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 2025

Contents

Kaiser Permanente Transitioning to New Vendor for Home Medical Equipment

Kaiser Permanente is making it easier for our members who use medical equipment and supplies at home. **Effective December 1, 2025, we are transitioning from Apria Healthcare to AdaptHealth for Home Medical Equipment and Supplies (HME)** as part of our commitment to continually provide the highest quality care, services, and support.

AdaptHealth allows patients to place resupply orders via email, text message, mobile application, or through an online portal. This self-service ordering system will provide our patients with order history, real-time alerts, confirmation of delivery, and the opportunity to connect with a patient support representative 24 hours a day.

Patients who may be impacted by this change will be notified through a series of communications from both Kaiser Permanente and AdaptHealth. **There will be no need for patients to return anything to Apria** as AdaptHealth will take ownership of all Apria equipment currently in place.

Current Apria patients will receive instructions on how to set up an account with AdaptHealth for:

1. Ordering new or replacement equipment/supplies.
2. Changing payment to AdaptHealth (e.g., making one time or recurring auto-payments).

This transition will be rolled out following the schedule below:

- **Dec 1, 2025:** Georgia, Mid-Atlantic States
- **Feb 1, 2026:** Southern California, Northwest, Colorado
- **March 1, 2026:** Northern California, Washington
- **April 1, 2026:** Hawaii

Support and information on getting started will be available on AdaptHealth's website for Kaiser Permanente members: https://adapthealth.com/kaiser/. Additional questions or concerns should be directed to Member Services at 800-777-7902.

Skilled Nursing Facilities Quality Metrics Reporting

As part of our commitment to maintaining NCQA accreditation and supporting high-quality care, we are responsible for sharing key program information with our provider network. On October 31, 2025, Kaiser Permanente mailed contracted skilled nursing facilities (SNFs) information outlining a new reporting requirement.

Effective, January 1, 2026, all contracted SNFs must submit their quality metrics no later than the 15th of each month to the Kaiser Permanente Foundation Health Plan of the Mid-Atlantic States, Inc.'s Quality Department, with the first submission due by January 15, 2026, for the month of December 2025. On the next page, please see an example of the Provider Score Card that facilities will use to document their quality metrics.

SNFs should submit their Provider Score Card to the Kaiser Foundation Health Plan of the Mid-Atlantic State's Quality Department via one of the following two links on no later than the 15th of each month**:**

Non-CareStat Facilities
https://forms.office.com/r/eFER80bS3D

CareStat Facilities
https://forms.office.com/r/4z152RYuaa

This requirement is one piece of our SNF Quality Oversight program, which includes the following:

- SNF Quality Metric reporting requirements for the Provider Score Card to provide insight into the Provider's ability to meet the Quality Standards.
- Joint Operations Committee (JOC) meetings with our contracted SNFs to foster collaboration, review operational performance, and ensure that member care aligns with our shared clinical, quality, and utilization goals.
- Corrective Action Plan (CAP) process for any contracted SNF with a Centers for Medicare & Medicaid Services (CMS) Overall Quality Rating of less than 3 stars.

These oversight mechanisms, which are effective January 1, 2026, reflect our shared accountability for member safety and outcomes, and our commitment to working collaboratively toward high-quality post-acute care delivery.

Our Provider Manuals will be updated to reflect these changes on January 1, 2026. You can find all our Provider Manuals, resources, and educational materials on our Community Provider Portal at www.kp.org/providers/mas.

If you have any questions regarding this material or your facility's quality scorecard, please contact the Kaiser Permanente Health Plan of the Mid-Atlantic States' Quality Department via email at kpmas_qualityimprovementspecialists@kp.org.

Transition to PDPM Payment Methodology for Virginia Medicaid Skilled Nursing Facilities

On October 1, 2025, the Virginia Department of Medical Assistance Services (DMAS) transitioned from Resource Utilization Groups, Version IV (RUGS-IV) to the Patient-Driven Payment Model (PDPM) for case mix adjustment of rates and payments for skilled nursing facilities.

Medicaid reimbursement for skilled nursing facilities now follows the PDPM methodology; this affects only the Direct Care portion of the per diem rate. The new Direct Care values and case mix indices for each PDPM code are available on the DMAS website at https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/nursing-facilities/. Facilities should update their billing processes to include these codes and adhere to billing rules per DMAS guidelines.

The PDPM payment methodology applies to services rendered on or after October 1, 2025, and Kaiser Permanente's systems have been configured to support this change. **Claims submitted using the old payment methodology will be denied.**

For additional information and resources regarding this transition, please visit the DMAS website at www.dmas.virginia.gov.

Maryland Dual Special Needs Plan (DSNP) – Arriving January 1, 2026

Kaiser Permanente is excited to announce the upcoming launch of a new DSNP for members who are dually eligible for Medicare and Medicaid in Maryland. Available starting January 1, 2026, the DSNP offers benefits that are specifically targeted to dual eligible members, ensuring that they receive coordinated care and comprehensive support.

For members enrolled in this DSNP, Medicare will be the primary payer for most medical services. Medicaid will assist with any remaining costs as a secondary payer, including Medicare deductibles and copayments, depending on eligibility. Providers may not collect any copay or coinsurance from these members at the point of service and should bill Medicaid for any listed cost-shares, as applicable.

In addition to the copay collection requirements, providers are required to complete the DSNP Model of Care training by December 31, 2025. These training materials detail the specifics of the DSNP, including eligibility requirements, coordination of benefits, cost-sharing, and billing procedures.

Upcoming Actions and Key Dates

- Plan Launch: The new DSNP opened for applications starting on October 15, 2025. The first DSNP members will be effective in Maryland on January 1, 2026. The plan is available to new Kaiser Permanente members as well as existing members who meet eligibility criteria.
- Provider Notification: On October 31, 2025, Kaiser Permanente mailed contracted providers an announcement about the new plan.
- Provider Training: The required SNP Model of Care 2025 Training was included in the October mailing. These materials can also be found in the “Training Resources” section of our Community Provider Portal “Home” page.
- Provider Manual Updates: On January 1, 2026, Kaiser Permanente’s provider manuals will be updated with information about the DSNP to reflect these changes.

