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.

October 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.

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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 article.

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.*

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COVID-19 Cost-Sharing Waiver Discontinuation

The COVID-19 cost sharing waiver will discontinue on December 31, 2020 at 11:59 p.m. Eastern Time. We will notify providers promptly if it is extended.

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 December 31, 2020 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])
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)

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Procedure Codes	Description
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)
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source. (Effective 3/1/2020)
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

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

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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.

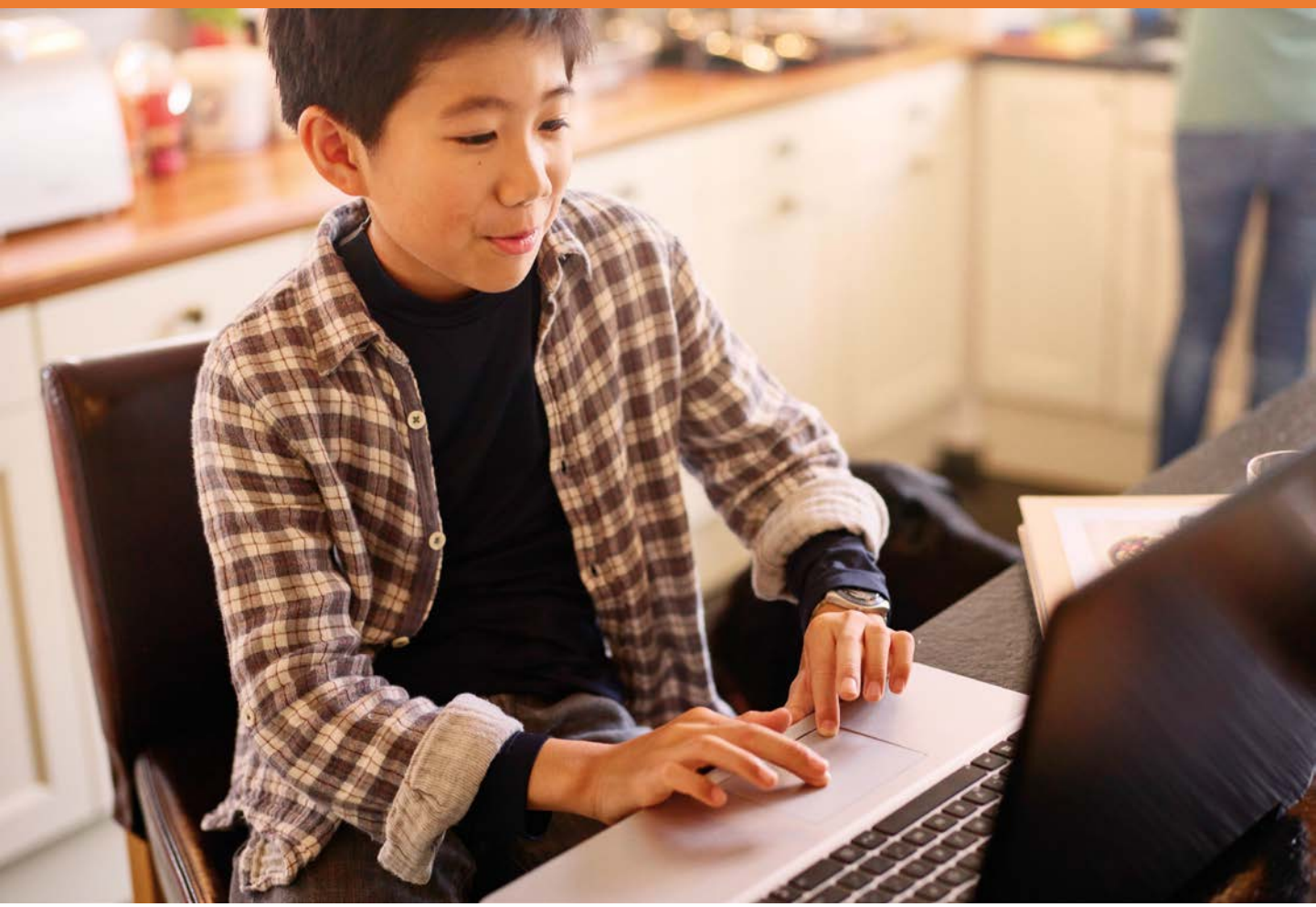
If there is any issue with a medication a member is taking, they will be notified about what they need to do. As always, members are encouraged to ask their physician or pharmacist about any concerns they have.

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	z20.828: 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 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.

2020 Access to Utilization Management (UM) Criteria

There are several ways to access the UM criteria sets, national guidelines and medical coverage policies:

- UM approved criteria set, and medical coverage policies can be accessed by UM staff and Kaiser Permanente physicians through Kaiser Permanente HealthConnect and the Clinical Library.
- Contracted network and community physicians and providers can access Kaiser Permanente HealthConnect and Clinical Library through their Online Affiliate access at https://cl.kp.org/natl/home.html.
- Hard copies of the criteria or Medical Coverage Policy or rule or protocol are available free of charge, please contact the Utilization Management Operations Center (UMOC) at 1- 800-810-4766 (follow the prompts). Behavioral Health inquiries may be called to 301-552-1212.
- The above number may also be used to reach a UM physician to discuss UM medical coverage policies related to medical necessity decisions.
- Emerging technology and regionally based medical technology assessment reports are communicated internally through the Kaiser Permanente Mid-Atlantic States (KPMAS) Provider Network Newsletter, Kaiser Permanente HealthConnect messaging and through regional emails. Current standings on new technologies related to medical necessity decisions can be discussed with a UM physician at the UMOC at 1-800-810-4766.
- Updates to medical coverage policies, UM criteria and new technology reports are featured in "Network News," our quarterly participating network provider newsletter. You can also access current and past editions of "Network News" on our provider website by visiting online at: http://www.providers.kaiserpermanente.org/mas/newsletters.html

2020 Utilization Management (UM) Approved Criteria Sets and Guidelines

Measurable and objective decision-making criteria ensure that decisions are fair, impartial and consistent. Kaiser Permanente utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, and regionally developed Medical Coverage Policies (MCP). Additionally, evidence-based clinical criteria supported by current peer reviewed literature are evaluated by specialty service chiefs and subject matter experts certified in their specific field of medical practice in the guideline development and renewal process.

All criteria sets are reviewed and updated annually, then approved by the Regional Utilization Management Committee (RUMC) as delegated by the Regional Quality Improvement Committee (RQIC). Our Utilization Management (UM) criteria is not designed to be the final determinate of the need for care but has been developed in alignment with local practice patterns and are applied based upon the needs and stability of the individual patient.

Types of UM Criteria in Use:

- Non-Behavioral UM Criteria
- Behavioral Health UM Criteria

I. Nationally Recognized UM Criteria

II. Internally developed UM criteria

   A. National Transplant Services (NTS) Transplant Patient Selection Criteria

   B. Medical Coverage Policy (MCP)

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 11*

NON - BEHAVIORAL HEALTH
Utilization Management Criteria

Referral Service Type	
Ambulance Services	Milliman Care Guidelines (MCG)
Outpatient Services	1. MCP 2. MCG
Durable Medical Equipment (DME) and Supplies	1. MCP 2. MCG 3. National Coverage Determination – Local Coverage Determination (NCD - LCD)
Orthotics and Prosthetics	1. MCP 2. MCG 3. NCD - LCD
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	EPSDT[1] Guideline
Home Health Services	MCG
Physical Therapy, Occupational Therapy/ Speech Therapy (PT/OT/ST)	1. KPMAS MCP 2. MCG
Transplant Services	1. National Transplant Network Services Patient Selection Criteria 2. InterQual® Criteria: Transplant, Adult & Pediatric Hematology/Oncology
Hospice (In-patient/Out-patient)	MCG
Inpatient (Concurrent Review) Services	MCG
Neonatal Care	KPMAS MCP MCG
Acute Rehabilitation (Inpatient)	MCG
Skilled Nursing Facility for Virginia FAMIS only	MCG

Sources:

[1] Federal EPSDT Medical Necessity Guidelines
https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[2] VA Medicaid Contract Medallion 4.0 and FAMIS

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NON-BEHAVIORAL HEALTH

Nationally Recognized Utilization Management Criteria

1. MCG Guidelines 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,** released by MCG in February 2020 after systematic evidence-based review by MCG. The new edition went live in KPMAS on July 7, 2020.

