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.

December 2020

COVID-19: World Health Crisis Update

COVID-19 has had an unprecedented impact on the United States and remains prevalent in communities in the Mid-Atlantic region. We appreciate your continued partnership on our response to addressing the spread of the virus; and for providing prompt and compassionate care to our members and patients.

We continue to work to address questions you have, and in this publication, 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. The most up-to-date information is regularly posted to Kaiser Permanente of the Mid-Atlantic States' Community Provider Portal (CPP) at www.providers.kp.org/mas.

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 and testing; and effective March 19, 2020, Kaiser Permanente will not charge member cost-sharing for 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.

There is no need to seek additional authorization to provide COVID-19-associated screening, diagnosis or testing to 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 publication.

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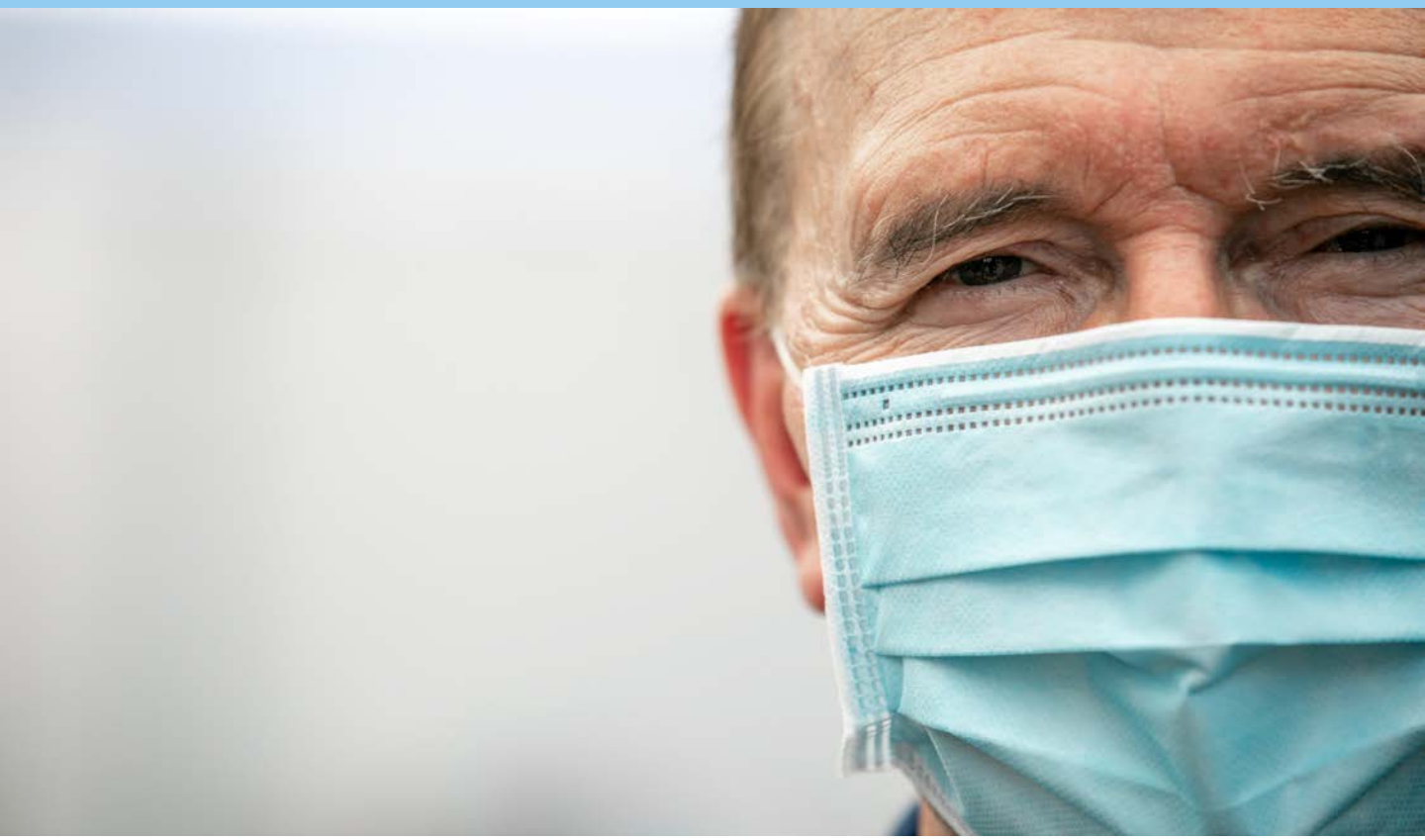

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Important Notes:

- *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 their employer group.*
- *There is a temporary exception for Virginia Medicaid members. For more information, see "Virginia Medicaid Member and Out-of-Pocket Costs."*
- *There may be some reprocessing of claims related to COVID-19 care that may take 30 days or longer. Your patience is appreciated as appropriate benefit adjudication is finalized.*

COVID-19 Cost-Sharing Waivers

COVID Treatment: Kaiser Permanente will waive all out-of-pocket cost sharing for all medical and hospital services for COVID-19 treatment and/or for episodes of care where COVID-19 is the primary diagnosis. This policy will be in effect through March 31, 2021, or the last day of the month following the end of the national public health emergency, whichever is later. Other provisions may apply where required by Federal or state law or regulation. As state laws in the Mid-Atlantic region effect this timeline, we will make updates to our policy. (A limited number of commercial self-funded groups may apply cost sharing for COVID-19 treatment.)

COVID Diagnostic Testing: Kaiser Permanente will continue to waive all out-of-pocket cost sharing for all COVID-19 diagnostic testing for members. This policy will be in effect through March 31, 2021 or the last day of the month following the end of the national public health emergency, whichever is later. Other provisions may apply where required by Federal or state law or regulation.

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Providers will be notified by letter when the COVID-19 cost sharing waiver discontinues. The update will also be posted to the CPP. 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 1-800-777-7904 (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.

