Provider E-News

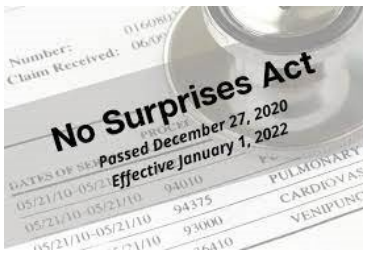
Provider Services Department

KAISER PERMANENTE

January 2022

Business Updates

Support for HR-133 provider directory validation



As you know, **effective January 1, 2022**, the Consolidated Appropriations Act 2021, also called the No Surprises Act, requires payers to establish a verification process to confirm directory information at least every 90 days. To support this new requirement, we have developed a HR-133 Provider Directory FAQ and a newly designed provider demographics update forms page to make this verification an easy process. Please visit this page to verify your information as soon as possible, and as often as necessary, to keep your provider directory information accurate. We appreciate your assistance in keeping our provider directory compliant and accurate for our members.

New Transplant Services provider manual page available

As mentioned in the December 2021 Provider Update, as of January 1, 2022, Kaiser Permanente is partnering with Kaiser Permanente National Transplant Services for all transplants except kidney surgeries. We have created a Kaiser Permanente Transplant Services provider manual page dedicated to this topic to provide more information and support for this new process. You will find information about NTS, a brief description of the process for requesting a transplant, a provider job aid for requesting these services, and several links with supporting information.

Monitored Anesthesia Care

As you are aware, Kaiser Permanente requires prior authorization for Monitored Anesthesia Care (MAC) for gastrointestinal procedures. While Medicare covers MAC for routine gastrointestinal endoscopic procedures, we have elected to continue our review of medical necessity for MAC for our non-Medicare patients.

The most common form of sedation for these procedures is conscious sedation, which is typically delivered by a gastroenterology nurse. This usually involves the use of midazolam and fentanyl. We do not require review for conscious sedation, which would always be covered as part of the procedure.

There may be times when the gastroenterology provider thinks that MAC is necessary, which is delivered by an anesthesiologist or nurse anesthetist, and commonly involves the use of propofol.

The use of MAC is typically reserved for the following conditions:

- history of failed conscious sedation
- BMI > 40
- complex airways issues
- significant comorbidities

We conduct pre-service reviews for MAC according to these criteria. Please see our Monitored Anesthesia Care clinical criteria for more information.

New claims pre-pay email inbox available for inquiries

Do you have a question about your claims pre-pay review? We have established a dedicated email inbox to address these questions. Please send any claims pre-pay questions to Pre-Pay-Inbox@kp.org and a representative will contact you regarding your inquiry. See our Pre-payment claims review process provider manual page on our Kaiser Permanente provider site for more information. **Please note this email may only be used for claims pre-payment inquiries; other inquiries will not be addressed using this venue.**

Cotiviti Phone Number Correction

It has come to our attention that the phone number provided in the Cotiviti DRG Audit Determination letters is incorrect. **The correct phone number is 770-379-2166**. The prefix in the letters of 349 is incorrect. Cotiviti is updating their letter templates. In the meantime, please update your records with the correct 379 number.

HEDIS® Medical Record Review Season: February – May 2022

From February through mid-May 2022, Kaiser Foundation Health Plan of Washington will be conducting HEDIS medical record reviews on members enrolled in a Kaiser Permanente plan in 2021 to measure the quality of care provided to our members. Our medical record reviewers will be contacting your office to request remote access to your electronic medical record system (preferred), and/or request that medical records are faxed or mailed. We appreciate your assistance in providing access to the medical information as requested. Your prompt response will ensure that your group's HEDIS measures accurately represent the high quality of care that you provide to our members.

Please contact Susie Jorgensen, HEDIS Program Coordinator at Susie.R.Jorgensen@kp.org or 206-630-1274 if you have any questions.

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Changes to clinical review criteria for continuity of care

Effective January 1, 2022, we have updated the clinical review criteria for Continuity of Care. Section 113 - Ensuring Continuity of Care of the Consolidated Appropriations Act 2021, also called the No Surprises Act, requires health carriers to ensure members have continuity of care with respect to terminations of certain provider or facility contractual relationships.