Care Guidelines products licensed for 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.

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The 24th edition / 12.0 release 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

The **2020 InterQual Level of Care, April 2020 release** 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, National Transplant Service (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. The 2020 InterQual, April 2020 edition went live on **8/31/2020.**

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.

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- **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.

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

3. Medicare Coverage Database for National (NCD) and Local Coverage Determination (LCD) for 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 MCP 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 an 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.

4. 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, search EPSDT.

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BEHAVIORAL HEALTH

Nationally Recognized Utilization Management Criteria

Virginia Medicaid Behavioral Health and Substance Abuse Disorders Community Mental Health and Rehabilitation Services (CMHRS) and Addiction and Recovery Treatment Services (ARTS)

Traditional Behavioral Health (BH) Services	UM Criteria
Outpatient Therapy - Individual, Family & Group - BH	MCG
Inpatient Hospital - BH	MCG

Community Health Rehabilitative Services (CMHRS) [4]	UM Criteria
Mental Health (MH) Case Management	Registration Only
MH Peer Support - Individual	CMHRS after Initial Registration
MH Peer Support - Group	CMHRS after Initial Registration
Crisis Intervention	CMHRS after Initial Registration
Crisis Stabilization	CMHRS after Initial Registration
Intensive Community Treatment	CMHRS
Intensive In-Home	CMHRS
Therapeutic Day Treatment for Children School Day	CMHRS
Therapeutic Day Treatment for Children After School	CMHRS
Therapeutic Day Treatment for Children Summer	CMHRS
Day Treatment/Partial Hospitalization - Adults	CMHRS
Mental Health Skill Building Services	CMHRS
Psychosocial Rehab	CMHRS
Behavioral Therapy – Applied Behavioral Analysis (ABA)	CMHRS

Addiction and Recovery Treatment Services (ARTS)	UM Criteria
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Med Necessity Review Not Required
Outpatient	Med Necessity Review Not Required
Intensive Outpatient	American Society of Addiction Medicine (ASAM)[1]
Partial Hospitalization Program	ASAM
Residential Treatment	ASAM
Inpatient	ASAM
Opioid Treatment Program (OTP)	Med Necessity Review Not Required
Preferred Office Based Opioid Treatment (OBOT)	Med Necessity Review Not Required
Substance Use Disorder (SUD) Case Management	Registration Only
Peer Support Services	ASAM

Sources:

[1] DMAS mandating use of ASAM criteria as of April 1, 2017 in concert with the implementation of ARTS benefits that were previously carved out

[2] Federal EPSDT Medical Necessity Guidelines https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[3] * Source: VA Medicaid Contract Medallion 4.0 and FAMIS

[4] CMHRS

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 16*

5. American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder

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) effective April 1, 2017.
- The **ASAM criteria** is applied to all SUD for **Maryland Individual and Group Commercial and Federal health plans effective 01/01/2020**. MCG criteria is no longer used for Maryland Commercial Members SUD in 2020.

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 17*

6. Virginia Medicaid

- **CMHRS Manual for Virginia Premier's Behavioral Health Services**

CMHRS, Chapter IV of the DMAS Manual provide details on eligibility criteria & coverage requirements for behavioral health interventions that provide clinical treatment to individuals with significant mental illness or emotional disturbances.

CMHRS FAMIS Exception:

Members enrolled in FAMIS Virginia Premier have access to a subset of CMHRS:

- Intensive In-Home
- Therapeutic Day Treatment
- Mental Health Crisis Intervention
- Substance Abuse Crisis Intervention
- Mental Health Case Management Services

CMHRS Covered Services

1. Mental Health Case Management (H0023)
2. Therapeutic Day Treatment (TDT) for Children/ Assessment (H0035 HA/H0032 U7)
3. Day Treatment/Partial Hospitalization for Adults/Assessment (H0035 HB/H0032 U7)
4. Crisis Intervention (H0036)
5. Crisis Stabilization (H2019)
6. Intensive Community Treatment/Assessment (H0039/H0032 U9)
7. Mental Health Skill-building Services (MHSS)/Assessment (H0046/H0032 U8)
8. Intensive In-Home/Assessment (H2012/H0031)
9. Psychosocial Rehab (H2017/H0032 U6)
10. Behavioral Therapy/Assessment (H2033/H0032 UA)
11. Mental Health Peer Support Services or Family Support Partners – Individual (H0025)*
12. Mental Health Peer Support Services or Family Support Partners – Group (H0024)*

Note: please refer to the DMAS Manual for Peer Services Supplement

- **Addiction Recovery and Treatment Services (ARTS)**

ARTS – are comprehensive continuum of addiction and recovery treatment services based on the ASAM Patient Placement Criteria. This will include: (i) inpatient services to include withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv) intensive outpatient treatment; (v) outpatient treatment including Medication Assisted Treatment (MAT); (vi) substance abuse case management; (vii) opioid treatment services; and (viii) peer recovery supports. Providers will be credentialed and trained to deliver these services consistent with ASAM's published criteria and using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 18*

INTERNALLY DEVELOPED UM CRITERIA

The following NTS Transplant Patient Selection Criteria and KPMAS MCPs were approved between Q1-Q2 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. NTS Transplant Patient Selection Criteria

1. Bone Marrow Transplant
2. Liver Transplant
3. Intestinal Transplant and Intestine/Liver Transplant
4. Lung Transplant and Heart-Lung Transplant
5. Kidney Transplant
6. Simultaneous Pancreas Kidney (SPK) Transplant
7. Pancreas Transplant Alone (PTA) and Pancreas After Kidney (PAK) Transplant
8. Heart Transplant
9. Mechanical Circulatory Support Devices as a Bridge to Cardiac Transplant

B. New, Updated and Retired Medical Coverage Policy

1. Home Oxygen Therapy

Effective date: June 25, 2020

- Section II, C # 1, d Qualifying Requirements for Referral. Added additional PO2 criteria.
- Benefit Alert: “Marketplace” replaced with “Exchange”
- References were updated

2. Hyperbaric Oxygen Therapy

Effective date: June 25, 2020

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

3. Transgender Services: District of Columbia only

Effective date: June 25, 2020

- Section I. Internal & Outside Referral Guidelines:
  - Added - All transgender surgery referral require review by the “Transgender” Medical Director

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 19*

- Benefit Alert:
    - Added: Fed Members: Breast augmentation is not covered
- Section III D. Genital Surgery Clinical Review Criteria
    - # 2 Deleted: "The assessment provided by the Transgender Surgery Review Board (described below) can serve as the second referral."
    - # 3 Deleted: Mental health evaluation by the Transgender Surgery Review Board
- Section IV. Mastectomies with Chest Reconstruction Clinical Review Criteria
    - F. Deleted: Mental health evaluation by the Transgender Surgery Review Board
- References were updated

4. Transgender Surgery Commercial: Maryland, Virginia and Federal

Effective date: June 25, 2020

- Benefit Alert:
    - "Marketplace" replaced with "Exchange".
    - Added: Fed Members: Breast augmentation is not covered
- Section I. Internal & Outside Referral Guidelines:
    - Added - All transgender surgery referral require prior approval from Transgender Medical Director
- Section III D. Genital Surgery Clinical Review Criteria
    - # 2 Deleted: "The assessment provided by the Transgender Surgery Review Board (described below) can serve as the second referral."
    - # 3 Deleted: "Transgender Surgery Review Board" to perform the Mental health evaluation
- Section IV. Mastectomies with Chest Reconstruction Clinical Review Criteria
    - F. Deleted: Mental health evaluation by the Transgender Surgery Review Board
- Section V. Male to Female Chest Surgery, Breast Augmentation
    - A - E: Added - Clinical criteria to become eligible for breast augmentation of male to female members
- Section VI, A Exclusions from Transgender Surgery Coverage
    - # 1 Deleted: voice modification therapy
    - # 3 Added: facial hair removal when medically necessary
- References were updated

