network news

For practitioners and providers of Kaiser Permanente
Produced by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in partnership with the Mid-Atlantic Permanente Medical Group, P.C.

December 2021

COVID-19: World Health Crisis Update

COVID-19 has had an unprecedented impact on the United States and remains prevalent in communities in the Mid-Atlantic region. We appreciate your continued partnership on our response to addressing the spread of the virus; and for providing prompt and compassionate care to our members and patients.

We continue to work to address questions you have, and in this letter, are providing responses and direction for those we have received from our participating providers. We will continue to keep you informed as the situation evolves. The most up-to-date information is regularly posted to Kaiser Permanente of the Mid-Atlantic States' Community Provider Portal (CPP) at **providers.kp.org/mas**.

Contents

COVID-19: World Health Crisis Update - *Continued from page 1*

Member/Patient Costs and COVID-19 Cost-Sharing Waivers

COVID Diagnostic Testing and Treatment: Since the beginning of the COVID-19 pandemic and public health emergency, Kaiser Permanente has waived all out-of-pocket cost sharing for all testing and all medical and hospital services for COVID-19 treatment and/or for episodes of care where COVID-19 is the primary diagnosis. As public health emergency (PHE) declarations begin to be lifted, the following table outlines the cost shares for testing, treatment and vaccinations for each line of business.

Line of Business	COVID-19 Testing/Screening	COVID-19 Treatment	COVID-19 Vaccinations
Maryland (Commercial/ Marketplace plans)	Cost Share: $0 until the end of the month in which the Federal PHE ends	Cost Share: $0 until July 31, 2021 *Inpatient admissions with admission dates on or before July 31, 2021 will be covered at $0 cost share through discharge.	Cost Share: $0
Virginia (Commercial/ Marketplace plans)	Cost Share: $0 until the end of the month in which the Federal PHE ends	Cost Share: $0 until July 31, 2021 *Inpatient admissions with admission dates on or before July 31, 2021 will be covered at $0 cost share through discharge.	Cost Share: $0
District of Columbia (Commercial/ Marketplace plans)	Cost Share: $0 until the end of the month in which the Federal PHE ends	Cost Share: $0 until July 31, 2021 or end of the month in which the DC PHE ends, whichever is later *Inpatient admissions with admission dates on or before July 31, 2021 will be covered at $0 cost share through discharge.	Cost Share: $0
Medicare Advantage	Cost Share: $0	Cost Share: $0 until the end of 2021 plan year (December 31, 2021) or end of the month in which the Federal PHE ends, whichever is later	Cost Share: $0 until the end of the month in which the Federal PHE ends
Maryland Medicaid	Cost Share: $0	Cost Share: $0	Cost Share: $0
Virginia Medicaid	Cost Share: $0	Cost Share: $0	Cost Share: $0

There is no need to seek additional authorization to provide COVID-19-associated screening, diagnosis or testing to our members.

COVID-19: World Health Crisis Update - *Continued from page 2*

Important Notes:

- All self-funded members will have $0 cost sharing for screening, testing and diagnosis; however, some self-funded members may encounter a cost share for treatment of COVID-19 at the election of their employer group.
- There is a temporary exception for Virginia Medicaid members. For more information, see "**Virginia Medicaid Member and Out-of-Pocket Costs**," below.
- There may be some reprocessing of claims related to COVID-19 care that may take 30 days or longer. Your patience is appreciated as appropriate benefit adjudication is finalized.

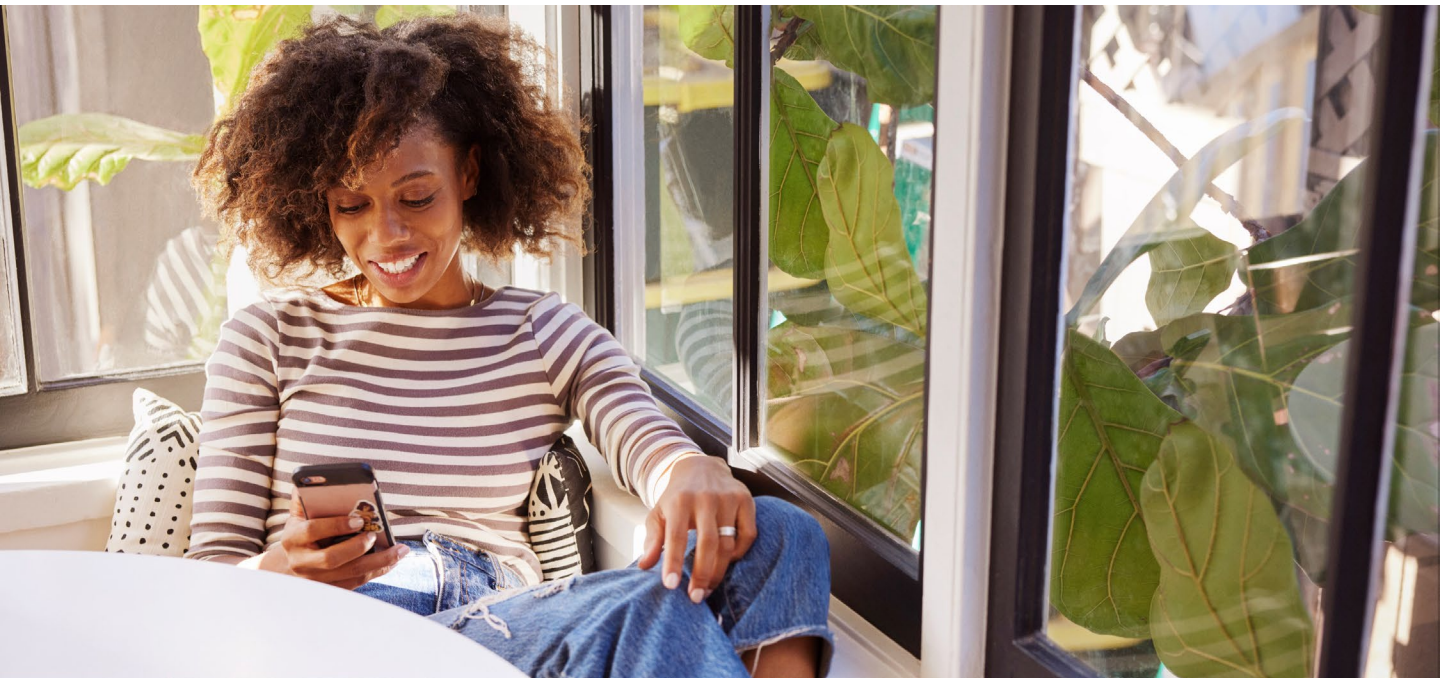
Other provisions may apply where required by Federal or state law or regulation. As state laws in the Mid-Atlantic region effect this timeline, we will make updates to our policy. (A limited number of commercial self-funded groups may apply cost sharing for COVID-19 treatment.)

Appointments for Kaiser Permanente Members Experiencing COVID-19 Symptoms

For those of you seeking to direct members to their KP providers for COVID-19 symptoms, testing or care, please advise them that we encourage members or their dependents who have recently traveled to an area of risk or think they have been exposed to the virus and are experiencing symptoms of COVID-19, like respiratory illness, to call the appointment and advice line at 703-359-7878 or 1-800-777-7904 (711 TTY) so we can assist with directing their care. To reduce possible exposure to others, we prefer that these members **not** make an appointment online or go directly to one of our facilities without calling ahead first.

Providing Telehealth Visits

We appreciate your efforts to limit the spread of COVID-19 in the community and encourage the use of telehealth visits. As the COVID-19 public health emergency comes to an end, Kaiser Permanente will continue to allow telehealth services when technology is available and when medically necessary and clinically appropriate to do so. Please check with local, state and federal jurisdictions to ensure that telehealth visits are performed in compliance with regulations and standards.



COVID-19: World Health Crisis Update - *Continued from page 3*

When verifying eligibility and benefits, providers must verify that the member's plan covers telehealth visits prior to rendering services virtually. Additionally, please ensure that you request a visual verification of members' Kaiser Permanente Identification Cards during telehealth visits, just as you would in-person in your medical office setting. While most members receive no-charge for telehealth visits, please use Online Affiliate to confirm the cost sharing for High Deductible Health Plan/HSA-qualified members who must first meet their deductible for telehealth visits unrelated to COVID-19 diagnosis and testing.