We encourage all providers to verify beneficiary eligibility and consult the forthcoming training materials for further details. As always, if you have any questions about a member’s eligibility, please contact Member Services at 800-777-7902.

We look forward to partnering with you to deliver exceptional care to our dually eligible members in the Mid-Atlantic region.

2026 Medicare Plan Changes: Provider Guidance for Member Support

To continue delivering high quality care in every market we serve, Kaiser Permanente is making thoughtful plan adjustments to ensure our Medicare program remains sustainable for 2026 and beyond. These changes include the closure of some plans effective January 1, 2026

The purpose of this article is to explain the scope of these changes so providers can help support our members through this transition.

Members with plan closures

A subset of individual Medicare plan members across Maryland, Virginia, and Washington, D.C. will be affected by plan closures and **must re-enroll in a new Kaiser Permanente Medicare plan by December 31, 2025** to avoid gaps in KP Medicare Advantage coverage and continue seeing their providers. Kaiser Permanente will continue to offer Medicare Advantage plans in all counties of our current Medicare service areas.

What Providers Need to Know

- Member Communication Timeline: In October, members received information about these changes through letters, calls, and emails with instructions to re-enroll. Providers should be ready for member questions because of this outreach.
- Enrollment Deadlines: All affected members must re-enroll by December 31, 2025, to maintain uninterrupted coverage.
- Re-enrollment Options:
  - Online: kp.org/medicare
  - Phone: (877) 370-8714
- Providing Support: Providers should be prepared to direct members who have Medicare health plan questions or are ready to enroll to visit kp.org/medicare or call Kaiser Permanente at (877) 370-8714 (TTY 711)
- **Providers will not be expected to proactively communicate with patients about these changes.**

Kaiser Permanente recognizes the critical role that providers play in helping members navigate these transitions and minimizing any potential disruption in care. Thank you for supporting Kaiser Permanente's ongoing commitment to providing our members with integrated, high-quality, and sustainable care.

Applied Behavior Analysis (ABA) Service Authorization Change for VA Medicaid – Unbundling of Services Under CPT Code 97155

Effective October 15, 2025, the Virginia Department of Medical Assistance Services (DMAS) now requires the "unbundling" or specification of the number of units requested for each type of ABA service.

As a result of this change, providers will no longer be able to request authorizations for the total number of units for any ABA services under the 97155 CPT code. Instead, providers will be required to submit service authorizations that include units for each separate treatment procedure code (97153, 97154, 97155, 97156, 97157, 97158, and 0373T).

DMAS has released a new ABA Initial Service Authorization Request Form with updated instructions to support this change. Providers can find this form on the "Provider Resources" page of the DMAS website. While existing authorizations will continue through the authorization end date, all new authorizations with start dates of October 15, 2025, or later must be requested using the new form.

DMAS mailed ABA providers the details of this change directly, and more information can be found on the "Medicaid Memos & Bulletins" page of the DMAS website.

As a reminder, for prior authorizations related to Virginia Medicaid, Kaiser Permanente follows DMAS' guidelines, as established in the Behavioral Health Redesign for Access, Value, & Outcomes (Project BRAVO). More information about Kaiser Permanente's ABA processes can be found in the ABA chapter of our provider manuals, accessible on the "Provider Information" page of our Community Provider Portal.

Applied Behavior Analysis (ABA) Chapter Added to Commercial and Virginia Medicaid Provider Manuals

Over the past year, we have engaged our ABA providers through mailings, emails, and townhalls to review ABA procedures, policies, and educational resources. In April, we notified our ABA providers about a new ABA chapter to be added to our Commercial and Virginia Medicaid provider manuals on June 11, 2025.

This chapter reflects the ABA procedures and policies outlined in our other previously published ABA educational materials. As always, our approach to caring for our members with autism spectrum disorder (ASD) which is driven by industry-standard guidelines that incorporate medical necessity, comprehensive clinical and progress documentation, effective therapy practices, active family engagement, and valuable feedback from ABA therapists.

Providers can access our provider manuals along with the KPMAS ABA Provider Reference Guide, ABA Authorization Request Form, and other resources on our Community Provider Portal at www.kp.org/providers/mas.

Should you have any questions, please contact our ABA Program Coordinators at ariel.x.wells@kp.org or katie.x1.williams@kp.org.

Revised List of Authorization-Waived Behavioral Health CPT Codes

In 2022, to meet the growing demand for therapy and medication management for mental health conditions, we temporarily lifted the authorization requirement for initial consultations and some routine care services.

Now that we have stabilized our internal services and access, we are working with our patients to internalize their care for some services including medication management and psychiatric follow-up care to the Mid-Atlantic Permanente Medical Group (MAPMG). In June of 2025, we revised the list of auth-waived services.

The following CPT codes require authorization and were removed from the list of authorization-waived services:

CPT Code	Description
H0014	ALCOHOL AND/OR DRUG SERVICES; AMBULATORY DETOXIFICATION
G2068	MEDICATION ASSISTED TREATMENT, BUPRENORPHINE; WEEKLY
90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN
90836	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN
90838	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN
99202	OFFICE/OUTPATIENT NEW SF MDM 15-29 MINUTES
99203	OFFICE/OUTPATIENT NEW LOW MDM 30-44 MINUTES
99204	OFFICE/OUTPATIENT NEW MODERATE MDM 45-59 MINUTES
99205	OFFICE/OUTPATIENT NEW HIGH MDM 60-74 MINUTES
99211	OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP
99212	OFFICE/OUTPATIENT ESTABLISHED SF MDM 10-19 MIN
99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN
99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30-39 MIN
99215	OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40-54

Revised List of Authorization-Waived Behavioral Health CPT Codes – Continued from page 8

Pre-authorization is still not required for initial consultations and some services.
The full list of authorization-waived CPT codes and their descriptions are listed below.

