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.

April 2020

Contents

COVID-19: World Health Crisis

COVID-19 continues to impact communities in the Mid-Atlantic region, and throughout the United States and world. We appreciate your partnership on our response to addressing the spread of the virus; and providing prompt and compassionate care to our members and patients.

We are working to address questions you have, and in this newsletter, are providing responses and direction for those we have received from our participating providers. We will continue to keep you informed as the situation evolves.

Member and Patient Costs
Members will not have to pay for costs related to COVID-19 screening, diagnosis, testing or treatment. This includes the care that your facility or practice provides to our members.

We believe that cost should not be a barrier to screening or testing for our members who have received a doctor's order to be tested or treated. Effective March 6, 2020, Kaiser Permanente will not charge member cost-sharing (co-pays, deductibles and/or coinsurance) for all medically necessary screening, diagnosis, testing and treatment for COVID-19. This policy applies to the cost of the visit, associated lab tests and radiology services at a hospital, emergency department, urgent care and provider offices where the purpose of the visit is to be screened, diagnosed, tested or treated for COVID-19. ***Note:*** *All self-funded members will have $0 cost sharing for screening, testing and diagnosis; however, some self-funded members may encounter a cost share for treatment of COVID-19 at the election of the employer group.*

COVID-19: World Health Crisis - *Continued from page 1*

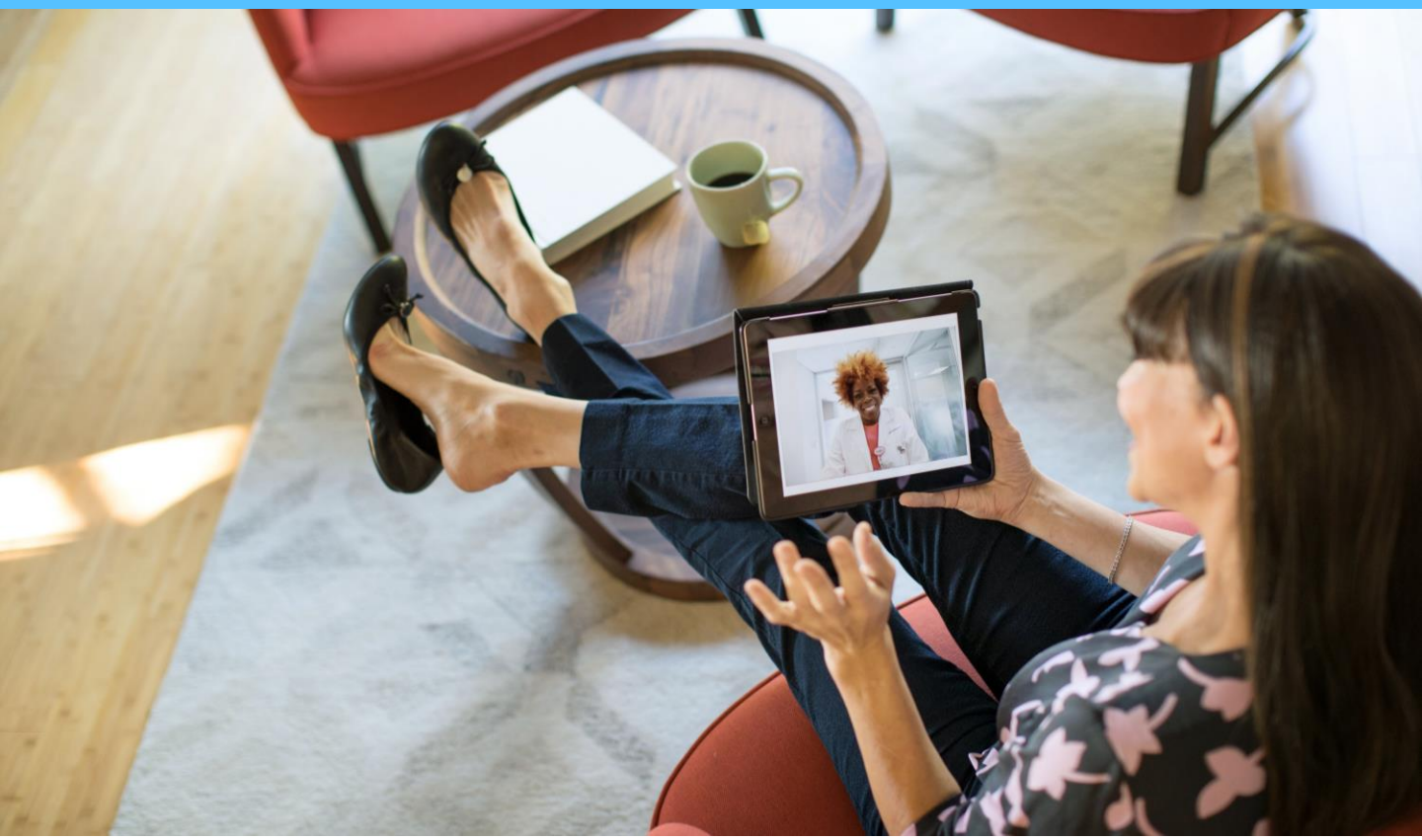
There is no need to seek additional authorization to provide COVID-19-associated screening, diagnosis testing or treatment for our members.

Please do not collect cost sharing for COVID-19 screening, diagnosis or testing or treatment-related services from our members. COVID-19 coding information is provided later in this notice.

Note: *There is a temporary exception for Virginia Medicaid members. For more information, see "**Virginia Medicaid Member and Out-of-Pocket Costs**," below.*

COVID-19 Cost-Sharing Waiver Discontinuation
Providers will be notified by letter, in the same manner as for this communication, when the COVID-19 cost sharing waiver discontinues. The update will also be posted to Kaiser Permanente of the Mid-Atlantic States' Community Provider Portal (CPP) at **providers.kp.org/mas**. You are encouraged to visit the CPP for ongoing updates and information about this initiative.

Appointments for Kaiser Permanente Members Experiencing COVID-19 Symptoms
For those of you seeking to direct members to their KP providers for COVID-19 symptoms, testing or care, please advise them that we encourage members or their dependents who have recently traveled to an area of risk or think they have been exposed to the virus and are experiencing symptoms of COVID-19, like respiratory illness, to call the appointment and advice line at 703-359-7878 or 800-777-7904 (711 TTY) so we can assist with directing their care. To reduce possible exposure to others, we prefer that these members **not** make an appointment online or go directly to one of our facilities without calling ahead first.



