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.

March 2025

Contents

Introducing Kaiser Permanente's Attestation Portal for Validating Provider Information

We are pleased to announce the launch of the Kaiser Permanente Attestation Portal, a streamlined platform designed to simplify your attestation process for validating provider information. This portal enhances the accuracy and efficiency of your 90-day provider demographics attestations, ultimately helping to maintain the integrity of our directory data.

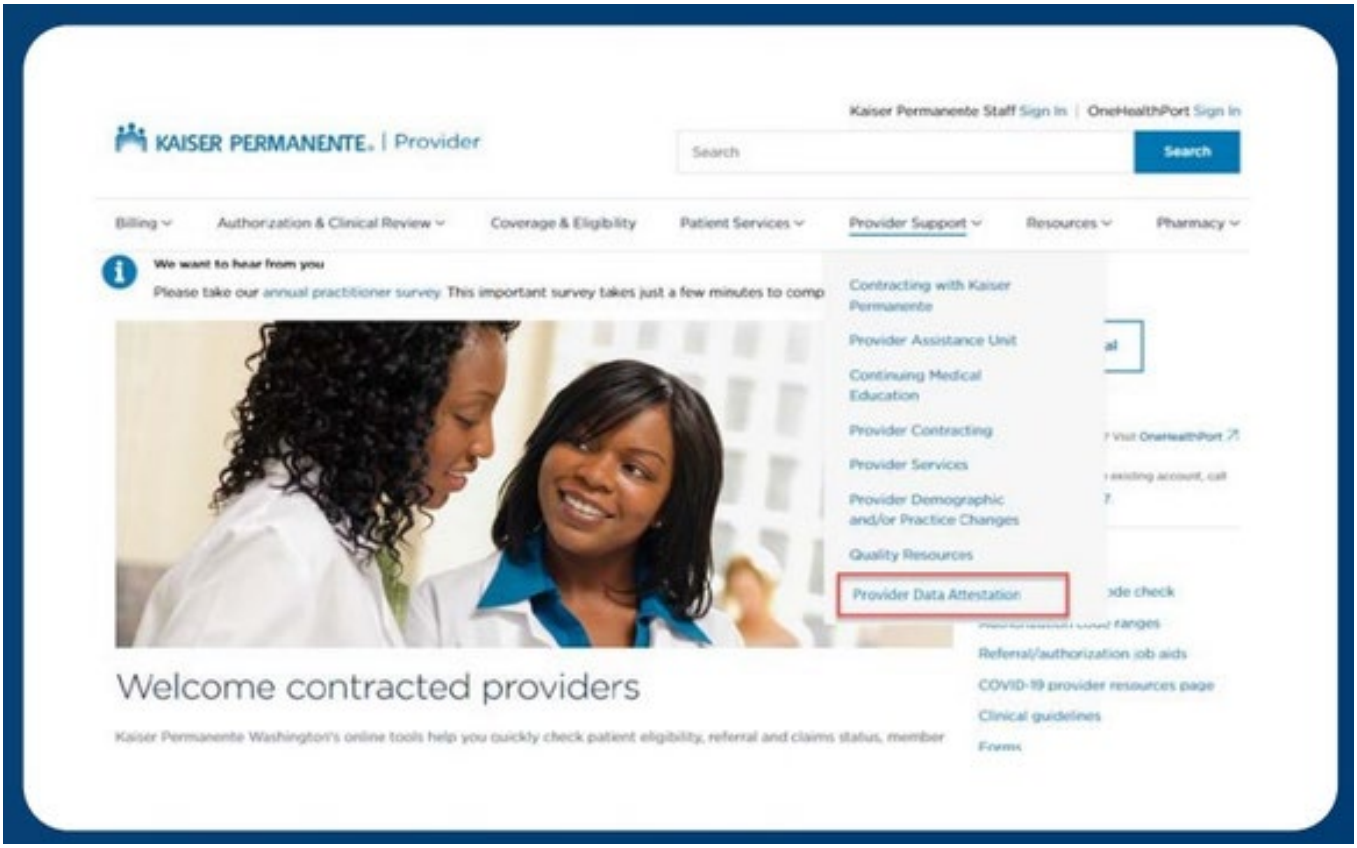
With a user-friendly interface, the Attestation Portal makes it easier to submit and manage your attestations, ensuring that provider information is up-to-date and accurate. In early 2025, we rolled this new platform out to a select group of providers in a pilot program, with plans to expand the rollout later in the year.