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 20*

5. **Pelvic Floor Rehab**

   Effective date: July 14, 2020

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

6. **Home Phototherapy**

   Effective date: July 14, 2020

   - References were updated

7. **Varicose Veins**

   Effective date: July 14, 2020

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

8. **Circumcision – RETIRED July 14, 2020**

   - MCG guideline will now be used to review circumcision

9. **Circumcision Revision – NEW July 2020**

   Effective date: July 14, 2020

10. **External Insulin Pump and Supplies**

    Effective date: July 14, 2020

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

11. **Dermal Fillers**

    Effective: August 26, 2020

    - References were updated

12. **Microwave Thermolysis with miraDry System for Axillary Hyperhydrosis**

    Effective: August 26, 2020

    - References were updated

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 21*

13. Infertility Diagnosis and Treatment

Effective: August 26, 2020

- Section IV. Definition of Infertility
  - Section E and F: ”Legally married” requirement for MD and Federal employees deleted as this applies only to IVF and not infertility.
  - Added Section G: Female patients who have undergone early menopause
- Section V. Patient workup:
  - Female Factor Workup - added “Initial referrals”
    - #5. Added VZV to Rubella
  - Male Factor Workup- added “Initial referrals”
- Section VIII, B. Female Treatments, Advanced Reproductive Infertility Treatments
  - # 1 – IVF: maximum limit of 3 cycles deleted; edited to 30 visits per referral.
  - # 2 - Frozen embryo transfer (FET) - Maximum limit of 3 cycles deleted; replaced with “each FET”
  - # 4, letter – Added: approval of members for PGD per clinical guideline reflected in the PGD medical coverage policy
- Section IX. Male factor workup, Infertility Specialist Referrals and Treatments
  - Section B. Infertility Specialist Referrals
    - # 2, a: Indication for referral to male infertility specialists for IVF and Intra-cytoplasmic sperm injection (ICSI) edited to male partner only
    - # 2, c: indication for a referral to male infertility specialists. Details on ICSI deleted.
- Section X. Male infertility treatments
  - Sperm extraction criteria for male factor infertility treatment edited to male partner only
- References were updated

14. Fertility Preservation for Iatrogenic Infertility – NEW August 2020

Effective: August 26, 2020

15. Cochlear Implant and Auditory Brain Stem Implants

Effective: August 26, 2020

- Section V, A
  - Pediatric criteria for Cochlear Implants for all children changed from 12 months to 9 months and 18 years of age
  - References were updated

2020 UM Approved Criteria Sets and Guidelines – *Continued from page 22*

16. **Morbid Obesity/Bariatric Surgery, Adolescents and Adults: District of Columbia, Federal and Virginia**

    Effective: August 26, 2020

    - References were updated

17. **Morbid Obesity/Bariatric Surgery, Adolescents and Adults: Maryland**

    Effective: August 26, 2020

    - References were updated

Communicating PCM Programs to Practitioners

Kaiser Permanente Mid-Atlantic States population care management programs (PCM) help you to monitor and manage your patients with chronic conditions. Members with diabetes, asthma, coronary artery disease, chronic kidney disease, hypertension, ADHD, and/or depression are enrolled into care management programs.

These programs are designed to engage your patients to help care for themselves, better under-stand their condition(s), update them on new information about their disease, and help manage their disease with assistance from your health care team and the population care management department. This information and education is designed to reinforce your treatment plan for your patient.

Members in these programs receive mailings, secure messages, texts, and/or phone calls periodically, including care gap reminders. Multi-media resources introduce the programs and provide education on topics such as the latest information on managing their condition, physical activity, tobacco cessation, medication adherence, planning for visits and knowing what to expect, and coping with multiple diseases. You receive member-level data to help you manage your panel, quality process, outcome information, and comparative quality reporting to help you improve your practice. In addition, you receive tools for you and your team, including online tools; shared decision-making tools such as best practice alerts, smart sets, and health maintenance alerts within KP HealthConnect; and direct patient management for our highest risk members by our Care Management Program.

Clinical practice guidelines are systematically designed tools to assist practitioners with specific medical conditions and preventive care. Guidelines are informational and not designed as a substitute for a practitioner's clinical judgment. Guidelines can be found online at Providers.KaiserPermanente.org/mas then click on Provider Information and select Clinical Library or call 877-806-7470.

Your patients do not have to enroll in the programs; they are automatically identified into a registry. If you have patients who have not been identified for program inclusion, or who have been identified as having a condition but do not actually have the condition, you can "activate" or "inactivate" them from the program using the CarePOINT "Modify Population" Module. Community providers who want to add or remove members from the program can call our message line anytime at 703-536-1465 in the Washington, D.C. Metro area or 410-933-7739 in the Baltimore area. Members can choose not to participate or can self-enroll by calling our message line anytime at 703-536-1465 in the Washington Metro area or 410-933-7739 in the Baltimore area. TYY 711.

2020 Practitioner/Provider Utilization Management (UM) Notification

Utilization Management/Resource Stewardship Program

At Kaiser Permanente, our UM program is a collaborative effort between the Medical Group and Health Plan leadership and staff designed to help our members receive the right care, in the right place at the right time.

The scope of the UM program encompasses quality management and resource stewardship across the care continuum. It consists of five major categories: Concurrent Review, Continuing Care, Transitions Care, Case Management and Referral Management (which includes Preauthorization and Post Service Review). The UM Department is organized around three Service Areas: Baltimore, District of Columbia/Suburban Maryland (DCSM) and Northern Virginia (NOVA). The UM activities within each service area include inpatient utilization review and management, transitions care and complex case management. Throughout these service areas, UM staff partner with the health care team to deliver medical, surgical and behavioral health care services to Kaiser Permanente Mid-Atlantic States (KPMAS) members. The Utilization Management Operations Center (UMOC) is a centralized telephonic UM and Referral Management hub designed to assist Mid-Atlantic Permanente Medical Group (MAPMG) practitioners, community-based practitioners and applicable KPMAS staff to coordinate health care services for KPMAS members.

Registered nurses and Durable Medical Equipment (DME) coordinators review and process outpatient referrals, request for DME and home care services. Nurses work collaboratively with licensed, board-certified UM physician managers and practitioners to safely and effectively execute completion of the referral management process within the specified time frame depending on the type and nature of the referral.

Practitioners and providers may contact the UMOC toll free for any inquiries and questions regarding UM issues and processes at 800-810-4766 and follow the appropriate prompts.

The UMOC staff also assist with the following:

- Provide information regarding UM processes
- Check the status of a referral or an authorization
- Provide free of charge, copies of the specific criteria/guidelines utilized for decision making
- Answer questions regarding a benefit denial decision.

All practitioners are able to discuss any non-behavioral health and/or behavioral UM medical necessity denial (adverse) decision with a Kaiser Permanente Physician Reviewer (UM Physician). Kaiser Permanente physician reviewers are available to speak with practitioners to discuss pre-service or concurrent medical necessity decisions during business hours: 8:30 a.m. to 5:00 p.m., Monday through Friday, except holidays.

Practitioners are notified about adverse decisions through verbal or electronic notification followed by a written letter. Medical necessity denial decisions can be discussed with the UM Physician by calling the UMOC at 800-810-4766 and select the appropriate prompt # of the Kaiser Permanente page operator at 888-989-1144.

2020 Utilization Management (UM) Accessibility, Communication and Hours of Operation

Accessibility of Utilization Management (UM) Operations

Accessibility is important to our members and providers. The Kaiser Permanente UM Department ensures that all members and providers have access to UM staff, physicians and managers 24 hours a day, 7 days a week. Staff is identified by name, title and organization name when they initiate or return calls regarding UM issues. The table below provides the specific UM hours of operations and main responsibilities.

UM staff is available eight hours a day during normal business hours for inbound collect or toll-free calls to 1-800-810-4766 regarding UM issues.

Communication After Business Hours

Communication received after normal business hours is addressed the next business day.

After business hours, members' first line of contact is through the Kaiser Permanente Member Services Department. Members are instructed to follow prompts to be directed to the Call Center. The phone number is listed on member's ID card.

After business hours, practitioners and providers may contact the Utilization Management Operations Center (UMOC) toll-free number at 1-800-810-4766 and follow prompts to be directed to the Call Center (available 24 hours, 7 days a week).

UM staff receive inbound communication regarding UM issues after normal business hours through the following means:

- UMOC telephonic toll-free number 1-800-810-4766, Option 1 (Member) or Option 2 (Provider):
- Kaiser Permanente HealthConnect Online Affiliate
- Kaiser Permanente HealthConnect (KPHC) messaging system-available to those providers linked to the KPHC system
- Direct email to a UM staff person

2020 UM Accessibility, Communication and Hours of Operation – *Continued from page 25*

Communication Services to Members with Special Needs

Communication with deaf, hard of hearing or speech-impaired members is handled through Telecommunications Device for the Deaf (TDD) or teletypewriter (TTY) services. TDD/TTY is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. The UMOC staff have a speed dial button on their phones to facilitate sending and receiving messages with the deaf, hearing or speech impaired. Additionally, a separate TDD/TTY line for deaf, hard of hearing, or speech impaired KPMAS member is available through Member Services Department. Members are informed of the access to TDD/TTY through the Member's ID card, the Member's Evidence of Coverage Manual, and the Annual Subscriber's Notice.

