KAISER PERMANENTE®

Provider Update

News for Kaiser Permanente Washington Contracted Providers • DECEMBER 2021

Implementing the No Surprises Act: Have you verified your information?

AN IMPORTANT MANDATE, EFFECTIVE JANUARY 1, 2022, will bring changes to how provider directory information is validated. 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. You can learn more about the Consolidated Appropriations Act on the Congressional website.

Please send responses and rosters in a timely manner for all verification requests and outreach.

- Do our members know how to get to or contact your office?
- Are we able to make accurate referrals?
- Have you checked to make sure Kaiser Permanente has all of the correct information regarding your practice?
- Have you sent an updated and accurate roster?
- Have you responded to Credentialing questions or requests for new documentation?
- Have you responded to quarterly directory verification or outreach?

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Provider Update is published quarterly for Kaiser Permanente contracted providers. Send story ideas and comments to Provider Communications.

Coverage provided by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., referred to as Kaiser Permanente in this publication.

BUSINESS OFFICE NEWS

2022 Calendar

EFT deposit and check mail dates

Provider reimbursement checks are scheduled to be deposited ACH or mailed on the following dates. Mailed checks should arrive within approximately three business days.

JANUARY	6, 13, 21, 27	**APRIL**	7, 14, 21, 28
FEBRUARY	7, 10, 17, 25	**MAY**	5, 12, 19, 26
MARCH	7, 10, 17, 24, 31	**JUNE**	6, 9, 16, 23, 30

Kaiser Permanente holidays

NEW YEAR'S DAY
Friday, December 31, 2021

MARTIN LUTHER KING JR. DAY
Monday, January 17

PRESIDENTS' DAY
Monday, February 21

MEMORIAL DAY
Monday, May 30

PROVIDER NEWS

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Implementing the No Surprises Act: Have you verified your information?

Please feel free to contact us if you think any of your information may be incorrect. You can reach out to your Provider Service Consultant or you can email Provider Services.

If you know any of your demographics are changing, or have changed, please let Provider Services know at least 60 days in advance, or as soon as possible. Please submit a Provider Information Update Form on our provider website Provider demographic and practice changes.

HR 133: The No Surprises Act

SEC. 2799B–9. Provider requirements to protect patients and improve the accuracy of provider directory information.

(a) Provider Business Processes. Beginning no later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer...

Such providers shall submit provider directory information to a plan or issuers, at a minimum–

(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;

(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;

(3) when there are material changes to the content of provider directory information of the provider or facility described in section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as applicable; and

(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

Medicare Benefits 2022 Update

Select individual Medicare Advantage plans to include new over-the-counter benefit

EFFECTIVE JANUARY 1, 2022, Kaiser Permanente Washington is introducing a new supplemental over-the-counter (OTC) benefit on select individual Medicare Advantage plans. The OTC benefit will be administered by Medline Industries on behalf of Kaiser Permanente. The benefit will provide members with a quarterly limit that can be used to order products online and by phone from a set list of products outlined in the OTC catalog. Ordered products will then be shipped free of charge to the member's home address. The OTC benefit will be offered on Kaiser Permanente Washington Harbor, Anchor, Key, Vital, Columbia, and Centennial individual Medicare Advantage plans with varying benefit coverage limits ranging between $25 and $75 per quarter. The benefit limit does not roll over from quarter-to-quarter and each order must meet a minimum order amount of $15. To view the catalog or place an order, members can visit kp.org/otc/wa.

Select individual Medicare advantage plans to include new embedded preventative dental benefit

EFFECTIVE JANUARY 1, 2022, Kaiser Permanente Washington is introducing a new supplemental embedded preventative dental benefit on select individual Medicare Advantage plans. This new benefit will cover preventive dental services up to an annual maximum and will be offered to Key, Harbor, Centennial, and Columbia individual Medicare Advantage plan members. The annual maximum varies by plan, ranging between $400 and $1,000. Members can use this benefit with participating Delta Dental of Washington providers and are covered for preventive and diagnostic services, including oral examination, bite-wing X-ray, panoramic X-ray or complete series, routine preventive teeth cleaning, fluoride treatments. Providers should note that while this benefit is only offered on select Kaiser Permanente Washington individual Medicare Advantage plans, other individual Medicare Advantage plans may have an existing dental reimbursement allowance. Additionally, all individual Medicare Advantage plans continue to offer an optional supplemental comprehensive dental benefit for a $54 monthly premium.