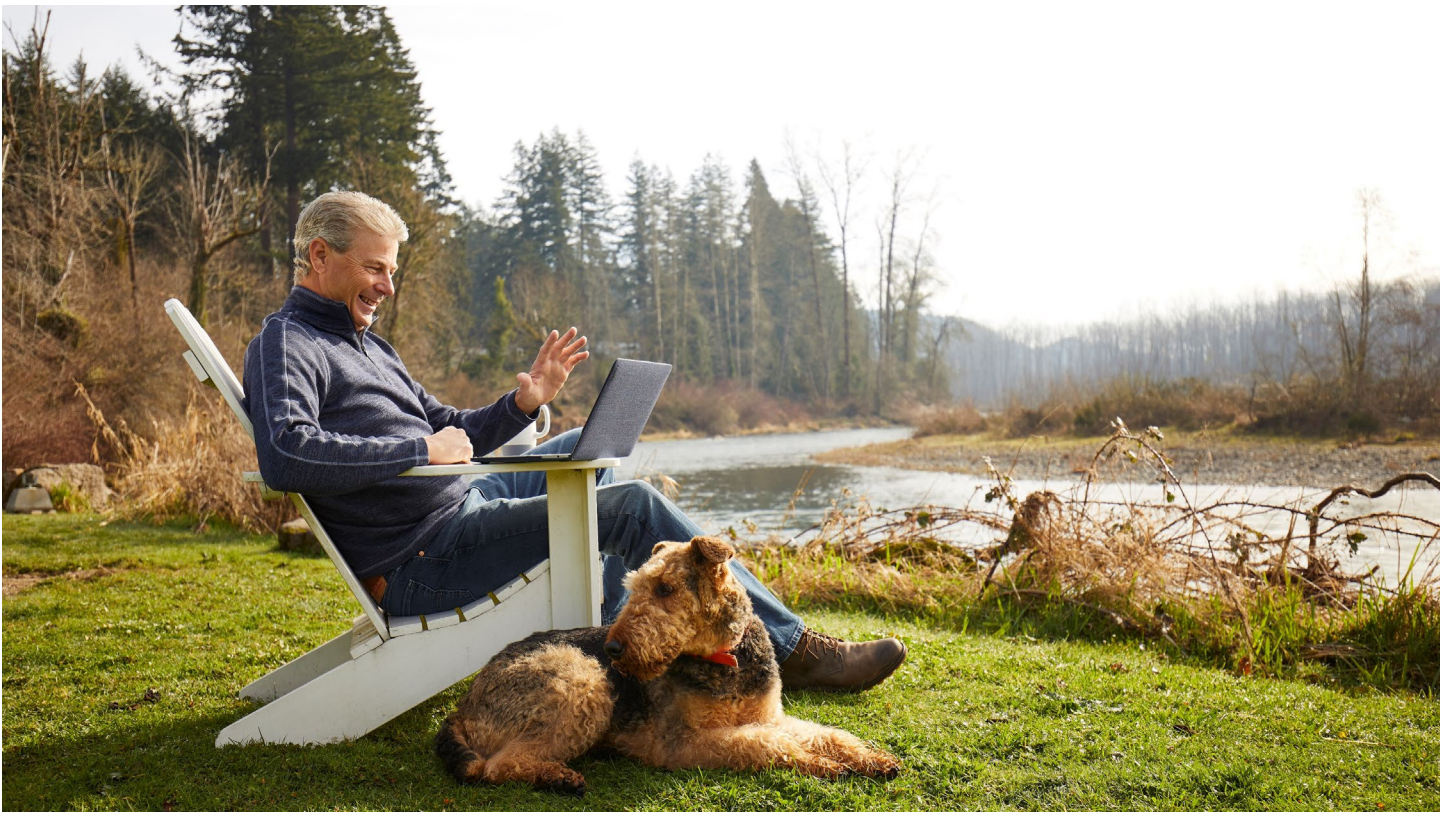
Providers should update systems and procedures to enable the use of modifiers GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system), or telehealth place of service (POS code 02) when billing for services delivered via telehealth. If billing on a UB04, please append the modifier to the HCPCS code.

For Eligible Telehealth Visits Provided to Commercial or Medicare Members

Please use POS (place of service) 02 when submitting your professional services claims for these encounters. Modifier 95 is equally accepted for telehealth services on a professional service claim form (CMS 1500).

For Eligible Telehealth Visits Provided to Maryland or Virginia Medicaid Members

Professional services provided via Telehealth should be identified with a GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system) modifier, as appropriate, and are billed using the usual place of service code that would be appropriate as if it were a non-telehealth claim on a professional services claim form (CMS 1500).



COVID-19: World Health Crisis Update - *Continued from page 4*

Guidance from Medicare and Medicaid Programs about Telehealth Services During the COVID-19 State of Emergency

Medicare and both MD and VA Medicaid programs have issued specific guidance regarding telehealth services including coding/billing, waivers for originating site, telehealth and behavioral health as well as telehealth care provided from a hospital setting. For more information, please refer directly to this guidance for regional Medicaid programs.

Medicare:

- Telehealth Frequently Asked Questions

MD Medicaid:

- COVID-19 Provider Updates

VA Medicaid:

- COVID-19 Provider information
- COVID-19 Provider Flexibilities Related to COVID-19 (Issued: March 19, 2020)

Coding for Telehealth Services Using an Institutional Claim Form (UB04 Claim Form)

For providers that are *unable to submit a professional CMS 1500 claim form*, and use institutional billing form, may submit claims for professional services with modifier 95 appended to eligible HCPCS/CPT on the institutional billing (UB claim forms) to submit claims for services that were:

- Performed remotely using real-time audio-visual telehealth technology or telephonic/audio-only when video technology is not available to the patient;
- Performed by a licensed, certified or otherwise qualified professional practicing within their scope of practice; and
- Where same standard of practice and documentation for the service or visit were maintained.

Claim Form	CMS 1500		UB04 (Per Extenuating Circumstances Noted Above)
Line of Business	Place of Service Code	Modifier Options	HCPCS (Modifier)
Commercial	02	GT, GQ, 95	HCPCS (GT, GQ or 95)
Medicare	02		HCPCS (95)
VA Medicaid	Usual Place of Service Code	GT, GQ, 95	HCPCS (GT, GQ or 95)
MD Medicaid	Usual Place of Service Code	GT, GQ, 95	HCPCS (GT, GQ or 95)

For more information, visit CPP to view our COVID-19 Telehealth Guide for providers.

Care Notes

Providers are encouraged to provide members with a written clinical summary of COVID-19 screening, diagnosis, testing and treatment results that members can then share with their Kaiser Permanente care team.

COVID-19: World Health Crisis Update - *Continued from page 5*

COVID-19 Testing

The latest CDC and health authority guidance directs clinicians to use their judgment to determine if a patient has signs and symptoms of COVID-19 and should be tested. For the most up-to-date coronavirus care guidelines from the CDC visit https://www.cdc.gov/coronavirus.

COVID-19 Lab Test Coding

All COVID-19 lab tests should be coded using the following procedure codes. These tests are no-charge to all members.

Procedure Codes	Description
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (Effective 5/20/2020)
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (Effective 6/25/2020)
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed (Effective 6/25/2020)
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected (Effective 8/10/20)
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum (Effective 8/10/20)
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected (Effective 10/6/20)
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected (Effective 10/6/20)
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

COVID-19: World Health Crisis Update - *Continued from page 6*

Procedure Codes	Description
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen (Effective 8/10/20)
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer (Effective 8/10/20)
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative (Effective 9/10/20)
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
87426	Severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) (Effective 6/25/2020)
87428	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; adenovirus enteric types 40/41; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B (Effective 11/10/2020)
87635	Infectious agent detection by (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) [COVID-19] (Do not use this procedure for Medicare members)
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique (Effective 10/6/20)
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique (Effective 10/6/20)
87811	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) (Effective 10/6/20)
D0604	Antigen testing for a public health related pathogen, including coronavirus (Effective 1/1/2021)
D0605	Antibody testing for a public health related pathogen, including coronavirus (Effective 1/1/2021)
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source. (Effective 3/1/2020)

COVID-19: World Health Crisis Update - *Continued from page 7*

Procedure Codes	Description
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of an HHA, any specimen source. (Effective 3/1/2020)
U0001	Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Test Panel (Use only for tests performed by CDC)
U0002	Private labs (e.g., Quest) 2019-nCoV Coronavirus, SARS-CoV-2/2019- nCoV (COVID-19) (Use for Medicare members or Commercial members)
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R
U0005	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date and time of specimen collection. (List separately in addition to either HCPCS code U0003 or U0004) (Effective 1/1/2021)

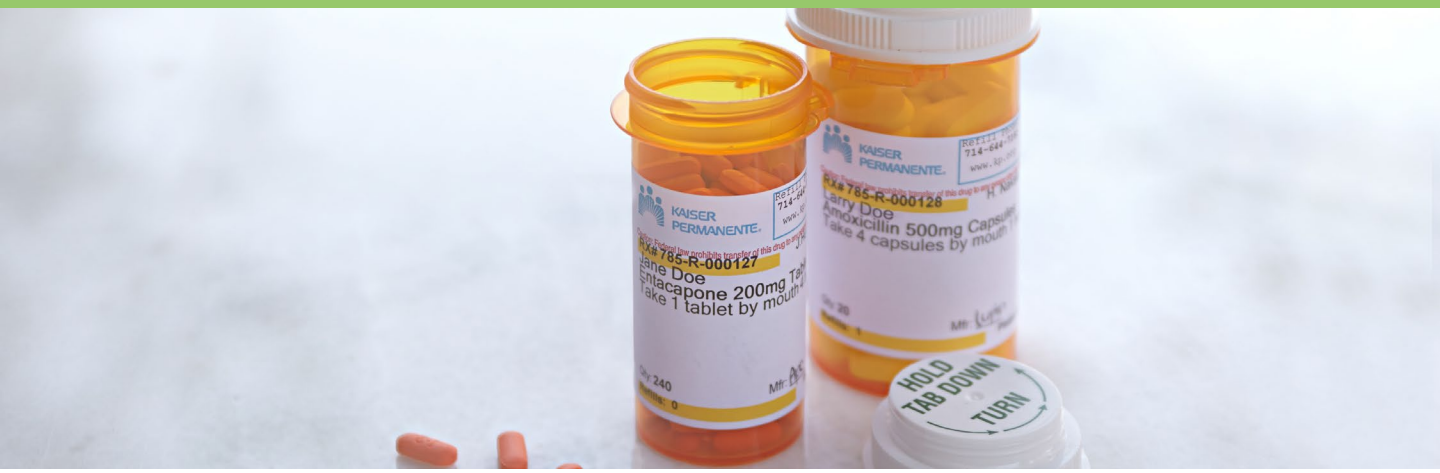
COVID-19: World Health Crisis Update - *Continued from page 8*

Other Associated Diagnostic Testing	
87400	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Influenza, A or B, each
87486	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique
87581	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, amplified probe technique
87633	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets

Procedure Codes	Description
99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease (Effective 9/10/20)

Monoclonal Antibody Therapy Administration	
Procedure Codes	Description
M0243	Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring
M0239	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring

Monoclonal Antibody Therapy Drug Supply	
Procedure Codes	Description
Q0243	Injection, casirivimab and imdevimab, 2400 mg (Provided at no cost and should not billed on a claim)
Q0239	Injection, bamlanivimab-xxxx, 700 mg (Provided at no cost and should not billed on a claim)



COVID-19: World Health Crisis Update - *Continued from page 9*

Virginia Medicaid Member and Out-of-Pocket Costs

Effective March 16, 2020, the Virginia Department of Medical Assistance Services has directed all Medicaid Fee-for-Service Providers and Medicaid Managed Care Organizations, of which Kaiser Permanente is a participating provider, to eliminate cost sharing **for all visits and services** as of March 16, 2020.

Prescription Drug Coverage and Mail Order Pharmacy

It's a good idea for members to refill their prescriptions online and have them delivered by mail.

You may receive member requests for prescription drug refills that you've prescribed. In your clinical judgment, please process these requests as expeditiously as possible.