Non-English-speaking members may discuss UM related issues, requests and concerns through the KPMAS language assistance program offered by an interpreter, bilingual staff, or the language assistance line. The UMOC staff have the Language Line programmed into their phones to enhance timely communication with non-English-speaking members. Language assistance services are provided to members free of charge. The following table describes the access and hours of operations for UM services.

2020 UM Accessibility, Communication and Hours of Operation – *Continued from page 26*

2020 UTILIZATION MANAGEMENT HOURS OF OPERATION

UM Department Section	Hours of Operation	Core Responsibilities
Emergency Care Management (ECM)- Clinical Call Center Department Emergency Room Notifications and Admissions	24 hours/day, 7 days/ week and holidays ECM Support Line: 1-844-552-0009	• 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
UMOC: • Outpatient Referrals • Specialty Referrals • 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. Call 1-800-810-4766 Weekends and Holidays, except Clinical Trials: 8:30 a.m. to 5:00 p.m. for Urgent and emergent referrals and care coordination referrals	• 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, Occupational and Speech Therapies (PT/OT/ST)	Monday through Friday: 8:30 a.m. to 5:00 p.m. 1-800-810-4766 Weekends and Holidays: 8:30 a.m. to 5 p.m. for Urgent and routine discharge care coordination referral DME HOTLINE 1-855-632-827 RN Weekend: Call 301-960-1436	• Conduct pre-service and concurrent review of Home Care, DME, PT/OT/ST • Post-service review provided to Kaiser members outside a Kaiser medical facility

2020 UM Accessibility, Communication and Hours of Operation – *Continued from page 27*

UM Department Section	Hours of Operation	Core Responsibilities
Continuing Care Hub	Monday through Friday: 8:00 a.m. to 4:30 p.m. Weekends/Holidays: 8:30 a.m. to 4:30 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 appeals decisions
UM Hospital Services Non-Behavioral Health located at affiliated hospitals	Seven days a week & holidays 7:00 a.m. to 5:30 p.m. *Limited Evening hours* 3:00 p.m. to 11:30 p.m. at the following Premier Hospitals only: • Holy Cross Silver Spring • Washington Hospital Center • Virginia Hospital Center	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 Fax: 855-414-4707	Conduct concurrent review and transition care management for members in the acute rehab and SNF settings
UM Hospital Services – Behavioral Health (BH) located at affiliated hospitals:	Seven days a week: 8:00 a.m. to 4:30 p.m. Including major holidays BH Status Line: 301-552-1212 Fax: 855-414-1703	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 BH Status Line: 301-552-1212 Fax: 855-414-1703	Conduct pre-service and concurrent review of behavioral outpatient services

2020 UM Accessibility, Communication and Hours of Operation – *Continued from page 28*

UM Department Section	Hours of Operation	Core Responsibilities
Outpatient Continuing Care: Complex Case Management Renal Case Management Virtual Home Care Program (VHCP)	Monday through Friday 8:30 a.m. to 5:00 p.m. Excluding weekends and major holidays VHCP: 8:00 a.m. to 12:30 a.m. Seven days per week, including weekends and holidays Self-Referral Line 301-321-5126 or 866-223-2347	Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members

Board Certification Policy

If not already board certified, all Kaiser Permanente physicians and contracted physicians and podiatrists who work for us are required to obtain a board certification in their contracted specialty by a recognized organization. KPMAS recognizes the following boards:

- American Board of Medical Specialties (ABMS)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Oral and Maxillofacial Surgeons
- American Board of Podiatric Medicine (ABPM)
- American Board of Podiatric Surgery (ABPS)
- American Midwifery Certification Board
- American Osteopathic Association (AOA) Directory of Osteopathic Physicians
- ANCC Certification for Nurse Practitioners
- NCC Certification for Nurse Practitioners
- NCCPA Certification for Physician Assistants
- Pediatric Nursing Certification Board (PNCB)
- American Academy of Nurse Practitioners
- American Association of Nurse Anesthetists

Kaiser Permanente physicians and network physicians and podiatrists must obtain and maintain board certification in a recognized specialty throughout the life of their contract or employment with Kaiser Permanente. Failure to obtain board certification within five years of completion of training will result in termination from the Health Plan.

Physicians and podiatrists whose certification lapses during the course of their contract or employment will be given two years following the expiration of their board certification to obtain recertification. (This does not apply to hourly/pool Kaiser Permanente physicians.) Physicians who were practicing in a specialty prior to the establishment of board certification of that specialty are exempt from this policy with respect to that specialty.

Culturally and Linguistically Appropriate Services Standards

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The standards are organized by four themes:

- Principal Standard
- Governance, Leadership and Workforce (Standards 2-4)
- Communication and Language Assistance (Standards 5-8)
- Engagement, Continuous Improvement and Accountability (Standard 9-15)

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

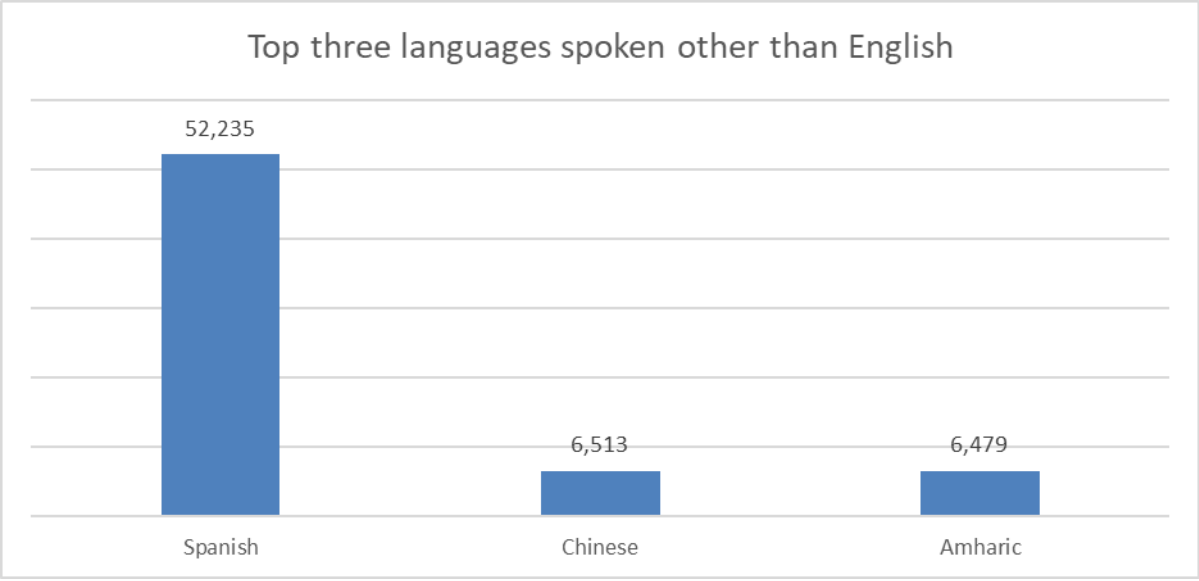
CLAS Standards – *Continued from page 30*

Engagement, Continuous Improvement and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: U.S. Department of Health & Human Services, Office of Minority Health (OMH).

The Enhanced National CLAS Standards address demographic trends and changes and brings relevance to new national policies and legislation, such as the Affordable Care Act. Kaiser Permanente has voluntarily adopted the federal CLAS standards to help ensure we are respectful of and responsive to the health beliefs, practices, and needs of diverse patients.



Source: Equity, Inclusion, & Diversity Annual Report January 1, 2019 – December 31, 2019. Data shows the demographic profile by language for overall Kaiser Permanente members.

We continue to meet the challenges of serving diverse communities and provide high-quality services and care by tailoring services to an individual's culture and providing care in their preferred language. In this way, health professionals can help bring about positive health outcomes for diverse populations.

