KAISER PERMANENTE®

This document is effective 05/09/2023 and is subject to revisions.

NATIONAL CLAIMS ADMINISTRATION

The content of this FAQ pertains to members of Kaiser Foundation Health Plan, Inc. and its subsidiary health plans ("Kaiser Permanente"). For members covered by Kaiser Permanente Insurance Company, please see the separate COVID-19 FAQ for KPIC Claims Administration.

COVID-19: Claims Processing FAQ for Providers | V21Updated as of 05/09/2023

The U.S. Department of Health and Human Services (HHS) announced the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, will expire at 11:59 PM on May 11, 2023.

1. **Will timely filing requirements for claims be waived, if providers' claims submissions are delayed due to impacts from COVID-19 after May 11, 2023?**

   No, Kaiser Permanente will not waive timely filing requirements, except when regulators have issued orders explicitly suspending or modifying the requirements (and then only for the required period).

2. **Will Kaiser Permanente waive the requirement for authorization for some or all claims for dates of service beginning May 12, 2023?**

   Covid-19 testing and treatment (therapeutics) received in and out of network will follow applicable network processes, policies and authorization requirements, except where regulators have issued orders explicitly modifying the requirements.

3. **Should providers collect cost sharing for COVID-19 testing or treatment (therapeutics) services from our members?**

   Providers should not collect cost sharing for diagnostic and screening (employment, school/camp, travel and at-home) testing for dates of service between March 5, 2020 through May 11, 2023 for all lines of business.

   Providers should not collect cost sharing for treatment (therapeutics) services applied for dates of service (admissions) from April 1, 2020 through July 31, 2021. After July 31, 2021, limited exceptions may have applied.

   Beginning with dates of service May 12, 2023, for CA Members, Health & Safety Code 1342.2 will apply for services related to COVID-19 diagnostic and screening, testing, and treatment (therapeutics).

   Beginning with dates of service May 12, 2023, for Members outside CA, COVID-19 diagnostic and screening, testing and treatment (therapeutics) will be covered under the applicable plan

cost-sharing and other terms and conditions for coverage, for Medicare and Commercial members.

	In Network	Out of Network
Commercial	**Testing, Treatment (therapeutics)**	
CA	Waive Cost Share	Waive cost share for dates of service from May 12, 2023 through November 11, 2023.
Outside CA	Applicable plan cost sharing rules apply	No coverage unless emergency or urgent care services, or member's plan covers out-of-network services.

	In Network	Out of Network
Medicare	**Testing, Treatment (therapeutics)**	
All Members	Applicable plan cost sharing rules apply	Applicable plan cost sharing rules apply

	In Network	Out of Network
Medicaid	**Testing, Treatment (therapeutics), Vaccine**	
CA – Medi-Cal	Waive Cost Share, typically $0.00,	Waive cost share, typically $0.00, for dates of service from May 12, 2023 through September 30, 2024.
Outside CA	Waive Cost Share for dates of service from May 12, 2023 through September 30, 2024.	Waive Cost Share for dates of service from May 12, 2023 through September 30, 2024.

4. What are the requirements for submitting COVID-19 related claims?

Please use the appropriate COVID-19 codes for testing (diagnosis and screening) and treatment (therapeutics) that have been established for COVID-19. Please distinguish between diagnosis and screening (employment, school/camp, travel and at home) testing. For more information related to CDC's ICD-10-CM Official Coding and Reporting Guidelines October 1, 2022 – September 30, 2023, ICD-10-CM Guidelines April 1 2023 FY23 (cms.gov). If you do not charge a cost share because you are providing a service related to the COVID-19 test, please utilize the CS modifier on your claim to indicate this when appropriate.

5. Can providers submit claims for authorized office visits that were converted to telehealth visits?

We appreciate your efforts to continue to limit the spread of COVID-19 in the community. You may convert authorized office visits to telehealth visits, where clinically appropriate and technology is available, without seeking additional authorization from Kaiser Permanente.

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.