COVID-19: World Health Crisis - *Continued from page 2*

Providing Telehealth Visits

We appreciate your efforts to limit the spread of COVID-19 in the community and encourage the use of telehealth visits. You may convert authorized office visits to telehealth visits, where clinically appropriate and technology is available, without seeking additional authorization from Kaiser Permanente.

Please ensure that you request a visual verification of members' Kaiser Permanente Identification Cards during telehealth visits, just as you would in-person in your medical office setting. All members (Commercial, Individual and Family, Medicare and Medicaid) are covered for telehealth visits. While most members receive no-charge for telehealth visits, please use Online Affiliate to confirm the cost sharing for High Deductible Health Plan/HSA-qualified members who must first meet their deductible for telehealth visits unrelated to COVID-19 diagnosis and testing.

Kaiser Permanente will follow Medicare rules regarding telehealth visits for commercial members as outlined in "Medicare Telehealth Frequently Asked Questions," dated March 17, 2020.

- **For eligible telehealth visits provided to Commercial or Medicare members**: Please use POS (place of service) "02" when submitting your professional services claims for these encounters.
- **For eligible telehealth visits provided to MD Medicaid members:** Telehealth services are identified with a "-GT" modifier and are billed using the place of service code that would be appropriate as if it were a non-telehealth claim.

Please go to the CPP at **providers.kp.org/mas** for further details on use of the Medicare method and MD Medicaid method for telehealth visit billing. Additional coding information is provided later in this notice for COVID-19 related care.

COVID-19: World Health Crisis - *Continued from page 3*

Care Notes
Providers are encouraged to provide members with a written clinical summary of COVID-19 screening, diagnosis, testing and treatment results that members can then share with their Kaiser Permanente care team.

COVID-19 Testing
The latest CDC and health authority guidance directs clinicians to use their judgment to determine if a patient has signs and symptoms of COVID-19 and should be tested. For the most up-to-date coronavirus care guidelines from the CDC visit **www.cdc.gov/coronavirus**.

COVID-19 testing requires specimens from the nose, throat or lungs which must be collected by a health care provider. Patients may not request tests directly from approved clinical laboratories. COVID-19 tests are only available by a doctor's order.

COVID-19 Lab Test Coding
All COVID-19 lab tests should be coded using the following procedure codes. These tests are no-charge to all members.

Procedure Codes	Description
U0001	Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Test Panel **(Use only for tests performed by CDC)**
U0002	Private labs (e.g. Quest) 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) **(Use for Medicare members or Commercial members)**
87635	Infectious agent detection by (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) [COVID-19] **(Do not use this procedure for Medicare members)**
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

Other Associated Diagnostic Testing	
87400	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; **Influenza, A or B, each**
87486	Infectious agent detection by nucleic acid (DNA or RNA); **Chlamydia pneumoniae**, amplified probe technique
87581	Infectious agent detection by nucleic acid (DNA or RNA); **Mycoplasma pneumoniae**, amplified probe technique
87633	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets

COVID-19: World Health Crisis - *Continued from page 4*

Virginia Medicaid Member and Out-of-Pocket Costs
Effective March 16, 2020, the Virginia Department of Medical Assistance Services has directed all Medicaid Fee-for-Service Providers and Medicaid Managed Care Organizations, of which Kaiser Permanente is a participating provider, to eliminate cost sharing **for all visits and services** as of March 16, 2020.

Prescription Drug Coverage and Mail Order Pharmacy
It's a good idea for members to refill their prescriptions online and have them delivered by mail.

You may receive member requests for prescription drug refills that you've prescribed. In your clinical judgment, please process these requests as expeditiously as possible.

Members can avoid standing in line by receiving prescriptions through our mail order service. Members can sign up on **kp.org/rxrefill** and receive their medications in about 3-5 business days. For urgent prescriptions, members should visit their closest Kaiser Permanente medical center pharmacy.

We have relaxed our "refill too soon" edits to permit earlier access to refills. Additionally, on a case by case basis, using clinical judgment and in compliance with regional or state executive orders, a pharmacist may dispense a refill even sooner than the edit allows. Regular benefit co-pays will apply to prescription drugs.

We are also monitoring all regional, state and federal emergency executive orders and will comply with any requirements related to prescribing and dispensing.

Monitoring Drug Supply Chains
We are closely monitoring the drug supply chain to identify any potential shortages of drugs produced in countries affected by COVID-19.

Our physicians, pharmacists and supply chain specialists continually work together to ensure that our members have access to needed medication. Within our integrated health system, we take steps such as identifying alternate supply sources or therapeutic agents whenever a drug shortage issue is identified, working closely with our physicians.

COVID-19: World Health Crisis - *Continued from page 5*

If there is any issue with a medication a member is taking, they will be notified about what they need to do. As always, members are encouraged to ask their physician or pharmacist about any concerns they have.

COVID-19 ICD-10 Coding

Proper diagnosis is needed to represent the care provided and ensure we can identify and track the at-risk population. As a reminder, effective March 6, 2020, all visits associated with screening, testing, diagnosis and treatment for the COVID-19 will be no charge for all members. The no charge coverage includes visits, associated labs, radiology and vaccine (when available) if members suspect or were exposed to the coronavirus or are under investigation for exposure to COVID-19. Medically necessary treatment of COVID-19 is also being covered at no-charge.

Please use the scenarios below to find the most specific and accurate diagnosis code. Using these codes will support no-charge claims processing associated with COVID-19 screening, diagnosis, testing and treatment services.

Care Scenario	Use ICD-10 DX Code:
Concern about a possible exposure to COVID-19, but ruled out after evaluation	z03.818: Encounter for observation for suspected exposure to other biological agents ruled out
Actual or suspected exposure to someone who is infected with COVID-19; Person under investigation	z20.828: Contact with and (suspected) exposure to other viral communicable diseases
Asymptomatic patient screened for COVID-19	Z11.59: Encounter for screening for other viral diseases
Confirmed Coronavirus	U07.1: 2019-nCoV acute respiratory disease
Case of acute bronchitis confirmed as due to COVID-19	U07.1: 2019-nCoV acute respiratory disease **and** J20.8: Acute bronchitis due to other specified organisms
Cases of Bronchitis not otherwise specified (NOS) due to the COVID-19	U07.1: 2019-nCoV acute respiratory disease **and** J40: Bronchitis, not specified as acute or chronic
Cases of lower respiratory infection, not otherwise specified (NOS) or an acute respiratory infection, NOS associated with confirmed COVID-19	U07.1: 2019-nCoV acute respiratory disease **and** J22: Unspecified acute lower respiratory infection
Cases of respiratory infection, NOS due to COVID-19	U07.1: 2019-nCoV acute respiratory disease **and** J98.8: Other specified respiratory disorders
Cases of ARDS (Acute Respiratory Distress Syndrome) due to COVID-19	U07.1: 2019-nCoV acute respiratory disease **and** J80: Acute respiratory distress syndrome

COVID-19: World Health Crisis - *Continued from page 6*

On February 20, 2020 the CDC announced a new ICD-10, U07.1: 2019-nCoV acute respiratory that became effective on April 1, 2020 and may not be used for billed claims until that date.

