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

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

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

Kaiser Permanente is committed to preventing disease, promoting health, and serving our members by Caring for Hawaii’s People like Family. We take pride in the skills, experience and caring that our physicians and staff offer our members. Working as a team, our medical staff provides comprehensive, high quality medical care to more than 226,000 members statewide.

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

Kaiser Permanente appreciates your willingness to work with us and looks forward to a continued valuable relationship. Thank you for your participation and should you need additional information or have any questions, please do not hesitate to contact the Provider Contracting and Relations staff at (808) 432-5658.
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Chapter 1:
The Kaiser Permanente Medical Care Program

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

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

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

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

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

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

Kaiser Permanente service areas are subject to change at any time.

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

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

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

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

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

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

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

**Our Medical Group’s Values Statement**

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

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

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

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

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

Should you need additional information or have any questions, please do not hesitate to contact the Provider Contracting and Relations department:

For general information/assistance (Facilities & non-Physicians):
(808) 432-5658
(808) 432-5777, ext. 1369, ext. 1365 or ext. 1373
Mon.-Fri., except State holidays
7:45am-4:30pm

For general information/assistance (Physicians):
(808) 432-5897
Mon.-Fri., except State holidays
7:45am-4:30pm

For assistance with QUEST Integration Service Coordination:
Kaiser Permanente QUEST Integration Provider Call Center
(808)432-5330 (Oahu)/1-800-651-2237 (toll-free) or by TTY 1-877-447-5990Mon – Fri
except State holidays
7:45am – 4:30pm

For questions regarding bills or payment status:
Community Medical Services Representative

(808) 432-5330 (Oahu)
(800) 651-2237 (toll-free)
(808) 432-5433 (facsimile)
Mon.-Fri., except State holidays
7:45am-4:30pm

For routine transfers:
Transfer Coordinators
(808) 432-7252
(808)432-7250 – after hours
Fax: (808) 432-7251
7:45am-4:30pm
7 days a week except
State holidays

*For emergency transfers to Kaiser Permanente Moanalua Medical Center & routine transfers after clinic hours:*

**Emergency Hotline**
(808) 432-7038
24 hours

*For questions regarding out of plan services and authorization:*

**Authorization and Referrals Management**
(808) 432-5687
(808)432-5691 (facsimile)
Mon.-Fri., except State holidays
7:45am-5:00pm

*For questions regarding the QUEST Integration program:*

**Kaiser Permanente QUEST Integration Call Center**
432-5330 or toll-free at 1-800-651-2237
Mon – Fri except State holidays
7:45am – 4:30pm
Chapter 3: Membership Identification Cards

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

![Membership Card Example]

Kaiser Permanente QUEST Integration members also have a Kaiser Permanente QUEST Integration Card (example below).

<table>
<thead>
<tr>
<th>Medical Record Number</th>
<th>[XXXXXXX]</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Member Name]</td>
<td></td>
</tr>
<tr>
<td>Effective Date</td>
<td>[MM/DD/YYYY]</td>
</tr>
<tr>
<td>Primary Clinic</td>
<td>[Clinic Location]</td>
</tr>
<tr>
<td>Third Party Liability</td>
<td>[Third Party Liability]</td>
</tr>
<tr>
<td>Clinic Phone Number</td>
<td>[XXX-XXX-XXXX]</td>
</tr>
</tbody>
</table>

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

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

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

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

Member Rights and Responsibilities

Member Rights

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

For detailed information about member rights to privacy, please refer to Notice of Privacy Practices. A member can find the Notice of Privacy Practices on our Web site at kaiserpermanente.org, or contact our Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

A member has the right to:

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

• Refuse care, treatment and services.

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

• Establish a relationship with a specialist or qualified practitioner of women’s health services to assure continuing care.

• Receive information and discuss with his/her doctor his/her medical condition, available treatment options, alternatives and diagnosis in a manner appropriate to his/her condition and his/her ability to understand.

• Obtain language interpretation services when required to understand his/her care and services.

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

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

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

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

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

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

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

• Have his/her cultural, psychological, social, and spiritual needs considered and respected.

• Be assured of privacy and confidentiality of all communications and records related to his/her care and have his/her confidentiality protected. The member or a person of his/her choosing can request and receive a copy of or access his/her medical records and request to amend or correct the record, within the limits of the law. In addition, the member has the right to limit, restrict or prevent disclosure of PHI.

• Be treated in a safe, secure, and clean environment free from physical and drug restraints except when ordered by a doctor, or in the case of an emergency, when it is necessary to protect him/her or others from injury.
• Receive appropriate and effective pain management as an important part of his/her care plan.

• Get an explanation of his/her bill and benefits regardless of how he/she pays. The member has the right to know about our available services, referral procedures, and costs.

• Receive other information and services required by various state or federal programs.

• When appropriate, be informed about the outcomes of care, including unanticipated outcomes. Be informed of the ability to change providers if other qualified providers are available.

• Discuss "do not resuscitate" wishes or advance directive instructions for healthcare with your surgeon and anesthesiologist prior to an operative procedure when you wish to have the “do not resuscitate” honored in the event of a life threatening emergency during an operative procedure.

• Medicaid patients receiving services in the Ambulatory Surgery Center who wish to file a complaint or voice a concern may contact the Medicaid Ombudsman, Hilopaa, at www.hilopaa.org, or by calling 1-808-791-3467 (Oahu), 1-808-270-1536 (Maui). Medicare patients may contact the Office of the Medicare Beneficiary Ombudsman at www.medicare.gov.

**Member Responsibilities**

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

• Provide accurate and complete information about his/her present and past medical condition.

• Follow the treatment plan agreed on by the member and his/her health care practitioner. The member has a responsibility to inform his/her health care practitioner if the member does not understand or cannot follow through with his/her treatment.

• Understand his/her health problems and participate in developing mutually agreed upon treatment goals, to the extent possible.

• Identify himself / herself appropriately and use his/her Kaiser Permanente identification card in accordance with Kaiser Permanente policies and procedures.

• Cooperate with our staff to help ensure proper diagnosis and treatment of his/her illness or condition.

• Keep his/her appointments or if he/she cannot keep them, cancel appointments in a timely manner.

• Know his/her benefit coverage and its limitations.

• Cooperate in signing a release form when he/she chooses to refuse recommended treatment or procedures.

• Realize the effects his/her lifestyle has on his/her health and understand that decisions he/she makes in his/her daily life, such as smoking, can affect his/her health.
• Be considerate of others by respecting the rights and feelings of the staff and respect the privacy of other patients.

• Refrain from disturbing or disrupting operations and administration and cooperate with staff to allow services to other patients to be performed without interruption.

• Follow all hospital, clinic, and health plan rules and regulations, including respecting hospital visiting hours.

• Cooperate in the proper processing of third party payments.

• Inform us when he/she or his/her covered dependents change addresses or other contact information.

• Be responsible for his/her actions. If he/she refuses treatment or does not follow instructions, his/her care may be rescheduled should his/her action or behavior interfere with facility and/or patient care. Should his/her medical condition change, the treatment plan may be modified.

• For Ambulatory Surgery Center (ASC) patients, provide a responsible adult to transport him/her home from the ASC and remain with him/her for 24-hours, if required by his/her provider.

Hospital Patient Rights

Patient Rights

As a person receiving our services, the patient has specific rights regardless of his/her age, cultural background, gender, gender identity, sexual orientation, financial status, national origin, race, religion, or disability.

A patient in the Moanalua Medical Center also has the right to:

• Receive information about his/her rights and responsibilities when he/she is admitted.

• Receive orderly transfer and discharge for his/her welfare, for other patients’ welfare, or other causes as determined by his/her physician. Also, the patient has the right to receive reasonable advance notice and discharge planning by qualified hospital staff to help ensure appropriate post-hospital placement and care.

• Request visits by clergy at any time and participate in social and religious activities, unless doing so infringes on the rights of other patients or would compromise his/her medical care.

• Receive and use his/her own clothing and possessions as space permits, unless doing so infringes on the rights of other patients, is in violation of hospital safety practices, or would compromise his/her medical care.

• Give informed consent before the start of any recording, films, or other images for purposes of non-patient care.

• Access protective and advocacy services.

• Access appropriate educational services when a child or adolescent patient’s treatment necessitates a significant absence from school.
• Protection from requests to perform services for Kaiser Foundation Hospital that are not included for therapeutic purposes in his/her plan of care.

• Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation as specified in federal regulations on the use of restraints and seclusion.

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

• File a complaint in the hospital, either verbally or in writing, with the department manager or supervisor. If the patient is not satisfied with the response, the patient may contact Hospital Administration, which is located on the first floor of the hospital or reached through the operator at 432-0000.

The patient may also contact The Joint Commission (an independent, not-for-profit organization that accredits and certifies health organizations and programs) by phone, mail, fax or email. Phone: Toll free U.S., Weekdays 8:30 a.m. – 5 p.m. Central time, (800) 994-6610. Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL. 60181. Fax: (630) 792-5636. Email: complaint@jointcommission.org.

Rights and Responsibilities of QUEST Integration Members
A QUEST Integration member has these additional rights and responsibilities.

QUEST Integration Member Rights
A QUEST Integration member has a right to:

• Not be held responsible for Kaiser Permanente debts in the event of insolvency.

• Not be held responsible for services provided to him/her for which the Department of Human Services (DHS) does not pay Kaiser Permanente.

• Not be held responsible for covered services provided to him/her for which DHS or Kaiser Permanente does not pay the health care provider that performed the service.

• Not be held responsible for payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount he/she would owe if Kaiser Permanente provided the services directly.

• Direct access to a specialist through a standing referral or an approved number of visits if the QUEST Integration member is an enrollee with special health care needs, as determined through an assessment by an appropriate health care professional.

• Freely exercise his/her rights and can expect that exercising those rights does not adversely affect the way Kaiser Permanente treats him/her.

• Receive information in accordance with federal and State-specified information requirements for language, format, translation, interpretation, etc. [42 CFR 438.100(a)(1 and 2)].
• Be furnished health care services in accordance with requirements for access, availability, and quality of services (42CFR438.206 through 42CFR438.210).
• Receive services out of network if Kaiser Permanente is unable to provide them in-network and not pay more than if the services had been provided in-network.
• Receive services according to the appointment waiting time standards.
• Receive services in a culturally competent manner.
• Receive services in a coordinated manner.

QUEST Integration Member Responsibilities

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

• Also, a QUEST Integration member must notify Kaiser Permanente at 432-5330 or toll-free at 1-800-651-2237 if:
  ○ Another person, organization or program is liable for the cost of care for his/her illness or injury (such as no-fault insurance for a car accident, or worker's compensation for an injury on the job)
  ○ He/She will need continuing medical care while visiting on another island
  ○ He/She is going to be away from home for more than 90 days

MEMBER INQUIRY AND GRIEVANCES PROCESS

Definitions

- Action:
  1. The denial or limited authorization of a requested service, including the type or level of service.
  2. The reduction, suspension, or termination of a previously authorized service.
  3. The denial, in whole or in part, of payment for a service.
  4. The failure to provide services in a timely manner as defined by the State of Hawaii.
  5. The failure of the health plan to act within prescribed timeframes
6. For a rural area member or for islands with only one contractor or limited providers, the denial of a member’s request to obtain services outside the network:
   a. From any other provider (in terms of training, experience, and specialization) not available within the network.
   b. From a provider not part of the network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days; however, KP is still responsible for reimbursement for the services the provider rendered.
   c. Because the only plan or provider available does not provide the service because of moral or religious objections.
   d. Because the member’s provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network.
   e. The State determines that other circumstances warrant out-of-network treatment.