Diagnosis Related Group prepay reviews to begin next month

The Diagnosis-Related Group (DRG) Payment and Review policy was published and took effect January 1, 2021 and the post-pay reviews began June 1. Now, with the added **prepay** reviews scheduled to begin next month; we would like to remind you about the process.

You may receive correspondence from Cotiviti requesting medical records. The letter will provide clear instructions on how to submit the records directly to Cotiviti. The quickest and easiest way to submit records will be to use the Cotiviti Image Portal. The request letters will instruct you on how to sign up for portal access. Please do not submit the records to Kaiser Permanente, as that will only delay the process.

Once a claim review is complete, you will receive an audit determination letter and the opportunity to accept or dispute the determination. If you wish to dispute the findings, reconsideration requests should be submitted directly to Cotiviti. If you have any questions, please contact the Provider Assistance Unit at 1-888-767-4670.

Medicare coordination of benefits

WHEN A KAISER PERMANENTE MEDICARE-ELIGIBLE MEMBER is not eligible for or is not enrolled in our Medicare Advantage plans, we will coordinate benefits with traditional Medicare.

When Medicare is the primary payer, you must bill Medicare directly for services through the Medicare crossover process.

Note: Do not bill Kaiser Permanente for claims that will crossover electronically. This creates duplicate billing or payment. Remember to check your Medicare explanation of payment form, Reason Code MA18.

When Kaiser Permanente has referred the service, we will provide payment for all covered balances.

CMS Qualified Medicare Beneficiary program

The Qualified Medicare Beneficiary (QMB) program provides Medicare coverage of Part A and Part B premiums and cost sharing to low-income Medicare beneficiaries. In 2017, 7.7 million people (more than 1 out of 8 people with Medicare) were in the QMB program.

Billing protections for QMBs

Federal law forbids Medicare providers and suppliers, including pharmacies, from billing people in the QMB program for Medicare cost sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low-income Medicare beneficiaries. QMB is an eligibility category under the Medicare Savings Programs. In 2016, 7.5 million individuals (more than 1 out of 8 beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, states can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act).

New member ID cards on the way

To comply with new federal requirements under House Resolution 133 section 107, Kaiser Permanente physical and digital member ID cards have been updated to include out-of-pocket maximum (OOPM) limitation(s), deductible(s), kp.org website address, and telephone number.

Effective in December 2021, all members will have access to their new digital ID card which will be available on the Kaiser Permanente mobile app. Therefore, there will be no mass reissue of physical ID cards to all members. A new physical ID card will be issued to members only under the following circumstances:

- When a person enrolls in a new health benefit plan
- When a person's plan, OOPM, or deductible changes
- Upon member request

HR 133 – The No Surprises Act: Continuity of Care

AS OF JANUARY 1, 2022, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are implementing the requirements of HR 133 Consolidated Appropriations Act, 2021 - Division BB, Section 113 Ensuring Continuity of Care. Kaiser Permanente will provide a member impacted by a provider contract termination the opportunity to notify Kaiser Permanente of their need for continued care and will provide benefits under the same terms and conditions as would have applied prior to the contract termination. See the Continuity of Care policy for more details.

SEC. 2799A-3. Continuity of care

If the Plan or provider terminates the provider contract, the provider is no longer offering the benefited item or service due to a contract change, or the contract between the group and Plan are terminated, the member is eligible for continuity of care benefits.

- The Plan is required to notify the member of a contracted provider's termination and allow the member a reasonable amount of time to notify the Plan of their need for continuity of care.
- The member will be allowed to continue care with the terminated provider from the date the notice of termination is sent by the Plan, for 90 calendar days from receipt of the Plan's notice regarding contract termination, or when continued care is no longer needed for the member's medical condition – whichever is shorter.
- Members can qualify for continuity of care with a terminated provider when:
  - they are undergoing treatment for a serious or complex condition;
  - they are inpatient or institutionalized
  - they are scheduled for a nonelective surgery, to include necessary post-operative care
  - they are pregnant; or
  - they are terminally ill

Definitions:

- A "serious and complex condition" is:
  - an acute condition for which specialized treatment is needed to avoid death or permanent damage; or
  - a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital; **and**
  - requires specialized care over a prolonged period of time
- "Terminated": A terminated provider is one who's contract with the Plan has expired or has not been renewed. This does not include termination of the contract for failure to meet applicable quality standards or for fraud.