For more information related to CDC's ICD-10-CM Official Coding Guidelines - Supplement Coding encounters related to COVID-19 Coronavirus Outbreak please go to: **https://www.cdc.gov/coronavirus**.

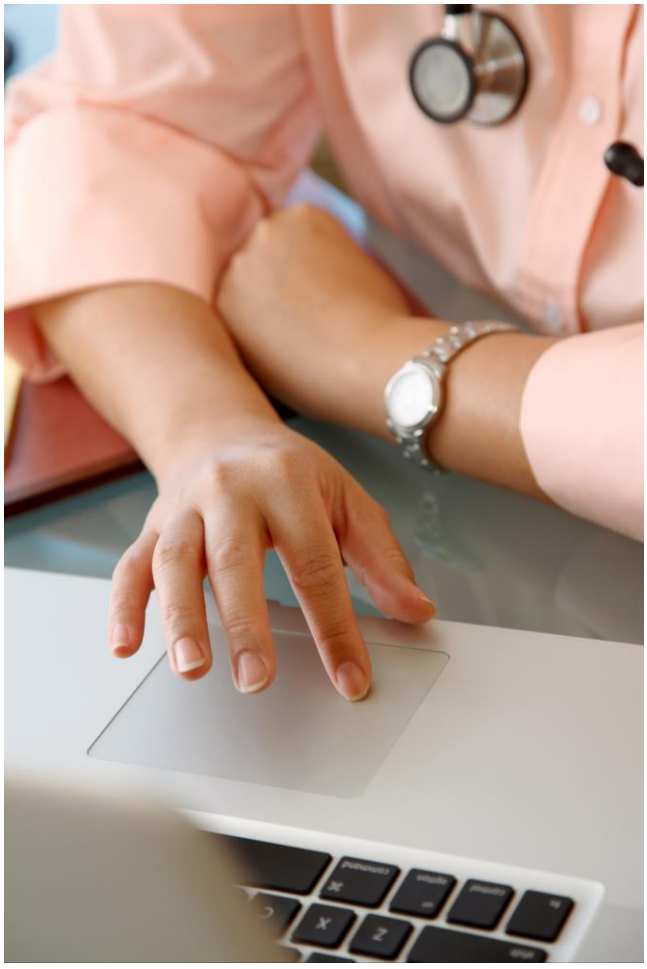
We will provide any additional information regarding COVID-19 coding to you as quickly as possible.

Encourage Self-Isolation and Social Distancing
Self-isolation and social distancing can limit the exposure of the virus to vulnerable individuals. For questions about self-isolating and social distancing, please refer to CDC guidance at: **https://www.cdc.gov/coronavirus**.

We will continue to keep you informed about changes and answer your questions as the situation evolves. If you have additional questions, please contact your account manager or email us at **provider.relations@kp.org**. You may also visit **kp.org** and the Community Provider Portal for continued updates.

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 the patient visit.



Content is viewable 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 are also embedded into KP HealthConnect for inclusion in the member *After Visit Summaries*, sent via secure messaging, or mailed directly to the patient's home. For health education programs, providers can:

- Refer or direct book members into health education programs through the eConsult system.
- Use KP HealthConnect, After Visit Summaries, hard copy flyers, or provide members with Call Center 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 301-816-6565 or 800-444-6696 (toll free).

Utilization Management Update November 2019 – January 2020

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) and Transplant Patient Selection Criteria were approved between **November 2019 to January 2020.**

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.

Updated Utilization Management (UM) Criteria, National Transplant Service (NTS) Patient Selection Criteria and Medical Coverage Policies

A. UM Nationally Recognized Criteria

1. Milliman Care Guidelines (MCG) 24th Edition

MCG are evidence-based clinical guidelines that span the continuum of care. They provide best practices criteria and content for healthcare professionals in most healthcare settings supporting decisions and easing patient transitions between settings.

The MCG 24th edition will be released by Spring of 2020 after systematic evidence-based review by MCG. Care Guidelines products licensed for Kaiser Permanente Mid-Atlantic States (KPMAS) include:

a. Ambulatory Care Guidelines - authorize established and emerging outpatient clinical procedures and technologies. The Ambulatory Care product covers procedures and diagnostic tests; imaging studies; injectable and other pharmacologic agents; durable medical equipment, prosthetics, orthotics and supplies; rehabilitation evaluations, services and modalities and referral management.