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

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

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

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

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

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

- **Organization determination:** an initial decision by Health Plan to pay or deny a request for payment or coverage of a service or item.
• **Sentinel Event:** an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response. The terms sentinel event and medical error are not synonymous; not all sentinel events occur because of error and not all errors result in sentinel events. A distinction is made between an adverse outcome that is primarily related to the natural course of the patient’s illness or underlying condition, and a death or major permanent loss of function that is associated with the treatment or lack of treatment of that condition, or otherwise not primarily related to the natural course of the patient’s illness or underlying condition. Kaiser Permanente sentinel events are inclusive of all Joint Commission Sentinel Events.

**General Requirements for Member Inquiries and Grievances**
- Members may designate a representative or provider to make an inquiry or file a grievance on their behalf and may request a State administrative hearing.
- Members may provide verbal consent for Kaiser Permanente staff to interact with the authorized representative or provider. The member’s designation will be documented in the applicable Kaiser Permanente system when consent from the member is provided verbally.
- Members will be provided with any reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers with TTD and interpreter capability.
- The Kaiser Permanente systems used to record and track inquiry and grievance information contain protected member demographic and medical care information. System users will handle this information in strictest confidentiality in accordance with Regional Policy 6226-06-01 “Regional Confidentiality and Security of Information” and MQD-RFP-2014-005.
- Members may submit an inquiry or file a grievance by calling 432-5955 or toll-free at 1-800-966-5955, or by TTY at 1-877-447-5990. Members may also write to us at: Kaiser Foundation Health Plan, Inc. Customer Service Center 711 Kapiolani Blvd., Honolulu, HI 96813

**Member Inquiry Process**
All member oral or written inquiries will be addressed and provided a response in a timely manner.
- All member inquiries will be entered into the MACESS tracking system.
- If at any time during the inquiry process (written or telephone request), the member expresses a complaint of any kind, the inquiry then becomes a grievance or appeal and the member will be given his/her grievance and/or appeal rights, as applicable.
**Member Grievance Process**

All members, member’s authorized representative, or provider acting on behalf of the member, may file oral or written grievances that will be addressed and resolved as expeditiously as the member’s health condition requires, no later than thirty days of the receipt of the initial expression of dissatisfaction. There is no time limit for filing a grievance. When the internal grievance is resolved, the member will be informed of his/her right to recourse through the State’s grievance review process.

**Process**

- Staff will attempt to resolve all member concerns at the point of origin and will employ service excellence behaviors. Concerns that are not resolvable at point of service will be pursued with necessary investigation and follow-up action to an appropriate and timely resolution.

- The Lotus Notes®-based Customer Feedback System (CFS) is the designated system for managing, documenting, tracking, monitoring, and resolving customer concerns. The most recent input document version will be used to enter data and create records in the system.

- The Customer Feedback Form (Form 91139) is the proper input/worksheet document for recording customer encounters. The Customer Feedback comment card “Let Us Here From You” (Form 99614, 5/97 revision or later) is the designated customer comment document for use within Kaiser facilities.

- All concerns will be documented in the CFS within two working days with responsibility for each case assigned to the appropriate Local Accountable Group. Concerns resolved at the point of origin will be documented in the CFS for tracking and trending.

- Grievances that are identified to include a clinical urgency will be referred to the appropriate Hospital or Clinic Manager, Supervisor or Physician Chief within 24 hours.

- The CFS will be used for recording, documenting the substance of the concern including any aspects of clinical care involved, tracking, and trending concerns and action taken. Any grievance registered by written correspondence will be dated-stamped to preclude delays in processing. All documentation submitted by or sent to the member is to be retained in a permanent file.

- All notices and written information provided to QUEST Integration members will include language block references for non-English language assistance in accordance with Government Programs Department Policy #6547-01-05 QUEST Integration Member Information and Policy #6547-03-04 Toll-Free Call Center. Government Programs will be responsible for maintaining the language block document and providing updated versions to the Customer Feedback Administration.

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

  o Reasonable attempts will be made to obtain a written form of authorization. Reasonable attempts are defined as one phone call and if unable to reach member, one letter will be mailed.
The requesting provider will be consulted when appropriate.

- The CFS Administrator will send a letter of acknowledgment to the member within five (5) business days of the entry of the grievance into the CFS.
- For grievances resolved at the point of contact the acknowledgement and resolution may be in the same letter.
- Local Accountable Groups will respond to all written and verbal grievances as expeditiously as the member’s health condition requires or within 30 calendar days after receiving the concern, whichever is earlier. The response to the member will include notification of the disposition of the concern and the member’s right to request a grievance review with the State’s Med-QUEST Division, along with review request instructions. The right to request a grievance review with the MQD is not offered until the member exhausts the internal grievance system.
  - The letter informs the member that he/she may request a Grievance Review by contacting the Med-QUEST Division at 808-692-8094 within thirty (30) days of member’s receipt of grievance disposition. They may also send their request in writing to:
    Med-QUEST Division
    Health Care Services Branch
    PO Box 700190
    Kapolei, HI 96709-0190
  
  The letter also informs members that Med-QUEST Division will review the grievance and contact the member with a determination within 90 days from the day the request is received. The grievance review determination made by Med-QUEST Division is final.

Member Appeals Process

All Members have the right to appeal the adverse decisions of Kaiser Foundation Health Plan, Hawaii Region (Health Plan), regarding:

- Payment for emergency or urgently needed services;
- Retrospective coverage of out-of-Plan medical services that a Member believes are covered and should have been provided, arranged or reimbursed by Health Plan;
- Issues pertaining to coverage or payment by Health Plan that do not qualify for review under the expedited or pre-service processes.

Appeals may be submitted in writing, via facsimile, electronic mail, or, if necessary, orally (to establish the appeal submission date, but must be followed by a written request) to the Regional Appeals Office. Appeals received by other Hawaii Region employees will be immediately forwarded to the Regional Appeals Office. QUEST Integration members have 30 days following the notice of action to file an appeal.

Members, providers acting on behalf of the member (with the member’s authorization) or their authorized representative may file an appeal by phone, mail, email or fax to the following:
Kaiser Foundation Health Plan, Incorporated
Attention: Regional Appeals Office
711 Kapiolani Boulevard, Honolulu, HI 96813; or
Phone: 808-432-5330, 1-800-651-2237 (toll-free) or 711 (TTY)
Facsimile to: 808-432-5230; or
Electronic mail at: KP.Hawaii.Appeals@kp.org

Appeals will be reviewed on an expedited basis when review under the 30-day process:
- Could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function (based on a prudent layperson’s judgment), or
- Would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request (based on a practitioner’s opinion that has knowledge of the member’s condition).

Appeals that do not qualify for expedited review will be completed in not longer than 30 days from receipt of the appeal through a single internal level. Appeals must be filed within 30 calendar days after notification of the adverse determination or action.

Decisions on expedited appeals will be made as expeditiously as required based on the member’s medical condition, but no longer than 3 business days from receipt of the appeal. The Member and the requesting provider (if the appellant is the provider) will be notified verbally, with follow up done in writing. Decisions on appeals will be communicated to the member in writing not longer than 30 calendar days from receipt of the appeal.

A Member, Licensed Independent Practitioner, Health Delivery Organization or the Member’s authorized representative, including his/her attorney, may file an appeal. Providers may file an appeal on behalf of a member with written consent. The Health Plan will not take punitive action against a provider who requests an expedited resolution or who supports a member’s appeal. If a Member is not satisfied with the determination of the appeal decision, they have the right to an administrative hearing by the Administrative Appeals Office (AAO) of the Hawaii Department of Human Services. Members will continue to have coverage under their insurance policy pending the outcome of their appeal. This applies to covered services only.

If the member has gone through Kaiser’s appeal process and is not happy with the decision we made about the appeal they can ask DHS for an Administrative Hearing by writing to the Administrative Appeals Office (AAO) of DHS. The AAO has to get the letter within 30 days from receiving Kaiser Permanente’s decision about the appeal. Letters should be mailed to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P. O. Box 339
Honolulu, HI 96809-0339
There is no cost for the Administrating Hearing. Members have the right to name someone to file the appeal on their behalf and must name that person in writing when the Administrative Hearing is requested. They may represent themselves at the hearing or have a lawyer, a relative, a friend or someone else there to speak for them. A decision will be received within 90 days from the date the request was received. Kaiser Permanente must follow the decision of the DHS Administrative Hearing. Members must go through Kaiser’s appeal process first before asking for a DHS Administrative Hearing.

**Expedited DHS Administrative Hearing**

If there was an expedited review of your appeal with Kaiser Permanente, and member is not satisfied with the decision, they may ask DHS for an expedited Administrative Hearing. They must submit their letter to the AAO within 30 days of getting Kaiser Permanente’s decision. An expedited administrative hearing needs to be reviewed and decided upon within 3 business days from when the request was filed.

**Continuation of Benefits During the Appeals Process or DHS Administrative Hearing**

If Kaiser Permanente decided to reduce, delay or stop anything that was already approved, members have the right to receive benefits during the appeals process or DHS Administrative Hearing process. In order for that to happen the member must file an appeal and ask for benefits to be continued in a timely manner. This means within 10 days of getting the notice from us, or, on or before the date that the service is going to be reduced, delayed or stopped. The services to be continued have to be something that was approved by an authorized provider and the time period covered by the original authorization must not be expired.

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

- Member withdraws their appeal;
- There was not a request for DHS Administrative Hearing within 10 days of getting the notice from us;
- The DHS Administrative Hearing does not decide in favor of the member;
- The original authorization limits are met or the time period expires.

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

**Access to Care Standards**

Kaiser Permanente consistently maintains a sufficient number of providers to service our members. Our providers must adhere to the following QUEST Integration program wait time standards and geo access standards to ensure timely access to care and services:
• Immediate care without prior approval for emergencies
• Within 24 hours for urgent care
• Within 24 hours for PCP pediatric sick visits
• Within 72 hours for PCP adult sick visits
• Within 21 days for PCP routine visits
• Within 21 days for routine behavioral health visits
• Within 4 weeks for visits with a specialist
• Within 4 weeks for non-emergency hospital stays

**Interpreter/translation services**

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

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

**Advance Directives for Health Care**

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

When a member provides an advance directive, an entry should be made in the medical record.
Provider Rights and Responsibilities

Provider Requirements

Role and responsibility

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

Kaiser defines a PCP as a MD or DO who is a board certified/eligible internist, family practitioner, or pediatrician. The definition does not include the other providers (general practitioner, ob/gyn, APRN, PA) in the QUEST Integration RFP, in part because there are no access issues preventing each QUEST Integration member from linking with an internist, family practitioner, geriatrician, or pediatrician. In addition, women (pregnant or non-pregnant) also have open access to an obstetrician/gynecologist and to see their ob/gyn regularly. However, each member also has access to primary care services.

- Certain members may also have regular specialty care, linked to a specialist for a particular chronic conditions. However, in addition, the member would also have a primary care physician who would work closely with the specialist. Kaiser’s physician assistants and nurse practitioners generally work in specialty areas, so do not provide primary care.