To help you get started, we've provided the following resources outlining the portal's features and functionalities:

- Kaiser Permanente Attestation Portal Introductory Video.
- Kaiser Permanente Attestation Portal Guide

Should you have any questions about the Attestation Portal or other Online Affiliate features, please visit the Online Affiliate Support Site at https://kpnationalclaims.my.site.com/support/s/.

Thank you for your continued partnership and commitment to maintaining accurate provider information. We look forward to working with you to streamline and enhance our processes.



Reminder: Provider Disputes & Appeals Process

Providers who disagree with a decision not to pay a claim in full or in part may file a payment dispute request. Payment disputes must be filed within 180 days of the date of the denial and/or Explanation of Payment.

Providers should include the reason for the dispute along with all necessary documentation.

Providers may submit disputes through Online Affiliate or in writing via mail.

Submitting disputes via Online Affiliate:

- Providers can access Online Affiliate or request access to the platform by navigating to the "Online Provider Tools" section of our Community Provider Portal at www.kp.org/providers/mas.
- For help with Online Affiliate or to contact our support team, please access the Online Affiliate Support Site at https://kpnationalclaims.my.site.com/support/s/.

More information about filing disputes can be found in chapter eight of our Provider Manual as well as in the "Claims" section of our Community Provider Portal at www.kp.org/providers/mas.

Disputes in writing should be mailed to the following address:

Mid-Atlantic Claims Administration
Kaiser Permanente
PO Box 371860
Denver, CO 80237-9998x 371860

New/Emerging Technologies and Medical Coverage Policy Update: 2025

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs), and Transplant Patient Selection Criteria were approved **between November 2024 and February 2025.**

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.

2025 Utilization Management Criteria and Guidelines

A. Non-Behavioral UM Criteria and Guidelines

- **Nationally Recognized UM Criteria**
  - MCG Health 29th Edition
  - InterQual Level of Care Criteria for Transplant Services
  - Adult and Pediatric CMS Coverage Database for National (NCD) and Local Coverage Determination (LCD) for DME and Supplies
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines

  Guidelines:
  - Center for Medicare and Medicaid Services (CMS) Benefit Policy Manual, Chapter 8 Coverage of Extended Care (SNF) Services under Hospital Insurance
  - State of Maryland Department of Health and Mental Hygiene (DHMH), Maryland Medical Assistance Program, Nursing Home Transmittal #213

- **Internally Developed Criteria**
  - Medical Coverage Policies (MCP)
  - National Transplant Services (NTS) Transplant Referral Guidelines

B. Behavioral Health UM Criteria

- **Nationally Recognized UM Criteria**
  - MCG Health 29th Edition
  - InterQual for ABA Therapy
  - American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder (SUD)
  - Department of Medical Assistance Services (DMAS)

- **Internally Developed Criteria**
  - Medical Coverage Policies (MCP)

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 4*

Non-Behavioral Health
2025 Utilization Management Criteria

Referral Service Type Approved criteria sets are used in order of hierarchy	Commercial & Exchange Jurisdiction	Medicare	Medicaid (VA Medicaid and FAMIS)	Medicaid (MD HealthChoice)
Acute Rehabilitation (Inpatient)	MCG	MCG	MCG	MCG
Ambulance Services	MCP	NCD-LCD	MCG	MCP
Durable Medical Equipment (DME) and Supplies	MCP MCG NCD-LCD	NCD-LCD	MCP MCG NCD-LCD	MCP MCG NCD-LCD
Orthotics and Prosthetics	MCP MCG NCD-LCD	NCD-LCD	MCP MCG NCD-LCD	MCP MCG NCD-LCD
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services as applicable	Not Applicable	Not Applicable	EPSDT Guideline *Excludes FAMIS	EPSDT Guideline
Home Health Services	MCG	NCD-LCD	MCG	MCG
Hospice (In-patient/Out-patient)	MCG	NCD-LCD MCG	MCG	MCG
Inpatient (Concurrent Review) Services	MCG	NCD-LCD	MCG	MCG
Neonatal Care	MCG	NCD-LCD	MCG	MCG
Outpatient Services	MCP MCG	NCD-LCD	MCP MCG	MCP MCG
PT/OT/Speech	MCP MCG	NCD-LCD MCP MCG	MCP MCG	MCP MCG
Skilled Nursing Facility	MCG	CMS Chapter 8 Benefit Policy Manual	MCG for Virginia FAMIS only	MCG Transmittal 213
Transplant Services	National Transplant Network (NTN) Services Referral Guideline InterQual® Criteria: Transplant and Hematology Oncology	National Transplant Network (NTN) Services Referral Guideline InterQual® Criteria: Transplant and Hematology Oncology	National Transplant Network (NTN) Services Referral Guideline InterQual® Criteria: Transplant and Hematology Oncology	National Transplant Network (NTN) Services Referral Guideline InterQual® Criteria: Transplant and Hematology Oncology

