORMATION

Upon request from Kaiser Permanente, the contracted provider may be requested to provide other reasonable information for the Kaiser Permanente UM activities concerning members in the provider's facility. Such additional information may include, but is not limited to, the following data:

- Number of members admitted
- Number of members who were inpatients within the previous seven days
- Number of members who presented in the emergency department ("ED") and number of members admitted through the ED
- Type and number of procedures performed for members
- Number of member consults
- Number of deceased members
- Number of member autopsies
- Average length of member inpatient stay
- Quality Assurance/Peer Review process
- Number of member cases reviewed
- Final action taken for each member case reviewed
• Committee Membership (participation as it pertains to members and only in accordance with the terms of your contract)
• Other information as Kaiser Permanente may reasonably request

1.5 HOSPITAL ADMISSIONS OTHER THAN EMERGENCY SERVICES

A prior authorization must be obtained for all hospital admissions and for the provision of services, except for Emergency Services or other situations expressly allowed by the Agreement or this Provider Manual. Such authorization can be requested as described above by contacting the Outside Utilization Referral Services (OURS) office at 1-800-225-8883. Should the member require post stabilization care or continued hospitalization beyond the services authorized, Provider must contact OURS for further direction.

1.6 ADMISSION TO SKILLED NURSING FACILITY (SNF)

Requests for Skilled Nursing Facility placement should be referred to the Outside Utilization Referral Services (OURS) office at 1-800-225-8883.

1.7 HOME HEALTH/HOSPICE SERVICES

• Authorization for home health or hospice services is based on some of the following information:
  • A Medical Group physician must order and direct the requests for home health and hospice services.
  • The Kaiser Permanente Continuing Care staff review referral requests from Medical Group.
  • The member is an eligible Health Plan member.
  • The member requires the care in the member's place of residence within the Kaiser Permanente Service Area. Any place that the member is using as a home is considered the member's residence.
  • For Home Health services, the member, because of illness or injury, is confined to home. The member is not considered homebound when the member lacks transportation or is unable to drive. To be considered homebound absence from the home is infrequent and/or short in duration. A member is not considered homebound if the member would otherwise tolerate an absence from the home when receiving medical care.
  • The home environment is a safe and appropriate setting to meet the member's needs and provide Home Health Services.
  • There is a reasonable expectation that the needs of the member can be met by the provider.
  • Medically necessary care must be provided by a Registered Nurse or Therapist
  • The member and caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals.
• Services are provided under Health Plan coverage and benefit guidelines.

Such Home Health or Hospice services are authorized for a member only if the services are appropriate for the member’s clinical condition.

The Medical Group or designated physician develops a plan of care in collaboration with the provider.

Home Health and Hospice staff coordinate care with the Medical Provider. Home Health and Hospice manage the patient’s plan of care through on site visits with the member and telephone encounters to assess the member’s progress toward achieving goals in the plan of care. The Plan of Care is reviewed and revised with new Physician orders as needed to meet the needs of the member.

Discharge planning begins when the applicable plan of care is initiated during the start of care of Home Health or Hospice service.

1.8 DURABLE MEDICAL EQUIPMENT (DME)

Kaiser Permanente evaluates authorization requests for durable medical equipment for appropriateness based on, but not limited to, the following information:

• The member’s care needs
• The application of specific Health Plan coverage and benefits guidelines
• Utilization of formulary guidelines
• DME Formulary information may be available through email at: Clinical.Library@KP.org

1.9 NON-EMERGENT MEMBER TRANSPORTATION SERVICES

To serve Kaiser Permanente members and to coordinate care with our contracted providers, Kaiser Permanente has a twenty-four hour, (24 Hour), seven-day per week, centralized medical transportation department called the “HUB”, to coordinate and to schedule non-emergency medical transportation (NEMT services).

If a member is to be transferred from a non-Kaiser Permanente facility to a Kaiser Permanente Medical Center or other location designated by Kaiser Permanente, it is required that prior authorization be secured for the NEMT transport before the HUB is contacted to coordinate the transportation services.

If a transport order is authorized by an appropriate Southern California Permanente Medical Group or Plan physician, the HUB will make the transportation arrangements.
The Kaiser Permanente Discharge Planner or Continuing Care Coordinator will work with the HUB to arrange the transportation of the member.