2020 Adopting Emerging Technology for Utilization Management (UM) Referral Management

Medical research identifies new drugs, procedures, and devices that can prevent, diagnose, treat and cure diseases. The Kaiser Permanente Technology Review and Implementation Committee (TRIC) collaborates with the Kaiser Permanente Interregional New Technologies Committee (INTC), Emerging Therapeutics Committee and Regional Utilization Management Committee (RUMC) to assist physicians and patients in determining whether a new drug, procedure, or device is medically necessary and appropriate. TRIC recommends the inclusion or exclusion of new technologies as covered benefits to Health Plan and tracks inquiries for medical technology assessment. Together, they provide answers to important questions about indications for use, safety, effectiveness, and relevance of new and emerging technologies for the health care delivery system.

The INTC is comprised of physicians and non-physicians across Kaiser Permanente. If compelling scientific evidence is found indicating a new technology is comparable to the safety and effectiveness of currently available drugs, procedures, or devices, the committee will recommend the new technology be implemented internally by Kaiser Permanente and/or authorize for coverage from external sources of care for its indication for use. This technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

2020 New Technology Evaluation and Recommendation

Date Presented via INTC	National INTC Summary	KPMAS Recommendation	
	• Date Approved by TRIC: August 17, 2020 • Date Approved by RUMC: August 26, 2020	Adopt the Use of Sufficient Evidence of Efficacy	Do NOT Use Insufficient Evidence
December 16, 2019 National	Autologous Hematopoietic Stem Cell Transplantation for Multiple Sclerosis		X
November 4, 2019 National	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS) for Essential Tremor	X	
November 4, 2019 National	External Trigeminal Nerve Stimulation (eTNS) for Attentional Deficit Hyperactivity Disorder (ADHD)		X
November 4, 2019 National	Cell-Free DNA (cfDNA) Screening for Aneuploidy (Trisomy 21, 18, or 13) in Twin Pregnancies	X	
November 4, 2019 National	Semi-Active Robotic Arm-Assisted Surgical Systems (e.g., Mako, Navio, ROSA) for Knee and Hip Arthroplasty		X

2020 Adopting Emerging Technology for UM Referral Management – *Continued from page 32*

Date Presented via INTC	National INTC Summary	KPMAS Recommendation	
	• Date Approved by TRIC: August 17, 2020 • Date Approved by RUMC: August 26, 2020	Adopt the Use of Sufficient Evidence of Efficacy	Do NOT Use Insufficient Evidence
November 4, 2019 National	Robotic-Assisted Spinal Surgery		X
November 4, 2019 National	Intravascular Lithotripsy for Peripheral Artery Disease (PAD) and for Facilitating Transfemoral Access During Transcatheter Aortic Valve Replacement (TAVR)	Appropriate to use only in selected patients with complex, calcified vascular anatomy	X Insufficient evidence for routine use.
September 16, 2019 National	Next Generation Sequencing (NGS) – Tumor Molecular Profiling	Adopt the use of NGS for Stage III and Stage IV, metastatic, recurrent, relapsed, or refractory cancers	Do not use for early-stage cancer I and II
June 17, 2019 SCPMG MedTech Assessment Team	Trigeminal Nerve Stimulation for Attention Deficit Hyperactivity Disorder (ADHD)		X

Note:
Insufficient Evidence * DO NOT USE
* Indicates that there is insufficient evidence to adopt the technology for widespread use and that there will be certain cases which may require the use of one of the listed technologies after expert review.

Sufficient Evidence * ADOPT THE USE
*Adopting the use of new technology is subject to availability of benefit per member's health plan. Please verify coverage in the member's EOC or benefit document prior to use.

Integration of Care in KPMAS Patient Centered Medical Home (PCMH)

The concept of a “Patient Centered Medical Home” incorporates a commitment of primary care practitioners to work closely with patients and their families to provide whole-person oriented care that is continuous, well-coordinated, effective, culturally competent and tailored to meet the needs of each patient. The PCMH model develops relationships between primary care practitioners and providers, their patients and their patients’ families. In the PCMH model, primary care teams promote cohesive coordinated care by integrating the diverse, collaborative services a patient may need. This integrative approach allows primary care practitioners to work with their patients in making healthcare decisions. These decisions are based on the fullest understanding of information in the context of a patient’s values and preferences.

Appropriate care coordination depends in large measure on the complexity of needs of each individual patient or population of patients. Factors that increase complexity of care include multiple chronic care conditions, acute physical health problems, the social vulnerability of the patient, and the involvement of a large number of primary and specialty care practitioners and providers involved in the patient’s care. Patients’ preferences, self-care management abilities, and caregiver ability can also affect the need for support and care coordination.

The medical home team or PMCH Health Care Team (HCT), that may consist of nurses, pharmacists, nurse practitioners, medical assistants, case managers, educators, behavioral health therapists, social workers, care coordinators, and others, is led by the primary care physician who takes the lead in working with the patient to define their needs, develop and update plans of care, and coordinate care plans with the PCMH HCT.

Integration of Care in KPMAS PCMH – *Continued from page 34*

Care coordination, within the KPMAS PCMH model, includes the following components:

Determining and updating care coordination needs: coordination needs are based on a patient's individual health care needs and treatment recommendations and care plan that reflect physical, psychological, and social factors. Coordination needs are also determined by the patient's current health and health history; functional status; self-management knowledge and behaviors; and need for support services.

Create and update a proactive plan of care: establish and maintain a plan of care, jointly created and managed by patients, their families and/or caregivers, and their health care team led by the primary care physician. The patient-centered plan of care outlines the patient's current and long-term needs and goals for care, identifies coordination needs, and addresses potential gaps. The care plan anticipates routine needs and tracks current progress towards patient goals using evidence-based medicine.

Communication: Communication allows for the exchange of information, preferences, goals, and experiences among participants in a patient's care. Including communication across clinical resources and facilities and leveraging access to direct scheduling and referral systems. Communication about care needs may take place in person, by phone, in writing, and/or electronically. Communication is especially critical during transitions in care. Primary care practitioners and providers are included in the transfer of information during transitions. Examples of transition include from the inpatient hospital or skilled nursing facility (SNF) to the ambulatory setting (i.e., physician's office).

Align resources with population needs: Assess the needs of populations to identify and address gaps and disparities in services and care. Care coordination and feedback from practitioners, providers and patients should be used to identify opportunities for improvement (i.e., smoking cessation, weight management, self-management for diabetes, or health coaching).

KPMAS' PCMH model of care is designed to improve the quality, appropriateness, timeliness, and efficiency of care coordination including clinical decisions and care plans. An overall performance goal is to improve the quality and efficiency of health care for members with complex and chronic conditions.

To provide the care our PCMH vision requires, our primary care providers play a pivotal role in guiding the PCMH HCT to provide timely, comprehensive, well-coordinated care.

KPMAS is responsible for identifying patients who qualify for its disease management and complex case management programs, notifying the PCMH HCT of qualifying members, and maintaining a tracking mechanism to monitor these members. Notification to the PCMH HCT is conducted for each patient when they qualify for the disease management or complex case management programs, if they are identified outside of the PCMH. The PMCH HCT and care coordinators of respective disease management or complex case management use KPMAS electronic health record (KP HealthConnect) to document care plans and provide that information as needed to coordinate patient care. In addition, patients, their family members, or anyone on the health care team, may refer a patient for complex case management or disease management programs.

Network providers, Kaiser Permanente Members/ Caregivers can take advantage of these services by calling the Case management Referral Telephone Line at 301-321-5126 or toll free 866-223-2347, 24 hours a day, 7 days a week. Messages are checked Monday-Friday during business hours by our case managers.

