Behavioral health providers expanded

As part of our commitment to our members, we continually strive to provide better access to care and integration services within Kaiser Permanente Medical Centers. Over the past few years we’ve expanded the number of behavioral health providers, with a wide range of expertise within Kaiser Permanente. We’ve also extended service hours into the evening at many of our facilities to better accommodate our members.

To better care for our members, we have expanded behavioral health programs, offered across the region, within our medical centers. We have Intensive Outpatient Programs (IOP) designed to deliver a better continuum of care for discharged patients. We can schedule 24/7 evaluation and psychiatric consultation in our Clinical Decision Units (CDU’s) or Urgent appointments by contacting our Call Center at 1-800-777-7904.

Members referred to a Kaiser Permanente behavioral health provider experience the benefits of coordinated care with the co-location of primary care and specialty care services in one place in our behavioral health locations; all connected through our electronic medical record system. Members registered on kp.org can also e-mail their behavioral health provider’s office, view most laboratory results, and refill most prescriptions on-line.

After an initial consultation, if you determine a Kaiser Permanente Member requires follow-up care you will need to send via fax a proposed treatment plan for the patient to Kaiser Permanente Behavioral Health Utilization Management at (855) 414-1703.
Risk adjustment and hierarchical condition categories documentation basics

Provider documentation is required to support diagnoses that map to Hierarchical Condition Category (HCC) codes. The International Classification of Diseases–10 (ICD-10) guideline is the standard used to support diagnosis coding. The following information outlines documentation basics that may impact whether a diagnosis is a HCC or not.

Every note should include the following:
• Date of service
• Patient name & date of birth on every page
• Provider signature and credentials
• Only industry standard abbreviations
• Documentation of each medical condition being
  » Monitored/Managed
  » Evaluated
  » Assessed/addressed
  » Treated
  » Considered in your care of the patient
• Be as specific as possible – use signs and symptoms if diagnosis is not clear

Document on each condition the patient has that influences your ability to evaluate or treat the patient. This includes any of the following:

Pertinent conditions
• Document and code for any patient condition that is:
  » Present but stable
  » Managed on therapy
  » Requires observation
  » Requires referral to another provider for management
  » Influences your decision making in care of the patient
• Avoid documenting “history of” when the condition currently exists

In ICD 10 coding language, “history of” means that the patient no longer has the condition, in which case it cannot be coded as an active disease.
**Chronic conditions**

Chronic conditions are conditions that the patient has and is expected to have as an ongoing health issue.
- Document chronic conditions annually, even when stable with treatment
- Document that the condition is chronic
- Document severity/stage of condition (i.e. stage IV chronic kidney disease/major depression)
- Document associated conditions or complications and relationship to the underlying chronic condition (i.e. diabetic retinopathy, cirrhosis secondary to alcoholism)

**Active status**

Conditions that are present and unresolved or unlikely to resolve need to be documented at least annually.
- Forever codes – conditions that do not go away and patients are expected to have forever.
  - Examples: Amputation, Transplants, Alcoholism in remission, CHF
- Might be forever codes –
  - Ostomy, Cirrhosis, Diabetes, Hepatitis, Paraplegia/Quadriplegia – be specific

**“History of” or “Past” conditions**

History of Cancer – appropriate diagnosis when the patient has successfully completed treatment for malignancy, does not have active disease or metastases and is not being treated for cancer
- Cancer on a long term therapy (i.e. breast/prostate cancer on hormonal therapy) is active cancer, not “history of” cancer when the therapy is not prophylactic.
  - A patient with cancer who declines treatment is considered active cancer.
- History of stroke vs CVA – A stroke is an acute event and should not be diagnosed once a patient is discharged from the hospital.
  - Document deficits and diagnose history of stroke or the specific deficits (i.e. hemiplegia secondary to CVA)

**Conditions that require 2 codes billed together**

- Diabetic manifestations – nephropathy, neuropathy, etc.
- Document the causal relationship between the conditions using “secondary to” or “due to” statements and diagnose both conditions (i.e. neuropathy due to diabetes).
- Hypertensive renal disease – document & code both the hypertension & the renal disease
- Infections – document & code for both the type of infection & the organism
- Example: UTI & E. Coli

Medical coverage policy update IV - 2016

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) were approved between October 2016 to December 2016.