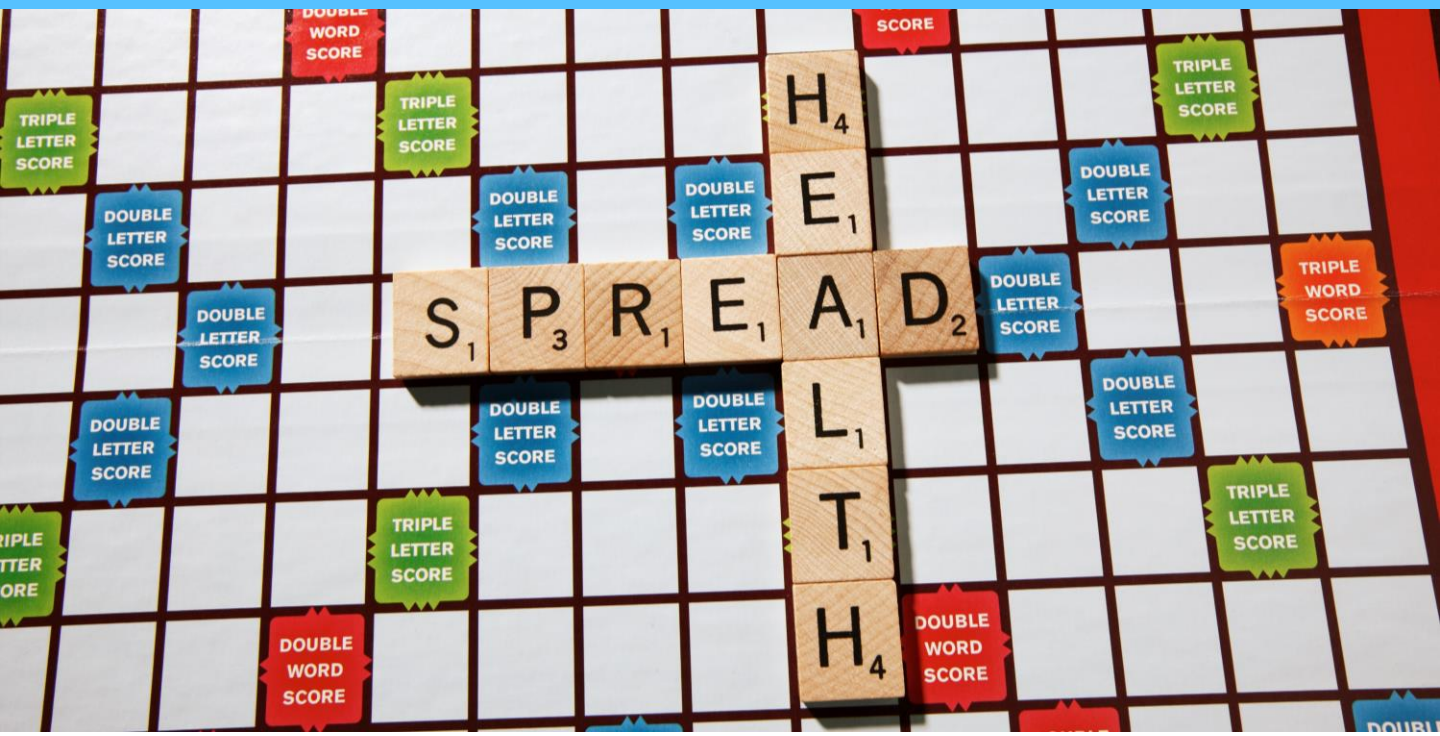
b. Behavioral Health Guidelines - address specific psychological, behavioral and pharmacologic therapies. This product covers 15 diagnosis groups at seven levels of care to help integrate behavioral health care with other utilization management efforts.

c. General Recovery Guidelines - support clinical decision-making when there is not a guideline for the diagnosis, or when the clinical situation is so complex that a specific guideline does not fit. These guidelines and tools expand the Care Guidelines to cover the entire spectrum of conditions and procedures requiring hospital admission, including complex cases.

d. Home Care Guidelines - maintain quality and efficiency beyond healthcare facility walls. The Home Care product enables well-defined and coordinated care plans to support patients at home, including therapy visit goals.

e. Inpatient and Surgical Care Guidelines - anticipate appropriate clinical resources and identify the next steps in proactive care for inpatients. This product provides detailed care pathways, admission and discharge criteria, goal lengths of stay, and other decision-support tools.

f. Recovery Facility Care Guidelines - coordinate plans for moving patients to -- and through -- recovery facilities to other appropriate care settings. This product provides recovery facility admission care and discharge criteria, including complete discharge plans.



Utilization Management Update November 2019 – January 2020 – *Continued from page 8*

The 24th edition release will include:

- Inpatient & Surgical Care: New guidelines addressing Readmission Risks and a Neonatal Facility Levels of Care Comparison Chart.
- Ambulatory Care: New guidelines for genetic medicine, imaging and specialty medications.
- Behavioral Health Care: New guidelines for therapeutic services.
- Home Care: Utilization models in Benchmarks and Data and new guidelines for behavioral health, orthopedics and pediatrics.
- Chronic Care: New assessments for wellness and self-care.
- Transitions of Care: New Home Health Assessment Tool & Skilled Nursing Facility Assessment Tool.
- Patient Information: New inpatient and discharge information for pediatric populations.
- References are now included in various calculators across our guidelines.
- Reviewer Statistics Dashboard in Cite and Indicia software solutions.

2. InterQual Level of Care for Transplant-Related Services, Adult and Pediatric

InterQual Level of Care is a commercially available criterion providing support for determining the medical appropriateness of hospital admission, continued stay and discharge. When a patient is admitted for transplant related services, except for Kidney Transplants, NTS transplant coordinators follow the patient using InterQual as the inpatient continued stay criteria set. The criteria set is updated annually by McKesson Health Solutions and the transplant coordinators are tested annually to establish inter rater reliability.

Utilization Management Update November 2019 – January 2020 – *Continued from page 9*

InterQual Level of Care Criteria Description

- **InterQual Acute Adult Criteria**

Help determine the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are age 18 or older. InterQual Acute Adult Criteria are organized by primary condition in this new 'condition specific' model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.

- **InterQual Acute Pediatric Criteria**

Help determine the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are less than 18 years of age. InterQual Pediatric Criteria also are organized by primary condition in a 'condition specific' model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.

3. **Medicare Coverage Database for National Coverage Determinations (NCD) and Local Coverage Determination (LCD) for Durable Medical Equipment (DME) and Supplies**

- UM will continue to use **Centers for Medicare and Medicaid Services (CMS): National and Local Coverage Determinations** as the primary criteria for Medicare Cost and Medicare Advantage members; and
- UM will continue to use **CMS National and Local Coverage Determinations** for DME, orthotic and prosthetic devices and services **only** in the absence of MCG or medical coverage policy for Commercial and Medicaid members in Maryland and Virginia

Coverage is limited to DME items and supplies that are reasonable and necessary for the diagnosis or treatment of an illness or injury. NCDs are made through an evidence-based process, which includes CMS' own research and is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development and Coverage Advisory Committee. In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on LCD.

The Medicare Coverage Database (MCD) contains all NCDs and LCDs, local policy articles and proposed NCD decisions. The database also includes several other types of national coverage policy related documents, including national coverage analyses, Medicare Evidence Development & Coverage Advisory Committee proceedings and Medicare coverage guidance documents.