Diversity

Members have the right to free language services for health care needs. We provide free language services including:

- **24-hour access to an interpreter.** When members call to make an appointment or talk to their personal physician, if needed, we will connect them to a telephonic interpreter.
- **Translation services.** Some member materials are available in the member's preferred language.
- **Bilingual physicians and staff**. In some medical centers and facilities, we have bilingual physicians and staff to assist members with their health care needs. They can call Member Services or search online in the medical staff directory at **kaiserpermanente.org**.
- **Braille or large print**. Blind or vision impaired members can request for documents in Braille or large print or in audio format.
- **Telecommunications Relay Service (TRS).** If members are deaf, hard of hearing, or speech impaired, we have the TRS access numbers that they can use to make an appointment or talk with an advice nurse or member services representative or with you.
- **Sign language interpreter services**. These services are available for appointments. In general, advance notice of two or three business days is required to arrange for a sign language interpreter; availability cannot be guaranteed without sufficient notice.
- **Video Remote Interpretation (VRI).** VRI provides on-demand access to American Sign Language & Spoken Language interpretation services at medical centers for members. It meets the need in the care experience of walk-in deaf patient and those in need of urgent care.
- **Educational materials**. Health education materials can be made available in languages other than English by request. To access Spanish language information and many educational resources go to **kp.org/espanol** or **kp.org** to access La Guía en Español (the Guide in Spanish). Members can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in La Guía en Español.
- **Prescription labels**. Upon request, the Kaiser Permanente of the Mid-Atlantic States pharmacist can provide prescription labels in Spanish for most medications filled at the Kaiser Permanente pharmacy.
- **After Visit Summary (AVS)**. AVS can be printed on paper and available electronically via kp.org for KP members after their appointment. If the member's preferred written communication is documented in KP HealthConnect for a non-English language, the AVS automatically prints out in that selected language. This includes languages such as Spanish, Arabic, Korean, and several others.

Diversity – *Continued from page 36*

At Kaiser Permanente, we are committed to providing quality health care to our members regardless of their race, ethnic background or language preference. Efforts are being made to collect race, ethnicity and language data through our electronic medical record system, HealthConnect®. We believe that by understanding our members' cultural and language preferences, we can more easily customize our care delivery and Health Plan services to meet our members' specific needs.

Currently, when visiting a medical center, members should be asked for their demographic information. It is entirely the member's choice whether to provide us with demographic information. The information is confidential and will be used only to improve the quality of care. The information will also enable us to respond to required reporting regulations that ensure nondiscrimination in the delivery of health care.

We are seeking support from our practitioners and providers to assist us with the member demographic data collection initiative. We would appreciate your support with the data collection by asking that you and your staff check the member's medical record to ensure the member demographic data is being captured. If the data is not captured, please take the time to collect this data from the member. The amount of time needed to collect this data is minimal and only needs to be collected once. Recommendation for best practices for collecting data is during the rooming procedure.

In conclusion, research has shown that medical treatment is more effective when the patient's race, ethnicity and primary language are considered.

To access organization wide population data on language and race, please access the reports via our Community Provider Portal at **providers.kp.org/mas** under *News and announcements*.

To obtain your practice level data on language and race, please email the Provider Experience Department at Provider.Relations@kp.org.

Language Services and Accessibility Requirements

ALL HEALTHCARE PROVIDERS AND INSURERS that receive federal funding, including our contracted/network providers and physicians, are required to comply with applicable federal civil rights laws and not discriminate, exclude people, or treat them differently when providing services. This includes providing language access services to non-English speaking patients for interpretation and translation of vital documents necessary for meaningful access.

Kaiser Permanente is legally required to and requires its contracted providers to provide language services for all patients with communication barriers to ensure they have equal access to services and information. This includes individuals with a primary language other than English and individuals who are deaf, deaf blind, and hard of hearing, and applies to everyone, from members seeking care, to members of the community seeking information. This includes:

- Providing free aids and services to people with disabilities to help ensure effective communication, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, braille, and accessible electronic formats)
  - Assistive devices (magnifiers, pocket talkers, and other aids)
- Providing free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- Contract and Network providers/physicians must provide language services for all interactions with the member and staff. This includes, but is not limited to:
  - All appointments with any provider for any covered services
  - Emergency services
  - All steps necessary to file complaints and appeals

Palliative Care and Hospice Access for Your Patients

The continuum of palliative care and hospice services available for members offers both internal and external services. The palliative care philosophy is an interdisciplinary approach to support members with a deteriorating medical condition with focus on pain and symptom management, emotional support, clarification of goals and advance care planning. Hospice services are focused on those with a terminal condition, prognosis of six months or less and a shift from aggressive treatments to comfort oriented care.

The following three internal palliative care service lines can be referred directly through order entry within KP HealthConnect.

Inpatient Palliative Care (IPC) consultation service is provided at core hospitals. The model includes an interdisciplinary team service comprised of a palliative care physician, nurse and social worker. The team meets with member and family to assess their understanding of the illness, to discuss realistic outcomes of treatments and to identify goals of care. The team also addresses pain and symptom management and provides consultation to hospital physicians and staff on end of life care.

Skilled nursing facility (SNF) palliative care service is a nurse consultation model available to members in the Mid-Atlantic service area in which the palliative care nurse works closely with the SNFs health care team. Members in the SNF setting are similar to those in the inpatient setting in terms of medical complexity and social needs, therefore the goals of this model are similar to the IPC consult model.

Advanced Illness Care Coordination (AICC) service is a clinical social work consultation model involving sessions with members and families with goals for each meeting such as advance care planning, emotional support, community resources and conversations related to end-of-life. The overall result is increased member and family understanding of the illness, ultimately fostering more informed choices. The AICC model has demonstrated increased hospice utilization and length of stay as well as improved quality of life for individuals facing advance illness and end of life situations.

External services include hospice services. Hospice services are provided by local hospice agencies throughout Mid-Atlantic. Please contact the Continuing Care HUB at 301-562-6683 for assistance with hospice referrals.

Medicare Part D Drug Formulary and Tiering Exception Process

The Kaiser Permanente Medicare Prescription Drug Benefit design for Direct Pay Medicare Part D members (approximately 50% of Kaiser Permanente's Medicare population) is based on a tiered cost-sharing structure for pharmacy benefits.

Each Part D drug on the drug formulary is assigned a drug tier or level; non-formulary drugs are made available at Tier 4 for members with medical necessity. Below are the drug tiers for Direct Pay Medicare Part D members:

- Tier 1 — Preferred generic drugs (select chronic condition drugs)
- Tier 2 — Generic drugs (all other generics)
- Tier 3 — Preferred brand-name drugs
- Tier 4 — Non-preferred brand-name drugs (all other brands)
- Tier 5 — Specialty-tier drugs
- Tier 6 — Injectable Part D vaccines

Medicare Part D Drug Formulary and Tiering Exception Process – *Continued from page 39*

The Center for Medicare and Medicaid Services (CMS) requires that a Health Plan with a tiered cost-sharing structure allow members to request a tiering exception. A tiering exception allows Direct Pay Medicare members to obtain a non-preferred brand drug at the more favorable co-pay that is applicable to drugs in the preferred brand drug tier.

Tiering exceptions apply to drugs in Tiers 2, 3 and 4 if the request meets the following criteria:

- Tier 2 generic drug at a Tier 1 preferred generic cost share when there is a drug in the same class and category that treats the same condition as the drug requested available in Tier 1.
- Tier 3 preferred brand at a Tier 2 cost share when there is no generic available for the requested drug and there is at least one brand drug from the same class and category that treats the same condition available in Tier 2 cost-share.
- Tier 4 non-preferred brand drug at a Tier 3 preferred brand or Tier 2 cost share when there is no generic available for the requested drug and there is at least one brand drug from the same class and category that treats the same condition available in the lowest cost share tier. Not applicable to non-formulary drugs.

Kaiser Permanente members or their provider may initiate a tiering exception request by calling Kaiser Permanente Mid-Atlantic Member Services at 1-888-777-5536, or via a written request to the following address/fax number:

Kaiser Permanente of the Mid-Atlantic States
Appeals and Complaints Resolution Department
2101 East Jefferson Street
Rockville, MD 20852
Fax: 301-816-6192

Members may find more details at www.kaiserpermanente.org\seniormedrx or by contacting Kaiser Permanente Member Services at the number above. Members may also refer to their Evidence of Coverage (EOC) and other plan materials for more details.

Once the tiering exception request is received, it will be reviewed by the Kaiser Permanente Pharmacy Benefit Prior Authorization Help Desk Pharmacist. Prescribing providers may receive a fax or phone call suggesting a drug from the preferred tier or requesting to provide documentation to support the tiering exception.

Prescribing providers are asked to promptly respond to these requests with all required information to facilitate the timely delivery of drugs to the patient.

A tiering exception may be granted when the provider has clearly documented:

- The lower tier drug will not be as effective as the requested drug in the higher tier, or
- The lower tier drug will have adverse effects for the member.

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 Food and 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
KP-VP VA Medicaid	Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List
MD 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.

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 Mid-Atlantic Permanente Medical Group (MAPMG) Physician Director of P&T Drug Utilization Management, develops a standard process for therapeutic conversion for these agents.