PCP Selection and Change

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

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

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

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

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

PCP Monitoring

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

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

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

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

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

Hospitalists

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

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

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

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

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

- Issues related to availability of health services from the health plan to a member, for example delays in obtaining or inability to obtain emergent/urgent services; medications; specialty care; ancillary services such as transportation; medical supplies, etc.;
- Issues related to the delivery of health services, for example, the PCP did not make a referral to a specialist; medication was not provided by a pharmacy; the member did not receive services the provider believed were needed; provider is unable to treat member appropriately because the member is verbally abusive or threatens physical behavior;
- Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the member; the provider reports that another provider has issues with cleanliness of office, instruments, or other aseptic technique was used; the provider reports that another provider did not render services or items which the member needed; or the provider reports that the plan’s specialty network cannot provide adequate care for a member.
- Benefits and limitations, for example, limits on behavioral health services or formulary;
- Enrollment and eligibility, for example long wait times or inability to confirm enrollment or identify the PCP;
- Member issues, including members who fail to meet appointments or do not call for cancellations, instances in which the interaction with the member is not satisfactory; instances in which the member is rude or unfriendly; or other member-related concerns; and
- Health Plan issues, including difficulty contacting the health plan or its subcontractors due to long wait times, busy lines, etc; problems with the health plan’s staff behavior; delays in claims payments; denial of claims; claims not paid correctly; or other health plan issues.
An appeal is a request for review of an action. An action is defined as any one of the following:

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

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

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

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

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

**Out-of-Plan/Network Referrals**

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

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

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

For LTSS services, QI service coordinators will be reviewing and authorizing services. The authorization will be tracked electronically via our electronic claim system. Referrals for services provided by non-Plan/non-Network providers must be reviewed and authorized through the established Plan referral authorization process. This process assures that Members are:
• Referred to the appropriate specialty provider;
• Referred to the providers who have met our service, quality, and credentialing requirements;
• Eligible for the requested medical service.

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

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

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

**Prior Authorizations**

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

Call the Kaiser QUEST Integration office at 432-5330 for:
- Ground transportation when medically necessary (see section below)
- Air and ground transportation, meals and lodgings for medically necessary care on another island or on the mainland
- Any member needing LTSS / HCBS
- Any member considered ‘At Risk’ (see page 81)

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

**Prior Authorizations for Non-Emergency Transportation Services**

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

KP16-017 Provider Manual_rev5.3.17
The most cost effective means of transportation that best meets the needs of the member’s specific circumstances will be used when medically necessary as indicated by the Service Coordinator or PCP as documented in the care plan. Free transportation available to the member (e.g., friends, relatives, volunteer services, own vehicle, facility serving the member, consolidation of appointments, etc.) should be explored before other means of paid transportation are considered unless medically prohibited. Bus tickets may be provided for individual trips. Bus passes will be considered when the cost of multiple bus tickets exceeds or is expected to exceed the cost of a bus pass.

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

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

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

**How to Submit a Prior Authorization**

Submit a prior authorization/referral form contact the following respective department listed below. You may also submit online via the following link: [http://providers.kaiserpermanente.org/html/cpp_hi/kponlineaffiliate.html](http://providers.kaiserpermanente.org/html/cpp_hi/kponlineaffiliate.html)

**Examples of prior authorizations/referrals:**

<table>
<thead>
<tr>
<th>Prior Authorization: Call the Kaiser QUEST Integration Service Coordinator at: 432-5330 or 1-800-651-2237 (toll-free). Fax: 432-5260</th>
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<tbody>
<tr>
<td>Adult Day Care Center (ADC)</td>
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<td>Adult Day Health Center (ADH)</td>
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<td>Assisted Living Facility (ALF) Community Care Management Agency (CCMA)</td>
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<td>Community Care Foster Family Home (CCFFHH)</td>
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<td>Counseling and Training</td>
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<td>Environmental Accessibility Adaptations</td>
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<td>Kaiser Authorization Dept. for Plan Referral Phone at:</td>
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<td>--------------------------------------------------------</td>
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<tr>
<td>Phone: (808) 432-5687</td>
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<td>Fax: (808) 432-5691</td>
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<td>Alt Fax: (808) 432-5667</td>
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- Durable medical equipment (DME) and medical
- Hearing aid
- Breast pump (rental beyond six months and all purchases)
- Radiology/lab/other diagnostic services:
  Specialty procedures require prior authorization
- Dialysis
- Prior authorization is required for all rehabilitation services except for the initial evaluation
- Referral External Sleep Study
- Transplant
- Contact lenses
- Hospice

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<tr>
<td>Residential Care Services or Type 1 or Type II Expanded Adult Residential Care Home (E-ARCH)</td>
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<tr>
<td>Home Delivered Meals</td>
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<td>Home Maintenance</td>
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<tr>
<td>Moving Assistance</td>
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<td>Non-Emergent Only Transportation</td>
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<td>Personal Assistance Service Level I (PA1)</td>
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<tr>
<td>Personal Assistance Service Level II (PA2)</td>
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<td>Personal Emergency Response Systems (PERS)</td>
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<tr>
<td>Skilled (or Private Duty) Nursing</td>
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<tr>
<td>Respite Care</td>
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<td>Specialized Medical Equipment and Supplies (SMES)</td>
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<tr>
<td>Nursing facility</td>
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<td>Lactation counseling beyond six months</td>
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</table>
Transition of Care

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

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

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

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

Kaiser Permanente will be responsible for the care and cost of inpatient services for members who moves to a different service area in the middle of a month and enrolls in a different health plan. Responsibility will continue until discharge or level of care change, whichever is first. For non-hospitalized members, the new health plan is responsible from the date of enrollment. Kaiser will be responsible for the care and cost of services provided to members who move to a different service area and remain with Kaiser QUEST Integration.
Pregnant members who are in their second or third trimester and are receiving medically necessary prenatal services the day before enrollment will be allowed to continue to receive care from their existing OB/GYN through the post-partum period, even if the provider is not in the new plan’s network.

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

Members transitioning when provider terminates from Kaiser:

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

Fraud, Waste and Abuse

Like all of us in Hawaii, Kaiser Permanente recognizes that acting responsibly with our resources is critical to our success. In addition, the Deficit Reduction Act of 2005 requires us to formally show our resolve in combating fraud, waste and abuse, especially in the administration of Federal and State health care programs such as Medicare and Medicaid. Therefore, Kaiser has revised the three policies described below. The Deficit Reduction Act requires that we make these policies available for all physicians, employees and you, our outside network partners.

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

2. Prevention, Detection, and Correction of Fraud, Waste and Abuse: This policy articulates our commitment to control fraud, waste and abuse through prevention, detection and correction of any violation of a Federal or State law, regulatory requirement, contractual obligation or organizational policy or procedure.
3. **Responsible Reporting of and Responding To Compliance / Ethics Concerns:** This policy provides guidance regarding the internal reporting of compliance and ethics concerns, highlighting expectations of individuals who report concerns, and for the organization in responding to them. Additionally, it outlines our standards for investigation and corrective actions regarding violations of state or federal law, regulatory requirement, contractual obligation or organizational policy or procedure. Any retaliation can seriously undermine the reporting process; therefore, this policy also aims to protect employees and staff from retaliation when they make a good faith report.

Please contact Community Medical Services at (808) 432-7529 if you have any questions.
Chapter 6

Quality Management Program

Integrated Quality Program

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

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

See attachment 1 – 2016 Quality Program Description Hawaii Region

Utilization Management Program

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

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

See Attachment 2 – 2016 Integrated Quality Management Program Description Kaiser Permanent Hawaii Region

Guidelines for Patient Medical Records

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

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

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

Providers are required to adhere to the following requirements:

- All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;

KP16-017 Provider Manual_rev5.3.17
• All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;

• All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;

• All medical records shall be legible, signed and dated;

• Each page of the paper or electronic record includes the patient’s name or ID number;

• All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;

• All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;

• All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;
• All medical records contain the patient’s past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;
• All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;
• All medical records include the provisional and confirmed diagnosis(es);
• All medical records contain medication information;
• All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);
• All medical records contain information about consultations, referrals, and specialist reports;
• All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
• All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;
• All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;
• All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and
• All medical records shall contain documented patient visits, which includes, but is not limited to:
  o A history and physical exam;
  o Treatment plan, progress and changes in treatment plan;
  o Laboratory and other studies ordered, as appropriate;
  o Working diagnosis(es) consistent with findings;
  o Treatment, therapies, and other prescribed regimens;
  o Documentation concerning follow-up care, telephone calls, emails, other electronic communication, or visits, when indicated;
  o Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
  o Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;
  o Hospitalizations and/or emergency department visits, if applicable; and
  o All other aspects of patient care, including ancillary services.

See Attachment 3 – Ambulatory Electronic Medical Records Management

See Attachment 4 – Release of Protected Health Information
Chapter 7:
Pharmaceutical Management Procedures and Drug Formulary

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

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

The QUEST Integration benefit also includes:

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

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

The formulary approval process ensures that available drugs meet established quality standards and that adequate information for their optimal use is provided, while limiting the availability of unsafe, "less than effective," or "ineffective" drugs, and drugs with a high potential for toxicity or abuse.
The drug formulary also supports cost management by promoting the use of effective but less costly therapeutic equivalents, reducing the number of therapeutically redundant drugs, optimizing pharmacy management or drug inventories, and maximizing leverage through the drug purchasing and bid process.

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

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

The following are three methods in which you may access the drug formulary:
1. Access the formulary online via the internet. See instructions for accessing the Lexi-Comp FormuLink™ Online site below.
Consumer Drug Formulary
2. Access the formulary via downloads to PDA or Pocket PC. See download instructions by PDA type below.
Consumer Drug Formulary for Palm OS
Consumer Drug Formulary for Pocket PC
3. Accessing the formulary via the kp.org website.
Formulary (list of covered drugs)

We will notify you of any changes to the formulary before the change takes effect. If you do not have access to the internet or have difficulties in accessing the formulary, you may email the call Pharmacy Administration Department at Hawaii.Drug.Info@Kp.org or call (808)432-5549 to request for a hardcopy to be sent to you.
CHAPTER 8: CREDENTIALING

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

Credentialing

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

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

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

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

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

Credentialing/Recredentialing Requirements

Each practitioner must provide/demonstrate that all the criteria noted below are met:

- A completed application which includes practitioner demographics, practice information, work history, educational background, and a personal attestation to the practitioner’s physical and mental well-being and the accuracy of the information provided.
- A current valid license to practice.
- The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility, as applicable.
- A valid DEA or CDS certificate, as applicable to the specialty.
- Appropriate education and training for the practice specialty.
- Explanations for any gaps in work history (initial credentialing only).
- Evidence of current, adequate professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate with exceptions only granted upon complete review.
- Acceptable history of malpractice claims experience.
- Compliance with medical record and facility site reviews (see attached Care Practitioner Site Visit Tool). The requirement is applicable to:
  - Primary care practitioners (defined as Internal Medicine, Family Practice, and Pediatrics) and OB/GYNs at the time of initial credentialing and recredentialing. Credentialing and re-credentialing requirements noted above apply to practitioners who provide health care services on behalf of Kaiser Permanente. These include, but are not limited to MDs, DOs, DPMs, DDSs, NPs, CNMs, PAs, PhDs, PSYs, CRNAs, LCSWs, ODs, and CNSs for Behavioral Health.
  - High Volume Specialists at the time of recredentialing.
- Acceptable performance as recorded in all practice information related to Kaiser Permanente members.
- Full disclosure requirements as identified in accordance with 42 CFR Part 455, Subpart B.