Utilization Management Update November 2019 – January 2020 – *Continued from page 10*

4. American Society of Addiction Medicine (ASAM) Criteria

The ASAM Criteria are outcome-oriented treatment and recovery services, designed by the ASAM and funded by the U.S. Substance-Abuse and Mental Health Services Administration (SAMHSA) to enhance the use of multidimensional assessments in developing patient-centered plans and to guide clinicians, counselors and care managers in making objective decisions on patient admissions, continuing care and transfer/discharge for addictive substance-related and co-occurring conditions and various levels of care intended to encourage further patient-matching and placement research. The result-based clinical care guidelines reflect a clinical consensus of adult and adolescent addiction treatment specialists, developed through the incorporation of extensive field review comments**.**

- The ASAM criteria is used for all Virginia Medicaid chemical dependency level of care decisions and referral determinations, as required by the Virginia Department of Medical Assistance Services (DMAS) on April 1, 2017. As of January 1, 2020, ASAM criteria is also used for Maryland Commercial and Federal Plans.
- The ASAM criteria is applied to all substance-use disorder (SUD) for Maryland Individual and Group commercial health plans effective January 1, 2020. MCG criteria is no longer used for MD Commercial Members SUD in 2020.

5. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines

EPSDT will continue to be in use for Medicaid members in Maryland and Virginia as required by the federal government. The federal mandated services include screening, vision, dental, hearing and diagnostic services in addition to treatment health care services for all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures. The federal requirements for children under age 21 who are enrolled in Medicaid may be found at **Medicaid.gov** by searching the term “EPSDT.”

6. Virginia Medicaid Community Mental Health Rehabilitative Services (CMHRS) Manual (for Virginia Premier’s Behavioral Health Services)

CMHRS are behavioral health services that provide clinical treatment to individuals with significant mental illness or emotional disturbances. CMHRS benefits are available to individuals who meet the service specific medical necessity criteria based on diagnoses made by Licensed Mental Health Professionals (LMHPs), practicing within the scope of their licenses.

CMHRS, Chapter IV of the DMAS Manual provide details on eligibility criteria, medical necessity criteria and coverage requirements for behavioral health interventions.

Utilization Management Update November 2019 – January 2020 – *Continued from page 11*

Community Services Boards/Behavioral Health Authorities

- Meet the residential, outpatient, employment and day support service needs of individuals with severe mental illness.
- Offer opportunities for occupational and residential independence for individuals with intellectual disability.
- Effectively treat individuals with substance use disorders.
- Support the efforts of schools, Departments of Social Services, law enforcement agencies and courts in a coordinated manner.
- Prevent further incidence of mental illness, intellectual disability and substance use disorders.
- Assist families in caring for members with mental illness, intellectual disability and substance use disorders.

CMHRS Services

a. **Intensive In-Home (IIH) for children and Adolescents** (H2012) **under age 21** are provision of intensive therapeutic interventions in the individual's residence (or other community settings as medically necessary and documented in the Comprehensive Needs Assessment and Individual Service Plan (ISP)), to improve family functioning and significant functional impairments in major life activities that have occurred due to the individuals' mental, behavioral or emotional illness in order to prevent an out of home placement, stabilize the individual and gradually transition the individual to less restrictive levels of care and supports.[1]

b. **Therapeutic Day Treatment (TDT) for Children** – are services that provide medically necessary, individualized and structured therapeutic interventions to children/adolescents with mental, emotional, or behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. [1]

c. **Day Treatment/Partial Hospitalization for Adults (H0035 HB)** – are interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition.[1]

d. **Psychosocial Rehab (H2017)** - is a program of two or more consecutive hours per day provided to groups of individuals in a community, nonresidential setting who require a reduction of impairments due to a mental illness and restoration to the best possible functional level in order to maintain community tenure.[1]

e. **Crisis Intervention (H0036)** – provision of immediate mental health care in the home or community, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention, available 24 hours a day, seven days per week.[1]

Utilization Management Update November 2019 – January 2020 – *Continued from page 12*

f. Intensive Community Treatment (ICT) (H0039) – provision of long term needed treatment, rehabilitation and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services in the community. [1]

g. Crisis Stabilization (H2019) – are services that provide intensive short-term mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature. The goal is to address and stabilize the acute mental health needs at the earliest possible time with ongoing services, avert hospitalization or re-hospitalization; provide a high assurance of safety and security in the least restrictive environment and mobilize the resources of the community support system, family members and others for ongoing maintenance, rehabilitation and recovery.[1]

h. Mental health skill-building services (MHSS) are provision of goal directed training and support to enable restoration of an individual to the highest level of baseline functioning and achieve and maintain community stability and independence in the most appropriate, least restrictive environment.[1]

i. Mental Health Case Management (H0023) – are services that are designed to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational and other services.[1]

j. Behavioral Therapy/Assessment (H2033/H0032 UA)

k. Mental Health Peer Support Services or Family Support Partners – Individual (H0025)[2]

l. Mental Health Peer Support Services or Family Support Partners – Group (H0024)[2]

- *Please refer to the DMAS Manual, Peer Services Supplement for information on Peer Support Services*

- Definition of CMHRS services were taken from Chapter IV of the DMAS CMHRS Manual[1]
- CMHRS criteria on coverage, eligibility, medical necessity criteria, service requirements, service units, service limitations, discharge criteria and exclusion criteria of are detailed in Chapter IV of the DMAS CMHRS Manual[1]

[1] *DMAS Manual: CMHRS, Chapter IV Covered Services and Limitations, 05/14/2019*
[2] *DMAS Manual, Peer Services Supplement for information on Peer Support Services*

Utilization Management Update November 2019 – January 2020 – *Continued from page 13*

B. NTS Patient Selection Criteria

Standards, Criteria and Interpretive Guidelines developed by Kaiser Permanente NTS

Transplant Patient Selection Criteria
Bone Marrow Transplant
Mechanical Circulatory Support Devices as a Bridge to Cardia Transplant
Heart Transplant
Lung and Heart-Lung Transplant
Intestine & Intestine/Liver Transplant
Liver Transplant
Kidney Transplant
Pancreas Transplant Along (PTA) + Pancreas After Kidney (PAK) Transplant
Simultaneous Pancreas / Kidney (SPK) Transplant

C. Updated Medical Coverage Policies

1. Nutritional Support

Effective date: November 20, 2019

- Section IV, C #1. Pediatric Coverage: exclusion of Federal Employees Health Benefits Plan (FEHBP) members from coverage
- References were updated