Providing Telehealth Visits
We appreciate your efforts to limit the spread of COVID-19 in the community and encourage the use of telehealth visits. Telehealth flexibilities permitted to providers who were not contracted to provide telehealth services or bill for telehealth services in the normal course of care prior to the COVID-19 public health emergency (e.g., ABA providers and home health agencies) will continue to be afforded the flexibility to bill for care provided via telehealth until January 31, 2021 at 11:59 p.m. EDT; this will be reconsidered as this public health emergency continues. 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.

Providers should update systems and procedures to enable the use of modifiers GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system), or telehealth place of service (POS code 02) when billing for services delivered via telehealth. If billing on a UB04, please append the modifier to the HCPCS code.

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. Modifier 95 is equally accepted for telehealth services on a professional services claim form (CMS 1500).

For Eligible Telehealth Visits Provided to Maryland or Virginia Medicaid Members
Professional services provided via Telehealth should be identified with a GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system) modifier, as appropriate, and are billed using the usual place of service code that would be appropriate as if it were a non-telehealth claim on a professional services claim form (CMS 1500).

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Guidance from Medicare and Medicaid Programs about Telehealth Services During the COVID-19 State of Emergency

Medicare and both MD and VA Medicaid programs have issued specific guidance regarding telehealth services including coding/billing, waivers for originating site, telehealth and behavioral health as well as telehealth care provided from a hospital setting. For more information, please refer directly to this guidance for regional Medicaid programs.

Medicare:

- Telehealth Frequently Asked Questions (Issued March 17, 2020)

MD Medicaid:

- COVID-19 Provider Updates

VA Medicaid:

- COVID-19 Provider information
- COVID-19 Provider Flexibilities Related to COVID-19 (Issued: March 19, 2020)

Coding for Telehealth Services Using an Institutional Claim Form (UB04 Claim Form)

For providers that are *unable to submit a professional CMS 1500 claim form*, and use institutional billing form, may submit claims for professional services with modifier 95 appended to eligible HCPCS/CPT on the institutional billing (UB claim forms) to submit claims for services that were:

- Performed remotely using real-time audio-visual telehealth technology or telephonic/audio-only when video technology is not available to the patient;
- Performed by a licensed, certified or otherwise qualified professional practicing within their scope of practice; and
- Where same standard of practice and documentation for the service or visit were maintained.

Claim Form	CMS 1500		UB04 (Per Extenuating Circumstances Noted Above)
Line of Business	Place of Service Code	Modifier Options	HCPCS (Modifier)
Commercial	02	GT, GQ, 95	HCPCS (GT, GQ or 95)
Medicare	02		HCPCS (95)
VA Medicaid	Usual Place of Service Code	GT, GQ, 95	HCPCS (GT, GQ or 95)
MD Medicaid	Usual Place of Service Code	GT, GQ, 95	HCPCS (GT, GQ or 95)

For more information, visit CPP to view our COVID-19 Telehealth Guide for providers.

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.

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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 as prescribed by the appropriate licensed provider.

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
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (Effective 5/20/2020)
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (Effective 6/25/2020)
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed (Effective 6/25/2020)
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected (Effective 8/10/20)
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum (Effective 8/10/20)
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected (Effective 10/6/20)
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected (Effective 10/6/20)
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])

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Procedure Codes	Description
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen (Effective 8/10/20)
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer (Effective 8/10/20)
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative (Effective 9/10/20)
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
87426	Severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) (Effective 6/25/2020)
87428	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; adenovirus enteric types 40/41; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B (Effective 11/10/2020)
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)
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique (Effective 10/6/20)
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique (Effective 10/6/20)
87811	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) (Effective 10/6/20)
D0604	Antigen testing for a public health related pathogen, including coronavirus (Effective 1/1/2021)
D0605	Antibody testing for a public health related pathogen, including coronavirus (Effective 1/1/2021)
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source. (Effective 3/1/2020)

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Procedure Codes	Descriptions
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of an HHA, any specimen source. (Effective 3/1/2020)
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)
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
U0005	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, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date and time of specimen collection. (List separately in addition to either HCPCS code U0003 or U0004) (Effective 1/1/2021)

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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

Procedure Codes	Description
99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease (Effective 9/10/20)

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.

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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.