Non-emergency medical transportation may or may not be a covered benefit for the member. In the event any transports of the member are not coordinated through the "HUB", and not properly documented as authorized referrals, payment for the transport may be denied.

1.10 EMERGENCY TRANSFERS

When a member presents to an emergency department and requires Emergency Services, immediately after screening and stabilization of the member, the provider is required to notify Emergency Prospective Review Program (EPRP) as set forth herein in order to arrange for the transfer of the member to an acute care hospital with the requisite capability.

SECTION XIV: QUALITY MANAGEMENT PROGRAM

1.1 INTRODUCTION

Kaiser Permanente Southern California (KPSC) maintains a Quality Management (QM) Program to objectively and systematically monitor and improve the quality, safety, and appropriateness of member care. The Regional and Medical Center Quality Departments work collaboratively toward the resolution of identified problems, and pursue opportunities for continuous improvement in the provision of member care/services and member safety.

The provider agrees to collaborate with Kaiser Permanente Health Plan through provision and sharing of provider-specific quality data/information during the contracting process and on an on-going basis. Shared information should include Quality/Risk data related to the identification, review, and resolution of quality of care issues regardless of the information source, (e.g., member complaints, clinical department referral, regulatory referral, Utilization Management referral) etc.), other quality improvement activities and public reports to consumers.
The KPSC Quality Management Program includes many aspects of clinical and service quality to include: patient safety, infection control, accreditation and licensing and the oversight of access to care opportunities that result in a potential quality of care issue. The KP quality improvement program is defined in the ‘Southern California Regional Quality Management Program Description’. The document serves to inform both internal and external audiences of how KPSC is organized to support our commitment to the provision of high quality, safe, outcome based patient care in accordance with professionally recognized standards.

The following Quality Documents are available for your review:

- Awards and recognition for our quality program presented by outside organizations
- Programs and systems within KP that promote quality improvement
- Our quality improvement structure
- Areas targeted by our quality goals

You can view and print these documents by logging on to [www.KP.org](http://www.KP.org). Click on “Locate our Services”, then “Forms and Publications”, select “Quality Report” To obtain a copy of the “Quality Program at KP” call our Member Services Call Center at 1- (800) 464-4000 or 1-(800) 777-1370 (TTY).

Patient safety is a central component of KPSC’s care delivery model. We believe our distinctive structure as a fully integrated health care delivery system provides us unique opportunities to design and implement effective, comprehensive safety strategies to protect our members. Providers play a key role in the implementation and oversight of patient safety efforts.

At KPSC, patient safety is every patient’s right and everyone’s responsibility. As a leader in patient safety, our strategic plan outlines six (6) focus areas. These themes include safe culture, safe care, safe staff, safe support systems, safe environment, and safe patients.

If you would like independent information about KP’s health care quality and safety, the following external organizations offer information online:

**The National Committee for Quality Assurance:**

The National Committee for Quality Assurance (NCQA) works with consumers, purchasers of health care benefits, state regulators, and health plans to develop standards that evaluate health plan quality in the ambulatory setting. KP is responsible to manage, measure, and assess patient care in order to achieve NCQA accreditation which includes ensuring that all members are entitled to the same high level of care regardless of the site or provider of care. Kaiser Foundation Health Plan (KFHP) is accredited by the NCQA. You can review the report card for Kaiser Permanente’s, Southern California Region at [www.ncqa.org](http://www.ncqa.org).
The Joint Commission:

The Joint Commission (TJC) is a healthcare accrediting organization. TJC Accreditation is recognized nationwide as a symbol of quality that reflects an organization’s compliance with TJC performance standards. To achieve and maintain TJC accreditation, KPSC facilities must undergo an onsite survey by The Joint Commission survey team at least every three (3) years. KPSC has adopted a set of The Joint Commission compliance expectations for contracted practitioners coming into our facilities. For more information on The Joint Commission performance standards visit: www.jointcommission.org.

1.2 QUALITY ASSURANCE AND QUALITY IMPROVEMENT PROGRAM

KPSC’s QM Program uses a multidisciplinary and integrated approach, which focuses on opportunities for improving operational processes including transitions in care, health outcomes, and patient and provider satisfaction.