If an individual who is a continuing care patient loses coverage due to certain types of termination of benefits, the health carrier must notify the individual of the termination and the individual's right to elect continued transitional care with the same provider that was previously providing care. The health carrier must also provide the individual with an opportunity to notify the health carrier of the individual's need for transitional care and permit the patient to elect to continue to have benefits provided under the same terms and conditions as would have applied had the termination not occurred.

You can learn more about the Consolidated Appropriations Act on the Congressional website, and you can review our Continuity of Care clinical review criteria on the Kaiser Permanente provider website.

COVID vaccine billing for Medicare Advantage enrollees

As of January 1, 2022, providers should bill COVID vaccines and boosters for Medicare Advantage members to Kaiser Permanente. Per the October 8, 2021 CMS Health Plan Management System (HPMS) Memo, vaccines will be covered at no cost to the member. COVID vaccines performed in-home are also covered. If you have any questions, please contact our Provider Assistance Unit at 1-888-767-4670.

Reminder regarding Appeals – Appointment of Representative (AOR)

Please remember to fill out an Appointment of Representative (AOR) form when filing an appeal on behalf of a member for both pre-service and post-service cases. Signatures from both the provider and the member are required. Submitting these signatures when filing the appeal will avoid any delays in review.

Medicare Advantage enrollment opportunities continue after AEP

The Medicare annual enrollment period (AEP) ended on December 7, 2021, but because Kaiser Permanente of Washington is a 5-star Medicare Advantage plan, Medicare beneficiaries have additional opportunities to enroll in our Kaiser Permanente Medicare Advantage plan or make a plan change to our

Medicare Advantage plan. There are many enrollment periods Medicare beneficiaries should be aware of, including:

- Medicare Advantage Open Enrollment Period (MA OEP)
  - Available to those enrolled in a Medicare Advantage (MA) plan who want to drop or switch their MA plan, including those already enrolled in Kaiser Permanente MA plan or another organization's MA plan. It can be used one time each year between January 1 – March 31. Outside of this time, MA OEP is also available to Medicare beneficiaries who are within 3 months of their Original Medicare Part A (hospital) and Part B (medical) effective date and want to change or drop the MA plan they enrolled in.
- Medicare 5-Star Special Enrollment Period
  - Available to all Medicare beneficiaries enrolled in Medicare Part A and Part B with an available 5-Star plan in their service area, including individuals already enrolled in a 5-Star MA plan. It can be used once between December 8 and November 30, to enroll in or switch to another 5-Star rated Medicare Advantage plan.

Want to learn more about Medicare Advantage enrollment periods? Check out this great Medicare.gov resource on Understanding Medicare Advantage & Medicare Drug Plan Enrollment Periods. Plan details, enrollment options and contacts for Kaiser Permanente's 5-Star rated Medicare Advantage plans can be found on **kp.org/wa/medicare**.

Appropriate Use of Adjustment Disorder when Diagnosing

Adjustment disorder is often used as a placeholder diagnosis for people who are new to mental health treatment and have no documented clinical history of mental illness. Adjustment disorder offers both provider and patient a brief period to thoroughly assess the patients' symptoms and determine if they are going to be brief or ongoing. Adjustment disorder is the development of emotional or behavioral symptoms in response to an identifiable stressor occurring within 3 months of the stressor's onset. The main difference between adjustment disorder and other disorders, such as major depressive disorder, is the persistence of symptoms. For adjustment disorder, symptoms do not last longer than 6 months and may even resolve without any treatment.

At Kaiser Permanente, we have almost 20,000 members who are diagnosed with adjustment disorder and have received over 30 visits of individual treatment. While there can be exceptions, the standard of 6-months or less for the diagnosis of adjustment disorder is what is most appropriate (based on lack of symptoms/stressors). We ask that you please take a look at your caseload and update adjustment disorder diagnoses for all patients with whom you feel it is most appropriate.