2. Preimplantation Genetic Diagnosis (PGD)

Effective date: November 20, 2019

- Section IV. Indications for coverage:
  - A 2-3 Detection of a genetic disorder in an embryo updated
  - Clarification on in-vitro fertilization (IVF) procedures, as secondary process to PGD treatment.
- Benefit alert updated
- References updated

3. Orthotics

Effective date: November 20, 2019

- Section VI. Joint Orthotics: Addition of hinged knee brace
- References were updated

Utilization Management Update November 2019 – January 2020 – *Continued from page 14*

4. **Habilitative Services, Maryland Jurisdiction**

   Effective date: November 22, 2019

   - Section D. Speech and Occupational Therapy exclusions updated
   - References were updated

5. **Habilitative Services, DC Jurisdiction**

   Effective date: November 22, 2019

   - Section D. Speech and Occupational Therapy exclusions updated
   - References were updated

6. **Habilitative Services, VA Jurisdiction Mid-Large Group Plan**

   Effective date: November 22, 2019

   - Section I: Added the word “Habilitative Services” to scope of MCP
   - Section II, A # 6: Coverage Overview and Section IV, B; Service Coverage by Age – Assistive technologies and devices removed from habilitative services coverage.
   - Age limit removed effective January 1, 2020 per recent update to Virginia Law § 38.2-3418.17.1

     Update made on:

     - Section IV A, C # 1 & Section IV, D: Service Coverage by Age: ABA treatment age limit removed
     - Section VIII, H: Definitions – EPSDT’s age limit removed.
   - Section IV, D and Section VII, D & E. Coverage clarified - VA Premier’s contract on EPSDT and Applied Behavior Analysis (ABA) benefit coverage are only applicable to VA Medicaid program and not the FAMIS plan.
   - Section VI, A: Exclusions on Speech and Occupational Therapy updated
   - References were updated

Utilization Management Update November 2019 – January 2020 – *Continued from page 15*

7. **Habilitative Services, VA Jurisdiction Small Group/Kaiser Permanente for Individuals and Families (KPIF) Plan**

   Effective date: November 22, 2019

   - Section II, A & B: maximum visit limit of 30 visits for each outpatient habilitative physical therapy, speech therapy and occupational therapy per member contract year will apply separately to habilitative and rehabilitative services.
   - Section II, C: reference to member's Evidence of Coverage (EOC) for benefit-specific limitations and exclusions.
   - Section III. Speech and Occupational Therapy exclusions updated
   - References were updated

8. **Compression Garments and Pneumatic Devices**

   Effective date: December 20, 2019

   - Benefit Alert section: Medicare Cost and Senior Advantage members who meet the medical coverage criteria will qualify to have coverage of compression garments & pneumatic devices as Kaiser Permanente's supplemental benefit.

9. **Acupuncture**

   Effective date: December 20, 2019

   - Section 2-C Allergic Rhinitis as an indication for acupuncture deleted
   - References were updated

10. **Vitiligo Treatment**

    Effective date: December 20, 2019

    - Section II Coverage and Exclusions
      - A. Covered Condition: # 2 Permanent depigmentation deleted
      - B. Criteria and Limitations:
        - B # 2 psoralen and ultraviolet A (PUVA) or narrowband ultraviolet B (NB-UVB) therapy deleted
        - B # 3 Medical supervision during PUVA treatment deleted
        - B # 6 Home based phototherapy NB-UVB added, coverage guideline reflected under Home Phototherapy MCP
      - C. Exclusions
        - Deleted: # 3 Home based phototherapy NB-UVB, #4 Home phototherapy units, # 5 NB-UVB therapy in combination with Vitamin D analogues
        - Added: # 5 split thickness skin grafting added as experimental and investigational
    - References were updated

Utilization Management Update November 2019 – January 2020 – *Continued from page 16*

11. Wide Bore Magnetic Resonance Imaging (MRI) and Open MRI

Effective date: December 20, 2019

- Section II, A Referral procedure for members with subjective claustrophobia
  - Section II, A # 5: Added Tysons Corner as one of the KPMAS Medical Center who offer MRI with intravenous (IV) sedation
  - Section II, A # 6: Deleted Medicare' geo-access since most Medicare patients are now covered under Medicare Advantage plans.
- References were updated

12. Reauthorization for Spinal Manipulation Therapy and Chiropractic Treatment

Effective date: December 20, 2019

- Section IV, A 2. Re-authorization of Spinal Manipulation Therapy and Chiropractic Care - authorization to initiate treatment increased to 5 visits while reauthorization increased up to 5 visits.
- References were updated

13. Mastectomy Prosthesis

Effective date: January 14, 2020

- Section III, A Clinical Indications for Referral
  - # 4, d: Added the word "breast" to Post-surgical breast form in camisole for clarity
  - # 7: Coverage of mastectomy sleeve: added reference to Compression Bandages and Garments medical coverage policy.
  - # 6: For clarity and consistency between coverage and limitation section, added "post-surgical camisole" to mastectomy bra on post-mastectomy garments' coverage.
- Section IV, A # 5: Replacements, Limitations and Exclusions: added the word "mastectomy" to the bra and "medical necessity" requirement when replacing post mastectomy garments.
- Benefit Alert: "Marketplace" replaced with "Exchange."
- References were updated

14. Genetic Testing

Effective date: January 14, 2020

- Benefit Alert: "Marketplace" replaced with "Exchange."
- References were updated

Utilization Management Update November 2019 – January 2020 – *Continued from page 17*

14. Genetic Testing

Effective date: January 14, 2020

- Benefit Alert: “Marketplace” replaced with “Exchange.”
- References were updated