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.

New or updated medical coverage policies

1. Breast reduction and gynecomastia
   Revision date: 10/25/2016
   New indication for coverage:
   • Male Gynecomastia secondary to Androgen Deprivation Therapy

2. Capsule endoscopy
   Revision date: 10/25/2016
   • References were updated

3. Spinal cord stimulator
   Revision date: 10/25/2016
   » References were updated

4. Nutritional support
   Revision date: 10/25/2016
   • Content revision for clarity:
     » Benefit Alert
     » Section IV, A and B
     » Section V, A and B
   • References were updated

5. Ambulance and non-emergency transport
   Revision date: 11/23/2016
   • References were updated

6. Benign skin lesion treatment
   Revision date: 11/23/2016
   • References were updated

7. Continuous passive motion device
   Revision date: 11/23/2016
   • References were updated

8. Single visit (NEW)
   Effective date: 12/07/16
   • Referral for single visits is a pre-authorization request for more than one request or visit where “no” Utilization Management (UM) criteria, standards or protocol could be applied or when there is lack of sufficient information to make a determination of medical necessity prior to or after a procedure, treatment or service.
9. Multiple visits (NEW)
   Effective date: 12/07/16
   • Referral for multiple visits is a pre-authorization request for more than one request or visit where “no” Utilization Management (UM) criteria, standards or protocol could be applied or when there is lack of sufficient information to make a determination of medical necessity prior to or after a procedure, treatment or service.

10. MRI: Wide bore and open MRI
    Revision date: 12/22/16
    • References were updated

11. Home phototherapy
    Revision date: 12/22/16
    • References were updated

12. Vitiligo treatment
    Revision date: 12/22/16
    • Added statements:
      a. Excimer Laser (XTRAC, PhotoMedex, Radnor, PA; EX-308, Ra Medical Systems, Inc Carlsbad, CA) therapy is NOT for treatment of extensive vitiligo. It is reserved only for localized disease that has been documented to be unresponsive to prior medical or phototherapy.
      b. Home phototherapy treatment. It is most effective for UV sensitive areas (face, neck, back, breast and arm) with much less response to UV resistant areas (knees, elbows, wrists, hands, ankles and feet). Phototherapy with the excimer laser (or other source of focal NB) has the advantage of applying targeted treatment only to the de-pigmented sites. NB-UVB, which has been studied more extensively, may also be useful (with larger units) for the treatment of extensive vitiligo and is more advantageous when compared with the excimer laser in terms of costs, duration of treatment sessions and patient compliance.
      c. Home based phototherapy (NB-UVB): are covered under Home Phototherapy MCP guidelines.
    • Deleted statement:
      » Home based phototherapy (NB-UVB) would not be covered unless there is a substantive evidence of severe medical conditions that have rendered a patient homebound
    • References were updated

    Revision date: 12/22/16
    • Expansion of coverage and criteria for adolescents; addition of definition of physical maturity
    • Adjust BMI requirements for more inclusion of patients between 40 and 50 BMI
    • Add indications: chronic DVT, stress incontinence, psychosocial distress in combination with other comorbidities and for persons with BMI >50

Retired medical coverage policies

1. Bone growth stimulator
   • replaced by MCG criteria effective 12/22/16
Pharmaceutical management information and updates

The KPMAS Regional Pharmacy & Therapeutics (P&T) Committee approves drug formularies for all lines of business, Commercial, Marketplace/Exchange, Medicare, Virginia Medicaid and MD HealthChoice (Medicaid).

The Regional P&T Committee, with expert guidance from various medical specialties, evaluates, appraises, and selects from available medications those considered to be the most appropriate for patient care and general use within the region. The purpose of the formulary is to promote rational, safe, and cost-effective drug use.

The formularies are updated monthly with additions and/or deletions approved by the Regional P&T Committee. The most recent information on drug formulary updates or changes can be accessed via the online Community Provider Portal for affiliated practitioners available at providers.kaiserpermanente.org/html/cpp_mas/formulary.html. To view the P&T Memos, you will be redirected to the KPMAS Clinical Library, a secured network, and asked to sign in and/or register for access.