All members (Commercial, Individual and Family, Medicare and Medicaid) are covered for telehealth visits. While most members do not pay cost sharing for telehealth visits, please use Online Affiliate to confirm the cost sharing for High Deductible Health Plan/HSA-qualified members.

Kaiser Permanente will follow Medicare rules regarding telehealth visits, as outlined in: "Medicare Telehealth Frequently Asked Questions," dated March 17, 2020.

MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET | CMS

Reimbursement for telehealth visits will follow regulatory guidelines. For eligible telehealth visits, please use Place of Service (POS) 02 and Modifier 95 when submitting your professional (CMS) claims for these visits.

6. **How do providers submit additional information (requested documents)?**
Kaiser Permanente provides two solutions to submit additional information requested for claims adjudication. Providers may mail to the address listed on the request letter or may utilize the online affiliate portal, see detailed information on this process below.

Kaiser Permanente has a capability available for providers to send requested documents, online via the provider On-Line Affiliate (OLA) link portal. A user account is required to use this feature.

If you already registered for Online Affiliate access, you may log in to utilize Kaiser Permanente's recently launched new capability that allows you to submit documents by signing on with the following link: https://epiclink-nc.kp.org/ncal/epiclink

If your provider group is not enrolled to utilize Online Affiliate, please click on the following link for further instructions on how to register: http://info.kaiserpermanente.org/html/cpp_nca/onlineaffiliate.html?

If your provider group is not enrolled to utilize Online Affiliate, please click on the following link for further instructions on how to register: http://providers.kaiserpermanente.org/html/cpp_ga/onlineaffiliateaccess.html?

7. **How can providers submit provider disputes online?**

Kaiser Permanente has a capability that is available for providers to send requested documents, online via the provider On-Line Affiliate (OLA) link portal. A user account is required to use this feature.

If you already registered for Online Affiliate access, you may log in to utilize Kaiser Permanente's recently launched new capability that allows you to submit documents by signing on with the following link: https://epiclink-nc.kp.org/ncal/epiclink

If your provider group is not enrolled to utilize Online Affiliate, please click on the following link for further instructions on how to register: http://info.kaiserpermanente.org/html/cpp_nca/onlineaffiliate.html?

8. **What is the status of the temporary suspension of "Medicare Sequestration" under the CARES Act and the Consolidated Appropriations Act?**

The CARES Act: Sec. 3709. Adjustment of Sequestration 2020 states that during the period beginning on May 1, 2020 and ending on December 31, 2020, the Medicare programs under title XVII of the Social Security Act (42 U.S.C. 1395 et seq.) shall be exempt from any reduction under any sequestration order issued before, on, or after the date of enactment of this Act. The Consolidated Appropriations Act 2021 extended the end date of the temporary suspension of sequestration to March 31, 2021. An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, signed into law on April 14, 2021, extends the suspension period to April 1, 2022. Cuts of 1% were imposed from April 1, 2022 – June 30, 2022. As of July 1, 2022 cuts of 2% were reimposed.

9. **May providers bill on an institutional UB-04 claim form for telehealth services?**

Notwithstanding CMS guidelines, Kaiser Permanente may allow certain institutional providers (e.g., those providers who typically bill on a UB-04 institutional claim form) to perform telehealth visits under certain circumstances. Please contact the applicable Kaiser Permanente clinical group for information specific to your organization.

10. **Is KP modifying Medicare rates in accordance with the CARES Act?**

In compliance of section 3710 of the CARES Act, Kaiser Permanente will increase the payment made to a hospital for COVID-19 admissions by a 20% increase to the DRG weight starting on January 27, 2020 for Medicare and March 27, 2020 for Commercial through May 11, 2023, as declared by the HHS secretary under the PHSA Section 319.

The 20% add on applies to providers that have Medicare contract rates using pricing calculated by the MS DRG (weight).

For claims using a COVID related ICD-10 diagnosis code, and using the Medicare weighting, Kaiser will reimburse with the 20% weight increase for discharges between April 1, 2020 – May 11, 2023.