

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.
June 2025



Contents

Launch of Commonwealth Coordinated Care Plus (CCC+).....	2	Provider Access to Health Education Materials...	14
Revised List of Authorization-Waived Behavioral Health CPT Codes.....	4	Member Rights and Responsibilities.....	14
ABA Chapter Added to Commercial and VA Medicaid Provider Manuals.....	6	Diversity.....	18
Online Affiliate Enhancements to Prior Authorization Requests.....	7	Appointment Wait Times Standards.....	20
Email Template for Provider Requests.....	9	Introducing Kaiser Permanente’s Attestation Portal for Validating Provider Information.....	23
New/Emerging Technologies & MCP Update.....	10	Provider Disputes & Appeals Process.....	24
UM Affirmative Statement.....	13	Provider Directory Validation Surveys.....	25
		Keeping Your Provider Data Updated.....	26
		Sample Provider Data Update Form Letter.....	27

Launch of Commonwealth Coordinated Care Plus (CCC+)

Effective July 1, 2025, Virginia Medicaid will be expanding 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 2

- **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.

Our Virginia Medicaid provider manual will be updated to reflect these changes on July 1, 2025. 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/members/cardinal-care-members/cardinal-care-managed-care/archived-information/ccp-plus/>.



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, as well as our contracted provider network, we will work 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).

Effective June 11, 2025, the following CPT codes will once again require authorization and will be 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 4

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

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.

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.



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 7

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.



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:

To

Provider.Demographics X

Cc

Sample Group Name - Sample Tax ID - Address Change


KAISER PERMANENTE®
 Company Logo or Letterhead

<<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)

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

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 **March 2025 to April 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. Redundant Skin Surgery & Panniculectomy

Effective Date: March 26, 2025

- References were updated

2. Sipiucel (Provenge)

Effective Date: March 26, 2025

- Section V. Indications - updated
- References were updated

3. Cervical Traction

Effective Date: March 26, 2025

- References were updated

4. Prosthodontics

Effective Date: March 26, 2025

- References were updated

5. Breast Implant Removal and Treatment of Complications

Effective Date: March 26, 2025

- References were updated

6. Medical Necessity for Pre-Authorization, Multiple Visit

Effective Date: March 26, 2025

- References were updated

7. Medical Necessity for Pre-Authorization, Single Visit

Effective Date: March 26, 2025

- References were updated

New/Emerging Technologies and MCP Updates – Continued from page 10

8. Fertility Preservation for Latrogenic Infertility

Effective Date: March 26, 2025

- Section IV. Clinical Indication - updated
- References were updated

9. Sialendoscopy

Effective Date: April 28, 2025

- References were updated

10. Functional Electrical Stimulation (NMES/FES)

Effective Date: April 28, 2025

- References were updated

11. Temporomandibular Disorders (TMD) or Temporomandibular Joint Disorder (TMJD) Syndrome Treatment

Effective Date: April 28, 2025

- References were updated

12. Orthonagtic Surgery

Effective Date: April 28, 2025

- References were updated

13. Lymphedema & Lipedema Surgical Treatment

Effective Date: April 28, 2025

- Section III A. Clinical Indication for Lymphedema Surgical Treatment – updated
- Section IV A & B. Exclusions - updated
- References were updated

14. Cologuard

Effective Date: April 28, 2025

- References were updated

15. Continuous Glucose Monitor (Devices)

Effective Date: April 28, 2025

- Section III. Clinical Indication – updated
 - B. Clinical Criteria, Peds
 - C. Required Clinical Criteria for Ongoing Use
 - D. Exclusion
- References were updated

16. Habilitative Services

Effective Date: April 28, 2025

- Section IV. Exclusion - updated
- References were updated

17. Radiofrequency Ablation for Benign Thyroid Nodules_NEW POLICY

Effective Date: April 28, 2025

New and Emerging Technologies

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): April 15, 2025
 Approved by the Regional Utilization Management Committee (RUMC): April 23, 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
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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.

01/29/2025	Cell Free DNA Blood Based Colorectal Screening		X
12/04/2024	Nidra for Restless Leg Syndrome (RLS)	X Only recommend in severe, recalcitrant cases of RLS when all other treatments have failed	
12/04/2024	Orofacial Myofunctional Therapy (OMT) (Monotherapy) for Mild to Moderate Obstructive Sleep Apnea (OSA)		X
10/30/2024	Nanodropper® Adaptor for Eyedrop Bottles	X Recommend to our members to purchase OTC but not to provide this within our MOBs	
10/30/2024	ProACT Adjustable Continence Therapy for Incontinence After Prostate Treatment		X



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

MCPs can be accessed through the **KP Clinical Library** by using the web link below:

<https://cl.kp.org/mas/home/search.html?q=medical%20coverage%20policy>.