A printed copy of each drug formulary is available upon request from the Provider Relations department, which can be contacted via email at Provider.Relations@KP.org.
Prior authorizations for select Medicare Part D prescriptions effective January 1, 2017

Medicare continues to require Part D plans to implement utilization management controls, such as prior authorizations, to determine how pharmacy claims should be paid by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare.

Beginning January 1, 2017, additional conditional prior authorizations will be placed on select Medicare Part D medications listed below:

- Alirocumab (Praluent)
- Chorionic gonadotropin (Novarel, Pregnyl)
- Corticotropin (HP Acthar Gel)
- Evolocumab (Repatha)
- Lomitapide mesylate (Juxtapid)
- Meperidine (Demerol)
- Methamphetamine (Desoxyn)
- Mipomersen (Kynamro)
- Progesterone vaginal (Crinone)

These select medications will only be covered under Part D benefit when:

- Prescribed for an FDA-approved indication or outlined in the CMS-approved compendia, and
- An associated diagnosis is documented in KP HealthConnect or written on the prescription.

These drugs will NOT be covered under the Part D drug benefit and patient will be charged the full member rate if one of the above criteria is not met.

To ensure appropriate claim adjudication, please indicate the “3 D’s”: DIAGNOSIS, DOSAGE, and DAYS SUPPLY.

Indicate diagnosis (using ICD codes), dosage, and days’ supply (as needed) in KP HealthConnect (KPHC) or write it on the prescription. If the diagnosis is missing or the dosage and days supply are not clear, pharmacy staff may contact you to confirm the information associated with that prescription.

Additional medications that have conditional prior authorization requirements for Medicare Part D members are:

- Amrix (cyclobenzaprine) tablets
- Aubagio (alemtuzumab) tablets
- Cyclobenzaprine tablets
- Daklinza (daclatasvir) tablets
- Esbriet (pirfenidone) capsules
- Fexmid (cyclobenzaprine) tablets
- Kalydeco (ivacaftor) tablets, packet
- Marinol (dronabinol) capsules
- Otezla (apremilast) tablets
- Revatio (sildenafil) suspension
- Stelara (ustekinumab) solution
- Technivie (ombitasvir, paritaprevir, ritonavir) tablets
- Baclofen (Gaboflen/Lioresal) IT
- Carisoprodol Products
- Daklofenac (Flector) Patch
- Lidocaine (Lidoderm) Patch
- Transmucosal Immediate-release Fentanyl (TIRF)
- Armadafinil (Nuvigil)
- Modafinil (Provigil)
- Tadalafil (Adcirca/Cialis)
- Tadalafil (Sildenafil) suspension
- AbobotulinumtoxinA (Dysport)
- OnabotulinumtoxinA (Botox)
- IncobotulinmtoxinA (Xeomin)
- Hydrocodone (Zohydro)
- Olysio
- Sovaldi
- Harvoni
- Somatropin products:
  » Genotropin
  » Humatrope
  » Norditropin
  » Nutropin
  » Nutropin AQ
  » Omnitrone
  » Saizen
  » Serostim
  » Zorbative
  » Tev Tropin
Kaiser Permanente ClaimsConnect

Our new claims processing system, Kaiser Permanente ClaimsConnect, has been up and running since February 8, 2016 and claims are now being processed by our centralized National Claims Administration (NCA).

We are pleased to say that we are processing claims at a faster rate and with more efficiency. Although as with any new system implementation, there are always some obstacles to overcome in the beginning. Over the past few months we have been closely monitoring the new process. Here are a few helpful tips to ensure that your claims are efficiently processed and paid:

- The best method for claim submission is electronic. It is more efficient and faster than paper claim processing and you will receive a claim acceptance through your clearinghouse. Use the 837P and 837I format. Our electronic payor ID has not changed, it is: 52095.
- For paper claims, use industry standard pre-printed RED claim forms. CMS-1500 (02-12) version for professional claims and UB-04 (CMS-1450) for institutional claims. Color photo copies or copies printed on color printers are not acceptable as the red color and the scaling of the image result in poor quality of the data on the form.
- Be sure to use current valid procedure codes and ICD-10 diagnosis codes.
- Our National Claims processing center receives claims for five different Kaiser Permanente regions and each region has a unique PO Box. Please make sure you send your claim to the correct PO Box for Mid-Atlantic States.
  Kaiser Permanente
  Mid-Atlantic Claims Administration
  P.O. Box 371860
  Denver, CO 80237-9998