New and updated payment policies

- Applied Behavioral Analysis (ABA) Therapy
- Associate Level Mental Health Care
- Code Editing
- Robotic Assisted Surgery
- Telehealth Services (Medicare)
- Telemedicine Services (Commercial)
- Virtual Care

What exactly is "subrogation"?

In its simplest terms, as it applies to your patients' health plan, subrogation allows the plan to recoup paid medical expenses that relate to a claim for damages against a third party.

Examples of third-party claims would be auto insurance, homeowner, or business liability claims. Subrogation may also be asserted against an uninsured or underinsured claim with your patient's own auto insurance carrier. Third-party claims typically do not pay for medical treatment up front but reimburse for damages (e.g., medical bills, lost wages, pain, and suffering) upon settlement.

Let's say that your patient is being treated for injuries sustained in an auto accident. She or he did not have available Personal Injury (PIP) or Medpay on their own automobile insurance policy, but they do have an open liability claim for bodily injury against the other driver's insurance (aka third-party). Therefore, your patient's health plan may have a subrogation provision in its contract which allows the health plan to process and recover their payments upon settlement of your patient's bodily injury claim.

As with any claim for damages, rights of recovery through subrogation can vary from health plan to health plan and from state to state. In the state of Washington, the statute of limitations is 3 years from the date of loss. However, if your patient is a minor, the 3-year statute begins on their 18th birthday. In addition, if your patient files a lawsuit, the third-party claim will remain open until a settlement is reached.

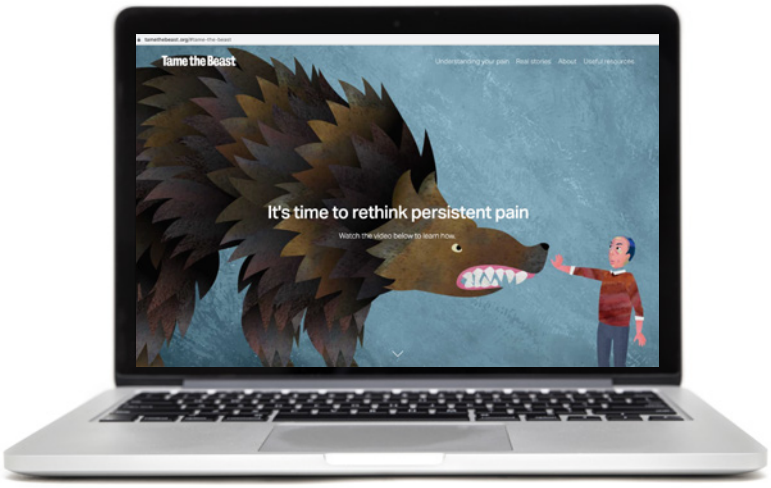
Subrogation recoveries help to reduce health plan expenses which translates to cost savings, thus lowering overall health care costs to your patients' health plan.

New resources for pain management and opioid safety available

KAISER PERMANENTE HAS RECENTLY made available to our contracted providers a set of resources we've developed to promote safer opioid prescribing in the context of whole-person care for persistent pain. Visit the quality resources page in the provider support section of our provider site to access resources for patients with persistent pain and the providers who care for them. All materials are evidence-based and were co-designed with primary care teams and patients who live with pain, with a focus on the use of long-term opioids. You'll find:

- **Scripting** to help providers explain to patients the rationale behind the most recent opioid safety guidelines and what to expect at their next visit, like requirements for regular urine drug screens, opioid care plan updates, and naloxone prescribing.
- **Quick reference guide** that summarizes options for alternative, non-pharmacologic treatments.
- **Resources for patients,** including a handout that helps patients better understand long-term pain and a list of educational videos that are publicly available and recommended by patients who live with persistent pain.

We hope these resources help enable productive conversations about opioid safety and support self-management in your patients with persistent pain. We'd love to hear from you if you have any feedback about these resources; please contact Mirian Aguirre.



Optical and hearing hardware changes

TO ENSURE AN EQUITABLE administration of benefits for members in all Kaiser Permanente Washington region service areas and to adhere to network adequacy requirements, we are making a slight change to our optical and hearing hardware benefits.