Please Note – These services must be billed on a CMS-1500 form for the waive to apply as this list applies to professional services.

CPT Code	Description
H0020	ALCOHOL AND/OR DRUG SERVICES; METHADONE ADMIN/SERVICE
G2067	MEDICATION ASSISTED TREATMENT, METHADONE; WEEKLY
G2078	TAKE HOME SUPPLY OF METHADONE; UP TO 7 ADD DAY SUPPLY
S0109	5 MG ORAL DOSE OF METHADONE
90791	PSYCHIATRIC DIAGNOSTIC EVAL
90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES
90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS
90849	MULTIPLE FAMILY GROUP PSYCHOTHERAPY
90853	GROUP PSYCHOTHERAPY
90839	PSYCHOTHERAPY FOR CRISIS
90840	EACH ADDITIONAL 15” FOR CRISIS
G0176	ART THERAPY
96127	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT
99307	SUBSEQUENT NURSING FACILITY CARE (10 MIN)
99308	SUBSEQUENT NURSING FACILITY CARE (15 MIN)
99309	SUBSEQUENT NURSING FACILITY CARE (25 MIN)
99310	SUBSEQUENT NURSING FACILITY CARE (35 MIN)

If you determine that a Kaiser Permanente member requires additional care beyond the services in this list, per the *Kaiser Permanente Participating Provider Manual, Section 14.2: Referrals and Authorizations for Behavioral Health Services (*www.kp.org/providers/mas) please submit a completed **Uniform Treatment Plan** (https://k-p.li/3r4oiw4) and fax it to Behavioral Health Utilization Management at 1-855-414-1703 for authorization of continuing care.

Treatment plans will be reviewed by a member of Kaiser Permanente’s Behavioral Health Utilization Management team. A Kaiser Permanente Behavioral Health provider may contact the treating provider if further clarification of the member’s clinical status and progress of the member’s condition is necessary. Should you have any questions regarding the member’s treatment plan or if you would like to discuss special patient circumstances, please contact our Behavioral Health Utilization Management team at 301-552-1212.

Specialized services or programs such as rehabilitation, partial hospitalization programs, or procedures such as TMS or ECT will still require a completed **Uniform Treatment Plan** (https://k-p.li/3r4oiw4) sent to Behavioral Health Utilization Management for referral authorization prior to care.

Behavioral Health Medicare Telehealth Requirements

Federal legislation and regulatory activity since 2021 introduced significant changes to Medicare Fee for Service (FFS) and Medicare Advantage (MA) plan coverage rules, including telehealth MH in-person visit requirements while providing for extension of public health emergency flexibilities through September 30, 2025. As these flexibilities have ended as scheduled, all Medicare qualified providers are expected to follow the established in-person visit requirements to deliver services via telehealth.

Key Requirements:

1. **In-Person Visit Timing:** An initial in-person visit must occur within six months **before** the first telehealth MH service, followed by in-person visits at least every 12 months during ongoing treatment.
2. **Exceptions:** There are no exceptions for the initial in-person visit. However, it does not apply to patients who began telehealth treatment during the public health emergency or its extensions. In such cases, only annual in-person visits are required. There are exceptions to the 12-month visit requirement, including:
    - documented provider and patient to agree on risk and burdens of requiring an in-person visit outweighing the benefits and
    - coverage by a provider in the same specialty and group when the treating practitioner is not available.
3. **Documentation:** Providers must document clear justification in medical records when foregoing the 12-month in-person visit, including patient agreement on the applicable risks and burdens outweighing benefits.
4. **Coverage:** The 12-month in-person visit requirements may be met by another practitioner of the same specialty and subspecialty in the same group as the practitioner providing telehealth services when the latter is not available.

Health Plan's Obligations: As a Medicare Advantage organization, we are required to monitor and ensure compliance with these in-person visit requirements and are accountable for overseeing and ensuring that all contracted providers adhere to these regulations. We appreciate your cooperation in complying with these requirements to ensure that our members receive the highest quality of care. We will be reviewing any implications on our referral process for Kaiser Permanente Medicare members and assessing the Medicare members currently receiving care via your organization for in person visit requirement timing.

Should you have any questions or need assistance, please call our Behavioral Health Access Call Center at 866-530-8778, Monday through Friday from 8:30 a.m. to 5 p.m.

Credentialing and Reimbursement Reminder Regarding Associate/Resident-Level Behavioral Health Clinicians

We value the care and dedication all of our behavioral health clinicians bring to our members and appreciate their commitment to maintaining compliance with our provider manual and billing standards. This article serves as a reminder of our credentialing and reimbursement policies regarding associate/resident-level behavioral health clinicians.

Associate/Resident-level clinicians, while valuable contributors to the behavioral health field, are typically required by state regulations—such as those set forth by the state's Board of Counseling—to operate under the supervision of independently licensed providers. Due to these restrictions, they are not eligible for credentialing under our current credentialing policies.

Due to this limitation, services performed by associate/resident-level clinicians are not reimbursable, as claims listing these individuals as the rendering provider cannot be accepted. While we recognize the valuable role associate/resident-level clinicians play in care delivery, claims must reflect a credentialed and independently licensed rendering provider to be considered valid under our reimbursement policies.

We appreciate your understanding and cooperation in ensuring that all submissions and services meet our credentialing criteria. Should you need clarification or assistance, please call our Behavioral Health Access Call Center at 866-530-8778, Monday through Friday from 8:30 a.m. to 5 p.m.

Launch of Commonwealth Coordinated Care Plus (CCC+)

Effective July 1, 2025, Virginia Medicaid expanded its coverage to include Long Term Services and Supports (LTSS) through a program known as Commonwealth Coordinated Care Plus (CCC+). This new membership and benefit program serves individuals aged 65 or older, as well as disabled children and adults who meet the criteria for nursing facility-level care and who choose to receive services at home or in community settings instead of institutional placement.