- List the member’s name and unique medical record number as it appears on the Kaiser Permanente medical ID card.
- Other insurance (i.e. Medicare): For CMS-1500, use boxes 9 and 11 to indicate the other health benefit plan. For UB-04, other insurance information should be entered into boxes 50-54 and insured’s information into boxes 58-60. Include the EOB/EOMB along with the claim.
- If you are submitting additional information for a claim, please include the assigned claim number, Kaiser Permanente member ID number, date of service, and billed amount to help identify which claim the additional information is associated with.
- When submitting a corrected claim, identify the claim using the correct submission type: CMS-1500 forms – use “7” for Resubmission Code in box 22 and Kaiser assigned claim number in Original Ref. No. field in box 22. UB-04 – indicate a resubmission for Type of Bill in box 4 (ex.: original bill type of 0131 will have a resubmission bill type of 0137)
- Rendering provider information: CMS-1500 – only the NPI is required in box 24J. UB-04 – submit NPI and name as needed in boxes 76-79.
- For professional claims billing consultation codes: Effective January 1, 2010, consultation codes are no longer payable by Medicare. CMS has advised physicians to use the appropriate new or established patient evaluation and management (E/M) code that represents where the visit occurs and that identifies the complexity of the visit performed. (For example: a new patient seen in the office would be billed the corresponding code in the 99201-99205 range and for a patient seen inpatient after admission would be billed the corresponding code in the 99231-99233 range.)
- Non-claims correspondence (disputes, appeals): Indicate on a cover sheet, the reason for the correspondence, member name, Kaiser Permanente medical ID number, and associated Kaiser Permanente claim number. This will aide in the processing of the correspondence.

Below are sample claim forms that highlight the key areas listed above. For additional information on Kaiser Permanente ClaimsConnect and NCA, you can visit our Community Provider Portal at providers.kaiserpermanente.org/mas or contact Provider Relations at 1-877-806-7470.
Enter Kaiser Permanente unique medical ID number and member name as it appears on the ID card.

For corrected claims, enter “7” in box 22 and the Kaiser Permanente claim number under Original Ref. No.

Only NPI is required in box 24J.

Indicate other insurance information here in boxes 9 & 11.
Indicate all insurance information in boxes 50-54, including other insurance. Enter the member’s name and Kaiser Permanente unique medical ID number as it appears on the ID card in boxes 58-60.

For corrected claims, indicate a resubmission in box 4 (ex.: original bill type of 0131 will have a resubmission bill type of 0137).

Enter Kaiser Permanente authorization number(s) in box 63.

Enter NPI and name of rendering provider as needed.
Kaiser Permanente electronic payment and remittance advice centralized enrollment processing

Kaiser Permanente has partnered with CAQH to process Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERAs) enrollments. With this partnership, Kaiser Permanente is moving to a National EFT/ERA enrollment platform. We request that all providers pursuing EFT/ERA enrollments utilize the CAQH web portal for these activities. The portal is available 24 hours a day/seven days a week for first time enrollment or changes.

Enrolling in EFT/ERA will provide the following benefits:
• Receive claims payments and remittance data faster and more efficiently,
• reduce processing costs, and
• improve office workflow.

If you are already enrolled in ERA & EFT with other insurers, you still must enroll with Kaiser Permanente and select the correct region to receive ERA & EFT.

Kaiser Permanente Regions:
• Kaiser Foundation Health Plan NORTHERN CALIFORNIA REGION.
• Kaiser Foundation Health Plan SOUTHERN CALIFORNIA REGION.
• Kaiser Foundation Health Plan COLORADO.
• Kaiser Foundation Health Plan MID ATLANTIC STATE REGIONS (MD, VA, Washington DC).
• Kaiser Foundation Health Plan NORTHWEST REGION (OR, WA).

Important Note: If you are a provider retrieving ERAs from a clearinghouse, you must remember to also complete the ERA set up with your clearinghouse as well as with Kaiser via the CAQH EnrollHub.

It is easy to get started now

Visit solutions.caqh.org for information and to create your secure account.