As of January 1, 2022, non-Medicare HMO members with an optical or hearing hardware benefit will be required to utilize Kaiser Permanente medical centers and contracted providers for coverage of those services. These members will no longer have the option of receiving these services from non-contracted providers and submitting a claim for reimbursement. Requiring non-Medicare HMO members to use Kaiser Permanente medical centers and in-network contracted providers for these services will insure members receive their maximum benefit and are not billed inappropriately.

Recent letters to providers

Effective January 1, 2022

Changes to medical necessity review criteria for AlloSure (PDF)

This notification applies to the following networks: Commercial HMO, POS, PPO.

Changes to medical necessity review criteria for Virtual/CT Colonography (PDF)

This notification applies to the following networks: Medicare Advantage.

Changes to medical necessity review criteria for External Trigeminal Nerve Stimulation for ADHD (PDF)

This notification applies to the following networks: Commercial HMO, POS, PPO, and Medicare Advantage.

Changes to medical necessity review criteria for Cell-Free Fetal DNA Analysis for Trisomies (PDF)

This notification applies to the following networks: Commercial HMO, POS, PPO, and Medicare Advantage.

Associate Level Mental Health Care (PDF)

Applies to: Commercial HMO, POS, PPO.

Effective February 1, 2022

Changes to medical necessity review criteria for restorative and cosmetic procedures (PDF)

This notification applies to the following networks: Commercial HMO, POS, and PPO

Clinical Updates

Clinical guidelines are regularly reviewed and updated. Announcements about changes are posted on our provider website.

Kaiser Permanente Washington to partner with National Transplant Services for most transplants

THE NATIONAL TRANSPLANT SERVICES (NTS) was created in 1995 to address the oversight of transplant services for Kaiser Permanente members. The goal of the NTS is to provide members with access to a network of transplant programs located at premier medical centers where successful outcomes are predictably high. The NTS is dedicated to ensuring continued access to premier transplant programs, which meet or exceed the NTS's stringent site selection criteria and are known nationally for their respective transplant programs. Our national structure allows us to improve levels of service and utilization of limited resources.

NTS provides case management and quality management/improvement activities for members seeking or having received a solid organ or blood and marrow transplant. The NTS is a unique program within Kaiser Permanente—we support every region, handle both individual patient and transplant population clinical issues, carry out traditional health plan functions (referrals, authorizations), work with internal and external providers, ensure our patients have the necessary clinical services, provide ongoing transplant-related patient education, and monitor the quality of the care provided by our transplant centers.

Effective January 1, 2022, Kaiser Permanente Washington will partner with NTS for all transplants except kidney surgeries. Please see the National Transplant Services page on the Kaiser Permanente national site for more information about the program. We will share more information in January regarding the process for referring your Kaiser Permanente patients for a transplant, and the many benefits this partnership will provide.

ARTICLES OF INTEREST

Kaiser Permanente Washington Health Research Institute

- **Relieving chronic pain with CBT.** Cognitive behavioral therapy with yoga-based movement helps with pain for those on long-term opioids. Read more
- **Roundup of 3 recent studies on dementia risk.** Researchers explore links between hearing loss, military service, and cognitive decline – and look at timeliness of diagnosis. Read more
- **Understanding young adults' experiences with cancer.** The VOICE study aims to improve the health and health care of people who had cancer as adolescents and young adults. Read more

SMART is now preferred treatment for many patients with moderate to severe asthma

The Kaiser Permanente Asthma Diagnosis & Treatment Guideline has received an interim update, making **SMART (single-inhaler maintenance and reliever therapy)** the preferred therapy for patients aged 4 and up with moderate to severe asthma (steps 3 and 4) who are new to daily treatment or whose asthma is not well controlled on their current regimen. SMART involves using a single inhaler for both daily maintenance and quick relief, and simplifies asthma treatment by avoiding confusion about which inhaler to use.

Because of formoterol's rapid onset of action, the ICS/LABA **budesonide/formoterol (Symbicort)** is the preferred SMART regimen for patients aged 4 and over. ICS-salmeterol inhalers (Wixela, Advair) should not be used for SMART. Patients with moderate to severe asthma that is already well controlled on another regimen do not need to switch to SMART.

Questions?

Katie Paul, MD, MPH, Clinical Lead, Clinical Improvement & Prevention

Mark La Shell, MD, Service Line Chief, Allergy & Asthma

Avra Cohen, RN, MN, Guideline Coordinator

Kaiser Permanente National Sedative-Hypnotic Practice Recommendations

WE ARE PLEASED TO SHARE the Kaiser Permanente Sedative-Hypnotics Practice Recommendations. To enhance the safer use of sedative-hypnotic medications, these practice recommendations were approved by the Kaiser Permanente National Controlled Substances Stewardship Committee, National Medication Committee, and the National Quality Committee.