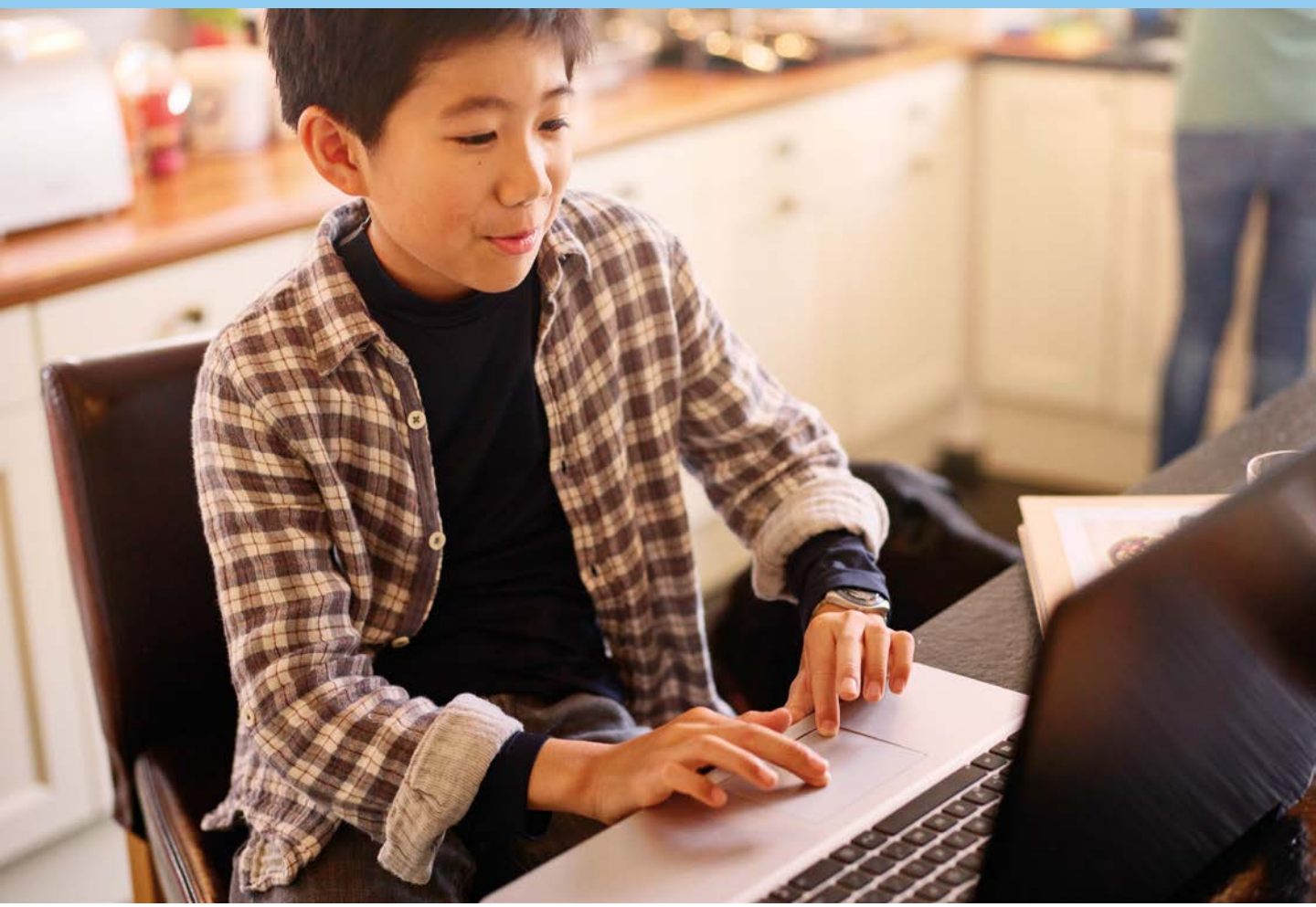
If there is any issue with a medication a member is taking, they will be notified about what they need to do. As always, members are encouraged to ask their physician or pharmacist about any concerns they have.

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 and diagnosis 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, effective March 19, 2020.

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.

Case 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	Z20.822: Contact with and (suspected) exposure to COVID-19 (Effective 1/1/2021) Z20.828: Contact with and (suspected) exposure to other viral communicable diseases
Asymptomatic Patient screened for COVID-19	Z11.52: Encounter for screening for COVID-19 (Effective 1/1/2021) Z11.59: Encounter for screening for other viral diseases
Confirmed COVID-19	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



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On February 20, 2020 the CDC announced a new ICD-10, U07.1: 2019-nCoV acute respiratory that will become 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.

Continue to 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. Please keep up-to-date on the evolving COVID-19 pandemic by visiting CPP, our provider portal, at www.providers.kp.org/mas. You may also visit www.kp.org for continued updates.

If you have additional questions, please contact your account manager or email us at provider.relations@kp.org.

2020 Utilization Management Affirmative Statement for Health Plan Staff and Practitioners

Kaiser Permanente practitioners and health care professionals make decisions about the care and services which 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.

Medical Coverage Policy Updates – September 2020 to November 2020

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

A. Utilization Management (UM) Criteria for Transplant Services

2020 InterQual Level of Care, April 2020 release is a commercially available criterion providing support to determine the medical appropriateness of hospital admission, continued stay and discharge of our transplant patients. When a patient is admitted for transplant related services, except for kidney transplants, National Transplant Service (NTS) coordinators follow the patient using InterQual as the inpatient continued stay criteria. The criteria set is updated annually by McKesson Health Solutions and the transplant coordinators are tested annually to establish inter-rater reliability.

1. 2020 InterQual Level of Care – General Surgical, Acute Criteria – Adult & Pediatrics
2. 2020 InterQual Level of Care – General Medical, Acute Criteria – Adult & Pediatrics
3. InterQual Level of Care Acute Criteria, Pediatric - General Transplant Section (General, Bone Marrow and Stem Cell Transplantation)
    a. 2020 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Adult
    b. 2020 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Pediatrics

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B. New and Updated Medical Coverage Policies

1. **Aquatic Therapy**

   Effective date: September 25, 2020

   - References were updated

2. **Capsule Endoscopy**

   Effective date: September 25, 2020

   - Section II, H. Added screening or surveillance of esophageal varices in cirrhotic persons with significantly compromised liver function (i.e., Child-Pugh score of Class B or greater) or other situations where a standard upper endoscopy with sedation or anesthesia is contraindicated as an indication for coverage
   - References were updated

3. **Cologuard**

   Effective date: September 25, 2020

   - References were updated

4. **PDL for Vascular Lesions**

   Effective date: September 25, 2020

   - References were updated

5. **Laser Treatment for Hair Reduction and Hair Removal**

   Effective date: September 25, 2020

   - Title of the policy edited from “Pulsed Dye Laser (PDL)” for Hair Removal and Hair Reduction to “Laser Treatment” for Hair Removal or Hair Reduction
   - References were updated