**Credentials and Privileges Committee**

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

**Approvals**

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

**Denial as Termination of Participation**

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

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

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

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

**Confidentiality of Credentialing Information**

All information obtained during the credentialing and recredentialing process is considered to be confidential except as otherwise required by law.
Chapter 9:  
Claim and Invoice Submission 

How to send Claims and Invoices to Kaiser Permanente 

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

For Claim Submission: 

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

Contact Numbers to Call for Billing Questions:  

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

For Invoice Submissions:  

Kaiser Permanente Accounts Payable  
QUEST Integration  
PO Box 178902  
Honolulu, HI 96817  
OR  
Email: HI-AP@kp.org 

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

Methods of Claims Submission  
Claims may be submitted by mail or electronically. Whether submitting claims on paper or electronically, only the UB-04 form will be accepted for facility services billing and only the CMS-1500 form, which will accommodate reporting of the individual (Type 1) NPI, will be accepted for professional services billing. Submitting claims that are handwritten, faxed or photocopied will be subject to processing delay and/or rejection. When CMS-1500 or UB-04 forms are updated by NUCC/CMS, KP will notify Provider when the KP systems are ready to accept the updated form(s) and Provider must submit claims using the updated form(s).
Supporting Documentation for Paper Claims
In general, the Provider must submit, in addition to the applicable billing form, all supporting documentation and information that is reasonably relevant and necessary to determine payment. At a minimum, supporting documentation that may be reasonably relevant may include the following, to the extent applicable to the services provided:

- Authorization
- Admitting face sheet
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment and visit notes as reasonably relevant and necessary to determine payment
- A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier
- A physician report relating to any claim under which a physician is billing an “Unlisted Procedure”, a procedure or service that is not listed in the current edition of the CPT codebook
- Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
- Therapy logs showing frequency and duration of therapies provided for SNF services
Electronic Data Interchange (EDI)
KP encourages Providers to submit electronic claims (837I/P transaction). Electronic claim transactions eliminate the need for paper claims. Electronic Data Interchange (EDI) is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. KP requires all EDI claims be HIPAA compliant.

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


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

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

CMS-1500 Field Descriptions
The fields identified in the table below as “Required” must be completed when submitting a CMS-1500 (02/12) claim form for processing:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MEDICARE/ MEDICAID/ TRICARE / CHAMPVA/ GROUP HEALTH PLAN/FECA BLK LUNG/OTHER</td>
<td>Not Required</td>
<td>Check the type of health insurance coverage applicable to this claim by checking the appropriate box.</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER</td>
<td>Required</td>
<td>Enter the patient’s Kaiser Permanente Medical Record Number (MRN)</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME</td>
<td>Required</td>
<td>Enter the patient’s name. When submitting newborn claims, enter the newborn’s first and last name.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
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<td>-----------------------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT'S BIRTH DATE AND SEX</td>
<td>Required</td>
<td>Enter the patient’s date of birth and gender. The date of birth must include the month, day and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>4</td>
<td>INSURED'S NAME</td>
<td>Required</td>
<td>Enter the name of the insured, i.e., policyholder (Last Name, First Name, and Middle Initial), unless the insured and the patient are the same—then the word “SAME” may be entered. If this field is completed with an identity different than that of the patient, also complete Field 11.</td>
</tr>
<tr>
<td>5</td>
<td>PATIENT'S ADDRESS</td>
<td>Required</td>
<td>Enter the patient’s mailing address and telephone number. On the first line, enter the STREET ADDRESS; the second line is for the CITY and STATE; the third line is for the nine digits ZIP CODE and PHONE NUMBER.</td>
</tr>
<tr>
<td>6</td>
<td>PATIENT'S RELATIONSHIP TO INSURED</td>
<td>Required</td>
<td>Check the appropriate box for the patient’s relationship to the insured.</td>
</tr>
<tr>
<td>7</td>
<td>INSURED'S ADDRESS</td>
<td>Required if Applicable</td>
<td>Enter the insured’s address (STREET ADDRESS, CITY, STATE, and nine digits ZIP CODE) and telephone number. When the address is the same as the patient’s—the word “SAME” may be entered.</td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED'S NAME</td>
<td>Required if Applicable</td>
<td>When additional insurance coverage exists, enter the last name, first name and middle initial of the insured.</td>
</tr>
<tr>
<td>9a</td>
<td>OTHER INSURED’S POLICY OR GROUP NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the policy and/or group number of the insured individual named in Field 9 (Other Insured’s Name) above. NOTE: For each entry in Field 9a, there must be a corresponding entry in Field 9d.</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>Required if Applicable</td>
<td>Enter the name of the “other” insured’s INSURANCE PLAN or program.</td>
</tr>
<tr>
<td>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>10a-c</td>
<td>IS PATIENT’S CONDITION RELATED TO</td>
<td>Required</td>
<td>Check “Yes” or “No” to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. NOTE: If “yes” there must be a corresponding entry in Field 14 (Date of Current Illness/Injury). Place (State) - enter the State postal code.</td>
</tr>
<tr>
<td>10d</td>
<td>CLAIM CODES (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>11</td>
<td>INSURED’S POLICY NUMBER OR FECA NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the insured’s policy or group number.</td>
</tr>
<tr>
<td>11a</td>
<td>INSURED’S DATE OF BIRTH</td>
<td>Required if Applicable</td>
<td>Enter the insured’s date of birth and sex, if different from Field 3. The date of birth must include the month, day, and FOUR digits for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>11c</td>
<td>INSURANCE PLAN OR PROGRAM NAME</td>
<td>Required if Applicable</td>
<td>Enter the insured’s insurance plan or program name.</td>
</tr>
<tr>
<td>11d</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN?</td>
<td>Required</td>
<td>Check “yes” or “no” to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If “yes” then fields 9 and 9a-d must be completed.</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Required if Applicable</td>
<td>Have the patient or an authorized representative SIGN and DATE this block, unless the signature is on file. If the patient’s representative signs, then the relationship to the patient must be indicated.</td>
</tr>
<tr>
<td>13</td>
<td>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Required</td>
<td>Have the patient or an authorized representative SIGN this block, unless the signature is on file.</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP)</td>
<td>Required if Applicable</td>
<td>Enter the date of the current illness or injury. If pregnancy, enter the date of the patient’s last menstrual period. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>15</td>
<td>OTHER DATE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>Not Required</td>
<td>Enter the “from” and “to” dates that the patient is unable to work. The dates must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2003</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>Required if Applicable</td>
<td>Enter the FIRST and LAST NAME of the KP referring or KP ordering physician.</td>
</tr>
<tr>
<td>17a</td>
<td>OTHER ID #</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI NUMBER</td>
<td>Required</td>
<td>Enter the NPI number of the KP referring provider.</td>
</tr>
<tr>
<td>18</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>Required if Applicable</td>
<td>Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.</td>
</tr>
<tr>
<td>19</td>
<td>ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>20</td>
<td>OUTSIDE LAB CHARGES</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>Required</td>
<td>Enter the diagnosis/condition of the patient, indicated by an ICD-9-CM (or its successor, ICD-10) code number. Enter up to 4 diagnostic codes, in PRIORITY order (primary, secondary condition).</td>
</tr>
<tr>
<td>22</td>
<td>RESUBMISSION</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
<td>Required if Applicable</td>
<td>For ALL inpatient and outpatient claims, enter the KP referral number, if applicable, for the episode of care being billed. NOTE: this is a 10-digit alphanumeric identifier</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24A-J</td>
<td>SUPPLEMENTAL INFORMATION</td>
<td>Required</td>
<td>Supplemental information can only be entered with a corresponding, completed service line. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. When reporting additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP – HIBCC codes, OZ – GTIN codes or contract rate, enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/information. The following qualifiers are to be used when reporting these services. 7 – Anesthesia information ZZ – Narrative description of unspecified code N4 – National Drug Codes (NDC) VP – Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard OZ – Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) CTR – Contract rate</td>
</tr>
<tr>
<td>24A</td>
<td>DATE(S) OF SERVICE</td>
<td>Required</td>
<td>Enter the month, day, and year (MM/DD/YY) for each procedure, service, or supply. Services must be entered chronologically (starting with the oldest date first). For each service date listed/billed, the following fields must also be entered: Units, Charges/Amount/Fee, Place of Service, Procedure Code, and corresponding Diagnosis Code. IMPORTANT: Do not submit a claim with a future date of service. Claims can only be submitted once the service has been rendered (for example: durable medical equipment).</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
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<td>-----------------------</td>
</tr>
<tr>
<td>24B</td>
<td>PLACE OF SERVICE</td>
<td>Required</td>
<td>Enter the place of service code for each item used or service performed.</td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td>Required if Applicable</td>
<td>Enter Y for &quot;YES&quot; or leave blank if &quot;NO&quot; to indicate an EMERGENCY as defined in the electronic 837 Professional 4010A1 implementation guide.</td>
</tr>
<tr>
<td>24D</td>
<td>PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER</td>
<td>Required</td>
<td>Enter the CPT/HCPCS codes and MODIFIERS (if applicable) reflecting the procedures performed, services rendered, or supplies used. IMPORTANT: Enter the anesthesia time, reported as the “beginning” and “end” times of anesthesia in military time above the appropriate procedure code.</td>
</tr>
<tr>
<td>24E</td>
<td>DIAGNOSIS POINTER</td>
<td>Required</td>
<td>Enter the diagnosis code reference number (pointer) as it relates the date of service and the procedures shown in Field 21. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained. IMPORTANT: (ICD-9-CM, (or its successor, ICD-10) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.)</td>
</tr>
<tr>
<td>24F</td>
<td>$ CHARGES</td>
<td>Required</td>
<td>Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc). Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
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<td>--------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>24G</strong></td>
<td>DAYS OR UNITS</td>
<td>Required</td>
<td>Enter the number of days or units in this block. (For example: units of supplies, etc.) When entering the NDC units in addition to the HCPCS units, enter the applicable NDC ‘units’ qualifier and related units in the shaded line. The following qualifiers are to be used: F2 - International Unit ML - Milliliter GR - Gram UN Unit</td>
</tr>
<tr>
<td><strong>24H</strong></td>
<td>EPSDT FAMILY PLAN</td>
<td>Not Required</td>
<td>Enter the qualifier of the non-NPI identifier. The Other ID# of the rendering provider is reported in 24j in the shaded area. The NUCC defines the following qualifiers: 0B - State License Number 1B - Blue Shield Provider Number 1C - Medicare Provider Number 1D - Medicaid Provider Number 1G - Provider UPIN Number 1H - CHAMPUS Identification Number EI - Employer’s Identification Number G2 - Provider Commercial Number LU - Location Number N5 - Provider Plan Network Identification Number SY - Social Security Number (The social security number may not be used for Medicare.) X5 - State Industrial Accident Provider Number ZZ - Provider Taxonomy</td>
</tr>
<tr>
<td><strong>24I</strong></td>
<td>ID. QUAL</td>
<td>Required, if Applicable</td>
<td>Enter the qualifier of the non-NPI identifier in the shaded area of the field, if applicable. Enter the NPI number in the non-shaded area of the field, if applicable. Report the Identification Number in Items 24i and 24j only when different from data recorded in Fields 33a and 33b.</td>
</tr>
<tr>
<td><strong>24J</strong></td>
<td>RENDERING PROVIDER ID #</td>
<td>Required if Applicable</td>
<td>Enter the non-NPI identifier in the shaded area of the field, if applicable. Enter the NPI number in the non-shaded area of the field, if applicable. Report the Identification Number in Items 24i and 24j only when different from data recorded in Fields 33a and 33b.</td>
</tr>
<tr>
<td>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>25</td>
<td>FEDERAL TAX ID NUMBER</td>
<td>Required</td>
<td>Enter the physician/supplier federal tax I.D. number or Social Security number of the billing provider identified in Field 33. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.\nIMPORTANT: The Federal Tax ID Number in this field must match the information on file with the IRS.</td>
</tr>
<tr>
<td>26</td>
<td>PATIENT’S ACCOUNT NO.</td>
<td>Required</td>
<td>Enter the patient’s account number assigned by the Provider’s accounting system, i.e., patient control number.\nIMPORTANT: This field aids in patient identification by the Provider.</td>
</tr>
<tr>
<td>27</td>
<td>ACCEPT ASSIGNMENT</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>TOTAL CHARGE</td>
<td>Required</td>
<td>Enter the total charges for the services rendered (total of all the charges listed in Field 24f).</td>
</tr>
<tr>
<td>29</td>
<td>AMOUNT PAID</td>
<td>Required if Applicable</td>
<td>Enter amount paid by other payer.\nDo not report collections of patient cost share</td>
</tr>
<tr>
<td>30</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td>Required</td>
<td>Enter the signature of the physician/supplier or his/her representative, and the date the form was signed.\nFor claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.</td>
</tr>
<tr>
<td>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>32</td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
<td>Required if Applicable</td>
<td>The name and address of the facility where services were rendered (if other than patient’s home or physician’s office). Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code. Do not use commas, periods, or other punctuation in the address (e.g., “123 N Main Street 101” instead of “123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9 digit zip code, include the hyphen.</td>
</tr>
<tr>
<td>32a</td>
<td>NPI #</td>
<td>Required if Applicable</td>
<td>Enter the NPI number of the service facility if it is an entity external to the billing provider.</td>
</tr>
<tr>
<td>32b</td>
<td>OTHER ID #</td>
<td>Required if Applicable</td>
<td>Enter the two digit qualifier identifying the non-NPI identifier followed by the ID number of the service facility. Do not enter a space, hyphen, or other separator between the qualifier and number.</td>
</tr>
<tr>
<td>33</td>
<td>BILLING PROVIDER INFO &amp; PH #</td>
<td>Required</td>
<td>Enter the name, address and phone number of the billing entity.</td>
</tr>
<tr>
<td>33a</td>
<td>NPI #</td>
<td>Required if Applicable</td>
<td>Enter the NPI number of the billing provider.</td>
</tr>
<tr>
<td>33b</td>
<td>OTHER ID #</td>
<td>Required if Applicable</td>
<td>Enter the two digit qualifier identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. If available, please enter your unique provider or vendor number assigned by KP.</td>
</tr>
</tbody>
</table>
UB-04 (CMS-1450) Field Descriptions