Members can avoid standing in line by receiving prescriptions through our mail order service. Members can sign up on **kp.org/rxrefill** and receive their medications in about 3-5 business days. For urgent prescriptions, members should visit their closest Kaiser Permanente medical center pharmacy.

We have relaxed our "refill too soon" edits to permit earlier access to refills. Additionally, on a case-by-case basis, using clinical judgment and in compliance with regional or state executive orders, a pharmacist may dispense a refill even sooner than the edit allows. Regular benefit co-pays will apply to prescription drugs.

We are also monitoring all regional, state and federal emergency executive orders and will comply with any requirements related to prescribing and dispensing.

Monitoring Drug Supply Chains

Currently, Kaiser Permanente is not experiencing any significant drug shortages related to this coronavirus. We are closely monitoring the drug supply chain to identify any potential shortages of drugs produced in countries affected by COVID-19.

Our physicians, pharmacists and supply chain specialists continually work together to ensure that our members have access to needed medication. Within our integrated health system, we take steps such as identifying alternate supply sources or therapeutic agents whenever a drug shortage issue is identified, working closely with our physicians.

If there is any issue with a medication a member is taking, they will be notified about what they need to do. As always, members are encouraged to ask their physician or pharmacist about any concerns they have.

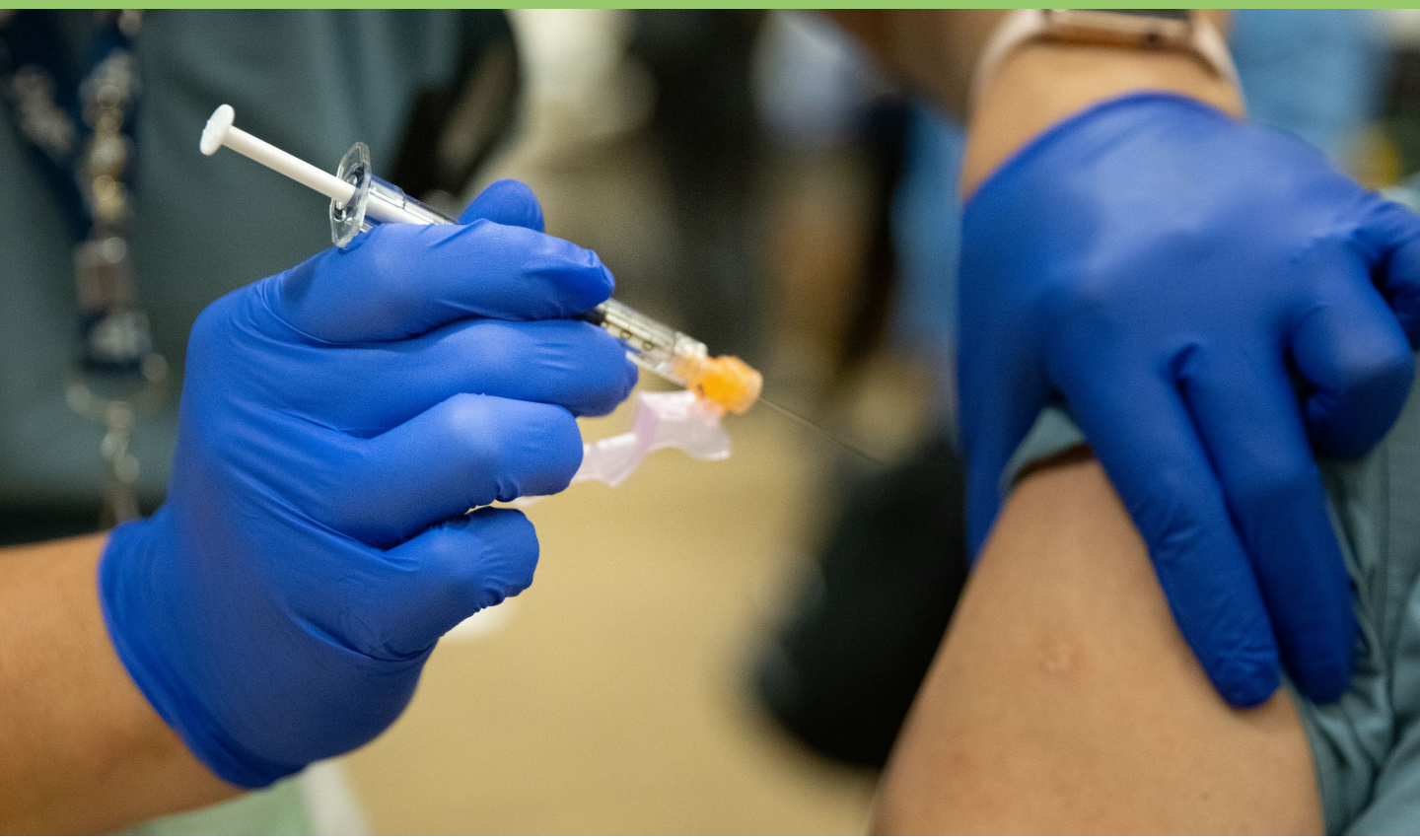
COVID-19: World Health Crisis Update - *Continued from page 10*

COVID-19 ICD-10 Coding

Proper diagnosis is needed to represent the care provided and ensure we can identify and track the at-risk population. As a reminder, effective March 6, 2020, all visits associated with screening, testing and diagnosis will be no charge for all members. The no charge coverage includes visits, associated labs, radiology and vaccine if members suspect or were exposed to the coronavirus or are under investigation for exposure to COVID-19. Beginning August 1, 2021, medically necessary treatment of COVID-19 will be covered according to the member's plan as outlined in the ***Member/Patient Costs and COVID-19 Cost-Sharing Waivers*** section of this article.

Please use the scenarios below to find the most specific and accurate diagnosis code. Using these codes will support no charge claims processing associated with COVID-19 screening, diagnosis, testing and treatment services.

Case Scenario	Use ICD-10 DX Code
Concern about a possible exposure to COVID-19, but ruled out after evaluation	Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out
Actual or suspected exposure to someone who is infected with COVID-19; Person under investigation	Z20.822: Contract with and (suspected) exposure to COVID-19 (Effective 1/1/2021) Z20.828: Contact with and (suspected) exposure to other viral communicable diseases
Asymptomatic Patient screened for COVID-19	Z11.52: Encounter for screening for COVID-19 (Effective 1/1/2021) Z11.59: Encounter for screening for other viral diseases
Confirmed COVID-19	U07.1: 2019-nCoV acute respiratory disease
Case of acute bronchitis confirmed as due to COVID-19	U07.1: 2019-nCoV acute respiratory disease and J20.8: Acute bronchitis due to other specified organisms
Cases of Bronchitis not otherwise specified (NOS) due to the COVID-19	U07.1: 2019-nCoV acute respiratory disease and J40: Bronchitis, not specified as acute or chronic
Cases of lower respiratory infection, not otherwise specified (NOS) or an acute respiratory infection, NOS associated with confirmed COVID-19	U07.1: 2019-nCoV acute respiratory disease and J22: Unspecified acute lower respiratory infection
Cases of respiratory infection, NOS due to COVID-19	U07.1: 2019-nCoV acute respiratory disease and J98.8: Other specified respiratory disorders
Cases of ARDS (Acute Respiratory Distress Syndrome) due to COVID-19	U07.1: 2019-nCoV acute respiratory disease and J80: Acute respiratory distress syndrome



COVID-19: World Health Crisis Update - *Continued from page 11*

On February 20, 2020, the CDC announced a new ICD-10, U07.1: 2019-nCoV acute respiratory that became effective on April 1, 2020 and may not be used for billed claims prior to that date.

For more information related to CDC's ICD-10-CM Official Coding Guidelines - Supplement Coding encounters related to COVID-19 Coronavirus Outbreak please go to: https://www.cdc.gov/coronavirus.

COVID-19 Vaccinations

Kaiser Permanente will cover the administration of any FDA-approved COVID-19 vaccine at no cost-share to all commercial and Medicaid members (see "Medicare Reimbursement" section below). Providers may bill for the administration of the vaccine but not the cost of the vaccine as they are provided at no cost by the Federal government. No authorization is required for the administration of COVID-19 vaccinations.

Medicare Reimbursement COVID-19 Vaccinations and Monoclonal Antibody Therapy –
Original Medicare will reimbursement COVID-19 vaccine administration and monoclonal antibody therapy administration (MAB) costs. Therefore, claims for COVID-19 vaccination and MAB administration should be submitted to Original Medicare via the appropriate Medicare Administrative Contractors directly and not to Kaiser Permanente. This provision is for COVID-19 vaccination and MAB administration only. All other Medicare Advantage claims including COVID-19 screening, testing, diagnosis and treatment will continue to be submitted to Kaiser Permanente for reimbursement. For additional information, go to:

- https://www.cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration
- https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion#Payment

COVID-19: World Health Crisis Update - *Continued from page 12*

All COVID-19 vaccine administration costs should be billed using the following codes:

Procedure Codes	Description
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **first dose (Pfizer)**
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **second dose (Pfizer)**
0011A	Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **first dose (Moderna)**
0012A	Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **second dose (Moderna)**
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1(ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose **(AstraZeneca)**
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1(ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; second dose **(AstraZeneca)**
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; **single dose (Janssen)**
D1701	SARSCOV2 COVID-19 VAC Administration mRNA 30mcg/0.3mL IM DOSE 1 **(Pfizer) Effective 3/15/2021**
D1702	SARSCOV2 COVID-19 VAC Administration mRNA 30mcg/0.3mL IM DOSE 2 **(Pfizer) Effective 3/15/2021**
D1703	SARSCOV2 COVID-19 VAC Administration mRNA 100mcg/0.5mL IM DOSE 1 **(Moderna) Effective 3/15/2021**
D1704	SARSCOV2 COVID-19 VAC Administration mRNA 100mcg/0.5mL IM DOSE 2 **(Moderna) Effective 3/15/2021**

COVID-19: World Health Crisis Update - *Continued from page 13*

Procedure Codes	Description
D1705	SARSCOV2 COVID-19 VAC Administration rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1 **(AstraZeneca) Effective 3/15/2021**
D1706	SARSCOV2 COVID-19 VAC Administration rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2 **(AstraZeneca) Effective 3/15/2021**
D1707	SARSCOV2 COVID-19 VAC Administration Ad26 5x1010 VP/.5mL IM SINGLE DOSE **(Janssen) Effective 3/15/2021**