6. **Breast Reduction Surgery and Gynecomastia Surgery**

   Effective date: September 25, 2020

   - References were updated

7. **SpaceOAR**

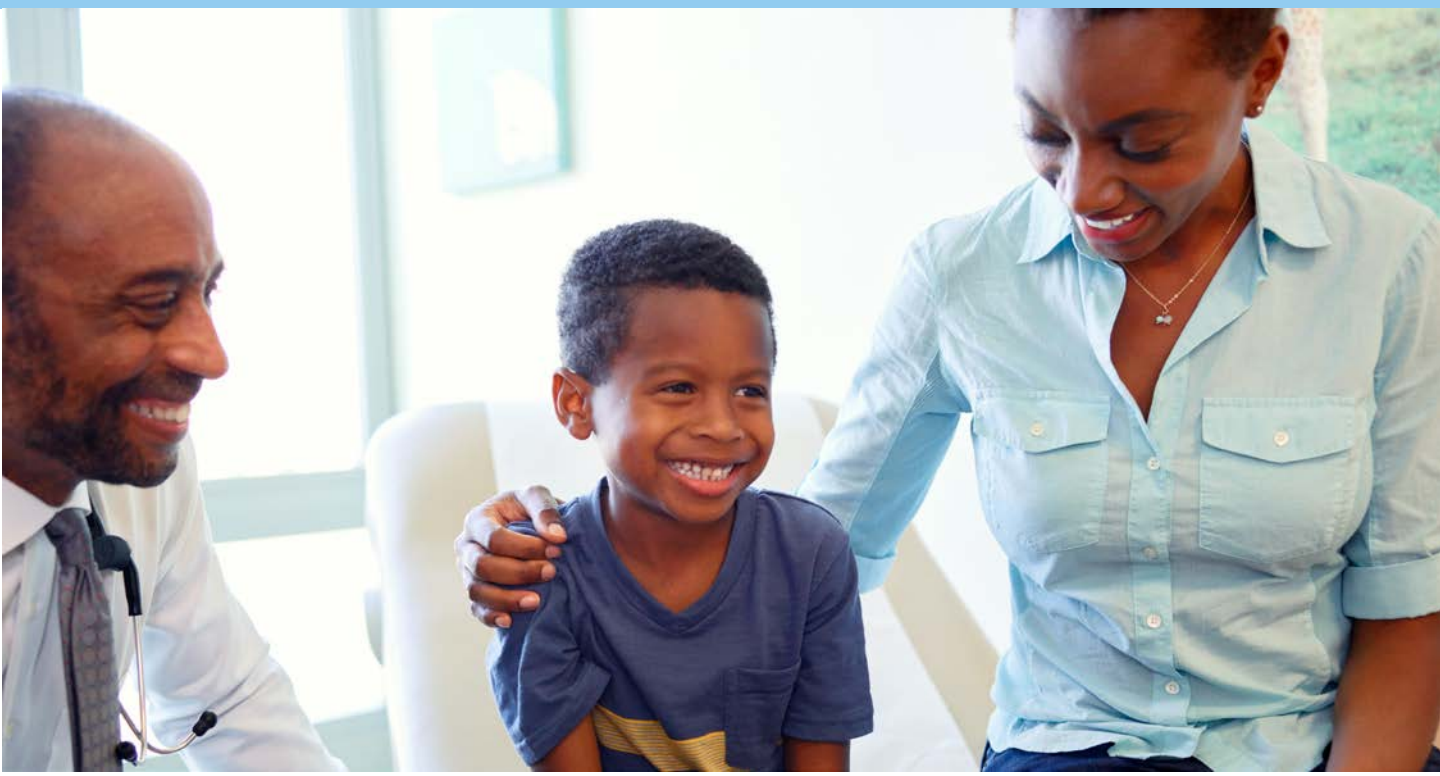
   Effective date: September 25, 2020

   - References were updated

8. **HFOV (High Frequency Flutter Valves and Oscillator Vest)**

   Effective date: October 15, 2020

   - References were updated



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9. **Endobronchial Valve**

   Effective date: October 15, 2020

   - Title modified since endobronchial valve is no longer limited to Zephyr after the Food and Drug Administration (FDA) approved Spiration valve system in December 2018.
   - Reference to Zephyr deleted and replaced with Endobronchial Valve
   - References were updated

10. **Spinal Cord Stimulation for Pain Management**

    Effective date: October 15, 2020

    - References were updated

11. **Ambulance Transportation**

    Effective date: October 15, 2020

    - Section V, B. Indications for Air Ambulance: Hospital to Hospital Air Transport
    - Added in # 3. “or is a contracted hospital for special services”
    - Section IV, B. Exclusions for both Ground Ambulance and Non-Emergency Medical Transportation. Deleted # 1: “Transportation by car, taxi, bus, gurney, van, wheelchair van, mini-van, and any other type of transportation other than a licensed ambulance or Ambulette.”
    - References were updated

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12. Benign Skin Lesion Treatment

Effective date: October 15, 2020

- References were updated

13. Continuous Passive Motion (CPM)

Effective date: October 15, 2020

- References were updated

14. Habilitative Services including Applied Behavioral Analysis (ABA) for Virginia Jurisdiction, Mid-Large Group

Effective date: November 18, 2020

- Section III, A: Habilitative Service by Age. Age limit has been removed
- Section IV. Discontinuation of Services. Criteria for completion and discontinuation of habilitative services including ABA has been replaced.
- Section VI, A: Exclusions. Added: #5_Therapy for Sensory Integration Disorder as an exclusion
- Section VII. Benefit Coverage
- Deleted: A. ABA services as not covered for Virginia Kaiser Permanente for Individuals and Families (VA KPIF) and Small Group Plans and Medicare members.
- Remaining items on section VII, from B-D moved to the Utilization Alert section.
- References were updated

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15. Habilitative Services including ABA for Virginia Jurisdiction, KPIF and Small Group

Effective date: November 18, 2020

- Utilization Alert
  - Deleted: Treatment of ABA as an exclusion
  - Added: effective January 1, 2021, there will be coverage of ABA treatment for VA KPIF and Small Group markets in compliance with updated mandate: Code of Virginia § 38.2-3418.17
- Section I, Coverage Overview: C & D added: conditions of medical necessity for habilitative services.
- Section II, Visit Limit
- Added: Visit limits does not apply to KPIF and Small Group plan members with the diagnosis of autism (based on the new mandate, Code of Virginia § 38.2-3418.17)
- Section III, Exclusions:
  - III, A - #2: Deleted: Treatment of ABA as an exclusion for VA KPIF and small group plans.
  - III, B_ Previous section on speech and occupational therapy services as an exclusion deleted and replaced
- Section IV: Criteria to discontinue ABA services replaced.
- References were updated