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

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PROVIDER NAME and ADDRESS</td>
<td>Required</td>
<td>Enter the name and address of the billing provider which rendered the services being billed.</td>
</tr>
<tr>
<td>2</td>
<td>PAY-TO NAME, ADDRESS, CITY/STATE, ID #</td>
<td>Required if Applicable</td>
<td>Enter the name and address of the billing provider’s designated pay-to entity.</td>
</tr>
<tr>
<td>3a</td>
<td>PATIENT CONTROL NUMBER</td>
<td>Required</td>
<td>Enter the patient’s account number assigned by the Provider’s accounting system, i.e., patient control number. 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-NNNNNNNNN 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>8</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>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>-------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>14</td>
<td>ADMISSION TYPE</td>
<td>Required</td>
<td>Indicate the type of admission (e.g. emergency, urgent, elective, and newborn).</td>
</tr>
<tr>
<td>15</td>
<td>ADMISSION SOURCE</td>
<td>Required</td>
<td>Enter the code for the point of origin of the admission or visit.</td>
</tr>
<tr>
<td>16</td>
<td>DISCHARGE HOUR (DHR)</td>
<td>Required if Applicable</td>
<td>Enter the two-digit code for the hour during which the patient was discharged.</td>
</tr>
<tr>
<td>17</td>
<td>PATIENT STATUS</td>
<td>Required</td>
<td>Enter the discharge status code as of the “Through” date of the billing period.</td>
</tr>
<tr>
<td>18-28</td>
<td>CONDITION CODES</td>
<td>Required if Applicable</td>
<td>Enter any applicable codes which identify conditions relating to the claim that may affect claims processing.</td>
</tr>
<tr>
<td>29</td>
<td>ACCIDENT (ACDT) STATE</td>
<td>Not Required</td>
<td>Enter the two-character code indicating the state in which the accident occurred which necessitated medical treatment.</td>
</tr>
<tr>
<td>30</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>31-34</td>
<td>OCCURRENCE CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter the code and the associated date (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.</td>
</tr>
<tr>
<td>35-36</td>
<td>OCCURRENCE SPAN CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter the occurrence span code and associated dates (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.</td>
</tr>
<tr>
<td>37</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>38</td>
<td>RESPONSIBLE PARTY</td>
<td>Not Required</td>
<td>Enter the name and address of the financially responsible party.</td>
</tr>
<tr>
<td>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>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
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<td>-----------------------</td>
</tr>
<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. Submissions that are received without the required service date(s) will be rejected with a request for itemization. Multiple/Different Dates of Service: 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 Plan Sponsor identification number.</td>
</tr>
<tr>
<td>52</td>
<td>RELEASE OF INFORMATION (RLS INFO)</td>
<td>Required if Applicable</td>
<td>Enter the release of information certification indicator(s).</td>
</tr>
<tr>
<td>53</td>
<td>ASSIGNMENT OF BENEFITS (ASG BEN)</td>
<td>Required</td>
<td>Enter the assignment of benefits certification indicator.</td>
</tr>
<tr>
<td>54A-C</td>
<td>PRIOR PAYMENTS</td>
<td>Required if Applicable</td>
<td>If payment has already been received toward the claim by one of the payers listed in Field 50 (Payer) prior to the billing date, enter the amounts here.</td>
</tr>
<tr>
<td>55</td>
<td>ESTIMATED AMOUNT DUE</td>
<td>Required if Applicable</td>
<td>Enter the estimated amount due from patient. Do not report collection of patient’s cost share.</td>
</tr>
<tr>
<td>56</td>
<td>NATIONAL PROVIDER IDENTIFIER (NPI)</td>
<td>Required</td>
<td>Enter the billing provider’s NPI.</td>
</tr>
<tr>
<td>57</td>
<td>OTHER PROVIDER ID</td>
<td>Required</td>
<td>Enter the service Provider’s Kaiser-assigned Provider ID, if any</td>
</tr>
<tr>
<td>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>58</td>
<td>INSURED'S NAME</td>
<td>Required</td>
<td>Enter the insured’s name, i.e. policyholder.</td>
</tr>
<tr>
<td>59</td>
<td>PATIENT’S RELATION TO INSURED</td>
<td>Required</td>
<td>Enter the patient’s relationship to the insured.</td>
</tr>
<tr>
<td>60</td>
<td>INSURED’S UNIQUE ID</td>
<td>Required</td>
<td>Enter the patient’s Kaiser Medical Record Number (MRN).</td>
</tr>
<tr>
<td>61</td>
<td>INSURED’S GROUP NAME</td>
<td>Required if Applicable</td>
<td>Enter the insured’s group name.</td>
</tr>
<tr>
<td>62</td>
<td>INSURED’S GROUP NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the insured’s group number. For Prepaid Services claims enter &quot;PPS&quot;.</td>
</tr>
</tbody>
</table>
| 63           | TREATMENT AUTHORIZATION CODE   | Required if Applicable                | For ALL inpatient and outpatient claims, enter the KP referral number, if applicable, for the episode of care being billed. 
NOTE: this is a 10-digit alphanumeric identifier |
| 64           | DOCUMENT CONTROL NUMBER        | Not Required                          | Enter the document control number related to the patient or the claim as assigned by KP. |
| 65           | EMPLOYER NAME                  | Required if Applicable                | Enter the name of the insured's (Field 58) employer. |
| 66           | DX VERSION QUALIFIER           | Not Required                          | Indicate the ICD version indicator of codes being reported. 
At the time of printing, Kaiser only accepts ICD-9-CM diagnosis codes on the UB-04. ICD-10 standards for paper and EDI claims will be implemented by KP for outpatient dates of service and inpatient discharge dates on/after October 1, 2014. |
<p>| 67           | PRINCIPAL DIAGNOSIS CODE       | Required                              | Enter the principal diagnosis code, on all inpatient and outpatient claims. |
| 67A-Q        | OTHER DIAGNOSES CODES          | Required if Applicable                | Enter other diagnoses codes corresponding to additional conditions that coexist or develop subsequently during treatment. Diagnosis codes must be carried to their highest degree of detail. |
| 68           | BLANK                          | Not Required                          | Leave blank. |
| 69           | ADMITTING DIAGNOSIS            | Required                              | Enter the admitting diagnosis code on all inpatient claims. |
| 70a-c        | REASON FOR VISIT (PATIENT REASON DX) | Required if Applicable               | Enter the diagnosis codes indicating the patient’s reason for outpatient visit at the time of registration. |
| 71           | PPS CODE                       | Required if Applicable                | Enter the DRG number to which the procedures group, even if you are being reimbursed under a different payment methodology. |</p>
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>72</td>
<td>EXTERNAL CAUSE OF INJURY CODE (ECI)</td>
<td>Required if Applicable</td>
<td>Enter an ICD-9-CM “E-code” (or its successor, ICD-10 code) in this field (if applicable).</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-9-CM (or its successor, ICD-10) procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed (if applicable).</td>
</tr>
<tr>
<td>74a-e</td>
<td>OTHER PROCEDURE CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter other ICD-9-CM (or its successor, ICD-10) procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims (in fields “A” through “E”) for any additional surgical and/or obstetrical procedures which were performed (if applicable).</td>
</tr>
<tr>
<td>75</td>
<td>BLANK</td>
<td>Not required</td>
<td>Leave blank.</td>
</tr>
</tbody>
</table>
| 76           | ATTENDING PHYSICIAN / NPI / QUAL / ID | Required | Enter the NPI and the name of the attending physician for inpatient bills or the KP physician that requested the outpatient services.  
Inpatient Claims—Attending Physician
Enter the full name (first and last name) of the physician who is responsible for the care of the patient.  
Outpatient Claims—Referring Physician
For ALL outpatient claims, enter the full name (first and last name) of the KP physician who referred the Patient for the outpatient services billed on the claim. |
| 77           | OPERATING PHYSICIAN / NPI / QUAL / ID | Required If Applicable | Enter the NPI and the name of the lead surgeon who performed the surgical procedure.                                                                       |
| 78-79        | OTHER PHYSICIAN/ NPI/ QUAL/ ID       | Required if Applicable | Enter the NPI and name of any other physicians.                                                                                                         |
| 80           | REMARKS               | Not Required                          | Special annotations may be entered in this field.                                                                                                       |
| 81           | CODE-CODE             | Required if Applicable | Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate. |
Members with Other Insurance

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

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

Remittance Advice

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

Refer to the Remittance Advice Details (RAD) example form for a completed sample of RA. (See legend below)
1.1 Remittance Advice Details
A. Patient Name
B. Line of Business (LOB)
C. Service Dates
D. Claim Number (Claims System Number)
E. Code
F. Description
G. Billed
H. Contract (Amount Paid)
I. Adjust (Adjustment Amount)
J. Pt share
K. Provider Name (Vendor#)
L. Provider Address
M. Check#
N. Check Amount
O. Total for Provider
P. Interest Owed
Remittance Advice Report

Remittance Detail Report

Vendor: K  
Provider Address
City, State  Zip code

Vendor: K  
Provider ID#: 12724188
Provider Name:

Vendor ID: K
Check #: M  
Check Date: 07/01/2015  
Check Amount: N

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

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

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

<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Amt</th>
<th>Total</th>
<th>Adjust</th>
<th>RSN Penalty</th>
<th>Withhold Discount</th>
<th>Paymnt</th>
<th>Codes</th>
<th>Ins</th>
</tr>
</thead>
<tbody>
<tr>
<td>90999</td>
<td>5885</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>0.00</td>
<td>15.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1176.88</td>
<td>4693.12</td>
<td>3,23,45,</td>
</tr>
<tr>
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<td>0.00</td>
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<td>0.00</td>
<td>1177.24</td>
<td>4692.76</td>
<td>3,23,45,</td>
</tr>
<tr>
<td>C 05/18/15</td>
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<td>5885.00</td>
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<td>3,23,45,</td>
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</tr>
<tr>
<td>C 05/20/15</td>
<td>90999</td>
<td>5885.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>15.00</td>
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</tr>
<tr>
<td>15.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1176.88</td>
<td>4693.12</td>
<td>3,23,45,</td>
<td></td>
</tr>
</tbody>
</table>