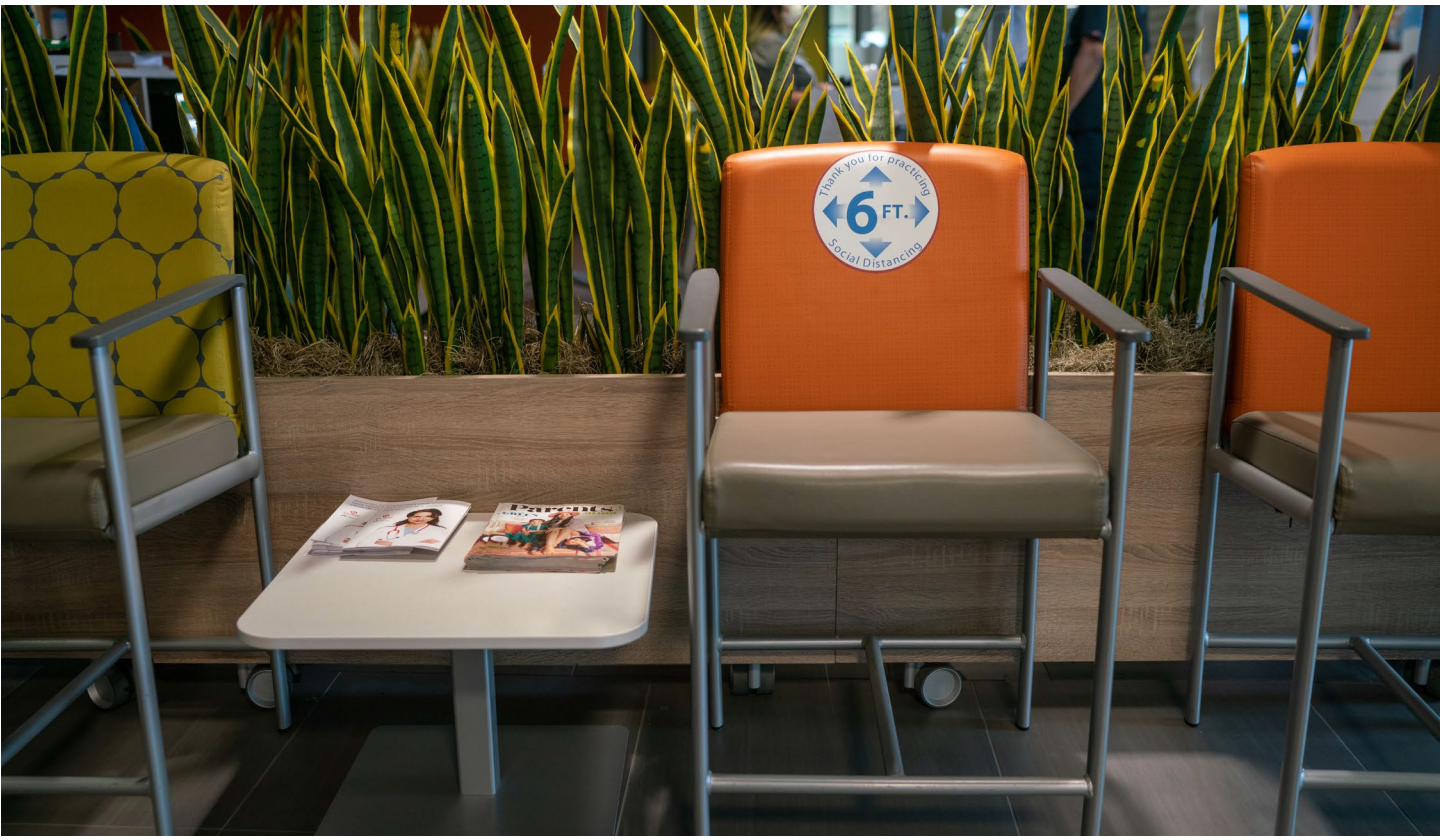
We will provide any additional information regarding COVID-19 coding to you as quickly as possible.

Continue to Encourage Social Distancing

Social distancing can limit the exposure of the virus to vulnerable individuals. For questions about self-isolating and social distancing, please refer to CDC guidance at: https://www.cdc.gov/coronavirus**.**

We will continue to keep you informed about changes and answer your questions as the situation evolves. Please keep up to date on the evolving COVID-19 pandemic by visiting CPP, our provider portal, at **providers.kp.org/mas**. You may also visit **kp.org** for continued updates.

If you have additional questions, please contact your account manager, or email us at **provider.relations@kp.org**.



2021 Utilization Management Affirmative Statement

Kaiser Permanente practitioners and health care professionals make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of care and service, and existence of health plan coverage. Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. The health plan does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or benefits or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and services or result in underutilization. In order to maintain and improve the health of our members, all practitioners and health professionals should be especially diligent in identifying any potential underutilization of care or service.

Medical Coverage Policy Update: September – November 2021

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) and Transplant Patient Selection Criteria were approved between **September 2021 to November 2021.**

We develop MCPs in collaboration with specialty service chiefs and clinical subject matter experts. MCPs specify clinical criteria supported by current peer reviewed literature and are used to guide decisions related to request for health care services such as devices, drugs, and procedures. The policies are reviewed and updated annually, reviewed for approval by the Regional Utilization Management Committee (RUMC), and are periodically reviewed by regulatory and accrediting agencies. Except where noted, our MCPs are primarily applicable only to commercial members.

New and Updated Medical Coverage Policies

A. Nationally Recognized Non-Behavioral UM Criteria

The **2021 InterQual Level of Care, April 2021 release** is a commercially available criterion providing support for determining the medical appropriateness of hospital admission, continued stay and discharge. When a patient is admitted for transplant related services, except for kidney transplants, National Transplant Service (NTS) transplant coordinators follow the patient using InterQual as the inpatient continued stay criteria set. The criteria set is updated annually by McKesson Health Solutions and the transplant coordinators are tested annually to establish inter rater reliability.

InterQual Level of Care for Transplant-related Services, Adult and Pediatric Description

1. **InterQual Acute Adult Criteria -** determines the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are age 18 or older. InterQual Acute Adult Criteria are organized by primary condition in this new "condition specific" model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.

MCP Update: September – November 2021 - *Continued from page 15*

2. **InterQual Acute Pediatric Criteria** - determines the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are less than 18 years of age. InterQual Pediatric Criteria also are organized by primary condition in a 'condition specific' model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.

    - 2021 InterQual Level of Care – General Surgical, Acute Criteria – Adult & Pediatrics
    - 2021 InterQual Level of Care – General Medical, Acute Criteria – Adult & Pediatrics
    - InterQual Level of Care Acute Criteria, Pediatric - General Transplant Section (General, Bone Marrow and Stem Cell Transplantation)
        - 2021 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Adult
        - 2021 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Pediatrics

MCP Update: September – November 2021 - *Continued from page 16*

B. Medical Coverage Policies

1. PDL for Vascular Malformations and Port Wine Stains

Effective date: September 27, 2021

- Policy Title: changed from Pulsed Dye Laser for Vascular Lesions to Pulsed Dye Laser for Vascular Malformations and Port Wine Stains
- Section III – Indications for Referral –
  - B & C: Port wine stains
    - Updated: qualifying criteria
    - Deleted: nevus flammeus which is an older terminology and may encompass benign lesions that fade by age 2 and thus no treatment is needed
  - E & F – Deleted: Nevus, non-neoplastic; & congenital non-neoplastic nevus
- References were updated

2. Laser Treatment for Hair Removal or Hair Reduction

Effective date: September 27, 2021

- References were updated

3. Cologuard

Effective date: September 27, 2021

- Section IV – Clinical indication for referral, Medicare and Maryland jurisdiction
  - Colon cancer screening start age edited from 50-75 to 45-75 based on 2021 USPTF recommendation
- References were updated

4. Breast Pump, Hospital Grade and Personal Pump

Effective date: September 27, 2021

- Section III, C – deleted the old reference language (no longer relevant), "*as in section #13 in section II, B.*"

5. Capsule Endoscopy

Effective date: September 27, 2021

- References were updated

6. Transperineal Placement of Absorbable Peri-rectal Spacer for Prostate Cancer Radiotherapy (Space OAR)

Effective date: September 27, 2021

- Section III – Description updated
- Section IV – Clinical indication: updated conditions for referral
- Section V – Added: contraindications
- Added: Section VI – Definition: Zubrod or ECOG (Eastern Cooperative Oncology Group) scale
- References were updated

7. Infertility Diagnosis and Treatment

Effective date: September 27, 2021

- Section VIII, B #1 – Advanced Reproductive (infertility) Treatments
  - Removal of number of cycles
  - As per SGF and KP, one cycle of IVF to be authorized at a time

MCP Update: September – November 2021 - *Continued from page 17*

8. **Breast Reduction and Gynecomastia Surgery**
   Effective date: September 27, 2021
   - Section V, A #8 and B #2 – Therapeutic measures prior to referral
     - Added: In addition to the criteria, obese patients (BMI greater than 35), must receive documentation of nutrition education for 3 or more months prior to referral for the procedure.
   - References were updated

9. **Feeding Therapy – New Policy**
   Effective date: September 27, 2021

10. **Purewick – New Policy**
    Effective date: September 27, 2021

11. **Aquatic Therapy**
    Effective date: September 27, 2021
    - References were updated

12. **Benign Skin Lesion Treatment**
    Effective date: October 19, 2021
    - Section III B – Clinical Indications for referral
      - Added: lesions need to be VISIBLY symptomatic and functionally obstructs body orifices
    - Section IV, B 2, 5 & 6 – Exclusions: added additional benign lesions
    - References were updated

13. **HFOV (High Frequency Flutter Valves and Oscillator Vest)**
    Effective date: October 19, 2021
    - References were updated

14. **Pre-Implantation Genetic Test**
    Effective date: October 19, 2021
    - Section IV – Indication for coverage of the following procedures in relation to PGT-SR & PGT-M added
      - D – Coverage for assisted hatching/IVF with to PGT-SR & PGT-M
      - F – Coverage of ICSI with PGT-M
      - Deletion of coverage for ICSI with PGT-SR

15. **Endobronchial Valves**
    Effective date: October 19, 2021
    - References were updated

16. **Spinal Cord Stimulator for Pain Management**
    Effective date: October 19, 2021
    - References were updated

17. **Ambulance Transportation**
    Effective date: October 19, 2021
    - References were updated

MCP Update: September – November 2021 - *Continued from page 18*

18. Wound Supplies

Effective date: October 19, 2021

- References were updated

19. Continuous Passive Motion (CPM) Device

Effective date: October 19, 2021

- References were updated

20. Transgender Surgery – Commercial: MD, VA and Feds

Effective date: November 29, 2021

- Utilization Alert – deleted: non-coverage of breast augmentation & facial feminization surgery for Federal members. These transgender related procedures will be covered effective January 1, 2022 according to 2022 Federal Employee Health Benefit Plan changes
- Section VI, B – Exclusion for Infertility Services: added “fertility preservation” in addition to infertility benefit as criteria for infertility benefit coverage.