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 5*

Behavioral Health
2025 Utilization Management Criteria

Referral Service Type Approved criteria sets are used in order of hierarchy	Commercial & Exchange Jurisdiction	Medicare	Medicaid (VA Medicaid and FAMIS)	Medicaid (MD HealthChoice)
Applied Behavioral Analysis (ABA)	MCG Determination of Medical Necessity InterQual® Determination of Hours/Units of Service ***March 2024 Release, BH: Behavioral Health Services; Applied Behavior Analysis Program***	MCG Determination of Medical Necessity InterQual® Determination of Hours/Units of Service ***March 2024 Release, BH: Behavioral Health Services; Applied Behavior Analysis Program***	DMAS Determination of Medical Necessity InterQual® Determination of Hours/Units of Service ***March 2024 Release, BH: Behavioral Health Services; Applied Behavior Analysis Program***	Not Applicable
Behavioral Health: Substance Use Disorder (SUD) specifically *All Levels, i.e., IP, OP, RTC, PHP, IOP	MCG /ASAM	MCG	ASAM	Not Applicable
Behavioral Health: Inpatient	MCG	MCG	MCG	Not Applicable
Behavioral Health: Outpatient ***Excludes SUD**	MCP MCG	MCG	MCG	Not Applicable
Behavioral Health: Partial Hospitalization ***Excludes SUD**	MCG	MCG	DMAS	Not Applicable
Behavioral Health: Mental Health Services (MHS) Covered Services	Not Applicable	Not Applicable	DMAS (see below for list of MHS services)	Not Applicable

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 6*

Mental Health Covered Services – Virginia Medicaid and FAMIS

Mental Health Services (MHS)	Criteria, Service Auth (SA) or Registration (R)
MH Case Management	Registration Only
MH Peer Support - Individual	DMAS SA after Initial Registration
MH Peer Support - Group	DMAS SA after Initial Registration
Mobile Crisis Response	DMAS Registration
23 Hour Crisis Stabilization	DMAS Registration
Community Stabilization	DMAS SA after Initial Registration
Residential Crisis Stabilization	DMAS after Initial Registration
Assertive Community Treatment	DMAS Service Auth
Intensive In-Home	DMAS Service Auth
Therapeutic Day Treatment for Children School Day	DMAS Service Auth
Therapeutic Day Treatment for Children After School	DMAS Service Auth
Therapeutic Day Treatment for Children Summer	DMAS Service Auth
Partial Hospital Program	DMAS Service Auth
Mental Health Skill Building Services	DMAS Service Auth
Psychosocial Rehab	DMAS Service Auth
Applied Behavior Analysis	DMAS Service Auth
Intensive Outpatient Program	DMAS Service Auth
Functional Family Therapy	DMAS Service Auth
Multisystemic Therapy	DMAS Service Auth

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 7*

Addiction Recovery and Treatment Services (ARTS)	Criteria, Service Auth (SA) or Registration (R)
ARTS 0.5 Early Intervention/SBIRT	No referral needed
ARTS 1.0 CD Outpatient Services	No referral needed
ARTS 2.1 CD Intensive Outpatient (IOP)	ASAM SA for BH IOP
ARTS 2.5 CD Partial Hospital Program (PHP)	ASAM SA for BH PHP
ARTS 3.1 Clinically Managed Low Intensity Residential	ASAM SA for BH RTC
ARTS 3.3 Clinically Managed Population Specific High Intensity Residential	ASAM SA for BH RTC
ARTS 3.5 Clinically Managed High Intensity Residential	ASAM SA for BH RTC
ARTS 3.7 Medically Monitored Intensive Inpatient	ASAM for Inpatient Service
ARTS 4.0 Medically Managed Intensive Inpatient	ASAM for Inpatient Service
CD OP Med Management - Addiction Medicine	No referral needed
OTP/OBAT Opioid Treatment Program/Preferred Office Based Addiction Treatment	No referral needed