16. Habilitative Services including ABA for DC Jurisdiction

Effective date: November 18, 2020

- Section VI, D: Exclusion as not medically necessary
  - Added: item #5. Therapy for Sensory Integration Disorder
- Section V, C: Referral management for other conditions. Criteria to be eligible for services
  - Deleted: item #1 - verification of member's benefit document to determine coverage or non-coverage of services. Reference to verify benefit moved to Utilization alert section.
  - Added: items #3 and 4 on speech therapy
- References were updated

17. Habilitative Services including ABA for MD Jurisdiction

Effective date: November 18, 2020

- Section I, Coverage Overview: B and C were added: stuttering and speech delay as conditions of medical necessity for speech therapy References were updated

18. Wound Supplies – NEW Policy

Effective date: November 18, 2020

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19. Nutritional Support

Effective date: November 18, 2020

- References were updated

20. Orthotics: Ankle-Knee-Foot (AKFO)

Effective date: November 18, 2020

Utilization Alert: Required criteria of therapeutic diabetic shoes coverage for Virginia Medicaid members

- References were updated

21. Preimplantation Genetic Testing

Effective date: November 18, 2020

- Policy title/procedure changed from Preimplantation Genetic Diagnosis to Preimplantation Genetic Testing
- Section IV, D: Indications for coverage. Medical necessity of intracytoplasmic sperm injection (ICSI) in the PGT-M/PGT-SR process to avoid contamination from non-fertilizing sperm
- Deleted: “carriers of single gene disorder (Cystic Fibrosis, Spinal Muscular Atrophy), where polymerase chain reaction (PCR) will be applied,”
- Replaced with “patients meeting criteria for PGT-M or PGT-SR.”
- References were updated

Medical Coverage Policy Updates – September 2020 to November 2020 – *Continued from page 17*

Access to MCPs is only two clicks away in HealthConnect. MCPs can be accessed through the KP Clinical Library by using the web link:

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 KPHC Home page and then type in “medical coverage policy” in the search box. All medical coverage policies will be displayed.

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

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

If you have clinical questions on use of our criteria, please feel free to contact:

Claudia Donovan, M.D.
Physician Director of Medical Policies, Benefits and Technology Assessment
Medical Director for Central East National Transplant Services
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

Pharmacy Updates: Drug Formulary Management

The Kaiser Permanente Mid-Atlantic States (KPMAS) has multiple drug formularies to promote rational, safe and cost-effective drug use for our Commercial, Medicare, Medicaid and Marketplace Exchange members.

Each drug formulary is a list of preferred drugs approved for use by the KPMAS Regional Pharmacy and Therapeutics (P&T) Committee. The KPMAS P&T Committee, with expert guidance from various medical specialties, evaluates, appraises and selects United States Food & Drug Administration (FDA)-approved drugs considered to be the most appropriate for use within the region.

Line of Business	Applicable Drug Formulary
Commercial	KPMAS Commercial Drug Formulary
Medicare Part D	Medicare Part D Drug Formulary
Kaiser Permanente – Virginia Premier Virginia Medicaid	Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List
Maryland HealthChoice	Maryland HealthChoice Preferred Drug List Note: some drugs used for mental health and substance abuse disorders are excluded from the KPMAS Drug Formulary but covered by Maryland Department of Health on the Maryland Medicaid Fee-For-Service Preferred Drug List
Marketplace Exchanges	KPMAS District of Columbia, Maryland and Virginia Marketplace Formulary

The KPMAS P&T Committee is comprised of physicians from primary care and specialty departments, pharmacists, and representatives from nursing and quality departments who review objective, evidence-based evaluations for the purpose of adding and/or deleting drugs from the drug formulary (preferred drug list).

The KPMAS P&T Committee promotes the use of generic drugs based on clinical effectiveness, safety, and therapeutic equivalence to a branded drug in accordance with all applicable federal, state and/or local statutes.

If an FDA AB-rated approved and therapeutically equivalent generic drug becomes available, the generic drug is added to the drug formulary without KPMAS P&T Committee review if the brand name drug is already on the drug formulary and has been reviewed in the past. The corresponding brand name drug is deleted from the drug formulary after review and approval by the KPMAS P&T Committee. Selected generic drugs such as hormonal therapy, narrow therapeutic index drugs, or non-formulary drugs may require a formal review by the KPMAS P&T Committee before they are added to the drug formulary.

Pharmacy Updates: Drug Formulary Management – *Continued from page 19*

Therapeutic conversions

Periodically a list of drugs with potential for significant member and organizational cost savings is targeted for therapeutic conversion. The KPMAS Clinical Pharmacy Team, in collaboration with the MAPMG Physician Director of P&T Drug Utilization Management, develops a standard process for therapeutic conversion for these agents.

This process assures proper communication, implementation, and education of healthcare providers, pharmacists and KPMAS members about each drug conversion.

Upon evaluation, if a member qualifies for therapeutic conversion, an order is placed to the pharmacy. The member is informed of the therapeutic conversion and asked to call the pharmacy to have the prescription filled when they are ready.

If the member, has an allergy or adverse reaction to the preferred drug, or the preferred product is ineffective for the member's treatment, a note is placed in the member's electronic medical record (EMR) so that the issue of the therapeutic conversion is not revisited.

Members who are converted to a new drug will be counseled by the dispensing pharmacist and provided patient education at the time of drug pick-up.

Pharmacy Updates: Drug Formulary Management – *Continued from page 20*

KPMAS formulary review (addition/deletion)

The drug formularies for each line of business and their corresponding pharmaceutical management processes are reviewed at least annually.

The KPMAS drug formularies are dynamic and updated regularly (monthly) with any additions and/or deletions approved by the KPMAS P&T Committee. Updates to the drug formularies are available on the KPMAS intranet for MAPMG providers and on the KPMAS Clinical Library (Patient Care Resources --> Drug Information --> Formulary) for affiliated providers. Providers are encouraged to review the drug formulary changes online regularly. Any FDA-approved drug may be evaluated for drug formulary addition or deletion, and any physician or member may request a review of a drug.

In order to request that a drug be reviewed by the KPMAS P&T Committee, a drug Addition/Deletion request form is completed by the requestor and forwarded to the Co-Chairs of the KPMAS P&T Committee along with supporting literature and references.