The process for development of these recommendations included identifying successful practices and opportunities both within and outside of Kaiser Permanente. The main recommendations are summarized below:

- Avoid starting new patients on benzodiazepines and sedatives for anxiety, insomnia, and panic disorder. SSRIs/SNRIs and non-pharmacological interventions such as cognitive behavioral therapy are the standard of care.
- Benzodiazepines and sedatives are not recommended for long term use. Discuss the risks of these medications including the risk of falls and cognitive impairment with patients with regular use of these medications and encourage them to taper off these medications.
- Behavioral interventions are first line therapy for insomnia. Medications are riskier and less effective.
- There is no indication for benzodiazepines and sedatives in the treatment of chronic insomnia. Patients with chronic insomnia should not be given these medications even for short-term, as needed use.
- The use of benzodiazepines with opioids is dangerous because it increases the risk of respiratory depression and death. It is recommended that patients are not started on this combination. Patients on this combination are encouraged to transition off one of the medications.

The full practice recommendations can be found on our provider website.

Additionally, the Kaiser Permanente Washington Clinical Guideline for Benzodiazepine and Z-Drug safety (PDF) is available for reference and guidance in benzodiazepine tapering support.

Kaiser Permanente 2021 drug formularies

THE KAISER PERMANENTE DRUG FORMULARIES are the cornerstone of medication therapy, quality assurance, and cost containment. The formularies are developed by the Pharmacy and Therapeutics (P&T) Committee. You can find formulary decision highlights from the most recent P&T Committee meetings on the Kaiser Permanente provider website.

Kaiser Permanente has 7 formularies

The table below outlines some of the major differences in these formularies. A closed formulary design describes a formulary in which preferred medications are covered and non-preferred (non-formulary) medications are generally not covered. Coverage of non-preferred medications is available through an exception process. An open formulary design describes a formulary in which both preferred and non-preferred medications are covered; however, preferred medications are available at a lower cost share for patients.

How to view the Kaiser Permanente formularies

- On the Kaiser Permanente provider website.
- On ePocrates, register free of charge.

If you have questions about formulary status of a drug or prior authorization, please contact our Pharmacy Help Desk toll-free at 800-729-1174 or by fax toll-free at 866-510-1765.

Medicare Part D Formulary updates

Notifications about drug removals from the Medicare Part D Formulary are now posted online on the pharmacy page of our provider website.

MEDICARE	INDIVIDUAL & FAMILY / SMALL GROUP	LARGE GROUP AND FEDERAL EMPLOYEE HEALTH BENEFIT				
Closed Design	**Open Design**	**Closed Design**	**Closed Design**	**Open Design**	**Open Design**	**Open Design**
Six tiers: • Preferred generic • Non-preferred generic • Preferred brand • Non-preferred brand • Specialty • Injectable Part D vaccines	**Four tiers:** • Preferred generic • Preferred brand • Specialty • Non-preferred generic & brand **PLUS:** • Self-administered oncology • Medical benefit	**Two tiers:** • Preferred generic • Preferred brand	**Three tiers:** • Preferred generic • Preferred brand • Preferred specialty	**Three tiers:** • Preferred generic • Preferred brand • Non-preferred	**Four tiers:** • Preferred generic • Preferred brand • Non-preferred generic & brand • Specialty	**Five tiers:** • Preferred generic • Preferred brand • Non-preferred generic & brand • Preferred specialty • Non-preferred specialty

Save these dates

Continuing medical education information is available on the Kaiser Permanente provider website.

SUICIDE PREVENTION 2021 (ONLINE – FREE)
January – December 2021
Register now

ORTHOPEDICS AND SPORTS MEDICINE FOR PRIMARY CARE
January 26, 2022
Register now

GERIATRICS FOR PRIMARY CARE
June 9, 2022
Register now

CARDIOLOGY FOR PRIMARY CARE
September 9, 2022
Register now

EVIDENCE-BASED MEDICINE
September 20, 2022
Register now

MENTAL HEALTH
October 13, 2022
Register now

COVID-19 notice

Please note courses will be presented as live virtual sessions using Microsoft Teams.

Contact

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