Sources:

1. DMAS mandating use of ASAM criteria as of April 1, 2017 in concert with the implementation of ARTS benefits that were previously carved out
2. Federal EPSDT Medical Necessity Guidelines https://www.medicaid.gov/Medicaid-CHIP-Program-%20%20Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html
3. * Source: VA Medicaid Contract Medallion 4.0 and FAMIS
4. Department of Medical Assistance Services (DMAS) criteria for Mental Health Services (MHS) formerly called as CMHRS- Community Mental Health Rehabilitative Services)

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 8*

New and Updated Medical Coverage Policies

A. 2025 Transplant Clinical Standards

1. Liver Transplant Patient Referral Guidelines
2. Intestinal, Intestinal/Liver Transplant Patient Referral Guidelines
3. Kidney Transplant Patient Referral Guidelines
4. Pancreas Transplant Alone and Pancreas after Kidney Transplant (PTA/PAK) Patient Referral Guidelines
5. Simultaneous Pancreas Kidney (SPK) Transplant Patient Referral Guidelines
6. Blood and Marrow Transplant Patient Referral Guidelines
7. Heart Transplant Patient Referral Guidelines
8. Use of Mechanical Circulatory Support Devices as a Bridge to Cardiac Transplant

B. Medical Coverage Policy

1. Laparoscopic Magnetic Sphincter Augmentation for Gastroesophageal Reflux Disease (LINK Reflux Management System)_New 2024

Effective date: 11/21/2024

2. Eye Prosthesis_NEW

Effective date: 11/21/2024

3. Ambulance Transportation

Effective date: 11/21/2024

- References were updated

4. Gender Affirming Procs - MD, VA & Feds

Effective date: 11/21/2024

- Section III-D #2. Genital Surgery Clinical Review Criteria - Updated
- Section IV-E. Mastectomies with Chest Reconstruction Clinical Review Criteria
  - Language updated from terminology of “referral” to “letter of recommendation”
- References were updated

5. Gender Affirming Procs – DC Situs

Effective date: 11/21/2024

- Section III-D #2. Genital Surgery Clinical Review Criteria - Updated
- Section IV-E. Mastectomies with Chest Reconstruction Clinical Review Criteria
  - Language updated from terminology of “referral” to “letter of recommendation”
- Section V. Male to Female Chest Surgery, Breast Augmentation Clinical Review Criteria - Updated
- References were updated

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 9*

6. Vision Therapy

Effective date: 11/21/2024

- References were updated

7. Matrix-Induced Autologous Chondrocyte Implantation (MACI)

Effective date: 11/21/2024

- Section IV – B #2. Clinical Indications for MACI Referral
    - Patient's skeletally maturity with documented closure of growth plates (age greater than 15 years old) as a patient requirement for MACI changed to "greater than 10 years old).
- References were updated

8. NPWT (Wound Vacuum)

Effective date: 12/23/2024

- Grammatical change(s)
- References were updated

9. Chiropractic Therapy

Effective date: 12/23/2024

- Section III. Clinical Indications for Referral - Updated
- Grammatical change(s)
- References were updated

10. Viscosupplementation

Effective date: 12/23/2024

- References were updated

11. Sensory Integration Treatment (SIT)

Effective date: 12/23/2024

- Grammatical change(s)
- References were updated

12. Mechanical Stretching Device

Effective date: 12/23/2024

- Section V. Limitations/Exclusions (Subsections B & C) – Updated
- Grammatical change(s)
- References were updated

13. Hair Prosthesis

Effective date: 11/21/2024

- Medicare does not currently have a NCD for Hair Prosthesis
- LCDs/LCAs currently do not exist
- References were updated