Drug formulary addition/deletion requests should include the following:

- Name, strength and dosage form of the drug being requested;
- Reason for the request with clinical references of its safety and effectiveness;
- What drug this would replace on formulary (if any); and
- Contact information of the requesting physician along with their specialty.

Drug Addition/Deletion request forms are available on the KPMAS intranet for MAPMG providers, and from the KPMAS Clinical Library (Patient Care Resources --> Drug Information --> Formulary) for affiliated providers.

Based upon the KPMAS P&T Committee review, a drug or biological will be classified into an appropriate category:

A. Formulary drug (F) - A drug, including specific strengths and dosage forms, reviewed and approved on the basis of sound clinical evidence that supports the safe, appropriate and cost-effective use of the drug. May be prescribed by all credentialed prescribers, except where state laws and/or regulations prohibit.

B. Formulary drug with Criteria or Guidelines (FC) - A formulary drug that includes specific criteria for prescribing and/or dispensing. Prescribers may prescribe these drugs as long as criteria are met, and the specific criteria are documented in the medical record. Criteria must be measurable and operationally practical.

C. Formulary drug with Restrictions (FR) - A formulary drug with prescribing restricted to specific prescribers, e.g., specialty departments.

D. Non-formulary drug (NF) - A drug not officially accepted for inclusion into the drug formulary. This includes, drugs that have been reviewed but not accepted to the drug formulary; new drugs not yet reviewed for addition to the drug formulary; a brand, strength or dosage form of a drug not approved for addition to the formulary.

E. Non-formulary drug with Criteria or Guidelines (NFC) - A drug that has not been accepted to the formulary, though drug rider coverage for this drug meets specific criteria for use. The specific criteria are documented on the prescription.

Pharmacy Updates: Drug Formulary Management – *Continued from page 21*

F. Non-formulary drug with Restrictions (NFR) - A drug that has been reviewed, but not accepted into the formulary. Drug rider coverage for this drug meets specific restrictions for use when prescriptions are written by or are written in consultation with the specific prescribers, e.g., specialty, departments.

Affiliated providers can keep current with drugs on all KPMAS drug formularies by visiting the KPMAS Clinical Library (Patient Care Resources --> Drug Information --> Formulary) and MAPMG providers can search all KPMAS formularies via the intranet. Providers are encouraged to check their respective websites regularly for any changes or updates.

A printed copy of each drug formulary is available upon request from the Provider Experience department at 1-877-806-7470, via the affiliated provider website or via the intranet for MAPMG providers.

Quality limits or quotas

The KPMAS P&T Committee may set quantity or refill limits for drugs in the following circumstances:

- Medication safety concerns;
- Potential for waste or diversion associated with high cost; or
- Drug shortage situations.

These limits will be reviewed annually or as appropriate, such as in the setting of a drug shortage.

The drug formulary also lists drugs for which quantity limits apply as described in the Evidence of Coverage. Drugs with established quantity limits are marked with abbreviation “QL” in the drug formulary list.

Prior authorizations and Step Therapy

The KPMAS P&T Committee may establish prior authorization criteria or step therapy for certain drugs based on the following:

- Significant potential for off label indications without data to support wide-spread utilization
- Significant safety concerns
- Significant concerns for abuse or misuse
- Based on criteria established by Health Plan, Kaiser Permanente nationally, national treatment guidelines available for a specific therapy or disease state, or state and regulatory mandates

For a complete list of drugs requiring prior authorizations visit the Community Provider Portal at http://providers.kaiserpermanente.org/html/cpp_mas/formulary.html?

- Commercial formulary and prior authorization http://providers.kaiserpermanente.org/html/cpp_mas/formulary.html?#Covered drugs
- Maryland HealthChoice formulary and prior authorization criteria: http://providers.kaiserpermanente.org/html/cpp_mas/formulary.html?#Maryland Health Choice Preferred Drug List
- Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List and prior authorization criteria: http://providers.kaiserpermanente.org/html/cpp_mas/formulary.html?#Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List

Pharmacy Updates: Drug Formulary Management – *Continued from page 22*

Formulary changes and drug updates

The KPMAS P&T Committee publishes drug formulary decisions for all lines of business to ensure that health care providers are kept informed with the most recent updates to each drug formulary. These updates are published monthly on the affiliated provider website and the MAPMG intranet.

A printed copy of each drug formulary is available upon request from the Provider Relations department at 1-877-806-7470, via the KPMAS Clinical Library or via the intranet for MAPMG providers.

Non-formulary exceptions process

The non-formulary exceptions process provides providers and members with access to non-formulary drugs and facilitates prescription drug coverage of medically necessary, non-formulary drugs as determined by the prescribing provider.

Members can obtain a non-formulary drug outside of the exception process at any time by paying full price for the drug, when the prescribing provider deems it is not medically necessary and not harmful but agrees to prescribe based on patient demand.

Please note that Medicare members can request a tiering exception and Marketplace Exchange members have an open formulary.

Pharmacy Updates: Drug Formulary Management – *Continued from page 23*

Highlights of the non-formulary exceptions process:

- Non-formulary drugs should be used only if the patient fails to respond to formulary drug therapy, or has special circumstances requiring the use of a non-formulary drug.
- The provider makes the final decision regarding what drug is appropriate for the member. If the appropriate drug is not on the drug formulary and is deemed medically necessary by the provider, he/she documents the reason for the medical necessity in the patient's medical record and on the pharmacy prescription order. This documentation is transferred with the prescription to the Kaiser Permanente pharmacy or network pharmacy for appropriate dispensing.
- If an affiliated (network) provider prescribes a non-formulary drug without the appropriate exception reason documented, they should expect a telephone call from a pharmacist to suggest a formulary alternative or to obtain a non-formulary exception reason in order for the same documentation to take place. This allows Kaiser Permanente to track the use of non-formulary agents and decide whether they should be re-evaluated for drug formulary inclusion.

Some reasons why a provider may grant an exception to the formulary include:

- Allergy/adverse reaction to formulary product; or
- Treatment failure to a formulary drug.