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

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

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

If you have clinical questions on the use of our criteria, please contact:

Christine Assia, M.D.

Physician Director of Medical Policies, Benefits and Technology Assessment

Emergency Physician, Advanced Urgent Care/ECM/UMOC

[Christine C Assia Christine.C.Assia@kp.org](mailto: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

240-620-7257

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.

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.

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 14

- 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 15*

- 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 16**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](https://www.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 18

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.



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 20**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 21

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	<p>Within thirty (30) calendar days of the Member's request</p> <p>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.</p>
Maternity Care	<p>Prenatal care appointments must be made available to pregnant Members as follows:</p> <ul style="list-style-type: none"> • First trimester – Within seven (7) calendar days of 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



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.

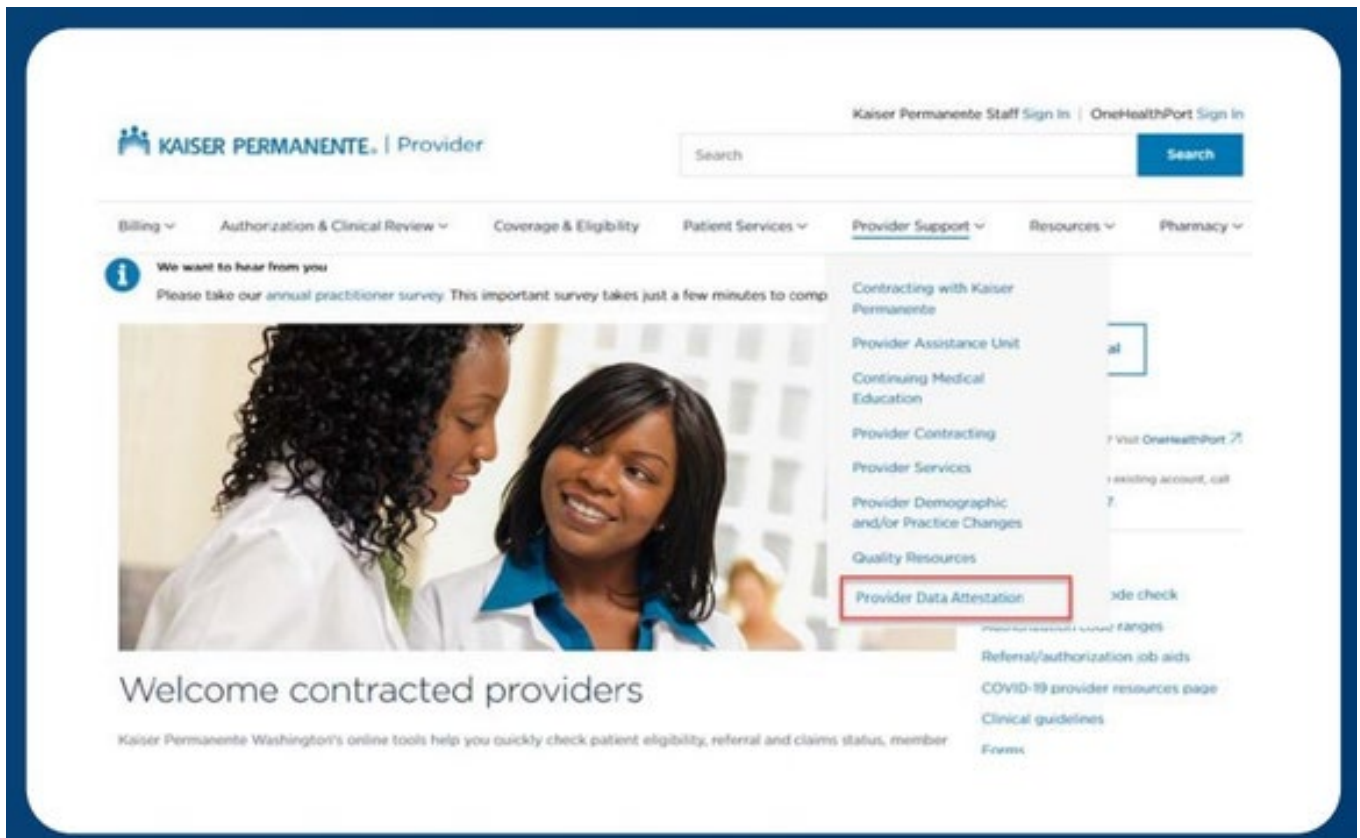
With a user-friendly interface, the Attestation Portal makes it easier to submit and manage your attestations, ensuring that provider information is up-to-date and accurate. In early 2025, we rolled this new platform out to a select group of providers in a pilot program, with plans to expand the rollout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



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.**

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
 Provider Experience
 4000 Garden City Drive
 Hyattsville, MD 20785