With respect to Covered Services provided to Members, Provider shall participate in KPSC’s QI program as established and amended from time to time, which includes cooperating with KP’s QI activities to monitor and evaluate Covered Services provided to Members (such as tracking and regular reporting on quality, patient safety, regulatory indicators and providing performance data), facilitating review of such Covered Services by KPSC’s QI committees and staff, and cooperating with any independent quality review and improvement organization or other external review organization evaluating KPSC as part of its QI program (including NCQA).

The quality of care members receive is monitored by KPSC’s oversight of Providers. You will be monitored for various indicators and required to participate in some KP processes. For example, we monitor and track the following:

- Patient access to care
- Patient complaint and satisfaction survey data of both administrative and quality of care issues
- Compliance with KP policies and procedures
- UM statistics
- Quality of care indicators as necessary for KP to comply with requirements of Department of Managed Health Care (DMHC), NCQA, Medicare, The Joint Commission and other regulatory and accreditation bodies
- Performance standards in accordance with your Agreement
- Credentialing and re-credentialing of Providers

In any of the above situations, when KP reasonably determines that the Provider’s performance may adversely affect the care provided to members, KP may take corrective actions in accordance with your Agreement.
1.3 MONITORING AND REPORTING REQUIREMENTS

The Agreement identifies particular events which must be reported to Kaiser Permanente’s QM Program by provider and particular monitoring actions which must be performed by provider in conjunction with Kaiser Permanente’s QM Program. In addition, as part of its required participation in KP’s QM Program and in addition to the claims submission requirements set forth in Section X of this Provider Manual, and to the extent permitted by state and federal law, Provider must promptly notify KP and, upon request, provide information about any Do Not Bill Event (as defined in Section X.1.11) that occurs in connection with services provided to a Kaiser Permanente Health Plan Member.

SECTION XV: EMERGENCY SERVICES

When Health Plan members present in your Emergency Room for treatment, we expect you to triage and treat them in accordance with EMTALA requirements, and to contact Kaiser Permanente’s Emergency Prospective Review Program (EPRP) once the member has been stabilized or stabilizing care has been initiated.* You may contact EPRP at any time, including prior to stabilization to the extent legally and clinically appropriate, to receive relevant member-specific medical history information which may assist you in your stabilization efforts and any subsequent post-stabilization care. EPRP has access to member medical history, including recent test results, which can help expedite diagnosis and inform further care. In addition, EPRP can authorize post-stabilization care at your facility, as required under each member’s Evidence of Coverage in order for non-emergency care to be a covered benefit, or assist in making other appropriate care arrangements.

* Please note: Under the EMTALA regulations issued September 2003; providers may, but are not required to, contact EPRP once stabilizing care has been initiated but prior to the member’s actual stabilization, if such contact will not delay necessary care or otherwise harm the member.

EPRP provides a statewide emergency services notification system in California for all Health Plan members. It also provides authorization for requested post-stabilization care and must be contacted prior to a stabilized Health Plan member’s admission to your facility, unless your Agreement establishes a different process.

EPRP
1-800- 447-3777
Available 7 days a week
24 hours a day

EPRP PROVIDES:
• Access to clinical information 24 hours a day, every day of the year, to help you in evaluating a member’s condition and to enable our physicians and the treating physicians at your facility, to quickly determine the appropriate treatment for the member.

• Emergency physician to emergency physician discussion regarding a member’s case 24 hours a day, every day of the year.

• Authorization of post-stabilization care, 24 hours a day, every day of the year, or assistance with making appropriate alternative care arrangements.

1.1 POST STABILIZATION AUTHORIZATIONS

If there is mutual agreement at the time of the phone call as to your provision of post-stabilization services, EPRP will authorize you to provide the agreed-upon services and give you a confirming authorization number. If requested, Kaiser Permanente will also provide a written confirmation of the services authorized and the confirmation number. This authorization number must be included with the claim for payment for the authorized services. The authorization number is required for payment, along with the following:

• All reasonably relevant information relating to the post-stabilization services on your claim submission consistent with the information provided to EPRP as the basis for the authorization; and

• EPRP must have confirmed that the member was eligible for and had benefit coverage for the authorized post-stabilization services provided.

If EPRP authorizes the admission of a clinically stable member to your facility, Kaiser Permanente’s Outside Utilization Resource Services (OURS), will follow that member’s care in your facility, including any authorization of subsequent care, until discharge or transfer.