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Retroactive authorization reminder

In accordance with Administrative Simplification Best Practice Recommendations on Extenuating Circumstances, Kaiser Permanente will accept a request for retroactive authorization if the request meets either of the following guidelines:

- The request precedes a bill for services (no claim received by Kaiser Permanente) and is within 14 days of the service OR
- The request precedes a bill for services (no claim received by Kaiser Permanente) and one of the extenuating circumstances applies

Extenuating circumstances:
If your request for retroactive authorization qualifies under the guidelines above, you may submit your request to Review Services via OneHealthPort, or telephone. If your request is more than 14 days after the date of service, please indicate which of the extenuating circumstances apply. Extenuating circumstances fall into three categories:

- Unable to Know Situation – The provider and/or facility is unable to identify from which health plan to request an authorization. The patient is not able to tell the provider about their insurance coverage, or the provider verified different insurance coverage prior to rendering services.
- Not Enough Time Situations – The patient requires immediate medical services and the provider is unable to anticipate the need for a preauthorization immediately before or while performing a service.
- An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

In each case, the provider is unable to request prior authorization for services as required by the provider's contract and the member's coverage agreement. Kaiser Permanente will accept the request for authorization more than fourteen calendar days after services are delivered as long as the provider made the request prior to submitting the claim for payment.

Providers are encouraged to request the authorization as soon as they are able. **If an attempt was not made to request the authorization your provider reconsideration may be declined.**

Provider Payment Policy Updates and Notices

Kaiser Permanente Code Editing payment policy reminder and update

Kaiser Permanente's Code Editing payment policy requires that claims must be billed in accordance with CMS guidelines. We have made updates to the laterality and Z codes sections of the policy, described below.

Laterality guidelines state claims should be billed using appropriate ICD-10, CPT and modifier codes specifying whether condition occurs on left, right, is bilateral or is unspecified.

Example:

- Diagnosis S62.617A- Displaced fracture of proximal phalanx of Left little finger
- Diagnostic Procedure CPT 73660-TC-RT Radiologic examinations; toe(s), minimum of 2 views

The diagnosis indicates Left little finger, but the procedure shows a Right modifier.

Z Codes that may only be Principal/First-Listed Diagnosis guidelines state certain Z codes must be reported as the principal/first listed diagnosis code, except when there are multiple encounters on the same day and the medical records for the encounters are combined. Please see the ICD-10-CM Official Guidelines for Coding and Reporting for more details.

If you have any questions, please contact the Provider Assistance Unit at 1-888-767-4670.

Please review our recently updated payment policies on the Kaiser Permanente provider site:

- Code Editing
- Manipulative Services (Chiropractic)
- Telehealth Services (Medicare)

Provider Notices

Please check our provider site on a regular basis for provider manual changes and updates. We communicate changes to the provider manual in the Provider eNews and in our Provider Updates for your convenience. However, it is your responsibility to remain updated on our changes by visiting our site regularly for updates on our policies and procedures. Thank you for your partnership in the care of our members.

Provider Notices:

- **Botox products updated prior authorization criteria**
- **Omalizumab (Xolair) updates to coverage under the medical benefit**
- **Abatacept (Orencia) updates to coverage under the medical benefit**
- **Changes to medical necessity review criteria for low-dose computed tomography screening for lung cancer**
- **Changes to medical necessity review criteria for bariatric surgery**
- **Shoulder arthroscopy**
- **Changes to medical necessity review criteria for restorative and cosmetic procedures (PDF)**

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CME and Workshop Opportunities

Continuing Education Opportunities

Kaiser Permanente Washington offers a variety of continuing medical education courses throughout the year, detailed on our CME Catalog page. Check out current opportunities below.

January 26, 2022	Orthopedics and Sports Medicine for Primary Care
June 9, 2022	Geriatrics for Primary Care
September 9, 2022	Cardiology for Primary Care

Please remember to advise your Provider Services Consultant

Have you made any recent changes to your practice?

Don't forget to let us know so we can update our provider directory. On our provider site home page, click on Provider Support, and choose Provider Demographic and/or Practice Changes. You will find several helpful links on that page to provide us with information.

On this page, you will be able to:

- Add new practitioners or term practitioners, including advanced registered nurse practitioners, physician assistants, and locum tenens
- Submit staff changes: in case we must adjust our records of clinic staff with Kaiser Permanente Electronic Medical Record (EMR) access.
- Submit demographic and business updates, including:
  - Clinic/services location updates
  - Close a clinic location
  - Remit/billing "Pay to" address updates
  - Tax ID update / Tax ID address update / 1099 address update

Thank you for helping us maintain a compliant and accurate provider directory.