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 10*

14. Orthosis, Upper Extremity

- Grammatical change(s)
- References were updated

15. Infertility Procedure and Treatment

- Section IV: Definition of Infertility (Subsections H, I, and K) – Updated
- Section VI: Initial Specialist Consultation Referral Female (Subsections B, D, and E) – Updated
- Section VII: Female Treatment (Subsection B) – Updated
- Section XI: Definitions (Subsection D) – Updated
- References were updated

16. Prostheses, Lower Extremity - NEW

Effective date: 12/23/2024

17. Genetic Testing

Effective date: 01/22/2025

- Section III (Subsections B & C #6) - Updated
- References were updated

18. Corneal Collagen Cross Linking

Effective date: 01/22/2025

- References were updated

19. Biofeedback

Effective date: 01/22/2025

- References were updated

20. Hippotherapy

Effective date: 01/22/2025

- References were updated

21. Routine Foot Care

Effective date: 01/22/2025

- References were updated

22. Virtual Colonoscopy: DC, VA, and Feds

Effective date: 01/22/2025

- References were updated

23. Virtual Colonoscopy: MD

Effective date: 01/22/2025

- References were updated

24. Orthosis Lower Extremity/Foot

Effective date: 01/22/2025

- Grammatical changes(s)
- Part D: Therapeutic Shoes – Updated
    - Section V: Documentation of Orthosis Referral (Subsection B)
- References were updated

25. Dental Services outside of medical benefit

Effective date: 02/27/2025

- Update on Utilization Alert (Bullets 2 & 3)
- References were updated

26. Fetal Echocardiogram

Effective date: 02/27/2025

- References were updated

27. Cranial Remodeling Bands and Helmets

Effective date: 02/27/2025

- References were updated

28. Home UVB Phototherapy

Effective date: 02/27/2025

- Section III: Clinical Indications for Referral (Subsection 6)
- Section IV: Therapeutic and Administrative Measures Prior to Referral for Home Therapy (Subsection B)
- References were updated

29. Homecare

Effective date: 02/27/2025

- Grammatical change(s)
- References were updated

30. Blepharoplasty

Effective date: 02/27/2025

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from page 12*

31. Mechanical Stretching Device

Effective date: 02/27/2025

- Section V: Limitations/Exclusions
- Grammatical change(s)
- References were updated

32. Pectus Excavatum Surgery

Effective date: 02/27/2025

- References were updated

33. Electric Lift

Effective date: 02/27/2025

- Section III: Referral (Subsection 8)
- Section IV: Limitations/Exclusions

34. Pharmacogenetic Testing for Behavioral Health Disorders - Retired

Effective date: 02/27/2025

- MCG criteria to be used moving forward

New and Emerging Technologies

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): 11/26/2024
Approved by the Regional Utilization Management Committee (RUMC): 12/23/2024

INTC Presentation Date	National Interregional New Technology Committee (INTC) Conclusion http://cl.kp.org/pkc/national/cpg/intc/specialty.html	KP-MAS Recommendation - Adopt the use of technology Sufficient evidence	KP-MAS Recommendation – Do not recommend Inconclusive or Insufficient evidence
Sufficient evidence: Quality and quantity of evidence is good, should be used in most cases where indications are met.			
Insufficient evidence: Quality and/or quantity is low or moderate, further research or trials are needed. Can be used in selected cases but not for general use for this diagnosis or indication.			
8/23/2024	Digital Psychological Applications for Patients with Irritable Bowel Syndrome		X
8/23/2024	Arthroscopic Deployment of a Resorbable Shoulder Spacer for Massive Rotator Cuff Tendon Tears (InSpaceTM Subacromial Tissue Spacer System, Stryker)		X

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 guidelines 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:

Christine Assia, M.D.
Physician Director of Medical Policies, Benefits and Technology Assessment
Emergency Physician, Advanced Urgent Care/ECM/UMOC
Christine.C.Assia@kp.org

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

Marisa R Dionisio, RN
Marisa.R.Dionisio@kp.org

2025 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.

Kaiser Permanente's Mid-Atlantic Headquarters has Moved

As of January 6, 2025, Kaiser Foundation Health Plan of Mid-Atlantic Staties, Inc.'s (Kaiser Permanente) regional headquarters has moved to a new location at the address below:

4000 Garden City Drive
Hyattsville, MD 20785

Going forward, we ask that you direct all pertinent written correspondence to the new address.