1.2 POST STABILIZATION ADMISSIONS

If the member is admitted to your facility as part of the stabilizing process and you have not yet been in contact with EPRP, you must call Outside Utilization Resource Services (OURS), in order to discuss authorization for continued admission as well as any additional appropriate post-stabilization care once the member’s condition is stabilized. After you have notified Kaiser Permanente and received initial authorization, you will be contacted daily by a RN Case Manager in OURS to provide updates on the member’s clinical progress and stability to transfer back to any designated Kaiser Permanente plan facility.
LIKE EPRP, OURS NOTIFICATION ALSO PROVIDES:

- Access to clinical information 24 hours a day, every day of the year, to help you in evaluating a member's condition and to enable our physicians and the treating physicians at your facility, to quickly determine the appropriate treatment for the member.

- Physician to physician discussion regarding a member's case 24 hours a day, every day of the year.

- Authorization of post-stabilization care, 24 hours a day, every day of the year, or assistance with making appropriate alternative care arrangements.

OURS may deny authorization for some or all post-stabilization services. The verbal denial of authorization will be confirmed to you in writing. OURS may request that the member be transferred to a Kaiser Permanente-designated facility for continuing care or OURS may authorize certain post-stabilization services in your facility on the condition that such services be rendered under the management of a physician who is a member of your facility's medical staff or who has contracted with Kaiser Permanente to manage the care of our members being treated in community hospitals.

If OURS denies authorization for requested post-stabilization care, Kaiser Permanente has no financial responsibility if you nonetheless choose to provide the care. If the Health Plan member insists on receiving such unauthorized post-stabilization care from your facility, we strongly recommend that you require that the member sign a financial responsibility form acknowledging and accepting his or her sole financial liability for the cost of the unauthorized post-stabilization care and/or services.

Note: If the member wishes to discuss the process of filing a claim with Kaiser Permanente, please refer the member to Kaiser Permanente’s Member Services Department at 800-464-4000, available the days and hours set forth in the Key Contacts section of this Provider Manual. A Member Services Representative will explain the claims process to the member.

SECTION XVI: CULTURAL DIVERSITY

At Kaiser Permanente (KP), we are committed to improving the quality of care provided to our increasingly diverse membership. Member’s cultural needs are considered and respected at every point of contact. This is integral for providing a cultural competent system of care.
A person’s culture is composed of many factors. Examples include:

- Ethnicity
- Gender
- Physical/mental ability
- Race
- Sexual orientation
- Age
- Language
- Education
- Health literacy/beliefs
- Religion/spirituality
- Income

At Kaiser Permanente, we

- Value differences in culture, experience and perspective
- Seek out and consider differing points of view
- Treat all individuals with dignity and respect
- Make all individuals feel important and welcome
- Seek to understand different medical needs based on diversity and promote culturally and linguistically appropriate care

### 1.1  NON DISCRIMINATION

The Kaiser Permanente Medical Care Program (KPMCP) does not discriminate in the delivery of health care based on race/ethnicity, color, national origin, ancestry, religion, sexual orientation (including gender, gender identity, or gender related appearance/behavior whether or not stereotypically associated with the person’s assigned sex at birth), marital status, veteran’s status, age, genetic information, medical history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment or any other protected status.

It is also the policy of KPMCP to require that facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 ("ADA") and Section 504 of the Rehabilitation Act of 1973 ("Section 504") and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability. Kaiser Permanente is committed to providing equal access for members with disabilities.

As a provider for HMO products offered by KP, you are expected to adhere to KP’s “Nondiscrimination in the Delivery of Health Care Policy” and to all other federal and state laws and regulations that prohibit discrimination on the basis of disability.

### 1.2  KP’S LANGUAGE ASSISTANCE PROGRAM
All Providers must cooperate and comply with KP’s Language Assistance Program by assisting any limited English proficient (LEP) KP member with access to KP’s Language Assistance Program services.