Key details about CCC+ include:

- **Enrollment and Eligibility:** Enrollment in CCC+ is determined by the Virginia Department of Medical Assistance Services (DMAS), following a pre-admission screening (PAS) by an approved LTSS screening team. Members must meet specific financial and functional eligibility criteria, and DMAS will send Kaiser Permanente approved members' CCC+ enrollment information.
- **Care Coordination:** Each CCC+ member will be assigned a dedicated Care Coordinator through Kaiser Permanente to facilitate access to necessary services and support.
- **CCC+ Waiver:** Members enrolled in the CCC+ Waiver receive waiver-related services directly from Kaiser Permanente in addition to their standard medical services.
- **Covered Benefits:** Kaiser Permanente will cover both waiver and non-waiver services designed to offer alternatives to institutional care. CCC+ covered benefits include:
    - Adult Day Health Care
    - Personal Assistance Services (agency-directed and/or consumer-directed). Note: if the member selects consumer-directed care, they will also have access to Services Facilitation and F/EA management services.
    - Private Duty Nursing Services (up to 112 hours per week)
    - Personal Emergency Response System
    - Respite Care (agency-directed and/or consumer-directed)
    - Skilled Private Duty Respite Care (agency-directed)
    - Assistive Technology (up to $5,000 annually)
    - Environmental Modifications and Vehicle Modifications (up to $5,000 annually)
    - Transition services (for eligible members transitioning from nursing facilities or long-stay hospitals back to the community)
- **Patient Pay:** Members whose income exceeds a certain threshold will be required to contribute to their LTSS costs. This patient pay amount is determined by the local Department of Social Services (DSS). Providers should bill members directly for their patient pay amount per DMAS guidelines. Kaiser Permanente will reimburse providers, deducting the applicable patient pay amount as indicated in monthly files received from Sentara, our Virginia Medicaid business partner.

Launch of Commonwealth Coordinated Care Plus (CCC+) – *Continued from page 12*

- **Developmental Disability (DD) Waivers:** Members enrolled in a DD Waiver (Building Independence [BI], Community Living [CL], and Family and Individual Supports [FIS]) will receive their waiver services, targeted case management, and waiver-related transportation directly from Virginia Medicaid. Kaiser Permanente covers only their non-waiver medical services.

On July 1, 2025, we updated our Virginia Medicaid provider manual to reflect these changes. You can find all our provider manuals, other resources, and educational materials on our Community Provider Portal at www.kp.org/providers/mas.

More information about CCC Plus can be found on the Department of Medical Assistance Services (DMAS) website at the following link: https://www.dmas.virginia.gov/for-members/cardinal-care-members/cardinal-care-managed-care/archived-information/ccc-plus/.

Online Affiliate Enhancements to Prior Authorization Requests

Online Affiliate is receiving some updates to improve the clarity of the prior authorization information that providers can see on the platform. This article outlines some of these key enhancements.

What is changing?

You'll now see an Authorization Number that includes a dash and a number (e.g., -1 or -2) following the referral number. This format helps identify different parts of a single authorization. For example, if an authorization includes multiple services or is partially approved, it may be split into separate parts—each with the same base number but a different suffix. It's important to click into each part to view the full details of the determination.

A new Overall Authorization Status column has been added. This may include new status types such as Partially Authorized. For example, if your request includes multiple services and some are approved while others are denied, the overall status will show as Partially Authorized. The Overall Authorization Status column replaces the previous Referral Status column.

Why is this change happening?

In January 2024, the Centers for Medicare & Medicaid Services (CMS) released the Interoperability and Prior Authorization Final Rule (CMS-0057-F). This rule is designed to make health information more accessible and to streamline the prior authorization process—including how service lines are managed. A key goal of the rule is to move the industry toward fully electronic prior authorizations, reducing delays and improving care coordination.

At Kaiser Permanente, we're committed to supporting this transition. These changes help reduce administrative burden on patients, providers, and payers alike, while also advancing our sustainability efforts. We will continue to enhance our systems to align with CMS requirements and will keep you informed as new updates become available.

Do I need to change how I submit prior authorization requests to Kaiser Permanente?

No. The prior authorization request process remains the same.

Do I need to change how I submit a claim or authorization to Kaiser Permanente?

No. Our system can accept authorization numbers with or without the dash (-), so there's no need to adjust how you submit claims or authorizations.

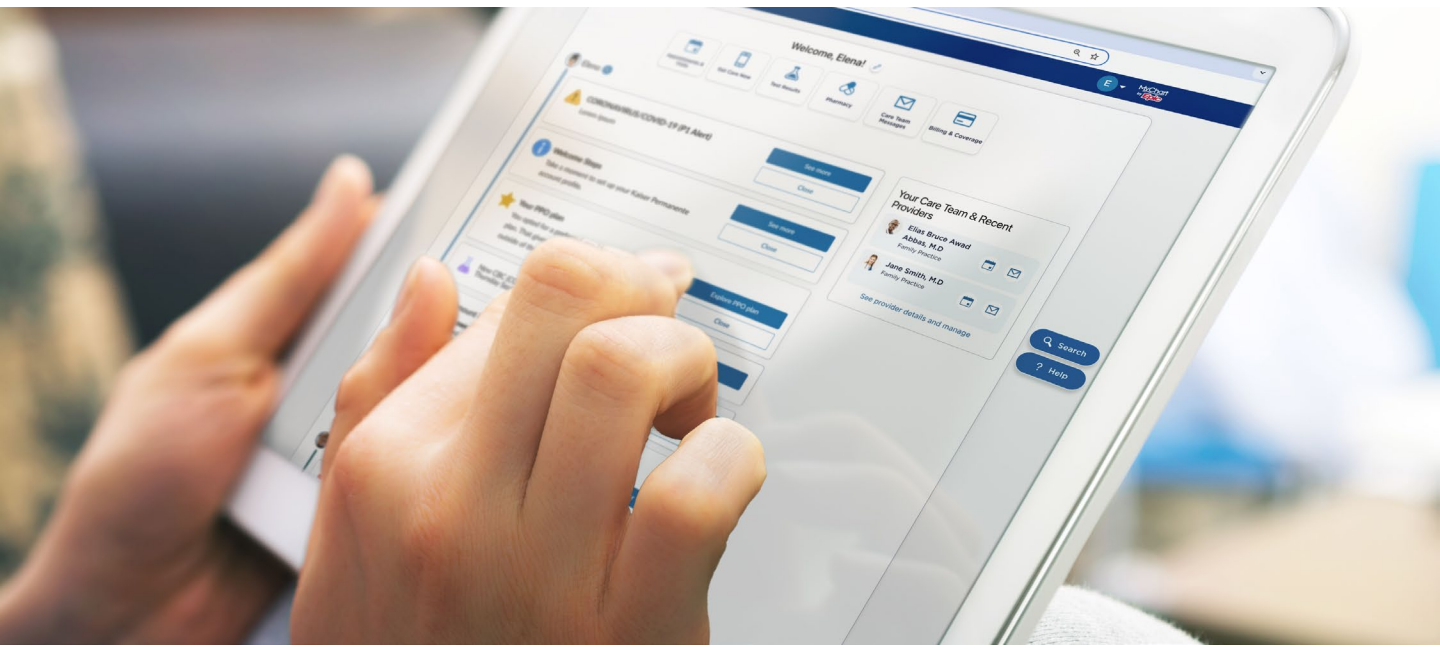
Online Affiliates Enhancements to Prior Authorization Requests – Continued from page 14