---

Claim Totals: 17655.00 0.00 0.00 14124.00 0.00 0.00 45.00 0.00 45.00 0.00
45.00 0.00 0.00 0.00 3531.00 O 14079.00 0.00

CLAIM EOB SUMMARY

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

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

Total for Processed Claims:

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

**Total for HMO B -**:  

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

Remittance Detail Report

**Vendor: Vendor Name**  
**Address**  
**City, State Zip Code**

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

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

Total for **Vendor Name**:  

---
Remittance Advice

Remittance Detail Report

<table>
<thead>
<tr>
<th>Vendor: Name</th>
<th>Address</th>
<th>City, State, Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Total for payee Vendor Name - [Check # M]</th>
</tr>
</thead>
<tbody>
<tr>
<td>17655.00</td>
</tr>
<tr>
<td>0.00</td>
</tr>
</tbody>
</table>

Total Interest Amount: 298.75
Total Penalty Amount: 0.00

CODES SUMMARY

- [3] Co-payment Amount
- [C] Contracted Rate Payment
- [45] Chg exceeds fee sched/max allowbl or contrctd/legisltd fee, use only with Group Codes PR/CO

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

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

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

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

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

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

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

Claim Codes

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

For specific claim codes and applicable DLPs, refer to the Pend/Hold Code Matrix.
<table>
<thead>
<tr>
<th>Claim Code</th>
<th>Applied to Claim</th>
<th>Applied to Service Line</th>
</tr>
</thead>
</table>
| Pend/Hold  | Pends/holds the claim for manual review.  
  - **Note:** The difference between a pend code and a hold code is on whether they hold a claim when there is a denial code on the claim. If a denial code is on the claim with a pend code, the claim will deny. If a denial code is on the claim with a hold, the claim will hold for review. | Pends/holds the claim for manual review. |

| Deny       | Denies the claim.  
  - **Note:** If the claim has a hold code, it will not auto-deny. Instead, the claim will hold for review to determine if the denial stays or will be overwritten. | Denies the service.  
  - **Note:** A service line may be denied, but the claim is still payable with a status of Clean. These are sometimes referred to as *Clean Denials*. |

| Informational | No effect. Claim code and description may be set up to print on RA and/or EOB to provide payment explanation. | No effect. Claim code and description may be set up to print on RA and/or EOB to provide payment explanation. |

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

### Claim Code Distribution

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

- [Hawaii Distribution Scheme](#)
- [Northwest Distribution Scheme](#)

See [Resolving Claim Codes](#).

### CRM Process

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

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

You cannot bill a member in the following situations:
- **You** fail to follow Kaiser Permanente’s procedures which results in our non-payment to you
- Member is a no-show for a scheduled appointment for covered services.

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

Reporting Requirements

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

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

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

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

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

QUEST stands for:

Quality Care
Universal Access
Efficient Utilization
Stabilizing Cost
Transforming provision of health benefits to public clients

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

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

How to reach us

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

Kaiser Permanente QUEST Integration members have two cards:

1. Kaiser Permanente QUEST Integration Card

2. Kaiser Permanente Identification Card

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

• Member’s Kaiser Permanente Member Identification Number
• Member’s name
• Effective date of member’s Kaiser Permanente QUEST Integration coverage
• Primary clinic name and telephone number
• Benefit category
• Third Party Liability (TPL) information

QUEST Integration Covered Benefits and Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary and Acute Care Services (In alphabetical order)</strong></td>
<td></td>
</tr>
<tr>
<td>Cornea Transplants and bone graft services</td>
<td>Services medically necessary to find out the cause and to treat these conditions under the direction of a licensed physician</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Services provided for complete or almost complete kidney failure, which is called End Stage Kidney Disease (End Stage Renal Disease or ESRD), in the following settings:</td>
</tr>
<tr>
<td></td>
<td>• Hospital inpatient,</td>
</tr>
<tr>
<td></td>
<td>• Hospital outpatient,</td>
</tr>
<tr>
<td></td>
<td>• Non-hospital dialysis facility</td>
</tr>
<tr>
<td></td>
<td>• Member’s home</td>
</tr>
<tr>
<td></td>
<td>Dialysis services include:</td>
</tr>
<tr>
<td></td>
<td>• Lab tests</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B vaccines</td>
</tr>
<tr>
<td></td>
<td>• Alfa-Epoetin (EPO) provided during dialysis</td>
</tr>
<tr>
<td></td>
<td>• Drugs related to ESRD</td>
</tr>
<tr>
<td></td>
<td>• Home dialysis equipment</td>
</tr>
<tr>
<td></td>
<td>• Continuous ambulatory peritoneal dialysis (CAPD)</td>
</tr>
<tr>
<td></td>
<td>• Physician services</td>
</tr>
<tr>
<td></td>
<td>• Hospital stays</td>
</tr>
<tr>
<td><strong>Durable medical equipment (DME) and medical supplies such as:</strong></td>
<td><strong>Purchased or rented medical equipment or supplies which are medically needed to reduce medical disability and restore or improve function. Prior approval is required.</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Oxygen tanks and concentrators</td>
<td></td>
</tr>
<tr>
<td>• Ventilators</td>
<td></td>
</tr>
<tr>
<td>• Wheelchairs</td>
<td></td>
</tr>
<tr>
<td>• Crutches and canes</td>
<td></td>
</tr>
<tr>
<td>• Eyeglasses</td>
<td></td>
</tr>
<tr>
<td>• Orthotic devices</td>
<td></td>
</tr>
<tr>
<td>• Prosthetic devices</td>
<td></td>
</tr>
<tr>
<td>• Hearing aids</td>
<td></td>
</tr>
<tr>
<td>• Pacemakers</td>
<td></td>
</tr>
<tr>
<td>• Medical supplies (surgical dressings, continence and ostomy supplies)</td>
<td></td>
</tr>
<tr>
<td>• Foot appliances (orthoses, prostheses)</td>
<td></td>
</tr>
<tr>
<td>• Orthopedic shoes and casts</td>
<td></td>
</tr>
<tr>
<td>• Orthodigital prostheses and casts</td>
<td></td>
</tr>
<tr>
<td>• Other medically necessary durable medical equipment covered by the Hawaii Medicaid program</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Emergency and post stabilization services</strong></th>
<th><strong>Services provided in an Emergency room for emergent or urgent condition. Members may pay for services received in an emergency room for non-emergent services.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care to stabilize the condition from the emergency visit is provided related to an emergency medical condition to improve or resolve a condition.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) Services</strong></th>
<th><strong>Routine checkups for children and youth under the age of 21. Includes, but is not limited to, medical and behavioral health screening exams, diagnostic tests, immunizations, preventive care, etc.</strong></th>
</tr>
</thead>
</table>
### Family planning services

Including, but not limited to:

- Counseling
- Consultation
- Medical examination
- Laboratory tests
- Contraceptive pills
- Contraceptive devices
- Emergency contraception
- Pregnancy testing
- Diagnosis of infertility
- Sterilizations
- Elective abortions (provided by Med-QUEST but not Kaiser. See Covered by Med-QUEST but not by Kaiser at the end of the section)

Services provided to males and females who are sexually active and of childbearing age. All services are confidential and voluntary.

### Habilitation

Habilitative services and devices help a person keep, learn or improve skills and functioning for daily living that were never learned or acquired to a developmentally appropriate level. Services and devices include:

- Audiology Services
- Occupational Therapy
- Physical Therapy
- Speech-Language Therapy
- Vision Services

Devices associated with these services including augmentative communication devices, reading devices, and visual aids but exclude those devices used specifically for activities at school.

### Hearing Services

Hearing services include:

- Diagnostic
- Screening
- Preventive
- Corrective services/equipment/supplies as prescribed by a
<table>
<thead>
<tr>
<th>Service</th>
<th>Under age 21</th>
<th>Age 21 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Exam</td>
<td>One time a year</td>
<td>One time a year</td>
</tr>
<tr>
<td>Hearing aid fitting and orientation*</td>
<td>Two times every three years</td>
<td>One time every three years</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>One every 24 months</td>
<td>One every 24 months</td>
</tr>
</tbody>
</table>

*Prior approval is required

**Home health services**

Services are part-time or intermittent care for members who do not require hospital care and are homebound due to illness or injury. The service is provided under the direction of a physician in order to prevent hospital or institutional care.

**Hospice Care**

Medically necessary services provided to terminally ill individuals in the home, outpatient, and inpatient settings by agencies certified by Medicare as hospice agencies.

**Inpatient hospital medical and surgical services**

Includes the cost of room and board for inpatient stays. The services include:
- Nursing care
- Medical supplies
- Equipment and drugs
- Diagnostic services
- Physical therapy
- Occupation therapy
- Audiology, and speech-language pathology

**Inpatient hospital maternity/newborn care services**

Stays must be allowed for up to 48 hours after natural birth or up to 96 hours after a cesarean section for healthy women with uncomplicated deliveries and postpartum stays. The patient and physician may agree to an early discharge.

**Medical services related to dental needs**

Kaiser covers dental services to treat medical conditions done in a medical facility like a hospital. Med-QUEST, not Kaiser, covers dental services through the month of a member’s 21st birthday. Adults age 21 or older may receive emergency dental services.

Also see *Covered by Med-QUEST but not Kaiser Permanente* at the end of this section.

**Outpatient hospital services including, but not limited to:**
- Family planning

Services provided may be preventative, diagnostic, therapeutic, rehabilitative or palliative.
- Medical services related to dental needs
- Imaging Services
- Laboratory studies
- Oncology services
- Diagnostic testing
- Ambulatory surgery services
- Physical Therapy
- Occupational therapy
- Speech therapy
- Blood storage and processing
- Respiratory services
- Audiology services
- Cardiology services
- Chemotherapy services
- Surgeries performed in a free standing ambulatory surgery center (ASC) and hospital ASC

**Physician services including, but not limited to:**
- Physical examinations
- Screening examinations
- EPSDT screenings children and youth under age 21

**Podiatry (foot disease) services including, but not limited to:**
- Professional services, not involving surgery
- Diabetic foot care

Services provided by or under the direct supervision of physicians (doctors of medicine or osteopathy). Services must be medically necessary and non-experimental.
<table>
<thead>
<tr>
<th>inpatient and outpatient</th>
<th>Prenatal visits meeting the periodicity and standards currently recommended by the American Congress of Obstetricians and Gynecologists (ACOG).</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnostic radiology procedures and surgical procedures involving ankle and below</td>
<td>• Health education and screening for conditions which could make a pregnancy “high risk”</td>
</tr>
<tr>
<td>• Foot and ankle care for infection or injury</td>
<td>• Fetal development</td>
</tr>
<tr>
<td></td>
<td>• Labor and delivery</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic ultrasound</td>
</tr>
<tr>
<td></td>
<td>• Fetal stress and non-stress testing</td>
</tr>
<tr>
<td></td>
<td>• Prenatal vitamins</td>
</tr>
<tr>
<td></td>
<td>• Lactation counseling - up to six months *</td>
</tr>
<tr>
<td>Pregnancy-related services including, but not limited to:</td>
<td>• Breast Pump rental – up to six months *</td>
</tr>
<tr>
<td>• Prenatal visits</td>
<td>• Breast Pump purchase – requires prior approval</td>
</tr>
<tr>
<td>• Diagnostic tests (x-ray and laboratory)</td>
<td></td>
</tr>
<tr>
<td>• Treatment of missed or threatened abortions</td>
<td>* May be extended with prior approval</td>
</tr>
<tr>
<td>• Delivery of infant</td>
<td></td>
</tr>
<tr>
<td>• Post-partum care (up to 60 days)</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Drugs, including over-the-counter drugs, prescribed by a physician or other health care provider licensed for prescription privileges and is on the list of approved drugs. Drugs must be medically necessary to optimize the member’s medical condition (including children receiving CAMHD services).</td>
</tr>
<tr>
<td></td>
<td>Includes the following:</td>
</tr>
<tr>
<td></td>
<td>• Medication management and patient counseling</td>
</tr>
<tr>
<td></td>
<td>• Drugs required to be covered by statute, including antipsychotic medication and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for a U. S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder,</td>
</tr>
<tr>
<td></td>
<td>• Drugs approved by the FDA that are eligible pursuant to the</td>
</tr>
</tbody>
</table>
Omnibus Budget Reconciliation Rebates Act and necessary to treat members for human immunodeficiency virus, acquired immune deficiency syndrome, or Hepatitis C, or a member needing transplant immunosuppressives (without the need for a prior authorization). Mosquito repellents covered only through October 31, 2017 for women age 14 to 45 years old when prescribed by your doctor and picked up from a Kaiser Permanente pharmacy.