21. Orthotics – Foot and Ankle

Effective date: November 29, 2021

- Section V, A – Clinical indication for therapeutic shoes: added peripheral neuropathy
- References were updated

22. Nutritional Support: Enteral Formula, Equipment and Supplies

Effective date: November 29, 2021

- References were updated

MCP Update: September – November 2021 - *Continued from page 19*

23. Habilitative Services VA Mid-Large Commercial

Effective date: November 29, 2021

- Section VI – Section A of exclusion was replaced
- References were updated

24. Habilitative Services VA Small Group/KPIF

Effective date: November 29, 2021

- Utilization Alert: effective January 1, 2021, ABA coverage is applicable to VA Individual (KPIF) and Small Group OFF Exchange plans only. It remains non-covered for ON Exchange plans.
- Section III – Exclusion: sections A and B are replaced
- References were updated

25. Habilitative Services MD

Effective date: November 29, 2021

- Section I, D – entire section of exclusion has been replaced
- References were updated

26. Habilitative Services DC

Effective date: November 29, 2021

- Section II – Exclusion – entire section has been replaced
- References were updated

Access to MCPs is only two clicks away in Health Connect.

Medical Coverage Policies can be accessed through the **KP Clinical Library** by using the web link below:
https://clm.kp.org/wps/portal/cl/MAS/search_iframe?query=medical+coverage+policy&x=0&y=0**.**

Click on the Clinical Library section on the right side of the KPHC Home page and then type in “medical coverage policy” in the search box. All medical coverage policies will be displayed.

Please contact the Utilization Management Operations Center (UMOC) at 1-800-810-4766 to receive a copy of the UM guideline or criteria related to a referral.

All Practitioners have the opportunity to discuss any non-behavioral health and or/behavioral health Utilization Management (UM) medical necessity denial (adverse) decisions with a Kaiser Permanente Physician reviewer (UM Physicians).

If you have clinical questions on use of our criteria, please feel free to contact:

Claudia Donovan M.D.
Physician Director of Medical Policies, Benefits and Technology Assessment
Medical Director for Central East National Transplant Services
Claudia.K.Donovan@kp.org

If you have administrative questions concerning accessing or using our criteria, please contact:

Marisa R Dionisio, RN
Marisa.R.Dionisio@kp.org
240-620-7257

Member Rights and Responsibilities: Our Commitment to Each Other

Kaiser Permanente is committed to providing you and your family with quality health care services. In a spirit of partnership with you, here are the rights and responsibilities we share in the delivery of your health care services.

Member rights

As a member of Kaiser Permanente, you have the right to do the following:

RECEIVE INFORMATION THAT EMPOWERS YOU TO BE INVOLVED IN HEALTH CARE DECISION MAKING

This includes your right to do the following:

a. Actively participate in discussions and decisions regarding your health care options.

b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved – no matter what the cost is or what your benefits are.

c. Receive relevant information and education that helps promote your safety in the course of treatment.

d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.

Member Rights and Responsibilities – *Continued from page 21*

e. Refuse treatment, provided that you accept the responsibility for and consequences of your decision.

f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an advance directive, a durable power of attorney for health, a living will, or another health care treatment directive. You can rescind or modify these documents at any time.

g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.

h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your authorized representative will be asked to provide written permission before your records are released, unless otherwise permitted by law.

RECEIVE INFORMATION ABOUT KAISER PERMANENTE AND YOUR PLAN

This includes your right to the following:

a. Receive the information you need to choose or change your primary care physician, including the names, professional levels and credentials of the doctors assisting or treating you.

b. Receive information about Kaiser Permanente, our services, our practitioners and providers, and the rights and responsibilities you have as a member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies.

c. Receive information about financial arrangements with physicians that could affect the use of services you might need.

d. Receive emergency services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

e. Receive covered, urgently needed services when traveling outside the Kaiser Permanente service area.

f. Receive information about what services are covered and what you will have to pay and examine an explanation of any bills for services that are not covered.

g. File a complaint, a grievance, or an appeal about Kaiser Permanente, or the care you received, without fear of retribution or discrimination; expect problems to be fairly examined; and receive an acknowledgement and a resolution in a timely manner.

RECEIVE PROFESSIONAL CARE AND SERVICE

This includes your right to the following:

a. See plan providers; get covered health care services; and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring and professional manner.

Member Rights and Responsibilities – *Continued from page 22*

b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.

c. Be treated with respect and dignity.

d. Request that a staff member be present as a chaperone during medical appointments or tests.

e. Receive and exercise your rights and responsibilities without any discrimination based on age; gender; sexual orientation; race; ethnicity; religion; disability; medical condition; national origin; educational background; reading skills; ability to speak or read English; or economic or health status, including any mental or physical disability you may have.

f. Request interpreter services in your primary language at no charge.

g. Receive health care in facilities that are environmentally safe and accessible to all.

Member responsibilities

As a member of Kaiser Permanente, you have the responsibility to do the following:

PROMOTE YOUR OWN GOOD HEALTH

a. Be active in your health care and engage in healthy habits.

b. Select a primary care physician. You may choose a doctor who practices in the specialty of internal medicine, pediatrics, or family practice as your primary care physician.

c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.

d. Work with us to help you understand your health problems and develop mutually agreed-upon treatment goals.

e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.

f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.

g. Schedule the health care appointments your physician or health care professional recommends.

h. Keep scheduled appointments or cancel appointments with as much notice as possible.

i. Inform us if you no longer live or work within the plan service area.

Member Rights and Responsibilities – *Continued from page 23*

KNOW AND UNDERSTAND YOUR PLAN AND BENEFITS

a. Read about your health care benefits and become familiar with them. Detailed information about your plan, benefits and covered services is available in your contract. Call us when you have questions or concerns.

b. Pay your plan premiums and bring payment with you when your visit requires a copayment, coinsurance, or deductible.

c. Let us know if you have any questions, concerns, problems, or suggestions.

d. Inform us if you have any other health insurance or prescription drug coverage.

e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our plan.

PROMOTE RESPECT AND SAFETY FOR OTHERS

a. Extend the same courtesy and respect to others that you expect when seeking health care services.

b. Ensure a safe environment for other members, staff and physicians by not threatening or harming others.

2021 Maryland Medicaid CAHPS Results

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey designed to better understand patient experience with health care. The survey asks patients about their experiences with, and their ratings of, their health care providers and plans, including hospitals, doctors, and health and drug plans, among others. The survey focuses on matters that patients themselves say are important to them and for which patients are the best and/or only source of information.

In Spring 2021, a third-party vendor conducted the annual survey of a select number of Maryland Medicaid members on behalf of Kaiser Permanente and the Maryland Department of Health. The results from the survey are used to identify areas for the health plan and for providers to improve patient experience. The 2021 Maryland Medicaid CAHPS show the following results:

Measure	MD Adult		MD Child	
	2021	2019	2021	2019
Health Care Rating	61%	59%	78%	72%
PCP Rating	69%	65%	78%	80%
Specialist Rating	63%**	63%**	67%**	65%**
Health Plan Rating	58%	57%	86%	72%
Getting Needed Care	80%	86%	75%	83%
Getting Care Quickly	76%	83%	78%	85%
MD Communication	87%	89%	90%	95%
Customer Service	91%**	88%	87%**	88%
Care Coordination	80%**	83%	74%*	82%

** Base size less than 100 – interpret with caution

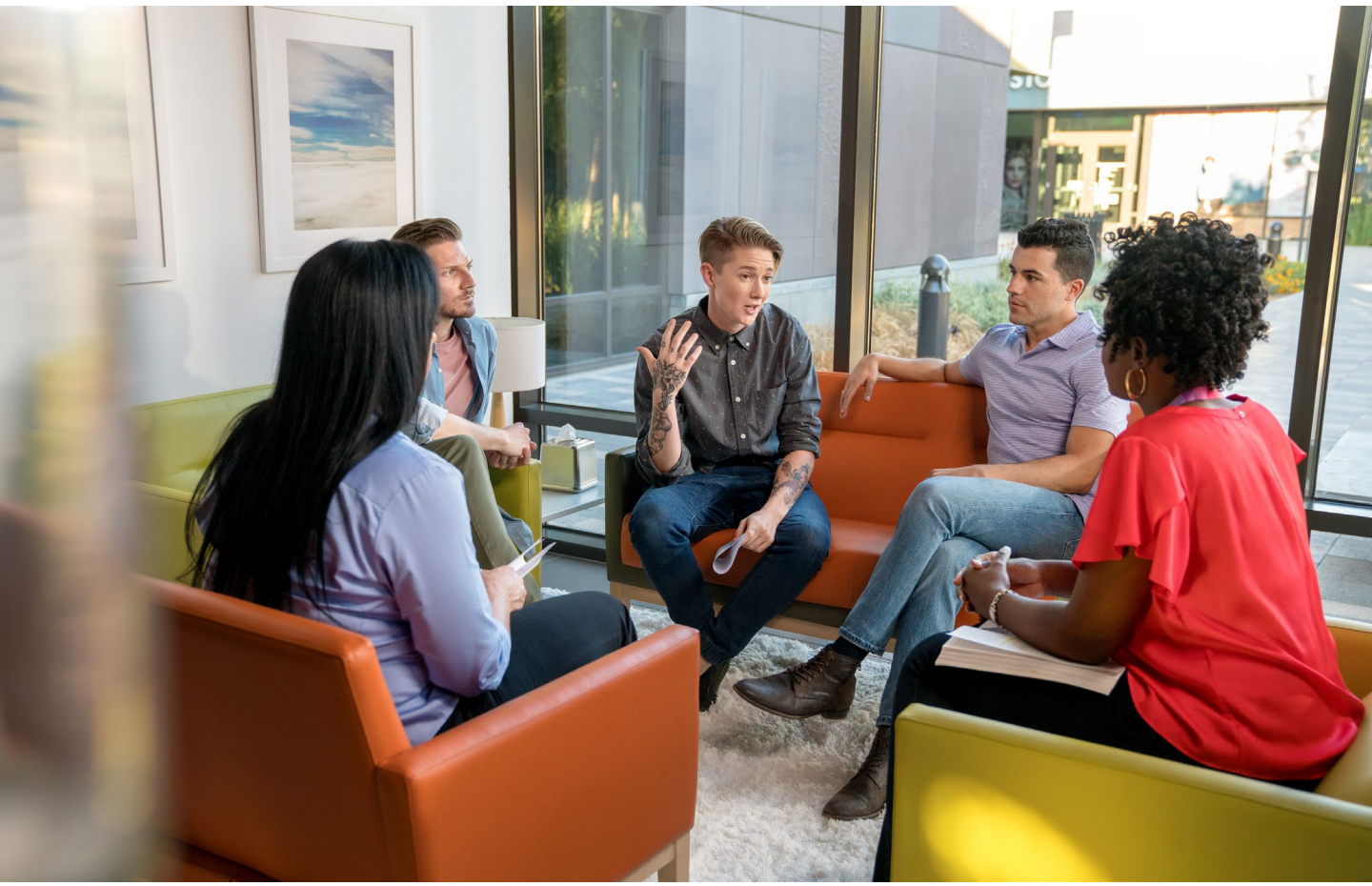
2020 results not reported per NCQA recommendation