15. Cardiac Rehabilitation

Effective date: January 14, 2020

- References were updated

16. Virtual Colonoscopy DC, VA and Feds

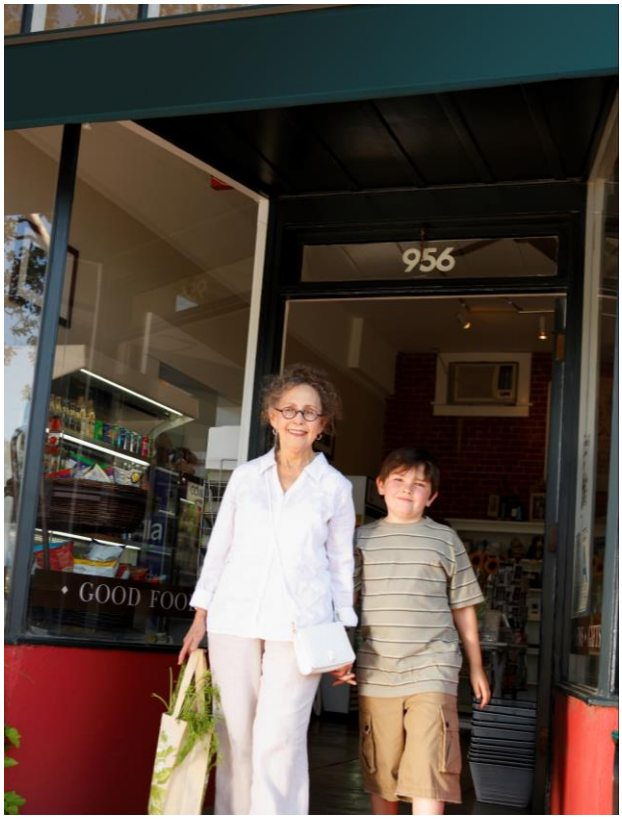
Effective date: January 14, 2020

- References were updated

17. Virtual Colonoscopy MD

Effective date: January 14, 2020

- References were updated



Access to MCPs is only two clicks away in HealthConnect.

MCPs can be accessed through the Kaiser Permanente Clinical Library by using the web link below:

https://clm.kp.org/wps/portal/cl/MAS/search_iframe?query=medical+coverage+policy&x=0&y=0.

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

Please contact the Utilization Management Operations Center (UMOC) at 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 Utilization Management (UM) medical necessity denial (adverse) decisions with a Kaiser Permanente Physician reviewer (UM Physicians).

If you have clinical questions on use of our criteria, please feel free to contact:
Claudia Donovan M.D.
Physician Referral Reviewer
Claudia.K.Donovan@kp.org

If you have administrative questions concerning accessing or using our criteria, please contact:
Marisa R Dionisio, RN
Marisa.R.Dionisio@kp.org
301-816-6689

Utilization Management Hours of Operation

UM Department Section	Hours of Operation	Core Responsibilities
Emergency Care Management (ECM) - Clinical Call Center Department	24 hours/day 7 days/ week, including holidays	• Process transfer requests for Members who need to be moved to a different level of care including emergency rooms, inpatient facilities and Kaiser Permanente Medical Office Buildings • Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities • Assist with repatriation from hospital to hospital • Support all cardiac transfers for level of care needed
Utilization Management Operations Center (UMOC): Outpatient, Specialty Referrals and Clinical Research Trials	Monday through Friday: 8:30 A.M. to 5:00 P.M. *except Clinical Trials:* 8:00 A.M. to 4:30 P.M. Weekends and Holidays*:* 8:30 A.M. to 5:00 P.M. for Urgent and emergent referrals and care coordination referrals, *except Clinical Trials*	• Conduct pre-service review of specialty referrals (outpatient and inpatient) to include external clinical trial requests • Weekends and holidays pre-service review of urgent/emergent referrals except clinical research trials
UMOC: • Durable Medical Equipment (DME) • Home Care • Rehabilitative Therapies • Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	Monday through Friday: 8:30 A.M. to 5:00 P.M Weekends and Holidays: 8:30 A.M. to 5 P.M. for Urgent and Routine discharge care coordination referrals	• Conduct pre-service and concurrent review of Home Care, DME, PT, OT and ST • Post-service review provided to Kaiser members outside a Kaiser medical facility

Utilization Management Hours of Operation – *Continued from page 19*

UM Department Section	Hours of Operation	Core Responsibilities
Continuing Care HUB	Monday through Friday: 8:30 A.M. to 5:00 P.M Weekends and Holidays: 8:30 A.M. to 5 P.M.	• Conduct pre-service and concurrent review of Home Hospice/Inpatient Hospice and Palliative Care services • Skilled nursing facility (SNF) placement for members from the community • Coordinate and transition members from long-term care (LTC) by entering referrals to transition them home • Center for QICs to notify of new appeals or appeal decisions
Non-Behavioral Health located at affiliated hospitals	Seven days a week and Holidays 7:00 A.M. to 5:30 P.M.	Conduct concurrent review and transition care management
SNF, Rehabilitation Services and Long-Term Acute Care Hospitals (LTACH)	Monday through Friday 8:00 A.M. to 4:30 P.M. Excluding weekends and major holidays	Conduct concurrent review and transition care management for members in the acute rehab and SNF settings
UM Hospital Services – Behavioral Health located at affiliated hospitals	Seven days a week: 8:00 A.M. to 4:30 P.M. Including major holidays	Conduct concurrent review and transition care management services of behavioral health service
UM Outpatient Services – Behavioral Health	Monday to Friday: 8:00 A.M. to 4:30 P.M. Excluding weekends and major holidays	Conduct pre-service and concurrent review of behavioral outpatient services
Outpatient Continuing Care, Complex Case Management and Renal Case Management	Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding weekends and major holidays	Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members