Providers must ensure that KP members or, if applicable, their family, caregivers or legal guardian(s) receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language. Providers should offer language assistance to KP members who appear to need it even if they do not ask for it or if their language preference was not indicated on the referral form. The proactive offer and/or use of language assistance services must be documented in the KP member’s medical record, even if the communication occurred directly with the Provider or Provider’s Qualified Bilingual Staff (QBS). If language assistance was utilized the type of service provided must be documented, along with the type/name of the service and the interpreter name and ID, either of the Provider, the Provider’s QBS or the contracted KP language assistance vendor. Should an LEP KP member refuse to accept language interpreter services, the Provider must document this refusal in the KP member’s medical record and the reason for such refusal. In addition, if language assistance was requested by the KP member and not provided the reason for not providing such services must be documented in the patient’s medical record. Please see the subsection titled “Documentation” below.

1.3 USING QUALIFIED BILINGUAL STAFF

Our expectation is that you will provide interpreter services in-person using your own qualified bilingual staff if you have them.

Your qualified bilingual staff should meet the regulatory standards set out in KP’s minimum quality standards for interpreters:

- Documented and demonstrated proficiency in both English and the other (target) language;
- Fundamental knowledge in both languages of health care, clinical, and medical terminology and concepts; and
- Education and training in interpreting ethics, conduct and confidentiality.

Provider must have a process in place to ensure ongoing competency of staff and to cooperate with KP by providing access to this information upon reasonable notice.

WHEN QUALIFIED BILINGUAL STAFF IS NOT AVAILABLE

In the event that you do not have qualified bilingual staff at the time services are needed, KP has made the following arrangements available to Providers when providing services to KP members. KP will directly reimburse the companies below for interpreter services provided to KP members. Neither members nor Providers will be billed by these companies for interpreter services.
1.4 TELEPHONE INTERPRETATION

Language Select is a company with the capability to provide telephonic interpreter services in two hundred (200) different languages. Phone interpreter services are available twenty-four (24) hours per day, seven (7) days per week through Language Select by calling: (855) 701-8100. This phone number is dedicated to the interpreter needs of members. While no lead time is needed to engage an interpreter through this service, Providers must have the following data elements available before placing the call:

- The KP Client ID number. This number will be provided to you, in writing, together with your authorization.
- KP referral or authorization number
- Member’s MRN
- Member’s language preference

Language Select customer service can be reached at 800-200-7067. In addition, Language Select offers an email address specific to KP if you wish to submit an issue through email (kp@languageselect.com). You will receive a follow-up response within 48 hours.

1.5 AMERICAN SIGN LANGUAGE SUPPORT

Interpreters Unlimited is a company with the capability to provide in-person interpreter services for members requiring Sign Language services (i.e. American Sign Languages, Spanish to Sign, etc.). At least one week’s advance notification of need for an ASL interpreter is recommended to help ensure interpreter is available. Please provide as much advance notice as possible when requesting an ASL interpreter. Interpreters Unlimited can be reached by calling: (844) 855-0249 seven (7) days a week. Providers may arrange in-person interpreter services for multiple dates of service with one call.

Providers must have the following data elements available before placing the request for service:

- KP Client ID number
- KP referral or authorization number
- Member’s MRN
- Date(s) of member’s appointment(s)
- Time and duration of each appointment
- Specific address and location of appointment(s)
- Any access or security measures the interpreter will need to know and plan for to gain entry to the place of service
- Any cancellation should be made at least twenty-four (24) hours in advance of the scheduled appointment
- Key Contact Name and Number for KP inquiries regarding the request for interpreter services
Interpreters Unlimited’s customer service can be reached at (800) 726-9891, (option 3 then option 1) twenty-four (24) hours per day, seven (7) days a week.

Note: Interpreters Unlimited’s interpreter will provide a Verification of Service form while onsite. Please ensure the Provider staff verify and sign this form.

Please inform KP of any complaints, concerns or questions that you have with the KP provided language assistance service vendors by calling (626) 405-6252.

1.6 FAMILY MEMBERS AND FRIENDS AS INTERPRETERS

The KP Language Assistance Program strongly discourages, but does not prohibit, adult family members and friends (age 18 and over) from serving as interpreters for members. Members must first be offered language assistance and informed of the benefits of using professional language assistance. If after that offer, the member refuses and prefers to use a family member, that refusal must be documented in the member’s medical record. However, the Provider can still elect to utilize language assistance services to ensure effective, accurate and appropriate communication occurs. Minor children should not be used as interpreters except in extraordinary situations such as medical emergencies where any delay could result in harm to a member/patient, and only until a qualified interpreter is available. Use of a minor child for interpretation under these circumstances should be documented in the medical record.