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Prevention Services are provided at no cost. Screening and immunizations guidelines are individualized to the individual.</th>
</tr>
</thead>
</table>
| Radiology/laboratory/other diagnostic services | Including, but are not limited to:  
- Diagnostic and therapeutic radiology and imaging  
- Screening and diagnostic laboratory test  
- Other medically necessary diagnostic or therapeutic service |
| Rehabilitation services  
- Physical therapy  
- Occupational therapy  
- Audiology  
- Speech-language pathology | Services must be therapeutic (rehabilitative, or therapy to prevent condition from worsening, or to prevent or delay institutionalization – not maintenance services) and provided to patients who are expected to improve in a reasonable period of time with therapy.  
Includes medically necessary habilitative services and devices to improve, develop or maintain skills and activities for daily living that were never reached to the appropriate level. It does not include applied behavioral analysis and routine vision services. |
| Sleep laboratory services | Services are provided for the diagnosis and treatment of sleep disorders and shall be performed by accredited Sleep laboratories. |
| Smoking cessation services | Services include, but are not limited to:  
- In person counseling sessions, individual or group.  
- Medications that are recommended by the Public Health Service guidelines  
Limited to two quit attempts per benefit period. |
| Sterilizations and hysterectomies | Covers both men and women if the following are met:  
- Age 21 years or older at time of consent  
- Mentally competent  
- Sterilizations require consent at least 30 days prior to the procedure |
| Transportation services:  
- Emergency and non-emergency | Transportation to and from medically necessary covered medical appointments for members who have no means of transportation and who reside in areas not served by public transportation, or cannot |
- **Ground and air transportation**

  Access public transportation.

  Travel services (transportation, lodging and meals) when treatment for a medical condition requires the member to receive services away from the island of residence. Includes travel services for the member and (if needed) an attendant.

  Prior approval is required.

### Vision services
- **Eye Exams**
- **Eyeglasses**

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

Contact lenses may be covered with prior approval. Emergency eye care for an emergency medical condition is covered for all members without prior approval.

Excluded vision services include:
- Orthoptic training
- Prescription fee
- Progress exams
- Radial keratotomy
- Visual training
- Lasik procedure

### Other Facility Services
- **Hospice services** – Care to individuals who are not expected to live more than six months

  Medically necessary services provided to terminally ill individuals in the home, outpatient, and inpatient settings by agencies certified by Medicare as hospice agencies

- **Nursing Facility**

  Includes Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), and subacute level of care in a hospital or nursing facility

### Behavioral Health Services
- **Standard behavioral health services** (includes psychiatric services and substance abuse treatment services)

  Includes:
  - Room/board,
  - Nursing care,
  - Medical supplies,
  - Equipment,
<table>
<thead>
<tr>
<th><strong>Medications and</strong></th>
<th><strong>Medications and</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication</strong></td>
<td><strong>Medication</strong></td>
</tr>
<tr>
<td>management, <strong>Diagnostic services,</strong></td>
<td>management, <strong>Diagnostic services,</strong></td>
</tr>
<tr>
<td><strong>Professional services,</strong></td>
<td><strong>Professional services,</strong></td>
</tr>
<tr>
<td><strong>Medically necessary services</strong></td>
<td><strong>Medically necessary services</strong></td>
</tr>
<tr>
<td><strong>Substance Abuse treatment Services</strong></td>
<td><strong>Substance Abuse treatment Services</strong></td>
</tr>
<tr>
<td><strong>Intensive Behavioral Therapy for children that include</strong></td>
<td><strong>Intensive Behavioral Therapy for children that include</strong></td>
</tr>
<tr>
<td>Applied Behavior Analysis (ABA) for the treatment of</td>
<td>Applied Behavior Analysis (ABA) for the treatment of</td>
</tr>
<tr>
<td>diagnosis.</td>
<td>diagnosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Ambulatory Mental Health</strong></th>
<th><strong>Includes:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Twenty-four (24) hour access line</strong></td>
<td><strong>Twenty-four (24) hour access line</strong></td>
</tr>
<tr>
<td><strong>Mobile crisis response</strong></td>
<td><strong>Mobile crisis response</strong></td>
</tr>
<tr>
<td><strong>Crisis stabilization</strong></td>
<td><strong>Crisis stabilization</strong></td>
</tr>
<tr>
<td><strong>Crisis management and crisis residential services</strong></td>
<td><strong>Crisis management and crisis residential services</strong></td>
</tr>
</tbody>
</table>

| **Psychotropic medications** | **Medications and medication management is the evaluation,** |
| and medication management | **Medication management is the evaluation,** |
|-----------------------------| **prescription, maintenance of psychotropic medications,** |
| **Psychiatric or** | **medication management/counseling/education,** |
| **psychological evaluation** | **promotion of algorithms and** |
| and treatment | **guidelines.** |
|-----------------------------| **Services to evaluate for and provide treatment of behavioral health** |
| **Medically necessary** | **services to include individual and group counseling and monitoring.** |
| **alcohol and chemical** | **Medically necessary** |
| **dependency services** | **alcohol and chemical** |
| **Methadone management** | **dependency services** |
| services | **Methadone/LAAM services for acute opiate detoxification and** |
|-----------------------------| **maintenance.** |

**Long Term Care Services & Supports (LTSS) Description** - Includes the Home and Community Based Services population as well as the ‘at risk’ population (those who do not meet nursing facility level of care but are at risk of deteriorating to the an institutional level of care based on a member’s functional assessment documented on the DHS 1147 form.

**At Risk Population** - Members are those who do not meet nursing facility level of care but are at risk of deteriorating to an institutional level of care based on the functional assessment. Guidelines define the types of services depending on the 1147 score, and may include home delivered meals, Personal Emergency Response System (PERS), personal care services, adult day care, adult day health and skilled/private duty nursing. The member must reside in his/her home, not required to be homebound, does not meet criteria for ICF/ID, and not residing in a care home/foster home or facility/institution. There may be a waitlist established.

<table>
<thead>
<tr>
<th><strong>Acute Waitlisted SNF/ICF</strong></th>
<th>Acute waitlisted SNF or ICF level of care services provided in an acute care hospital in an acute care hospital bed.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Day Care Center</strong></td>
<td><strong>Supportive care for four or more disabled adults. Services include</strong></td>
</tr>
<tr>
<td>(ADC)</td>
<td><strong>observation/supervision, coordination and implementation of</strong></td>
</tr>
<tr>
<td></td>
<td><strong>behavioral, medical and social care plans, and therapeutic, social,</strong></td>
</tr>
<tr>
<td></td>
<td><strong>educational, recreational, and other activities.</strong></td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Adult Day Health Center (ADH)</td>
<td>Organized day program with nursing oversight for adults with physical and/or mental conditions. The purpose is to help members to stay in the community as much as possible.</td>
</tr>
<tr>
<td>Assisted Living Facility (ALF)</td>
<td>For members living in ALF, services include personal care, supportive care (homemaker, chore and meal preparation), nursing, and medication oversight.</td>
</tr>
<tr>
<td>Community Care Management Agency (CCMA)</td>
<td>For members living in Community Care Foster Family Homes and other community settings, services by a CCMA include nurse delegation to the caregiver; assessments for needed services, supplies, and equipment; face-to-face monitoring and implementation of the care plan; and assisting the caregiver with adverse effects and/or changes in condition of members.</td>
</tr>
<tr>
<td>Community Care Foster Family Home (CCFFHH)</td>
<td>For members living in Community Care Foster Family Homes (certified private home with care provider living in the home), services include personal and supportive care, homemaker, chore, companion, nursing and medication oversight.</td>
</tr>
<tr>
<td>Counseling and Training</td>
<td>Member care training for members, families, and caregivers regarding health conditions, infection control, treatment regimens, equipment, crisis intervention, counseling on grief, substance abuse, nutrition, safety, among others.</td>
</tr>
<tr>
<td>Companion Services</td>
<td>Non-medical care, supervision, and socialization prior authorized by a service coordinator and documented in the service plan.</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptations (EAA)</td>
<td>Physical adaptations to the home needed to ensure the health, welfare and safety of the member, allowing member to stay at home as much as possible.</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>For members who cannot prepare meals without help and need meal services to stay independent and at home, nutritious meals are delivered to member’s home (excluding residential or institutional settings).</td>
</tr>
<tr>
<td>Homemaker or chore services</td>
<td>Activities provided when the regularly responsible person is temporarily absent or unable to provide the service. Services are prior authorized by a service coordinator.</td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>To maintain a safe and clean environment, services may include heavy-duty cleaning, minor repairs to essential appliances, and fumigation or extermination services.</td>
</tr>
<tr>
<td>Moving Assistance</td>
<td>Moving assistance can be provided in rare cases that members need to move to a new home (e.g. unsafe deteriorating home, member is evicted from current home, member is not able to afford home due to a rent increase; wheelchair bound member living on the first floor of a multi-story building without elevator.</td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>In addition to medical transportation, non-medical transportation can be offered so that members can have access to community services, activities, and resources in the care plan.</td>
</tr>
<tr>
<td>Nursing Facility (NF), Skilled Nursing Facility</td>
<td>Nursing facility services provided in a nursing facility licensed and certified to provide skilled nursing and rehabilitative services on a</td>
</tr>
</tbody>
</table>

83
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(SNF), or Intermediate Care Facility (ICF)</td>
<td>Nursing facility members require 24-hr a day assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).</td>
</tr>
<tr>
<td>Personal Assistance Service Level I (PA1)</td>
<td>Provided to members requiring help with independent activities of daily living to prevent a decline in the health and keep members safely in their home and communities. PA1 is for members who are not living with their family who perform these duties as part of a natural support. Services include: companion services such as meal prep, laundry, errands; and homemaker/chore services such as routine housecleaning, care of clothing and linen, shopping, yard work.</td>
</tr>
<tr>
<td>Personal Assistance Service Level II (PA2)</td>
<td>Provided to members needing moderate/substantial to total assistance with activities of daily living and health maintenance activities. Provided by Home Health Aide, Personal Care Aide, Certified Nurse Aide or Nurse Aide.</td>
</tr>
<tr>
<td>Personal Emergency Response Systems (PERS)</td>
<td>Electronic device coupled with a 24 hour emergency assistance service that helps members get immediate assistance in the event of an emotional, physical, or environmental emergency.</td>
</tr>
<tr>
<td>Residential Care Services or Type 1 or Type II Expanded Adult Residential Care Home (E-ARCH)</td>
<td>Residential care services are personal care services, nursing, homemaker, chore, companion services and medication oversight provided in a licensed private home by a care provider living in the home.</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Provided to members unable to care for themselves and are furnished short-term because care givers are absent or need relief. Three levels can be provided: hourly, daily, overnight.</td>
</tr>
<tr>
<td>Skilled (or Private Duty) Nursing</td>
<td>Provided to members requiring ongoing nursing care, provided by licensed nurses.</td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies (SMES)</td>
<td>Purchase, rental, lease, warranty costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that allow enable members to increase and/or maintain their abilities to perform activities of daily living and participate in the environment where they live.</td>
</tr>
<tr>
<td>Subacute Facility Services</td>
<td>Services provided in either a licensed nursing facility or licensed and certified hospital. Members do not require acute care, but need more intensive skilled nursing than most skilled nursing facilities.</td>
</tr>
</tbody>
</table>

**Emergency Services**

**Definitions:**

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

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

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

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

**Urgent Care:** Urgent care is defined as care for a sudden and unforeseen illness or injury which is required to prevent serious deterioration of the member’s health and which cannot be delayed until the member is medically able to safely return to the Hawaii Service Area to receive care from a Kaiser Permanente practitioner (if outside the Hawaii Service Area), or to travel to a Kaiser Permanente facility.