We have updated our documentation to reflect this change including our provider manuals – Commercial Manual (Chapter 10), Virginia Medicaid Manual (Chapter 10), and Maryland HealthChoice Manual (Section I; Section VI; Section VII). You may access these manuals on our Community Provider Portal at www.kp.org/providers/mas.

Kaiser Permanente's leaders, employees, and physicians are embedded within the communities we serve, with administrative offices in each of our 37 medical centers, 2 rehabilitation centers, and other administrative buildings throughout Maryland, Virginia, and the District of Columbia. We are committed to the communities we serve and are proud to have a robust presence throughout the Mid-Atlantic region.

DMAS Required PRSS Enrollment

In accordance with Federal requirements in the 21st Century Cures Act, all Virginia Medicaid managed care providers must enroll directly with DMAS through PRSS. Licensed Providers and Healthcare Professionals in the Commonwealth of Virginia can register with PRSS at the following link: https://virginia.hppcloud.com/. Providers must include valid National Provider Identifier (NPI), Tax ID, and Office Location information for successful enrollment.

Providers who fail to enroll in PRSS will be terminated as Virginia Medicaid MCO network providers and will no longer receive payments for Virginia Medicaid members enrolled in managed care.

Should you have any questions, please call the PRSS Provider Enrollment Helpline at 804-270-5105 or email vamedicaidproviderenrollment@gainwelltechnologies.com.

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 16*

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 17*

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.

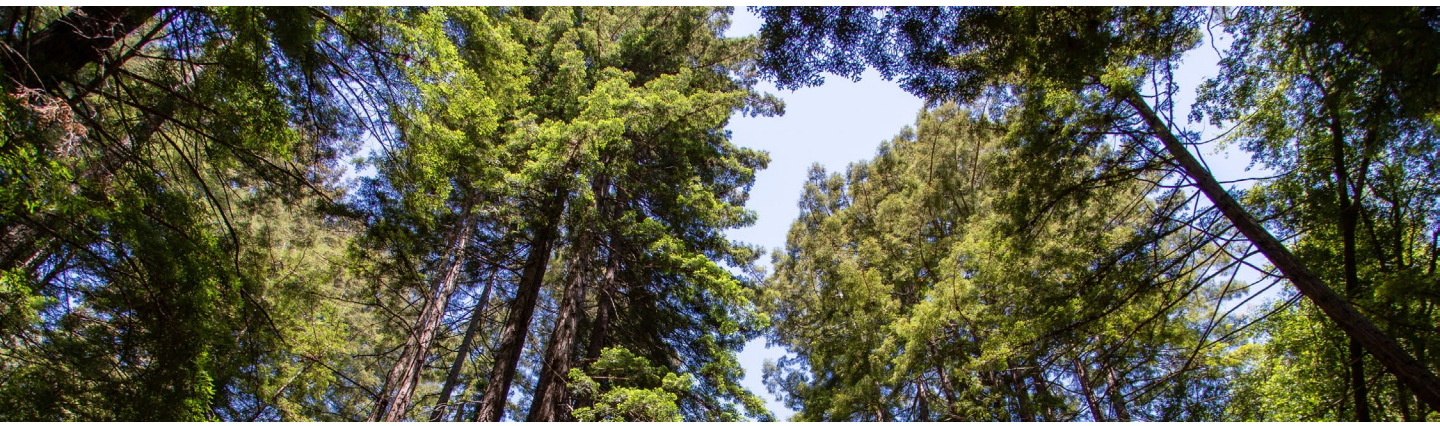
e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.

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 18*

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.

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, large print, or audio**. 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 patients 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.

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.

Diversity – *Continued from page 20*

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 **kp.org/providers/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 Access to Health Education Materials

Kaiser Permanente physicians and network providers have access to all health education materials to provide to patients as part of the After-Visit Summary and secure email communications, or to supplement discussion from the patient visit.

Content can be viewed through the centralized internal “Clinical Library” which is an electronic inventory of health education information that can be used for all visit types. Health education content and links to education videos, education webpages, and other resources are also embedded into KP HealthConnect for inclusion in the member After Visit Summary, sent via secure messaging, or mailed directly to patient’s addresses. For health education programs, providers can:

- Direct members to kp.org/appointments to register for classes.
- Use KP HealthConnect, After Visit Summaries, or hard copy flyers to provide members with information on how to self-register for programs.