1.7 DOCUMENTATION

Providers need to document the following in the KP Member's Medical Record:

- Language assistance was either offered (or requested) to (by) an LEP KP member;
- If language assistance was refused by the KP member; the reason why must be noted, i.e. used family member.
- What type of service was utilized (telephonic, in-person interpreter services or bilingual staff), for those members who accept/use language assistance;
- If language assistance was requested and not provided, the reason why must be noted; and
- Name, ID, association, of the vendor, person and/or family member (18 years of age or older) that provided such language assistance.

Providers must document the required information for KP to assess compliance, and cooperate with KP by providing access to that information upon reasonable notice.
1.8 ONSITE TRANSLATION SERVICES

The requirements set forth above also apply to KP member requests for the onsite verbal translation of documents related to such member's care (i.e., verbal translation of a written document provided to the KP member and related to services provided to such member). To the extent a KP member requests written translation of one or more documents, the member should be referred to Member Services.

1.9 STAFF TRAINING

Providers shall provide adequate training regarding the KP’s language assistance program requirements to Provider staff who have contact with KP’s LEP members. The training shall include instruction on:

- Understanding and complying with KP language Assistance Program
- Working effectively with KP’s LEP members;
- Working effectively with interpreters in person and through video, telephone and other media, as may be applicable; and
- Understanding the cultural diversity of KP’s member population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Providers must document that training has occurred and submit training materials, sign-in sheets, attestations, knowledge checks and other relevant materials to KP to allow KP to assess compliance, and cooperate with KP by providing access to that information upon reasonable notice.

1.10 COMPLIANCE WITH LANGUAGE ASSISTANCE

Providers must ensure they comply with KP’s Language Assistance Program requirements. Providers must cooperate with KP by providing any and all information necessary to access compliance, including but not limited to, participation in onsite audits and requests for documentation as required by KP.

SECTION XVII: COMPLIANCE

KP strives to demonstrate high ethical standards in our business practices. The Agreement details specific laws and contractual provisions with which you are expected to comply. This section of the Manual details additional compliance obligations.

1.1 COMPLIANCE WITH LAW
Providers are expected, and required by their Agreement, to conduct their business activities in full compliance with all applicable state and federal laws.

1.2 KP PRINCIPLES OF RESPONSIBILITY AND COMPLIANCE HOTLINE

The KP Principles of Responsibility (POR) is the code of conduct for KP physicians, employees and contractors working in KP facilities (KP Personnel) in their daily work environment. If you are working in a KP facility, you will be given a copy of the POR for your reference. You should report to KP any suspected wrongdoing or compliance violations by KP Personnel under the POR. The KP Compliance Hotline is a convenient and anonymous way to report a suspected wrongdoing without fear of retaliation. It is available twenty-four (24) hours per day, three hundred sixty-five (365) days per year. The toll free Compliance Hotline number is (888) 774-9100.

Additionally, Providers may review the KP POR and Vendor Code of Conduct at: http://www.kp.org/compliance and are encouraged to do so. The KP POR and Code of Conduct are applicable to interactions between you and KP and failure to comply with provisions of these standards may result in a breach of your Agreement with KP.

1.3 GIFTS AND BUSINESS COURTESIES

Even if certain types of remuneration are permitted by law, KP discourages Providers from giving gifts, meals, entertainment or other business courtesies to KP Personnel, in particular the following strictly prohibited items:

- Gifts or entertainment of any value
- Gifts, meals or entertainment that are provided on a regular basis
- Cash or cash-equivalents, such as checks, gift certificates/cards, stocks, or coupons
- Gifts from government representatives
- Gifts or entertainment that reasonably could be perceived as a bribe, payoff, deal or any other attempt to gain advantage
- Gifts or entertainment given to KP Personnel involved in KP purchasing and contracting decisions
- Gifts or entertainment that violate any laws or KP policy

1.4 CONFLICTS OF INTEREST

Conflicts of interest between a Provider and KP Personnel or the appearance of it, should be avoided. There may be some circumstances in which members of the same family or household may work for KP and for a Provider. However, if this creates an actual or potential conflict of interest, you must disclose the conflict at the earliest opportunity, in writing, to a person in authority at KP (other than the person who has the relationship with the Provider). You may call the toll free Compliance Hotline number at (888) 774-9100 for further guidance on potential conflicts of interest.
1.5 FRAUD, WASTE AND ABUSE