VA Medicaid Behavioral Health Enhancements

In 2021, Virginia's Department of Medical Assistance Services (DMAS) began enhancing their behavioral health program by adding six (6) core services for Virginia Medicaid members. These additional services are designed to rebalance the Virginia Medicaid mental health system and has been implemented throughout two (2) phases. The first phase became effective on July 1, 2021 and focused on enhancements to Mental Health Services (MHS) services, formerly known as Community Mental Health Rehabilitative Services (CMHRS). The second phase became effective on December 1, 2021. The services enhanced in the second phase were:

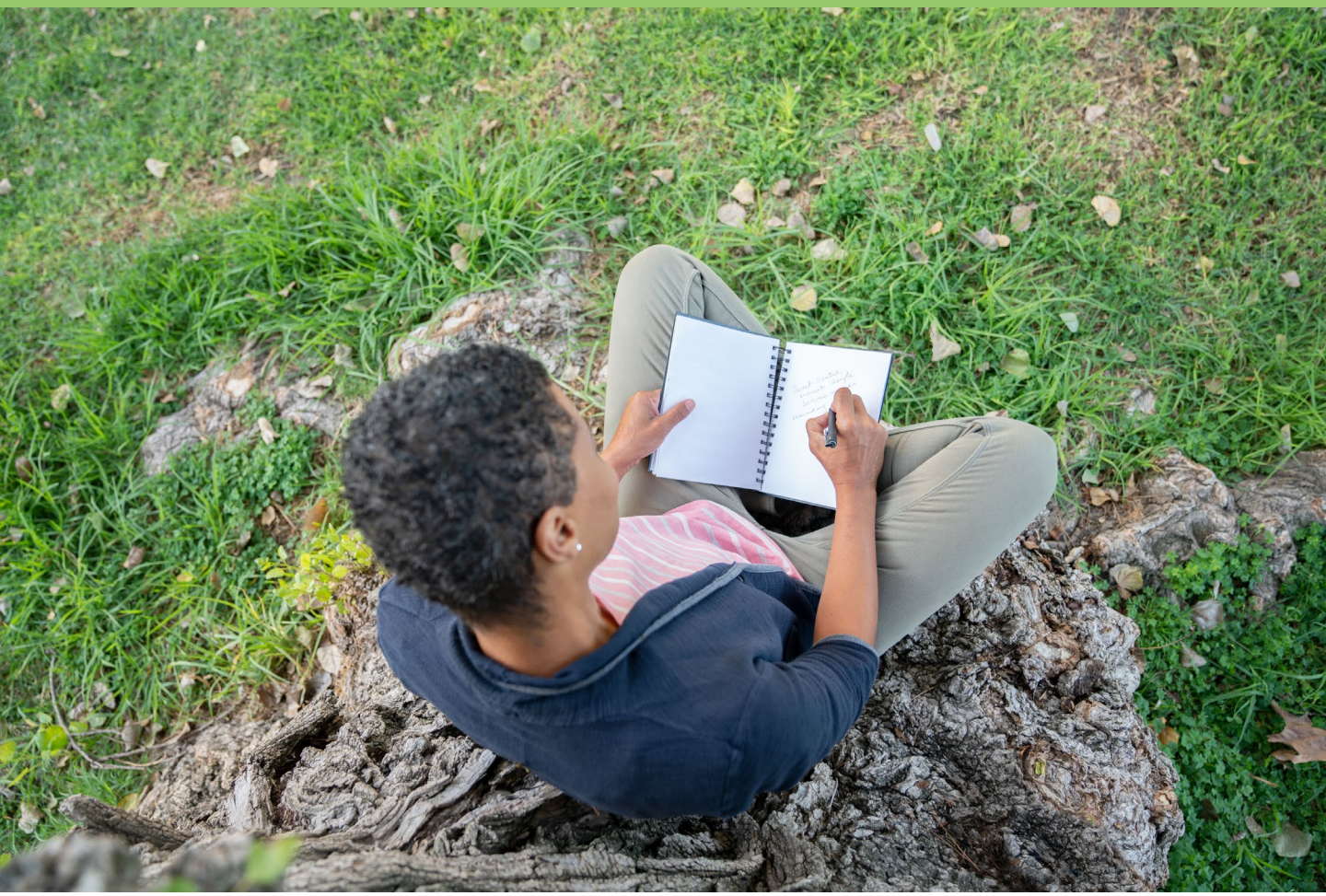
1. Functional Family Therapy (FFT)
2. Multisystemic Therapy (MST)
3. Comprehensive Crisis Services
    a. 23-Hour Crisis Stabilization
    b. Community Stabilization
    c. Mobile Crisis Response
    d. Residential Crisis Stabilization Unit (RCSU)
4. Applied Behavior Analysis Therapy (ABA)

FFT, MST, and Comprehensive Crisis Services are new services for our Virginia Medicaid members. ABA is a current service but DMAS is reframing and improving upon this program. Below is an overview of each behavioral health service.



VA Medicaid Behavioral Health Enhancements – *Continued from page 26*

New Behavioral Health Service	Service Description
Family Functional Therapy (FFT)	A short-term, evidence-based treatment program targeting youth between the ages of 11-18 who have received a referral for the treatment of behavioral or emotional problems including co-occurring substance use disorders. This is primarily a home-based service addressing both symptoms of serious emotional disturbance, as well as parenting/caregiving practices and/or challenges affecting the youth and caregiver's ability to function as a family.
Multisystemic Therapy (MST)	An intensive family and community-based treatment addressing the externalizing behaviors of youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. This is a home-based model for youth and families, targeting youth between the ages of 11 – 18 who are at high risk of out-of-home placement, or may be returning home from a higher level of care.
Comprehensive Crisis Services	
a. Mobile Crisis Response	Provides rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. This service is provided around the clock: 24-hours a day, 7-days a week. This purpose of this service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety in order to prevent the need for a higher level of care.
b. Community Stabilization	This is a short-term service and is designed to support an individual and their natural support system following contact with and initial crisis response service, or as a diversion to a higher level of care. Services are provided in an individual's natural environment and provide referral and linkage to other community-based services at the appropriate level of care.
c. 23-Hour Crisis Stabilization	This is a period of up to 23-hours in a community-based setting for crisis stabilization that provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis. This should be accessible 24-hours a day, 7-days a week, and is indicated for situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit is necessary.
d. Residential Crisis Stabilization Unit (RCSU)	This is a short-term, 24/7 residential psychiatric/substance related crisis evaluation and brief intervention service. These units serve as diversion or stepdown from inpatient hospitalization. This service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning.
Applied Behavior Analysis Therapy	The practice of behavior analysis as established by the Virginia Board of Medicine (§54.1-2900). Applied Behavior Analysis will replace and serve as an enhancement of our current Behavior Therapy service for youth. Updates to these services include procedure code and policy changes.



VA Medicaid Behavioral Health Enhancements – *Continued from page 27*

For more detailed information on these services, go to the DMAS' provider portal at www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home to see the Medicaid Bulletin dated for October 15, 2021. A direct link to the memo can also be found at https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid+Memo+2021.10.14.pdf.