Additional information on health education programs, tools, and resources is available by:

- Visiting kp.org/healthyliving/mas.
- Contacting the Health Education automated line at 301-816-6565 or toll-free at 800-444-6696.

Appointment Wait Times Standards

For your awareness, state and national regulatory bodies have established appointment wait times standards.

It's vital that our providers have adequate appointment availability so that we can maintain these medical care accessibility standards.

We conduct provider appointment availability surveys via mail or phone call so that we can report the results to regulators.

Your participation in conducting these reviews for your practice/group is critical.

The charts below lay out the appointment wait times standards (current as of the March 2025) that we are required to track. You can also find these standards included in our Provider Orientation document, which is located in the "Training Resources" section of our Community Provider Portal at www.kp.org/providers/mas.

Commercial – State of Maryland (MIA)

Appointment Type	Standard
Urgent care for medical services	Within 72 Hours
Inpatient Urgent Care for Mental Health Services	Within 72 Hours
Inpatient Urgent Care for Mental Health Services	Within 72 Hours
Outpatient Urgent Care for Mental Health Services	Within 72 Hours
Outpatient Urgent Care for Substance Use Disorder Services	Within 72 Hours
Routine Primary Care	15 Calendar Days
Preventive Care/Well Visit	30 Calendar Days
Non-urgent Specialty Care	30 Calendar Days
Non-urgent Mental Health Care	10 Calendar Days
Non-urgent Substance Use Disorder Care	10 Calendar Days
Urgent care for medical services	Within 72 Hours

Appointment Wait Times – *Continued from page 21*

Commercial – District of Columbia

Appointment Type	Standard
Primary Care	Within 7 Business Days
Behavioral Health Treatment, Including Substance Use Treatment	Within 7 Business Days
Prenatal Care	Within 15 Business Days
Specialty Care	Within 15 Business Days

Medicare Advantage – Centers for Medicare & Medicaid Services (CMS)

Appointment Type	Standard
Emergency or Urgent Care	Available Immediately
Non-Urgent or Emergent Services	Within 7 Business Days
Routine and Preventive Care	Within 30 Business Days

Maryland HealthChoice – Maryland Department of Health (MDH)

Appointment Type	Standard
Well-child assessments	Within 30 days of request
Initial assessment of pregnant and postpartum women and individuals requesting family planning services	Within 10 days of request
Urgent care	Within 48 hours of request
Routine and preventative primary care	Within 30 days of request
Routine specialist follow-up	Within 30 days of initial authorization from the enrollee's primary care provider, or sooner as deemed necessary by the primary care provider whose office staff shall make the appointment directly with the specialist's office
Initial visit for newborns	Within 14 days of discharge from hospital if no home visit has occurred; Within 30 days of discharge from hospital if an initial home visit occurred
Optometry	Within 30 days of request for regular appointments, including first appointment with a new or replacement provider; within 48 hours of request for urgent care
X-ray	Within 30 days for request for regular appointments; within 48 hours of request for urgent care
Lab	Within 30 days of request for regular appointments; within 48 hours of request for urgent care

Appointment Wait Times – *Continued from page 22*

Virginia Medicaid – Department of Medical Assistance Services (DMAS)

Appointment Type	Standard
Emergency Services, including Crisis Services	Immediately upon the Member's request
Routine Primary Care Services	Within thirty (30) calendar days of the Member's request Note: Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a medical condition if the schedule calls for visits less frequently than once every thirty (30) days, or for routine specialty services like dermatology, allergy care, etc.
Maternity Care	Prenatal care appointments must be made available to pregnant Members as follows: • First trimester – Within seven (7) calendar days or request • Second trimester – Within seven (7) calendar days of request • Third trimester – Within seven (7) calendar days of request • High-Risk Pregnancy – Within three (3) business days of identification of high-risk to the Contractor or maternity provider, or immediately if an emergency exists
Mental Health Services	Behavioral health appointments must be made available as expeditiously as the Member's condition requires and within no more than five (5) business days from the Contractor's determination that coverage criteria is met
Urgent Medical Conditions	Within 24 hours of the Member's request

Provider Directory Validation Surveys

The Kaiser Permanente provider directory validation survey is designed to adhere to the Center for Medicare and Medicaid Services (CMS) regulations and the new Consolidated Appropriations Act of 2021, also known as the No Surprises Act. The objectives of both are to ensure that members have access to accurate provider information. The survey not only addresses directory accuracy but also accuracy of our other provider data systems.