What are the different statuses I may see and what do they mean?

Status Type	What it means
Authorized	Indicates that the Utilization Management (UM) department has reviewed the request and granted full approval.
Partially Authorized	Indicates that only a portion of the requested services or quantities has been approved. This may occur when fewer units are authorized than requested (e.g., 6 out of 9 physical therapy sessions approved) or when multiple services are submitted and each receives a different determination (e.g., one service line approved, another denied).
Denied	Indicates the UM department has reviewed the request and denied authorization.
Pending Review	Indicates that the request requires evaluation by the UM department before a decision can be made. This status is primarily used to identify authorizations that need to be routed to UM work queues for manual review.
No Auth Required	Indicates that review by the UM department is not necessary.
Closed	Indicates that the request has been canceled, deleted, or carved out. UM review is not required, as no decision needs to be made for the service.
Dismissed	Indicates that the UM department is not responsible for making a determination on the request.
Withdrawn	This status is typically used for duplicate submissions or entries made in error.

Still have questions?

If you need additional support or clarification regarding these recent updates, please contact the Utilization Management Operations Center at 1-800-810-4766 and follow the prompts.



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 and efficient platform designed to simplify your attestation processes for validating provider information. This portal offers a user-friendly interface for submitting and managing your 90-day provider demographics attestations with ease and accuracy.

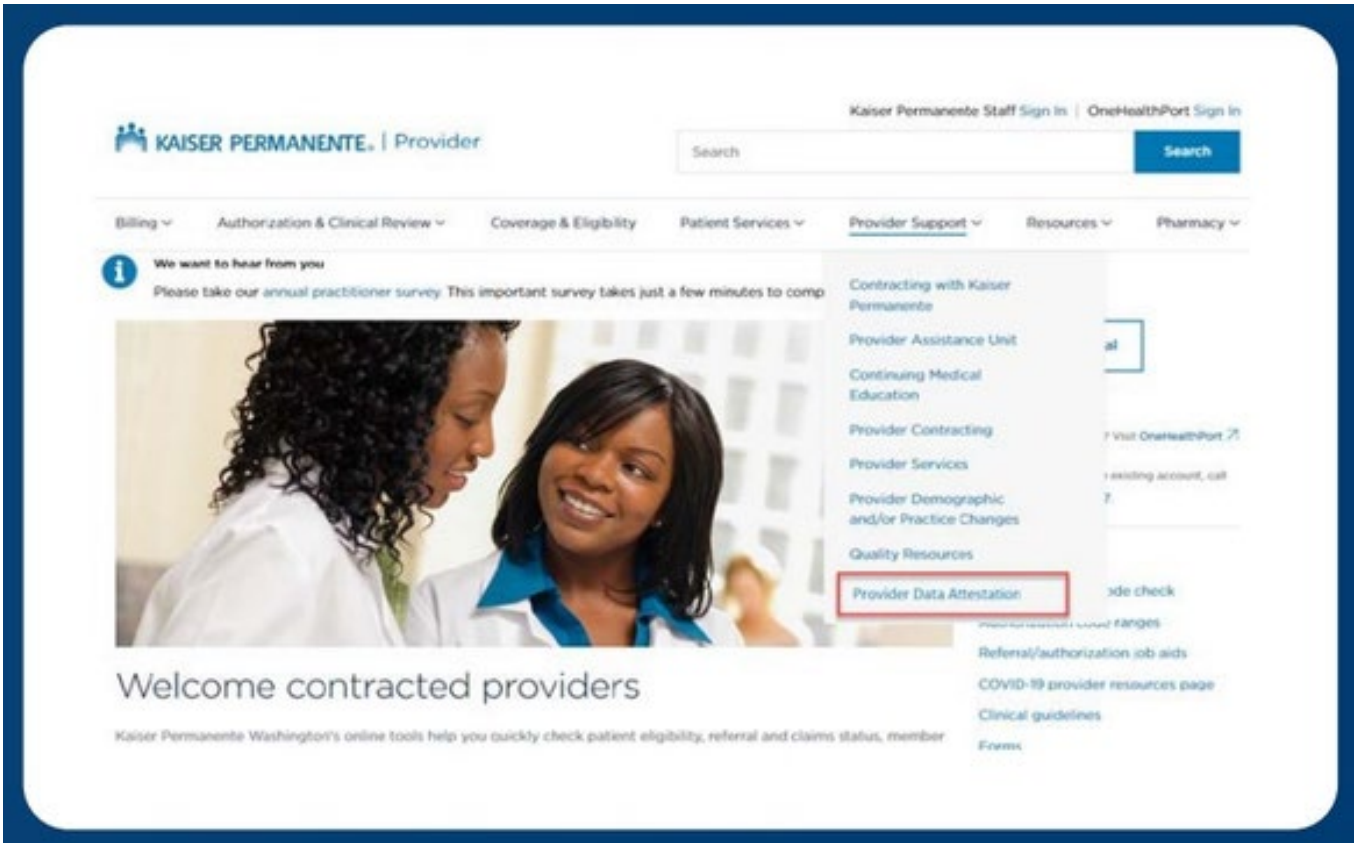
This year we enrolled a select group of providers in a pilot program, and we will be expanding this rollout to include more providers in 2026.