You are expected to comply with all applicable state and federal laws governing remuneration for health care services, including anti-kickback and physician self-referral laws. KP will investigate allegations of Provider fraud, waste or abuse, related to services provided to members, and where appropriate, will take corrective action, including but not limited to civil or criminal action. The Federal False Claims Act and similar state laws are designed to reduce fraud, waste and abuse by allowing citizens to bring suit on behalf of the government to recover fraudulently obtained funds (i.e., “whistleblower” or “qui tam” actions). KP Personnel may not be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

1.6 PROVIDERS INELIGIBLE FOR PARTICIPATION IN GOVERNMENT HEALTH CARE PROGRAMS

KP expects the Provider to (a) disclose whether any of its officers, directors, employees, or subcontractors are or become sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program or is convicted of a criminal offense related to the provision of healthcare and (b) assume full responsibility for taking all necessary steps to assure that your employees and agents directly or indirectly involved in KP business have not or are not currently excluded from participation in any federal program. KP will not do business with a health care practitioner who is or becomes excluded by, debarred from or ineligible to participate in any federal health care program or is convicted of a criminal offense related to the provision of health care.

1.7 VISITATION POLICY

When visiting KP facilities (if applicable), you are expected to comply with the applicable visitation policy, which is available at KP facilities upon request. “Visitor” badges provided by the visited KP facility must be worn at all times during the visit.

SECTION XVIII: CONFIDENTIALITY OF MEMBER INFORMATION

Health care providers, including Kaiser Permanente and you or your facility, are legally and ethically obligated to protect the privacy of members and members. Kaiser Permanente requires that you keep its members’ medical information confidential and secure. This requirement is based on state and federal confidentiality laws, as well as policies and procedures created by Kaiser Permanente.

As a contracted provider for Kaiser Permanente, you may not use or disclose the personal health information of a Health Plan member, except as needed to provide medical care to members or members, to bill for services or as necessary to regularly conduct business. Personal health information refers to medical information, as well as information that can identify a member, including a member’s address and telephone number.
Medical information may not be disclosed without the authorization of the member, except when the release of information is either permitted or required by law.

1.1 HIPAA AND PRIVACY RULES

As a contracted provider, you may have signed a document that creates a business associate relationship with Kaiser Permanente; as such relationship is defined by federal regulations commonly known as “HIPAA” (defined below). If you are providing standard member care services that do not require a business associate agreement, you still must preserve the confidentiality and privacy of our common members’ medical information as a HIPAA “covered entity”.

If you did not sign a business associate agreement, you are a "covered entity" as that term is defined under HIPAA, and the Privacy Rule issued by the Department of Health and Human Services. As a covered entity, you have specific responsibilities to limit the uses and disclosures of protected health information ("PHI"), as that term is defined by the Privacy Rule (45 CFR Section 164.501).

Certain data which may be exchanged as a consequence of your relationship with Kaiser Permanente is subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and its regulations (collectively, "HIPAA"). To the full extent applicable by the provisions of HIPAA, you must comply with HIPAA, including but not limited to the HIPAA standards for (i) privacy, (ii) code set, (iii) data transmission standards, and (iv) security regarding physical storage, maintenance, transmission of and access to individual health information.

You must use and disclose PHI only as permitted by HIPAA and the Privacy Rule, subject to any additional limitations, if any, on the use and disclosure of that information as imposed by your Agreement or any business associate agreement you may have signed with Kaiser Permanente. You must maintain and distribute a Notice of Privacy Practices to members using your services. You must distribute your Notice of Privacy Practices (45 CFR Section 164.520) to and obtain acknowledgements from members receiving services from you, in a manner consistent with your practices for other members. You must give Kaiser Permanente a copy of your Notice of Privacy Practices and give Kaiser Permanente a copy of each subsequent version of your Notice of Privacy Practices whenever a material change has been made to the original Notice.

You are required by HIPAA to provide a member with access to his or her PHI, to allow that member to amend his or her PHI, and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures. You must extend these same rights to Health Plan members who are members. If you amend, allows a member to amend, or include in your records any statement of a member pursuant to HIPAA requirements, you must give a copy of such item to Kaiser Permanente.