Or, speak with the CAQH EnrollHub Helpline at 1-844-815-9763.

Representatives are available 7 AM - 9 PM EST Monday - Thursday and 7 AM - 7 PM EST Friday.
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 or to supplement discussion from 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 is also embedded into KP HealthConnect for inclusion in member After Visit Summary or sent via secure messaging. For health education programs, providers can:

• Refer or direct book members into health education programs through eConsult system
• Provide members with information on how to self-register through KP HealthConnect After Visit Summary or hard copy flyers

Additional information on health education programs, tools, and resources is available by:
• Visiting kp.org/healthyliving
• Contacting the Health Education automated line (301) 816-6565 or 1-800-444-6696 (toll free)

Keeping the Provider Directory up to date

Please use the sample letter format on the next page to update us with any changes you may have throughout the year. It is very important that we have the most accurate information when we pull our data for the directory.

Changes may be made by fax to: (855) 414-2623, email Provider.Relations@kp.org, or by mail:
Kaiser Foundation Health Plan of The Mid-Atlantic States, Inc.
Provider Relations; Flr 2 East
2101 East Jefferson St.
Rockville, MD 20852

If you would like to request a provider directory please contact Member Services:
• For within the Washington, D.C., metro area call (301) 468-6000, (301) 879-6380 TTY
• All other areas outside of Washington, D.C., metro area call 1-877-777-7902, 1-800-700-4901 TTY
Requestor:
Requestor’s Correspondence Address:
Requestor’s Phone #:
Email:
Tax ID#:
Effective date of change(s):

Reason for the request:

**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 and NPI)
- Billing/Payment Address
- Management Correspondence Address (include Phone & Fax Number)

**Adding a provider to an existing group or deleting a provider from an existing group**
- Specify if adding or deleting provider
- Include the below listed information if adding or deleting a provider:
  * First Name, Middle initial, and Last Name
  * Gender
  * Date of Birth
  * Title or Degree
  * NPI #
  * CAQH #
  * UPIN or SSN
  * Medicare #
  * Medicaid Participation State(s)
  * Medicaid #
  * Primary Specialty (include secondary specialty if applicable)
  * Practice location (include Phone & Fax Number)
  * Billing/Payment Address
  * Management Correspondence Address (include Phone & Fax Number)
  * Foreign Languages
  * Effective date

**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 a signed and dated copy of the new W-9
- Billing/Payment Address
- Management Correspondence Address (include Phone & Fax Number)

**Email your letter to the Provider Relations Department at Provider.Relations@kp.org or fax to (855) 414-2623.**
View your claim status online now!

You are now able to view claims and check claim statuses electronically through our Kaiser Permanente Online Affiliate site. In order to access your claim records, each individual user must be enrolled for access to our Kaiser Permanente Online Affiliate site. If you have not already registered for access to Kaiser Permanente Online Affiliate, please do so at providers.kaiserpermanente.org/mas under the link “Online Affiliate Registration.” If you are already enrolled and having trouble accessing the site or need help enrolling online, please contact Provider Relations at 1-877-806-7470 for assistance.

Digital membership cards

Kaiser Permanente – Mid-Atlantic States has introduced a digital membership card – an electronic version of the physical membership card that eligible* Kaiser Permanente members can access via the Kaiser Permanente app on their smartphones.

The digital membership card does not replace the physical membership card, which we will continue to distribute and accept.

During an initial internal promotional period, we will encourage Kaiser Permanente physicians, providers, and staff who are also members to use the digital membership card. We plan to promote it to all members later this year.

Members will be able to use the digital membership card for services such as checking in for appointments and prescription pickup at Kaiser Permanente and participating affiliate facilities. Members also will have the ability to display digital membership cards for their family members and dependents on their mobile devices, and can email a copy of their digital membership cards to participating providers.

When a member presents for service with a digital membership card, your check-in procedure should remain the same. Your staff should validate membership as they currently do. Remember to record the medical record number and to ask the member to show a photo ID.

If you should have any questions about the new digital membership card, please email Provider Relations at Provider.Relations@kp.org.

* Until further notice, the digital membership card is not available to members in certain plans including Medicare, Medicaid, out-of-area, Flexible Choice Three Tier Point-of-Service, and FAMIS.
Utilization management affirmation 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.