The resources below help detail the features and functionalities of the Attestation Portal:

- 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.



2025 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 2025, 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 2025 Maryland Medicaid CAHPS show the following results:

Measure	MD Adult			MD Child		
	2025	2024	2023	2025	2024	2023
Health Care Rating	61%	59%	52%	66%	71%	64%
PCP Rating	65%	65%	62%	75%	77%	75%
Specialist Rating	66%	70%**	68%**	58%**	69%**	69%**
Health Plan Rating	60%	60%	53%	67%	66%	66%
Getting Needed Care	73%	75%	73%	77%	75%	75%
Getting Care Quickly	72%	73%	68%	75%	68%	73%
MD Communication	91%	91%	87%	91%	91%	89%
Customer Service	86%	89%**	91%**	89%	88%**	83%**
Care Coordination	75%	91%**	76%**	79%	80%	78%**

** Base size less than 100 – interpret with caution

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 September 2025 and November 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.

New and Updated Medical Coverage Policies

1. Orthosis, Lower Extremity, Foot and Soft Goods

Effective date: 09/29/2025

- Utilization alert added:
  - As a benefit enhancement for Senior Advantage members, therapeutic shoes are covered for peripheral neuropathy & diabetic foot disease
  - Due to the enhanced benefit for our SRA members, this MCP should be used for the medical necessity determination for therapeutic shoes for Medicare members with diabetes and peripheral neuropathy.

2. Endobronchial Valve

Effective date: 09/29/2025

- References were updated

3. Preimplantation Genetic Testing

Effective date: 09/29/2025

- References were updated

4. Spinal Cord Stimulation for Pain Mangement

Effective date: 09/29/2025

- References were updated

5. Wound Supplies

Effective date: 09/29/2025

- References were updated

6. Nutritional Support

Effective date: 09/29/2025

- Section V. A 1-C: “Clinical Indication: Adult Conditions, Enteral Supplies…”
  - Updated: Inability to maintain adequate nutrition through oral intake resulting in a failure to maintain a stable weight or being underweight as defined as having a Body Mass Index (BMI) less than 18.5 kg/m²
- References were updated

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from pg. 18*

7. Laser Treatment for Hair Reduction and Hair Removal

Effective date: 09/29/2025

- References were updated

8. External MRI

Effective date: 09/29/2025

- References were updated

9. Continuous Passive Motion Device

Effective date: 09/29/2025

- References were updated

10. Gender Affirming Surgery DC Jurisdiction

Effective date: 10/29/2025

- Utilization alert updated
- Section I. Internal & Outside Referral Guidelines
    - A – "Confirmation Surgery (GCS)" terminology replaced with "Affirmation Surgery (GAS)"
    - C – Added: to check member's EOC when reviewing requests for transition-related treatments
- Section II. Covered Sexual Reassignment Gender-Affirming Surgery Procedures – Section Deleted
- Section III. D, 2-e: Genital Surgery Clinical Review Criteria
    - "Informed consent to be obtained from the patient" deleted and replaced with "the ability to provide informed consent"
- Section IV. Mastectomies with Chest Reconstruction Clinical Review Criteria: FtM Members Eligibility Criteria for Mastectomies with Chest Reconstruction
    - E – "Breast/chest Surgery" terminology replaced with "Gender-Affirmation Surgery (GAS)"
    - #5 – Deleted: "A statement about the fact that informed consent has been obtained from the patient." & Replaced: "A statement about the fact that the member has the capacity to provide informed assent and that the legal guardians are in support of the surgical referral and can provide informed consent on behalf of the minor."
- Section V. Male to Female Chest Surgery, Breast Augmentation Clinical Review Criteria: MtF Members Eligibility for Breast Augmentation (Updated)
    - A – Deleted: Adolescent MtF patients 16 years and older to qualify for chest surgery under specific conditions.
    - E – "Breast/chest Surgery" terminology replaced with "Gender-Affirmation Surgery"
        - Deleted: For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the patient's chart.

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from pg. 19*

10. Gender Affirming Surgery DC Jurisdiction (continued)

- Section VI. Exclusions/Limitations
    - Added: “Coverage for infertility services is determined in accordance with the member’s KFHP infertility/fertility preservation benefits.”
- References were updated

11. Gender Affirming Surgery MD, VA, and Feds

Effective date: 10/29/2025

- Title and Scope of MCP Updated: No longer limited to Commercial and Fed members, but expanded to include MD/VA, Feds, Postal Service, Medicaid members for Maryland and Virginia Jurisdictions and Medicare if no CMS criteria available.
- Utilization alert updated
- Section I. Internal & Outside Referral Guidelines
    - A – “Confirmation Surgery (GCS)” terminology replaced with “Affirmation Surgery (GAS)”
    - C – Added: to check member’s EOC when reviewing requests for transition-related treatments
- Section II. Covered Sexual Reassignment Gender-Affirming Surgery Procedures – Section Deleted
- Section III. D, 2-e: Genital Surgery Clinical Review Criteria
    - “Informed consent to be obtained from the patient” deleted and replaced with “the ability to provide informed consent”
- Section IV. Mastectomies with Chest Reconstruction Clinical Review Criteria: FtM Members Eligibility Criteria for Mastectomies with Chest Reconstruction
    - E – “Breast/chest Surgery” terminology replaced with “Gender-Affirmation Surgery (GAS)”
    - #5 – Deleted: “A statement about the fact that informed consent has been obtained from the patient.” & Replaced: “A statement about the fact that the member has the capacity to provide informed assent and that the legal guardians are in support of the surgical referral and can provide informed consent on behalf of the minor.”
- Section V. Male to Female Chest Surgery, Breast Augmentation Clinical Review Criteria: MtF Members Eligibility for Breast Augmentation (Updated)
    - B – Deleted: Adolescent MtF patients seeking chest surgery must also have parental consent or be legally emancipated.
    - E – “Breast/chest Surgery” terminology replaced with “Gender-Affirmation Surgery”
        - Deleted: For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the patient’s chart.
    - F – Added: Evaluation for coverage of surgical breast augmentation “after a minimum” of 6 months of hormonal therapy.