Pharmacy Updates: Drug Formulary Management – *Continued from page 41*

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 does not agree to the therapeutic conversion, 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.

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 via the Community Provider portal for affiliated providers *(Clinical Departments & Specialties → Pharmacy → Drug Information → Formulary)*. 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 Formulary Addition and 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.

Pharmacy Updates: Drug Formulary Management – *Continued from page 42*

Drug formulary addition/deletion requests should include the following:

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

"Drug Formulary Addition and Deletion Request" form is available on the KPMAS intranet for MAPMG providers, and from the KPMAS Clinical Library *Clinical Departments & Specialties → Pharmacy → Drug Information → Drug Formulary Addition and Deletion Request Form)* 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.

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 (*Clinical Departments & Specialties → Pharmacy → 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.

Pharmacy Updates: Drug Formulary Management – *Continued from page 43*

Quantity 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; or
- 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.

Providers can review the complete list of drugs requiring prior authorizations by reviewing the formularies for each line of business on the MAPMG intranet site or via the Community Provider portal.

Formulary changes and drug updates

The KPMAS P&T Committee publishes drug formulary decisions for all lines of business to ensure that healthcare providers are kept informed with the most recent updates to each drug formulary. These updates are published monthly on the MAPMG intranet site or via the Community Provider portal.

A printed copy of each drug formulary is available upon request from the Provider Experience 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 exception process offers 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.

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.

Pharmacy Updates: Drug Formulary Management – *Continued from page 44*

- 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:

- 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.
- 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:
    - The pharmacist will contact the prescribing provider to discuss a formulary alternative or obtain the non-formulary exception reason.
    - If an appropriate non-formulary exception reason is obtained, the appropriate co-pay will be applied.
    - 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.
    - The member may request a review of their case through Member Services.

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.

Pharmacy Updates: Drug Formulary Management – *Continued from page 45*

The cost of members' drugs may vary depending upon the type of product and particular pharmacy benefit, however, providers can find general information on members' prescription co-payment and coinsurance information by member benefit plan type on the KPMAS Clinical Library *(Clinical Departments & Specialties → Pharmacy → 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 that they received at the beginning of this renewal year.

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 http://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.

Practitioner and Provider Quality Assurance and Credentialing

The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners under contract with the Mid-Atlantic Permanente Medical Group (MAPMG) and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KPMAS) are qualified, appropriately educated, trained, and competent.

All participating practitioners must be able to deliver health care according to KPMAS standards of care and all appropriate state and federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA) and KPMAS.

Provider responsibilities

- Provision of a current certificate of insurance when initiating a credentialing application.
- A certificate of insurance must also be submitted at annual renewal.
- Cooperation with pre-credentialing site and medical record-keeping review process
- Provide a minimum of 90 days notification to health plan of intent to terminate contract.
- Provider responsibilities in the credentialing process, include:
    - Submission of a completed application and all required documentation before a contract is signed.
    - Producing accurate and timely information to ensure proper evaluation of the credentialing application.
- Provision of updates or changes to an application within 30 days including:
    - Voluntary or involuntary medical license suspension, revocation, restriction, or report filed
    - Voluntary or involuntary hospital privileges reduced, suspended, revoked, or denied
    - Any disciplinary action taken by a Hospital, HMO, group practice, or any other health provider organization
    - Medicare or Medicaid sanctions, or any investigation for a federal healthcare program
    - Medical malpractice action

Provider rights

Provider rights in the credentialing process include:

- Be provided a copy of the Credentialing and Privileging policies and procedures upon written request.
- Reviewing the information contained in his or her credentials file.
- Correcting erroneous information contained in his or her credentials file.
- Being informed, upon request, of the status of their application.
- Appealing decisions of the credentialing committee if he/she has been denied re-credentialing, has had their participating status changed, been placed under a performance improvement plan, or had any adverse action taken against them.

These rights may be exercised by contacting the Kaiser Permanente Practitioner and Provider Quality Assurance Department by phone: 301-816-5853, fax: 301-816-7133, or mail to:

Kaiser Permanente Practitioner and Provider Quality Assurance
2101 East Jefferson Street, 6 West
Rockville, MD 20852

Maryland HealthChoice Access Standards and Outreach

As Kaiser Permanente Maryland HealthChoice Participating Providers, there are special requirements and outreach activities that you along with us must adhere to per the Maryland Department of Health (MDH). Participating providers are required to adhere to the appointment and access standards for Maryland HealthChoice members as defined by MDH. This table shows the appointment type and the associated access standard:

Type of Appointment	Access Standard
Initial health assessment appointment (upon enrollment)	Within ninety (90) days of enrollment
Children under the age of 21	Within thirty (30) days of enrollment
Maternity care – pregnant or post-partum	Within ten (10) days of enrollment
Members with Health Risk Assessment (HRA) that screen positive requiring expedited intervention	Within fifteen (15) business days from the date of receipt of the completed HRA
Urgent care	Withing 24 hours of the request
Emergency services	Available immediately upon request

In addition to meeting appointment and access standards, Participating Providers must effectively manage and implement outreach activities. Kaiser Permanente conducts outreach activities designed to ensure Maryland HealthChoice members get the medical care needed. In addition, Kaiser Permanente provides a dedicated on-boarding process that ensures a quality experience for new Maryland HealthChoice members. Our support and outreach services include a centralized team within our Clinical Contact Center that manages all outreach activities related to Maryland HealthChoice members, including but not limited to appointment reminders, appointment rescheduling, and member results outreach for events such as positive pregnancy tests.

Participating providers are required to make the necessary outreach to members to ensure the members are seen within the required timeframes for initial health care assessment and evaluation for ongoing health needs (e.g., timeliness of health care visits, screenings, and appointment monitoring). In the event, a member after two (2) unsuccessful attempts are made and documented to bring the member in for care, please contact Provider Relations at 877-806-7470. The Provider Relations representative will report the care gap concern to the Kaiser Permanente Medicaid office. Medicaid office will engage Case management for assistance. After additional attempts are made to bring members into care are unsuccessful the Medicaid office will notify the local/county health department for assistance.

More information regarding access standards and outreach can be found on our website at **providers.kaiserpermanente.org/mas** in the Kaiser Permanente Maryland HealthChoice Participating Provider Manual.

Member Complaint Procedures

We encourage members to let us know about the excellent care they receive as a member of Kaiser Permanente or about any concerns or problems they have experienced. Member Services representatives are dedicated to answering questions about members' health plan benefits, available services, and the facilities where they can receive care. For example, they can explain how to make members first medical appointment, what to do if members move or need care while traveling, or how to replace an ID card. They can also help members file a claim for emergency and urgent care services, both in and outside of our service area, or file an appeal. Also, members always have the right to file a compliment or complaint with Kaiser Permanente.

Member Assistance and Resource Specialists are available at most Kaiser Permanente medical office buildings administration offices, or members can call Member Services Monday through Friday, 7:30 a.m. to 5:30 p.m.