Once the provider chooses a non-formulary exception reason, the prescription will be covered at the appropriate co-payment.

If the provider determines that the non-formulary drug is not medically necessary, the provider will discuss the available formulary alternatives with the member. If the member insists on the non-formulary drug but an appropriate formulary alternative is available, the provider may still prescribe the non-formulary drug and document appropriately:

A. The provider will document the non-formulary drug as a patient request/demand, although not medically necessary. The drug will not be covered under the pharmacy benefit.

B. The member will pay full price for the drug if a non-formulary drug is not ordered through KP HealthConnect, there is no exception reason documented, and the member presents to a Kaiser Permanente pharmacy to fill the prescription. In this case, the following steps will occur:

    1. The pharmacist will contact the prescribing provider to discuss a formulary alternative or obtain the non-formulary exception reason.
    2. If an appropriate non-formulary exception reason is obtained, the appropriate co-pay will be applied.
    3. If a non-formulary exception reason is not obtained, then the member may get the non-formulary drug filled by paying full price for the drug.
    4. The member may request a review of their case through Member Services.

Pharmacy Updates: Drug Formulary Management – *Continued from page 24*

If the provider prescribes a non-formulary drug requested by a patient with a network pharmacy benefit without indicating a non-formulary exception and the member goes to a network pharmacy to fill the prescription, the member may do the following:

- Ask the pharmacist to request a formulary alternative or call the Pharmacy Benefit Manager to start the process for a non-formulary exception;
- Receive the non-formulary drug and pay the standard retail price;
- Contact KPMAS Member Services at 1-877-218-7750 and request a non-formulary exception review.

The cost of members' drugs may vary depending upon the type of product and particular pharmacy benefits. However, providers can find general information on members' prescription co-payment and coinsurance information by member benefit plan type on the KPMAS Clinical Library *(Patient Care Resources --> Drug Information --> Pharmacy Prescription Benefit Grid Summary*).

If members have questions about their pharmacy benefits, please refer them to the Kaiser Permanente Member Services, or their Evidence of Coverage document.

Websites to bookmark

MAPMG providers:

- KPMAS Drug Formularies (all lines of business) can be located at: http://pithelp.appl.kp.org/MAS/formulary.html
- The Drug Formulary Addition and Deletion Request Form can be accessed at: http://pithelp.appl.kp.org/MAS/phcy_therpeutics.html
- Affiliated Providers via KPMAS Clinical Library at: https://providers.kaiserpermanente.org/html/cpp_mas/pharmacytoc.html
- You will be asked to sign in with your user ID and password to access the co-payment and coinsurance information.
- If you do not have access to KPMAS Clinical Library and would like to gain access, please contact Provider Experience at 1-877-806-7470 Monday through Friday, 9 a.m. to 5 p.m., EST for assistance.

Medicare Part D: Formulary Changes Effective January 1, 2021

Every year the National Medicare Pharmacy & Therapeutics (P&T) Committee, which is made up of physicians and pharmacy professionals, carefully reviews our Medicare Part D Formulary and evaluates whether changes are necessary. Effective January 1, 2021, some drugs that were previously on the Medicare Part D Formulary will no longer be included.

The Medicare Part D Formulary includes all major drug categories and provides alternative therapy for those drugs that are not included on the formulary. To continue to provide high quality care while reducing drug costs, some drugs will only be covered if an exception is requested and the physician indicates the drug is medically necessary.

Kaiser Permanente physicians make decisions about care, including prescription drugs, based on what is best for their patients. If a physician determines that a drug which is not on the Medicare Part D Formulary is medically necessary for the patient, the formulary exception process allows the drug to be covered under the Medicare Part D benefit.

Members may receive a non-formulary medication under their Part D benefit after January 1, 2021 under the following circumstances:

1. Formulary Transition period
2. Medically Necessary Justification

The Formulary Transition period is for new and existing members who are formulary transition-eligible to receive a one-time temporary fill of at least a month's supply of medication, called a Formulary Transition fill. The member and prescribing provider will receive an informational letter within three business days of the Formulary Transition fill. If the prescriber provides a medically necessary justification for the non-formulary medication, the medication will continue to be covered under the member's Part D benefit.

Members receiving a transition letter for a non-formulary drug after January 1, 2021 have the following options:

1. Work with their pharmacy and/or physician to change their medication to one listed on the Medicare Part D formulary (e.g., obtain the generic alternative).
2. Request a type of coverage determination, known as a formulary exception.
    a. Once a prescriber's medically necessary supporting statement is received, an approved formulary exception will allow the member to continue to receive the non-formulary medication under their Part D benefit.

After the Formulary Transition fill has been provided or the Formulary Transition period has ended, and a formulary exception has not been received/approved, future fills for the non-formulary medication will reject at the point-of-sale. If the member wants to continue to receive the non-formulary medication, they will be asked to pay the full member rate.

Members are encouraged to refer to their Evidence of Coverage and our website (kp.org/seniorrx) for additional detailed information about exceptions or coverage determinations, including the appeals process.

The Medicare Part D Formulary is available on the KP website for members to review (kp.org/seniorrx).

2020 Maryland Medicaid Consumer Assessment of Healthcare Providers and Systems (CAPHS) Results

CAHPS is a survey designed to better understand patient experience with health care. The survey asks patients about their experiences with, and their ratings of, their health care providers and plans, including hospitals, doctors, and health and drug plans, among others. The survey focuses on matters that patients themselves say are important to them and for which patients are the best and/or only source of information.