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from pg. 20*

11. Gender Affirming Surgery MD, VA, and Feds (continued)

- Section VI-B. Exclusions/Limitations
    - #1. Requirement for Voice Modification Surgery
        - Added: "Provision of documentation that the patient is actively participating in at least 6 voice therapy sessions (per the MCG 75th percentile) and the recommended home exercises.
- References were updated

12. Vitiligo Treatment

Effective date: 10/29/2025

- References were updated

13. Acupuncture

Effective date: 10/29/2025

- References were updated

14. Phrenic Nerve Stimulator

Effective date: 10/29/2025

- Grammatical updates but no change to the content of the policy
- References were updated

15. Ambulance Transportation

Effective date: 10/29/2025

- References were updated

16. Matrix Induced Autologous Chondrocyte Implantation

Effective date: 10/29/2025

- Grammatical updates but no change to the content of the policy
- References were updated

17. Vision Therapy

Effective date: 10/29/2025

- Grammatical updates but no change to the content of the policy
- References were updated

18. Compression Garments

Effective date: 11/23/2025

- Section III. Clinical Indications
    - Added: Treatment for lipedema
- Section V – A1: Indications for Compression Bandages and Garments
    - Added: lipedema
- Section VII – A4: Determining type, amount and frequency of replacement compression bandages and garments.
    - Added: We will approve two (2) items for daytime and one (1) for nighttime for each limb initially for the reduction phase and for each replacement (maintenance phase).
- Section VIII –A1d: Pneumatic Compression Extremity Pump (Nighttime/Intermittent Use)
    - A – Non-Segmented or Segmented Pneumatic Pump without Calibrated Gradient Pressure (Manual Control)
        - Added: This device will be approved without the requirements in VIII.A.1.a.b.c. only for patients with lymphedema who are schedules for lymphovenous bypass surgery by MAPMG plastic surgeons. This device is intended to be used prior to surgery and then resumed 4 weeks after surgery to facilitate recovery.
    - B – Non-Segmented (Single) or Segmented (Multi-Chamber) Calibrated Gradient Pressure Pneumatic Pump (Programmable)
        - Added: The criteria in section VIII-A must all be present.
- Section IX. Repair or Replacement of Compression Pumps.
    - Added: Upon recommendation by manufacturer of “supplier” that the device is beyond repair.”

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from pg. 22*

19. Laparoscopic Magnetic Sphincter Augmentation

Effective date: 11/23/2025

- Section III-B. Clinical Indication
    - Updated: Presence of chronic GERD symptoms despite maximum medical therapy for the treatment of reflux defined as maximum (or maximum tolerated) dose of proton pump inhibitors (PPI) – edited from at least 6 months to 3 months.
- Section IV-C. Risks – Deleted
- Section IV-D. Adverse Events – Deleted
- References were updated

21. Viscosupplementation

Effective date: 11/23/2025

- References were updated

22. Sensory Integration Therapy

Effective date: 11/23/2025

- References were updated

23. Orthosis, Upper Extremity and Soft Goods

Effective date: 11/23/2025

- Grammatical updates but no policy content changes
- References were updated

24. Hair Prosthesis

Effective date: 11/23/2025

- References were updated

25. Eye Prosthesis

Effective date: 11/23/2025

- References were updated

New/Emerging Technologies and Medical Coverage Policy Update: 2025 – *Continued from pg. 23*

New and Emerging Technologies

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): 09/08/2025
Approved by the Regional Utilization Management Committee (RUMC): 09/29/2025

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.			
04/04/2025	Pulse Oximetry Accuracy in Patients with Skin Pigmentation		X More studies are needed to determine if changes need to be implemented to current SpO2 monitors that would impact in clinical management
04/04/2025	Dermasensor for Skin Cancer Prevention		X Per KPMAS subject matter experts, there is no evidence to utilize this technology
06/18/2025	Virtual Reality (VR) Therapy with FDA-cleared therapeutic devices for chronic pain		X No evidence for utilization. No response from the KPMAS subject matter experts as to the clinical utility/safety of this technology
06/18/2025	Intraosseous Radiofrequency Basivertebral Nerve Ablation for Chronic Vertebrogenic Low Back Pain		X No response from KPMAS subject matter experts. There is very low-certainty evidence (2 RCTs, 2 open-label extensions, 2 pooled analyses of single-arm data from trials; N=412) that the Intracept® procedure improved function, pain, and QOL in adults with CLBP (≥6 months)

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.

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 26*

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 27*

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.