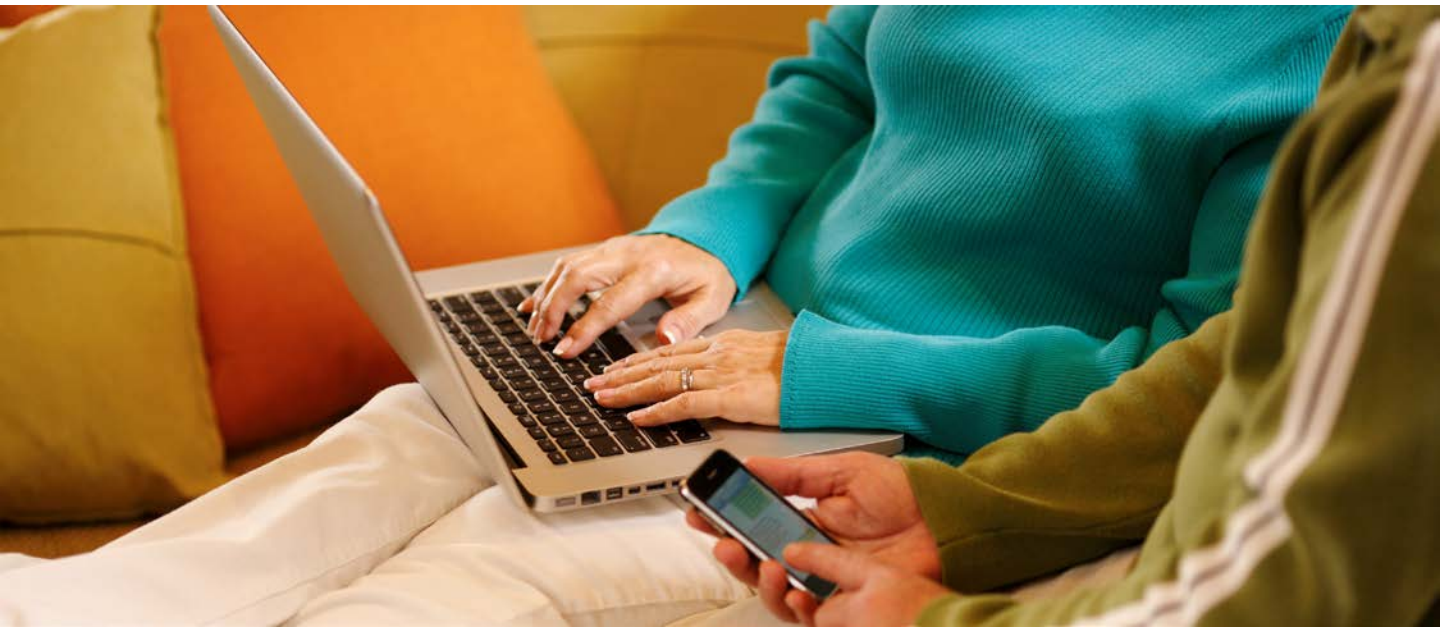
- Within the Washington, D.C. metro area, call 301-468-6000, 301-879-6380 TTY.
- Outside the Washington, D.C. metro area, call 800-777-7902 (toll free), 301-879-6380 TTY.
- Medicare Plus Plan members can call toll free: 888-777-5536, 866-513-0008 TTY, 8 a.m. to 8 p.m., 7 days a week.

Written compliments or complaints should be sent to:

Kaiser Permanente
Appeals & Complaints Resolution
2101 East Jefferson Street
Rockville, MD 20852

All complaints are investigated and resolved by a Member Services representative through coordinating with the appropriate departments.

Members have the right to file an appeal if they disagree with the Health Plan's decision not to authorize medical services or drugs or not to pay for a claim.



Member Complaint Procedures – *Continued from page 49*

Medically Urgent Situations

Expedited appeals are available for medically urgent situations. In these cases, call Member Services, Monday through Friday, 7:30 a.m. to 5:30 p.m.

- Within the Washington, D.C. metro area, call 301-468-6000, 301-879-6380 TTY.
- Outside the Washington, D.C. metro area, call toll free 800-777-7904 (TTY 711).
- After business hours, call an advice nurse
- Within the Washington, D.C., metro area, call 703-359-7878, 703-359-7878 (TTY 711).
- Outside the Washington, D.C., metro area, call toll free: 800-777-7904, 800-700-4901 TTY.

Members must exhaust the internal appeal process before requesting an external review/ appeal. However, an external review/appeal may be requested simultaneously with an expedited internal review/appeal when:

- Services are denied based on experimental/ investigational may be expedited with written notice by the treating physician that services would be less effective if not initiated promptly
- The denial involves medical necessity, appropriateness, healthcare setting, level of care, or effectiveness denials.
- The Health Plan fails to render a standard internal appeal determination within 30 (pre-service) or 60 (post-service) days and the member has not requested or agreed to a delay.

Members may also initiate an appeal for non-urgent services in writing. When doing so, please include:

- The member's name and medical record number.
- A description of the service or claim that was denied.
- Why members believe the Health Plan should authorize the service or pay the claim.
- A copy of the denial notice members received.

Send member's appeal to:

Kaiser Permanente
Appeals & Complaints Resolution
2101 East Jefferson Street
Rockville, MD 20852

Any member request will be acknowledged by an appeals analyst who will inform each member of any additional information that is needed and help obtain the information. The analyst will conduct research and prepare the members' request for review by the appeals/grievances committee. The analyst will also inform the member of the Health Plan's decision regarding the members' appeal/ grievance request along with any additional levels of review available to members. Detailed information on procedures for sharing compliments and complaints or for filing an appeal/grievance is provided in the members' Evidence of Coverage.

Member Complaint Procedures – *Continued from page 50*

Other Assistance

We are committed to ensuring that member concerns are fairly and properly heard and resolved. Members have the right to contact one of the following regulatory agencies to file a complaint about care or services that they believe have not been satisfactorily addressed by the Health Plan.

In Maryland

- Health Education and Advocacy Unit Consumer Protection Division Office of the Attorney General 200 St. Paul Place Baltimore, MD 21202, 877-261-8807 (toll free) **oag.state.md.us** E-mail: consumer@oag.state.md.us
- Maryland Insurance Administration Appeals and Grievance Unit 200 St. Paul Place, Suite 2700 Baltimore, MD 21202, (410) 468-2000, 1-800-492-6116 (toll free) 800-735-2258 (toll free TTY) (410) 468-2270 or (410) 468-2260 (fax) **mdinsurance.state.md.us**

In Virginia

- Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218, 877-310-6560 (toll free) 804-371-9032 (Richmond metropolitan area) **scc.virginia.gov/division/boi/webpages/ boiombudman.asp** E-mail: ombudsman@scc.virginia.gov
- State Corporation Commission Bureau of Insurance, Life and Health Division P.O. Box 1157 Richmond, VA 23218, 804-371-9691, 800-552-7945 (toll free) TDD 804-371-9206 **scc.virginia.gov**
- The Office of Licensure and Certification Department of Health 9960 Mayland Drive, Suite 401 Richmond, VA 23233-1463, 804-367-2106, 800-955-1819 (toll free) 804-527-4503 (fax) **vdh.state.va.us/olc** E-mail: mchip@vdh.virginia.gov

In the District of Columbia

- Department of HealthCare Finance Office of the Health Care Ombudsman and Bill of Rights 899 North Capital Street, N.E., 6th Floor Washington, DC 20002, 202-724-7491, 202-535-1216 (fax) **healthcareombudsman.dc.gov**

For federal employees

- United States Office of Personnel Management Insurance Services Programs Health Insurance Group 3 1900 E St., NW Washington, D.C., 20415-3630 202-606-0755 **opm.gov**

How to contact us

Member Services —Practitioners, providers or members can speak with a Member Services representative if assistance is needed with, or have questions about, the Health Plan or specific benefits. A Member Services representative is available Monday through Friday, 7:30 a.m. to 5:30 p.m.

- Within the Washington, D.C., metro area, call 301-468-6000, 301-879-6380 TTY.
- Outside the Washington, D.C., metro area, call toll free: 800-777-7902, 800-700-4901 TTY).
- Medicare Plus Plan members can call toll free: 888-777-5536, 866-513-0008 TTY, 8 a.m. to 8 p.m., 7 days a week.

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

Advance Directives

An Advance Directive is a legal document that allows members to make treatment preferences for serious or sudden health events. It also lets the member identify a health care agent. For additional details on Advance Directives and Advance Care Planning and Life Care Planning services, please visit www.kp.org/lifecareplan.

Referring Patients to Kaiser Permanente for Specialty Care

Referring your patients to Kaiser Permanente brings the advantages of the integrated care experience to our members as well as to you - the Participating Provider. Members referred to Kaiser Permanente providers for specialty care are seen by Mid-Atlantic Permanente Medical Group, P.C. physicians. With our recent expansions in specialty care services, members referred to a specialist within Kaiser Permanente are frequently seen more quickly than those referred to a specialist within our Participating Provider Network. In addition, all services rendered at a Kaiser Permanente medical center including lab, pharmacy, and radiology orders are documented within KP HealthConnect, our state-of-the art electronic medical record and care management system. The electronic capabilities and technology available through KP HealthConnect allow us to keep you and the patient connected with all aspects of the care that he/she receives within Kaiser Permanente. Members may access health information related to their Kaiser Permanente care at kp.org. Participating PCPs with access to KP HealthConnect Online Affiliate have real-time access to their patient's encounters/ visits, charts, lab results and more via the web at **providers.kp.org/mas.**

If you do not have access to KP HealthConnect or Online Affiliate and would like to enroll, you may download an enrollment package at **providers. kp.org/mas** or contact Provider Experience at 877-806-7470 for assistance.