To learn more about **all** of the enhancements, go to:

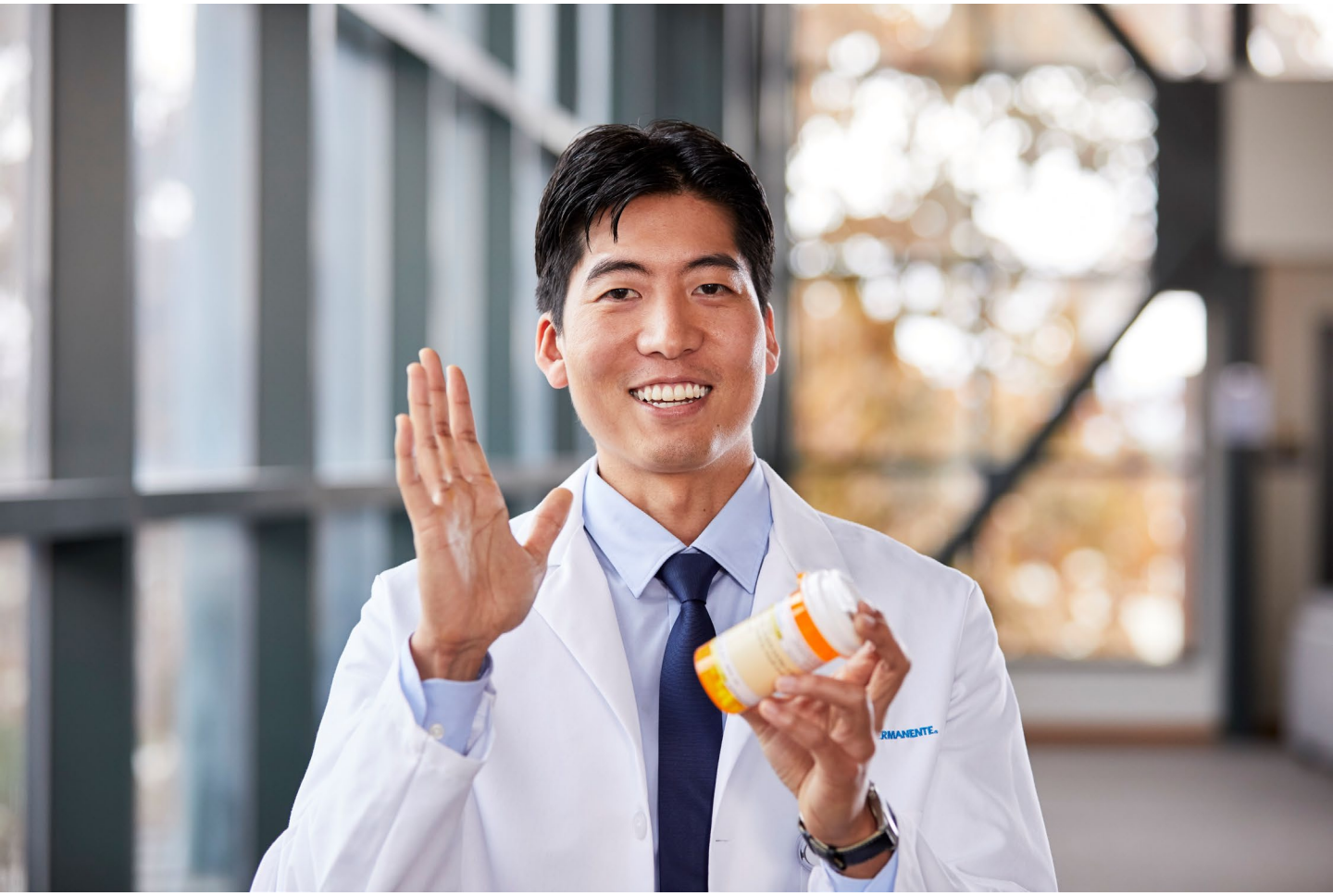
1. The DMAS Behavioral Health Enhancement website: https://www.dmas.virginia.gov/for-providers/behavioral-health/enhancements/
2. Virginia's DBHDS website: https://dbhds.virginia.gov/

The above services are covered for Virginia Medicaid participants. Participating providers will need to request authorization for these services. The appropriate DMAS Service Authorization form must be included. Requests may be faxed to Behavioral Health Utilization Management at 855-414-1703.

The Kaiser Permanente Virginia Medicaid Provider Manual, section *12.4 Mental Health Services*, has been updated to reflect these enhancements. You may access the manual on our Community Provider Portal at www.providers.kp.org/mas.

Medications or Pharmaceuticals Reminder for SNF Providers

All medications/pharmaceuticals are included in your Contract. There may be different payment methodologies when reviewing your contract details. All medications/pharmaceuticals should be supplied by the SNF and a Member should not be refused admission due to the terms of the reimbursement method in your agreement. If you have any questions regarding your contract details, please contact your Kaiser Contract Manager. This reminder applies to Commercial plans.



Online Affiliate Entity Agreements

All provider practices must have a signed Online Affiliate entity agreement on file before individual users can gain access to our online tools. If you are unsure if your practice has an agreement on file, please email kp-mas-onlineaffiliate@kp.org to inquire. Be sure to include your practice name and practice tax ID# in your inquiry.

Important Message from DMAS: VA Medicaid Provider Enrollment

Below is a message from the Virginia Department of Medical Assistance Services (DMAS).

This is an important message for all Medicaid providers. The Virginia Medicaid agency will launch a new technology platform in April 2022. Providers credentialed in one or more Managed Care Organizations will use the new Provider Services Solution (PRSS) to complete enrollment and maintenance processes. This change is part of the Medicaid Enterprise System (MES) project.

PRSS will be more efficient and make it easier for you to access information you need as a Medicaid provider. You will be able to update licenses and certifications and submit required attachments through the secure portal. You will also be able to request participation with MCO health plans during the enrollment/revalidation process through the portal.

The new system will also allow Virginia to comply with federal requirements for the 21st Century Cures Act.

We need your help to ensure that this transition is a success. If you need to enroll through PRSS, we will let you know, and we will send you a schedule in the coming months telling you when to take this action. The Virginia Medicaid agency is working with us to schedule enrollments for our providers beginning in the summer of 2022 to ensure an efficient process.

If you participate in more than one MCO network, you will receive information and instructions from each managed care health plan.

If you serve Medicaid fee-for-service members, you will also receive information directly from the Virginia Department of Medical Assistance Services (DMAS).

Next Steps

Please watch for updates on the PRSS system. We will share more information in the coming months, and we will ask you to take the following actions:

- *January 2022: Access training videos and other resources.*
- *March 2022: Providers with active credentials in the current Medicaid Provider Portal will receive new MES credentials via email. The Virginia Medicaid agency will ask you to confirm that you are able to use your new credentials to access the MES login page and that you can locate the PRSS Portal on the MES website. You will receive instructions at this time on how to assign other users to work on your behalf in PRSS through the delegate assignment process.*

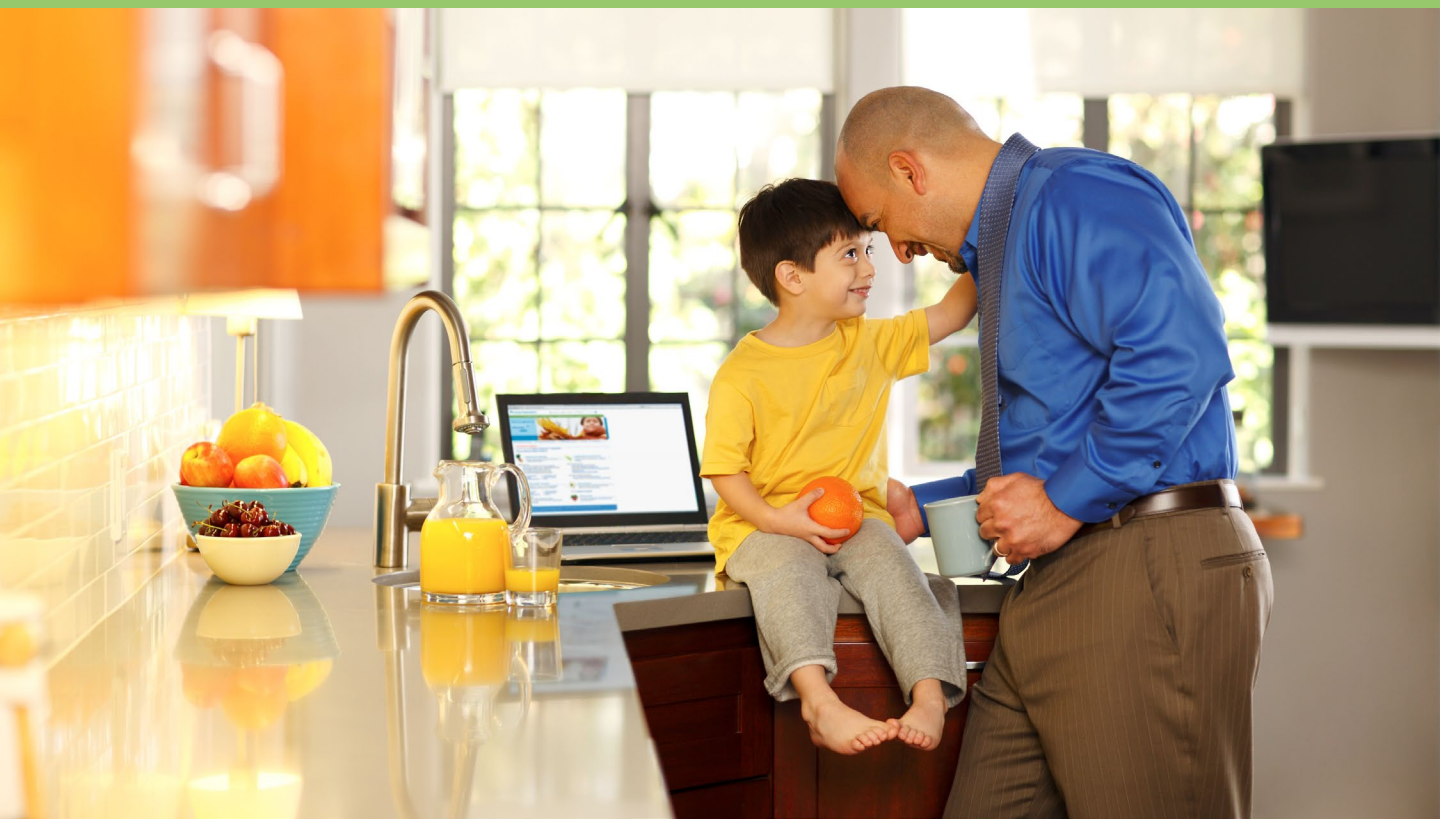
We will keep you informed as the project progresses so that you have plenty of time to take training, ask questions and get responses to your questions.

More information will be forthcoming with information on when you will need to enroll through PRSS. You may also go to https://www.dmas.virginia.gov/for-providers/medicaid-enterprise-system/managed-care-network-providers/ to learn more about the system.