When members are in need of urgent care, please contact the nearest clinic. After hours, call the Kaiser Permanente After Hours Advice Nurse (1-800-467-3011 from Neighbor Islands or 432-7700 from O'ahu).

**Services covered by Med-QUEST Division and other agencies not by Kaiser Permanente**

Some services are not covered by Kaiser Permanente QUEST Integration, but members can obtain services in other ways.

- **Community Care Services (CCS) Behavioral Health Program:** Adult members age twenty-one (21) years or older with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) may be eligible for
additional behavioral health service from the CCS program. Specialized behavioral health services include inpatient, outpatient therapy and tests to monitor the member’s response to therapy, and intensive case management. To find out more you may contact Ohana Community Care Services (CCS) at 1-888-846-4262.

- **Dental care:** Use your Medicaid card and see the dentist that accepts Medicaid Fee-for-Services. For help in finding a dentist or transportation, call Community Case Management Corp. You can reach them at 792-1070 or 1-888-792-1070 (toll-free).

- **Elective abortions or intentional termination of pregnancy (ITOP):** Use your Medicaid card and find a doctor that accepts Medicaid Fee-for-Services. Your doctor must submit the claim to the state. You do not need a referral from us. Call Community Case Management Corp. for help with transportation. You can reach them at 792-1070 or 1-888-792-1070 (toll-free).

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

- **Support for Emotional and Behavioral Development (SEBD) for children:** Behavioral health services are available for children with emotional and behavioral development issues. The Department of Health, through its Child and Adolescent Mental Health Division (CAMHD) provides behavioral health services, including transportation, to children and adolescents age three through twenty who need intensive behavioral health services.

- **Services for Individuals with Developmental Disabilities/Intellectual Disabilities (DD/ID):** The DOH Developmental Disability Division (DOH/DDD) provides Intermediate Care Facility/ID services to certain individuals. Kaiser coordinates activities for individuals with DD/ID with DOH/DDD*

- **Zero-To-Three or Early Intervention Program (EIP):** provides services such as transportation for the DD and biologically at risk children ages zero to three. Services covered include screening, assessment and home visits. Kaiser identifies and refers children who may qualify for EIP services during the EPSDT screening process.

- To find out more, you can contact CAMHD at one of the Family Guidance Centers listed below.

<table>
<thead>
<tr>
<th>Family Guidance Center</th>
<th>Address</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Oahu</td>
<td>860 Fourth Street, 2nd Floor</td>
<td>453-5900</td>
<td>453-5940</td>
</tr>
<tr>
<td></td>
<td>Pearl City, Hawaii 96782</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Non-covered services
Below is a list of services that are typically NOT covered under the QUEST Integration program but will be reviewed upon request for medical necessity on a case by case basis:

- Personal care items such as shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers, shoes, slippers, clothing, laundry services, baby oil, sanitary napkins, diapers for babies, soaps, lip balm, band-aids, and contact lens solution
- Non-medical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items, motor vehicles or furnishings
- Experimental and/or investigation services, procedures, drugs, devices and treatments; Drugs not approved by the Federal Drug Administration (FDA)
- Treatment of complications resulting from previous cosmetic, experimental or investigative services, or other services which are not covered
- Treatment of baldness, including hair transplants and topical medications, wigs and hairpieces
- Treatment of persons confined to public institutions
- All medical and surgical procedures, therapies, supplies, drugs and equipment for the treatment of sexual dysfunction or inadequacies
- Penile or testicular prostheses and related services
- Reversal of sterilization, in vitro fertilization, artificial insemination, sperm banking procedures, fertilization by artificial means and all procedures and drugs to treat infertility or enhance fertilization
- Bereavement counseling, employment counseling, primal therapy, long term character analysis, marathon group therapy, and/or consortium
- Routine foot care, treatment of flat feet
- Swimming lessons, summer camp, and gym membership
- Beds – Lounge beds, bead beds, water beds, day beds, overbed tables, bed lifters, bed boards, bed side rails if not an integral part of a hospital bed
- Contact lens for cosmetic purposes; bifocal contact lenses
- Oversized lenses, blended or progressive bifocal lenses, tinted or absorptive lenses (except for aphakia, albinism, glaucoma, medical photophobia) trifocal lenses (except as a specific job requirement), spare glasses
- Refractive eye surgery
- Physical exams for employment when the patient is self-employed or as a requirement for continuing employment (i.e., truck and taxi drivers’ licensing, other P.E.s as a requirement for continual employment by the State or Federal government, or by private practice)
- Physical exams and/or psychological evaluations as a requirement for Hawaii or other state’s drivers’ licenses or for the purpose of securing life and other insurance policies or plans
- Organ transplants not meeting the guidelines established by the Medicaid program and organ transplants not specifically identified as benefits
- Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment (by masseurs) and any other form of self care or self-help training and any related diagnostic testing
- Ambulance wait time, physician wait time, stand-by services, telephone consultations, telephone calls, writing of prescriptions, stat charges
- Treatment of pulmonary tuberculosis when treatment is available at no charge to the general public
- Treatment of Hansen’s Disease after definite diagnosis has been made except for surgical or rehabilitative procedures to restore useful function
- Topical application of oxygen
- Orthoptic training

**QUEST Integration Service Coordination**

Kaiser Permanente will identify those members who may be candidates for service coordination. For members new to KP and subject to initial assessment requirements and timeframes, the determination of need for LTSS will be included in that assessment.
Service coordination assignments will be determined by the LTSS Manager or someone on his/her behalf when the cases are received. Specifically, those who qualify for Service Coordination fall into one of five (5) categories:

- Adults with SHCN
- Children with SHCN
- Members receiving HCBS
- Members choosing self-direction
- Institutional LOC members residing in an institutional setting
- Dual eligibles

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

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

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

QUEST Integration service coordinators and support staff are located in the “hub” Kaiser Permanente clinics on the islands of Oahu and Maui. Communication through the electronic medical record allows all providers and support staff to have immediate access to pertinent medical and social information. Physicians, QUEST Integration service coordinators and support staff are supported by established systems within Kaiser Permanente to direct the QUEST Integration member toward selected preventive services, track patients' scheduled appointments and, when necessary, remind them about the need to fulfill the visit.
Referrals to QUEST Integration staff may be made by calling 432-5330 or 1-800-651-2237 (toll-free).

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**

Regular medical visits are very important to keep children healthy. These visits will help keep children well and prevent illness and the spread of disease. Regular checkups, immunizations (shots), and screening tests are included in well child care. These medically necessary services, including behavioral therapy for children, are provided at no cost. The behavior therapies include intensive behavioral therapy for children with autism spectrum disorder (ASD) that include applied behavioral analysis (ABA) for the treatment of children with an autism spectrum disorder (ASD) diagnosis.

For members under age 21, the QUEST Integration program provides these preventative services in a program called Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Elements of a complete EPSDT checkup include:

- Height, weight and blood pressure checks
- Eye Exams
- Hearing tests
- Lab tests
- Need for dental referral
- Immunizations, including but not limited to annual influenza shot (age 6 months through 20),
- Lead and tuberculosis (TB) assessments and screening
- Developmental/Behavioral, Mental and Physical assessments and screening
- Screening for behavioral health or substance abuse
- Medications – including Fluoride and multivitamins
- Referrals to specialist if problems found during exam
- Health education and guidance
- Education and guidance for growth and development
- Information regarding accessing care – appointments, advice nurse, after hours care

<table>
<thead>
<tr>
<th>Age</th>
<th>Physical Exam</th>
<th>Vaccine Type</th>
<th>Appointment Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td></td>
<td>Hepatitis B (HepB) Birth dose</td>
<td></td>
</tr>
<tr>
<td>2-3 weeks</td>
<td>Physical exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 months</td>
<td>Physical exam</td>
<td>Diphtheria-Tetanus-acellular Pertussis (DTaP), Haemophilus Influenza B (Hib), Polio, Pneumococcal Conjugate Vaccine (PCV), HepB, Rotavirus</td>
<td></td>
</tr>
<tr>
<td>Age Range</td>
<td>Event Description</td>
<td>Recommended Vaccines</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>4 months</td>
<td>Physical exam</td>
<td>DTaP · Hib · Polio · PCV · Rotavirus</td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>Physical exam</td>
<td>DTaP · Hib · Polio PCV · HepB · Rotavirus</td>
<td></td>
</tr>
<tr>
<td>9 months</td>
<td>Physical exam</td>
<td>Tuberculin skin test (TB/PPD)</td>
<td></td>
</tr>
<tr>
<td>12-13 months</td>
<td>Physical exam</td>
<td>Hepatitis A · Measles-Mumps-Rubella (MMR) · Varicella</td>
<td></td>
</tr>
<tr>
<td>15 months</td>
<td>Physical exam for QUEST Integration only</td>
<td>DTaP · HiB · PCV* * Listed vaccines recommended for all children at 15 months of age</td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td>Physical exam</td>
<td>Hepatitis A</td>
<td></td>
</tr>
<tr>
<td>23-24 months</td>
<td>Physical exam</td>
<td>TB/PPD skin test if needed</td>
<td></td>
</tr>
<tr>
<td>30 months</td>
<td>Physical exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td>Physical exam</td>
<td>TB/PPD skin test if needed · MMR · Varicella</td>
<td></td>
</tr>
<tr>
<td>4 years</td>
<td>Physical exam</td>
<td>TB/PPD skin test if needed · DTaP · Polio</td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td>Physical exam</td>
<td>TB/PPD skin test if needed · DTaP · Polio if not done at age 4 years</td>
<td></td>
</tr>
<tr>
<td>6 years</td>
<td>Physical exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 – 13 years</td>
<td>Physical exam every other year</td>
<td>TB/PPD skin test as indicated 11-12 years: tetanus-diptheria-acellular pertussis (Tdap), then tetanus (Td) every 10 years, Meningococcal Conjugate, Human Papillomavirus (HPV) series of three doses for both girls and boys.</td>
<td></td>
</tr>
<tr>
<td>14 – 21 years</td>
<td>Physical exam every other year</td>
<td>Catch-up vaccines</td>
<td></td>
</tr>
</tbody>
</table>

* Listed vaccines recommended for all children at 15 months of age.