In accordance with these regulations, provider data must be validated at least every 90 days. Therefore, Kaiser Permanente sends this provider directory validation survey each quarter, and providers are required to respond. Instructions are contained along with the survey, and **providers are reminded to return all pages with their response before the stated deadline.**

If you have any questions or concerns, please contact Provider Experience at 1-877-806-7470 or email us at provider.demographics@kp.org with the subject line: "Provider Directory Validation."

Thank you for communicating all data changes in a timely manner. We appreciate your cooperation!

Keeping Your Provider Data Updated

Keeping Kaiser Permanente updated with changes, adds, and terminations to your practice will ensure that our directory and data systems are accurate and help us provide an excellent healthcare experience to our members.

It is imperative that you ensure your information is current by notifying us in a timely manner of demographic changes, provider terminations, and/or provider additions to your practice. **If a provider is being added to your practice, your information must be communicated and updated in our system before treating our members.**

Please Note – When adding a new location to your current contractual agreement, the specialties below will require a credentialing application:

- Acute Care Hospital
- Behavioral Health Care Facility
- Clinical Laboratory
- Community Health Center/Community Service Boards
- Comprehensive Outpatient Rehabilitation Facility
- Dialysis Center
- Durable Medical Equipment
- Free-Standing ASC
- Home Health/Home Visiting Agency
- Hospice
- Long-Term Services or Support (LTSS)
- Physical Therapy & Speech Pathology Facility
- Portable X-Ray Supplier
- Skilled Nursing Facility
- Sleep Study Center
- Urgent Care Facility

More information about these requirements including the credentialing and re-credentialing process can be found in Kaiser Permanente's provider manuals – Commercial Manual (Chapter 10); Virginia Medicaid Manual (Chapter 10); Maryland HealthChoice Manual (Section VII). All our manuals can be accessed on the "Provider Information" page of our Community Provider Portal at www.kp.org/providers/mas.

Please utilize the provider update form to submit updates throughout the year. For your convenience, the form can be found on the following pages as well as on our Community Provider Portal at the following link:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/mas/ever/sample-add-change-letter-en.pdf.

All updates should be submitted to Provider Experience via one of the following methods:

Fax: 855-414-2623
Email: Provider.Demographics@kp.org
Mail: Kaiser Permanente
Provider Experience
4000 Garden City Drive
Hyattsville, MD 20785

Sample Provider Data Update Form Letter – Page One

Company Letterhead Logo

<<Date>>

Requestor:
Requestor's Correspondence Address:
Requestor's Phone #:
Email:
Tax ID#:
Effective date of change(s):

Reason for the request:

PLEASE DELETE SECTIONS NOT NEEDED BEFORE SUBMITTING

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)

Adding a new practice location

The following details must be included in your request:

- Address with City, State, and Zip Code
- Phone and Fax
- Tax ID
- Group NPI
- Billing/Payment Address
  - Must have Billing NPI- or list if it is the same as the group NPI
- Credentialing application for the following specialties is required:
  - Acute Care Hospital
  - Behavioral Health Care Facility - Ambulatory, Inpatient, Residential Treatment for BH and Substance Abuse, Applied Behavioral Analyst (ABA), Methadone Maintenance Program, Chemical Dependency Program
  - Clinical Laboratory
  - Community Health Center/ Community Service Boards
    - Rural Health Clinic
    - Federal Qualified Health Center
  - Comprehensive Outpatient Rehabilitation Facility
  - Dialysis Center- End Stage Renal Disease Providers
  - Durable Medical Equipment
  - Free-Standing ASC
  - Home Health/Home Visiting Agency
  - Hospice
  - Long-Term Services or Support (LTSS)
  - Physical Therapy & Speech Pathology Facility
  - Portable X-Ray Supplier
  - Skilled Nursing Facility
  - Sleep Study Center
  - Urgent Care Facility

Sample Provider Data Update Form Letter – Page Two

Company Letterhead Logo

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 the primary practice location
- Indicate whether the 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)

Email the request to the Provider Demographics Department at Provider.Demographics@kp.org or fax to 855-414-2623.

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