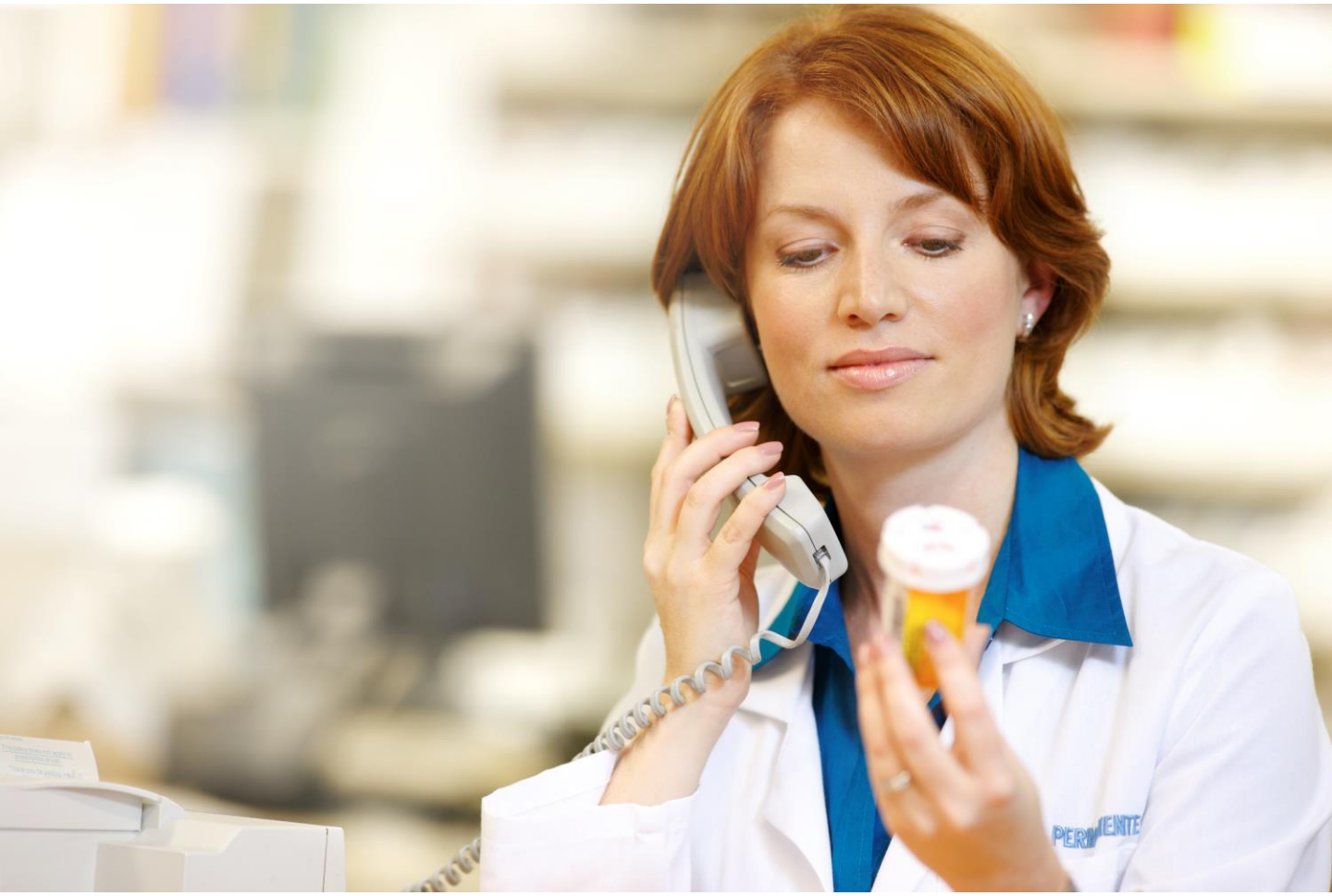
Pharmaceutical Management Information and Updates

The KPMAS Regional Pharmacy & Therapeutics (P&T) Committee approves drug formularies for all lines of business, Commercial, Marketplace/Exchange, Medicare, Virginia Premier and Maryland 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 **http://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**.



Drug Recall Information Available for Patients on kp.org

The Kaiser Permanente Drug Information Services (KP DIS) team is pleased to announce the availability of a new patient-facing website with content related to medication recalls affecting Kaiser Permanente members.

Members can access the website at **kp.org/drugrecalls**.

Please note that this website is associated with the KP.org platform but not within kp.org, so it does not require a login and does not sit behind a firewall.

Members can learn about this website through their healthcare providers by including the information in the After-Visit Summary (AVS) or if they receive a robocall from the KP DIS service for a consumer-level recall.

To insert the following information in the AVS, use the following KP HealthConnect smart phrase: **.drugrecall:** *"Drug recalls can result in emails and phone calls from your patients with questions and requests for further information. The National Kaiser Permanente Drug Information Services team in Pharmacy has developed a website that is patient-facing to help provide recall information that affects our members* - **kp.org/drugrecalls***."*

Important note: KP Drug Information will ONLY populate this site with patient materials related to consumer-level recalls that affect Kaiser Permanente patients. It is NOT meant to be a comprehensive drug recall site.

Market Withdrawal of All Ranitidine Products

On April 1, 2020, the U.S. Food and Drug Administration (FDA) requested all manufacturers of ranitidine, also known as Zantac, to stop producing and selling this medicine. All forms of prescription and over-the-counter ranitidine will no longer be available in the U.S. Providers are to discontinue prescribing ranitidine effective immediately.

Kaiser Permanente members who received a prescription for ranitidine tablets or oral syrup have been informed of the market withdrawal via letter with the following information:

Why is the FDA removing all ranitidine medicine from the market?

- The FDA has learned that an impurity called NDMA found in ranitidine can increase even when the medicine is stored correctly in your home. If the medicine is stored at higher than normal temperatures, the amount of impurity can increase even faster.
- NDMA is a probable carcinogen, which means it may cause cancer.

What should I do with my ranitidine medicine?

- You may continue to take your ranitidine prescription until you are able to pick up a different medicine. Once you find a different medicine, you should throw any ranitidine medicine away.
- Famotidine (also known as Pepcid) and cimetidine (Tagamet) are medicines that work in the same way as ranitidine. These medicines are sold over-the-counter (OTC) and are available in pharmacies, grocery stores and convenience stores.
  - Your local pharmacist can recommend a dose of famotidine or cimetidine that will be equal to the dose of ranitidine you are taking.
- Unfortunately, because ranitidine is no longer available, famotidine and cimetidine availability may be low due to an increase in demand.
- A different class of medicine called proton pump inhibitors may also be an option for you. These medicines can be purchased without a prescription and include esomeprazole (Nexium 24HR), lansoprazole (Prevacid 24HR) and omeprazole (Prilosec OTC). Long-term use of these drugs has been linked to safety problems (e.g., increased risk of broken bones, certain infections; and memory, heart and kidney problems).
- Please read the Drug Facts on the packaging of your OTC medicine carefully since it contains important information about the drug, including specific warnings.
  - Cimetidine can be associated with many drug interactions and it is important that you make sure you are not taking a medicine that can be affected by cimetidine. Please consult with your pharmacist where you are buying the medication or your physician by giving them a list of all your prescribed and OTC medicines.
- People who need to continue taking a liquid medicine should contact their primary health care provider before their current prescription runs out to discuss using a different medicine.

Members have been encouraged to contact their primary care providers or their local pharmacy if they have questions regarding which treatment option is best for them.

To see the press release from the FDA, please go to **https://www.fda.gov/news-events/press-announcements/fda-requests-removal-all-ranitidine-products-zantac-market**.

Providers with questions may contact Provider Experience at 877-806-7470 or by email at **provider.relations@kp.org**.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Provider Experience
2101 E. Jefferson Street
Rockville, MD 20852

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.