Diversity

Members have the right to free language services for health care needs. We provide free language services including:

- **24-hour access to an interpreter.** When members call to make an appointment or talk to their personal physician, if needed, we will connect them to a telephonic interpreter.
- **Translation services.** Some member materials are available in the member's preferred language.
- **Bilingual physicians and staff**. In some medical centers and facilities, we have bilingual physicians and staff to assist members with their health care needs. They can call Member Services or search online in the medical staff directory at **kaiserpermanente.org**.
- **Braille or large print**. Blind or vision impaired members can request for documents in Braille or large print or in audio format.
- **Telecommunications Relay Service (TRS).** If members are deaf, hard of hearing, or speech impaired, we have the TRS access numbers that they can use to make an appointment or talk with an advice nurse or member services representative or with you.
- **Sign language interpreter services**. These services are available for appointments. In general, advance notice of two or three business days is required to arrange for a sign language interpreter; availability cannot be guaranteed without sufficient notice.
- **Video Remote Interpretation (VRI).** VRI provides on-demand access to American Sign Language & Spoken Language interpretation services at medical centers for members. It meets the need in the care experience of walk-in deaf patient and those in need of urgent care.
- **Educational materials**. Health education materials can be made available in languages other than English by request. To access Spanish language information and many educational resources go to **kp.org/espanol** or **kp.org** to access La Guía en Español (the Guide in Spanish). Members can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in La Guía en Español.
- **Prescription labels**. Upon request, the Kaiser Permanente of the Mid-Atlantic States pharmacist can provide prescription labels in Spanish for most medications filled at the Kaiser Permanente pharmacy.
- **After Visit Summary (AVS)**. AVS can be printed on paper and available electronically via kp.org for KP members after their appointment. If the member's preferred written communication is documented in KP HealthConnect for a non-English language, the AVS automatically prints out in that selected language. This includes languages such as Spanish, Arabic, Korean, and several others.



Diversity – *Continued from page 31*

At Kaiser Permanente, we are committed to providing quality health care to our members regardless of their race, ethnic background or language preference. Efforts are being made to collect race, ethnicity and language data through our electronic medical record system, HealthConnect®. We believe that by understanding our members' cultural and language preferences, we can more easily customize our care delivery and Health Plan services to meet our members' specific needs.

Currently, when visiting a medical center, members should be asked for their demographic information. It is entirely the member's choice whether to provide us with demographic information. The information is confidential and will be used only to improve the quality of care. The information will also enable us to respond to required reporting regulations that ensure nondiscrimination in the delivery of health care.

We are seeking support from our practitioners and providers to assist us with the member demographic data collection initiative. We would appreciate your support with the data collection by asking that you and your staff check the member's medical record to ensure the member demographic data is being captured. If the data is not captured, please take the time to collect this data from the member. The amount of time needed to collect this data is minimal and only needs to be collected once. Recommendation for best practices for collecting data is during the rooming procedure.

In conclusion, research has shown that medical treatment is more effective when the patient's race, ethnicity and primary language are considered.

To access organization wide population data on language and race, please access the reports via our Community Provider Portal at www.providers.kp.org/mas under *News and announcements*.

To obtain your practice level data on language and race, please email the Provider Experience Department at **Provider.Relations@kp.org**.

Provider Data Validation Update

Effective January 1, 2022, an important mandate will bring changes to how provider directory information is validated. The *H.R.133 - Consolidated Appropriations Act 2021*, also called the *No Surprises Act*, requires payers to establish a verification process to confirm directory information at least every 90 days. For more information on the Consolidated Appropriations Act go to the Congressional website (include website). An excerpt from the regulation is below.

> **''SEC. 2799B–9. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.**
>
> ''(a) PROVIDER BUSINESS PROCESSES.—Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as applicable. Such providers shall submit provider directory information to a plan or issuers, at a minimum—
>
> ''(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;
>
> ''(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;
>
> ''(3) when there are material changes to the content of provider directory information of the provider or facility described in section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as applicable;
>
> and
>
> ''(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

Currently, each quarter Kaiser Permanente sends a provider data validation survey to all practices. We will continue to send these surveys quarterly. This survey satisfies the new mandate. You will be required and contractually obligated to provide an attestation that you have validated your information at least every 90 days. Respond to the survey by the due date to either attest that there are no changes or notify us of any changes to your provider data.

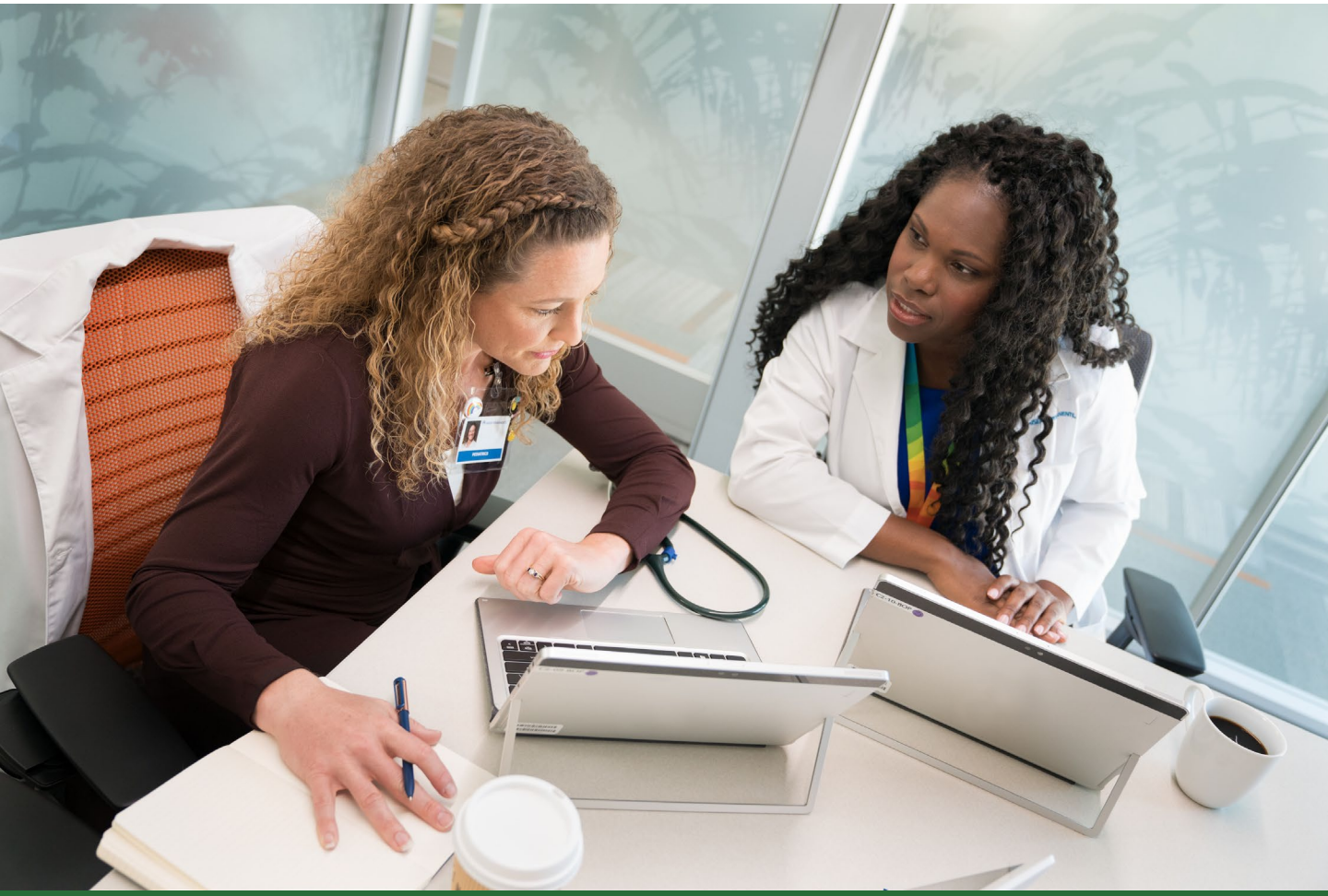
If you have new practitioners that need to be added to your practice, please submit a request in writing. Go to www.providers.kp.org/mas and follow the format in the sample provider demographic request letter.

Keeping Your Provider Data Updated

Be sure to submit any changes to your practice to Kaiser Permanente. Keeping Kaiser Permanente updated will ensure that our provider directory and data systems are accurate and help us to provide an excellent healthcare experience to our members. To access our provider directory online, go to kp.org. For your convenience, a sample form letter can be found on our Community Provider Portal at www.providers.kp.org/mas and on the following page. Utilize the sample to submit updates throughout the year.

Updates may be submitted to Provider Experience via:

Fax: 855-414-2623
Email: Provider.Demographics@kp.org
Mail: Kaiser Permanente
Provider Experience
2101 East Jefferson St., 2 East
Rockville, MD 20852



Sample Provider Data Update Form Letter

Company Letterhead Logo

<<Date>>
Requestor:
Requestor's Correspondence Address:
Requestor's Phone #:
Requestor's Email:
Tax ID#:
Effective date of change(s):
Reason for the request:

***PLEASE DELETE SECTIONS NOT NEEDED**

Address change (Specify if practice location or billing address is changing)

- Specify if adding or deleting address
- Include **old** and **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, **Tax ID** and **NPI**)
- Billing/Payment Address/Tax ID/NPI
- Management Correspondence Address (include Phone & Fax Number

Practice location addition

- Include **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, **Tax ID** and **NPI of Location**)
- Billing/Payment Address/Tax ID/NPI

Adding a provider to or deleting a provider from an existing group

- Specify if adding or deleting provider
- Include the information listed below if adding or deleting a provider:
    - First Name, Middle Initial, and Last Name
    - Gender
    - Title (*MD, CRP, CRNP, PA etc.)*
    - Date of Birth
    - NPI #
    - CAQH #
    - UPIN or SSN
    - Medicare #
    - Medicaid Participation State(*s*)
    - Medicaid #
    - Practicing Specialty
    - **Practicing Location(s) (*include phone & fax numbers*)**
        - Indicate whether practicing location is hospital based or office based
    - Billing/Payment Address (*include W-9*)
    - Management Correspondence Address (*include phone & fax number*)
    - Hospital Privileges
    - Foreign Languages
    - Effective Date
    - Provider Panel Status: Open or Closed
- ***A copy of provider licenses in all practicing states is required***

Changing the Tax Identification Number and/or the name of an existing group

- Include **old** and **new** tax ID number and/or group name
- Include effective date of the new tax ID number and/or group name
- Include NPI number
- Include a signed and dated copy of the new W-9
- Billing/Payment Address
- Management Correspondence Address (include phone & fax number)

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Provider Experience
2101 E. Jefferson Street
Rockville, MD 20852