In Spring 2020, a third-party vendor conducted the annual survey of a select number of Maryland Medicaid members on behalf of Kaiser Permanente and the Maryland Department of Health (MDH). The results from the survey are used to identify areas for the health plan and for providers to improve patient experience. The 2020 Maryland Medicaid CAHPS show the following results:

Measure	MD Adult		MD Child	
	2020	2019	2020	2019
Health Care Rating	69%	59%	71%	72%
PCP Rating	72%	65%	77%	80%
Specialist Rating	*77%***	*63%***	*79%***	*65%***
Health Plan Rating	62%	57%	70%	72%
Getting Needed Care	*82%***	86%	85%	83%
Getting Care Quickly	*85%***	83%	82%	85%
Provider Communication	97%	89%	97%	95%
Customer Service	*92%***	88%	88%**	88%
Care Coordination	*93%***	83%	82%	82%

Health Promotion and Education removed by National Committee for Quality Assurance (NCQA) for 2020
Shares Decision Making removed by NCQA for 2020
**Base size less than 100 – not reportable due to validity concerns

Medicare Advantage Conversion

Kaiser Permanente Medicare Advantage Providers play an integral role in the care and coordination of services for Medicare Advantage members. On January 1, 2021, we will complete our expansion and only offer Medicare Advantage plans.

Medicare Advantage will be expanded to the remaining Medicare Cost direct pay plan members in Virginia and the following counties in Maryland:

- Calvert
- Carroll
- Frederick

As a result, remaining Medicare Cost plan individual members will need to actively enroll in Medicare Advantage to maintain their Kaiser Permanente coverage. Medicare Cost members that do not actively enroll in Medicare Advantage by December 31, 2020 will lose Kaiser Permanente coverage until they elect Medicare Advantage. These members will only have Original Medicare until they elect Kaiser Permanente Medicare Advantage or another managed care organization.

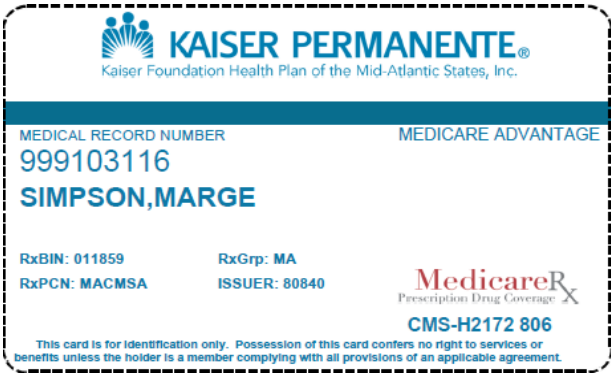
Medicare Advantage Conversion – *Continued from page 28*

It is important to become familiar with features and differences between the Medicare plans when providing and/or coordinating services to our members. There are several differences between the Medicare Cost and Advantage plans, which are detailed in the table below:

	Medicare Cost	Medicare Advantage
CMS Contract Number	H2150	H2172
Network	Signature network (MAPMG providers); access to out-of-network providers through Original MH2150edicare	• Medicare Advantage Signature Network (MAPMG providers + contracted providers required to meet MA network standards); no access to out-of-network providers in most circumstances • Select Network available to 5 grandfathered employer groups • Members may not use Original Medicare
Claims	Billed to the Center for Medicare and Medicaid Services (CMS) as primary and Kaiser Permanente as secondary	Billed to Kaiser Permanente as primary
Inpatient Hospitalization	Copay per benefit period	Copay for days 1-5; $0 unlimited thereafter
Home Health Referrals	Existing referrals will remain in effect and members may continue to receive care from their providers	New referrals will be authorized to replace existing referrals and members may continue to receive care from their providers
DME Referrals	Existing referrals will remain in effect and members may continue to receive supplies and equipment from their providers	New referrals will be authorized to replace existing referrals and some supplies will be provided by Apria

Medicare Advantage Conversion – *Continued from page 29*

The Medicare Cost and Medicare Advantage cards are different. The Kaiser Permanente Medicare Advantage member ID card has Medicare Advantage identified in the upper right corner and the CMS contract number H2172 in the lower right.



Please verify benefits by contacting Kaiser Permanente Member Services at 1-888-225-7202 or online via our Kaiser Permanente Community Provider Portal at www.providers.kp.org/mas.

Medicare Advantage members will have Kaiser Permanente as their primary insurance carrier. These claims should be submitted to Kaiser Permanente. Claims submitted to CMS after January 1, 2021 for a member transitioning to Medicare Advantage will be denied. Our claims mailing address is:

Kaiser Permanente
Mid-Atlantic Claims Administration
P.O. Box 371860
Denver, CO 80237-9998

Although claims will be submitted to Kaiser Permanente, the same billing requirements for CMS will apply.

Referrals for services for members moving from Medicare Cost to Medicare Advantage will not need to be reauthorized, with two specific exceptions - DME supplies and homecare referrals. All other referrals will remain in place throughout the transition from Medicare Cost to Medicare Advantage; there is no change to the referral and authorization requirements. Referrals and authorizations will still need to be obtained for specialty care services, hospitalizations, homecare, DME, orthotics/prosthetics and facility services. Providers may continue to request authorizations from Utilization Management Operations Center by phone at 1-800-810-4766 or by fax at 1-800-660-2019. Providers with referrals who need to be edited or reauthorized or changed will receive separate communication from UMOC.

To help support our Medicare Advantage Participating Providers, we have developed Medicare Advantage training tools. This information is available on our Community Provider Portal at www.providers.kp.org/mas. If you have any questions about the Medicare Advantage plan, please contact Provider Experience at 1-877-806-7470 or email provider.relations@kp.org.

Member Notice of Privacy Practices

The Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is committed to protecting the health information of its members. To see our Notice of Privacy Practices or download a copy, go to https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/privacy-practices.

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Keeping the Provider Directory Up-To-Date

Please keep Kaiser Permanente updated with any changes to your practice. You may use the sample letter format found on our Community Provider Portal at www.providers.kp.org/mas to submit updates to us throughout the year. Keeping Kaiser Permanente updated will ensure that our provider directory is accurate and help us to provide an excellent healthcare experience to our members.

Updates may be submitted to Provider Experience by:

Fax: 855-414-2623

Email: Provider.Demographics@kp.org

Mail: Kaiser Permanente
Provider Experience
2101 East Jefferson St., 2 East
Rockville, MD 20852

You may access our provider directory online at kp.org.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
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2101 E. Jefferson Street
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