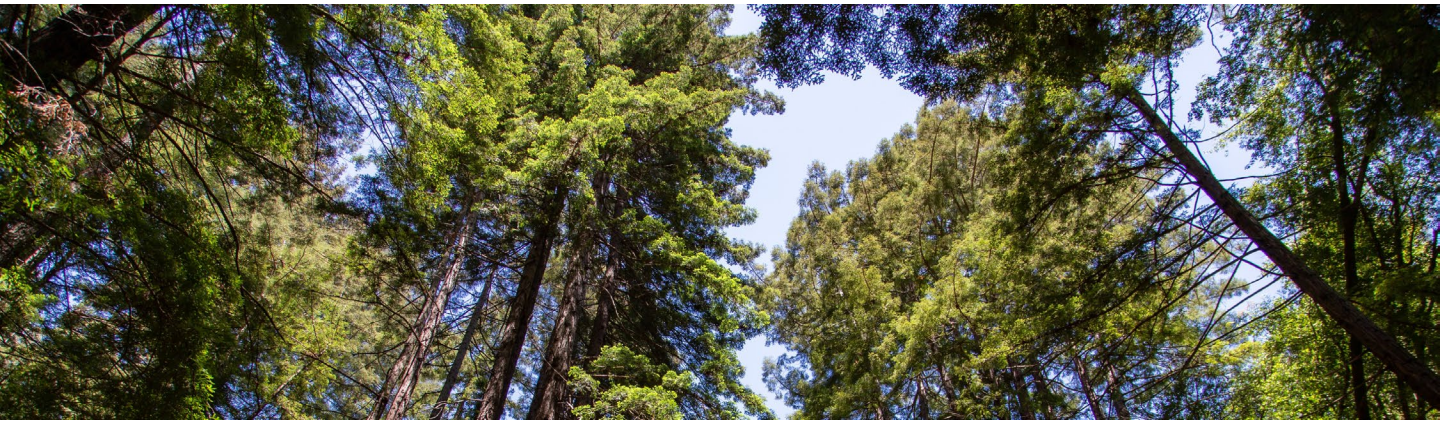
e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.

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 28*

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 30*

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 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 33*

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 34*

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. We also ask that you update us about status changes regarding your ability to accept new patients.

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:

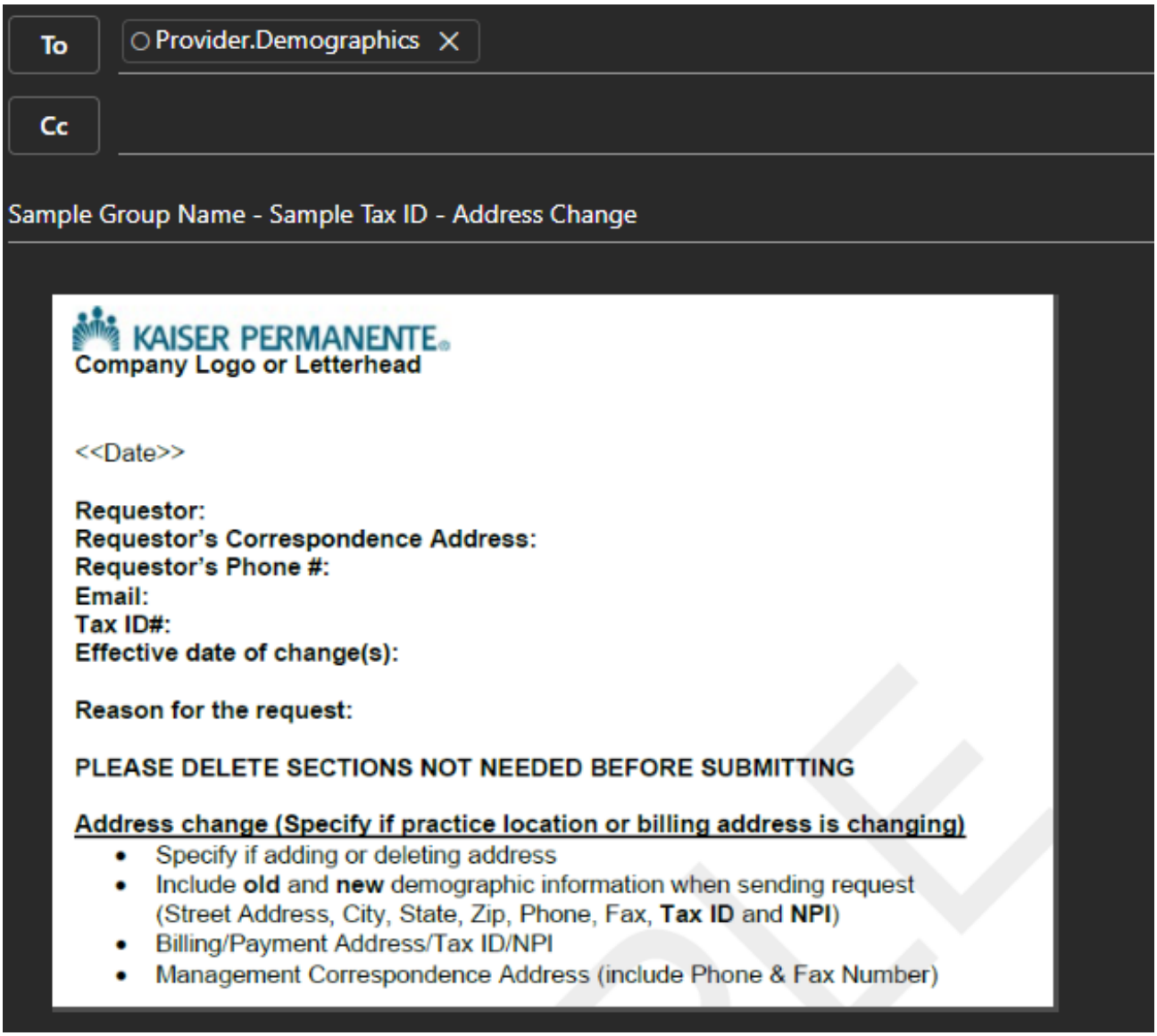
Fax: 855-414-2623
Email: Provider.Demographics@kp.org
Mail: Kaiser Permanente
Provider Experience
4000 Garden City Drive
Hyattsville, MD 20785

Email Template for Provider Requests

Our team remains committed to serving providers and the members they care for. To ensure that we can address requests promptly, we kindly ask that providers follow the guidelines below when emailing Provider.Relations@kp.org or Provider.Demographics@kp.org:

Please use the following format in the subject line of your emails:
Group Name - Tax ID - Type of Request (Termination/Add/Change/Update/etc.)

Include the details for your request in the body of your email. See the example below:



Thank you for your cooperation and for continuing to provide excellent care to our members.

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.