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 2021

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 letter, 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 **providers.kp.org/mas**.

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Member/Patient Costs and COVID-19 Cost-Sharing Waivers

COVID Diagnostic Testing and Treatment: Since the beginning of the COVID-19 pandemic and public health emergency, Kaiser Permanente has waived all out-of-pocket cost sharing for all testing and all medical and hospital services for COVID-19 treatment and/or for episodes of care where COVID-19 is the primary diagnosis. As public health emergency (PHE) declarations begin to be lifted, the following table outlines the cost shares for testing, treatment and vaccinations for each line of business.

Line of Business	COVID-19 Testing/Screening	COVID-19 Treatment	COVID-19 Vaccinations
Maryland (Commercial/ Marketplace plans)	Cost Share: $0 until the end of the month in which the Federal PHE ends	Cost Share: $0 until July 31, 2021 *Inpatient admissions with admission dates on or before July 31, 2021 will be covered at $0 cost share through discharge.	Cost Share: $0
Virginia (Commercial/ Marketplace plans)	Cost Share: $0 until the end of the month in which the Federal PHE ends	Cost Share: $0 until July 31, 2021 *Inpatient admissions with admission dates on or before July 31, 2021 will be covered at $0 cost share through discharge.	Cost Share: $0
District of Columbia (Commercial/ Marketplace plans)	Cost Share: $0 until the end of the month in which the Federal PHE ends	Cost Share: $0 until July 31, 2021 or end of the month in which the DC PHE ends, whichever is later *Inpatient admissions with admission dates on or before July 31, 2021 will be covered at $0 cost share through discharge.	Cost Share: $0
Medicare Advantage	Cost Share: $0	Cost Share: $0 until the end of 2021 plan year (December 31, 2021) or end of the month in which the Federal PHE ends, whichever is later	Cost Share: $0 until the end of the month in which the Federal PHE ends
Maryland Medicaid	Cost Share: $0	Cost Share: $0	Cost Share: $0
Virginia Medicaid	Cost Share: $0	Cost Share: $0	Cost Share: $0

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

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Important Notes:

- All self-funded members will have $0 cost sharing for screening, testing and diagnosis; however, some self-funded members may encounter a cost share for treatment of COVID-19 at the election of their employer group.
- There is a temporary exception for Virginia Medicaid members. For more information, see "**Virginia Medicaid Member and Out-of-Pocket Costs**," below.
- 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.

Other provisions may apply where required by Federal or state law or regulation. As state laws in the Mid-Atlantic region effect this timeline, we will make updates to our policy. (A limited number of commercial self-funded groups may apply cost sharing for COVID-19 treatment.)

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. As the COVID-19 public health emergency comes to an end, Kaiser Permanente will continue to allow telehealth services when technology is available and when medically necessary and clinically appropriate to do so. Please check with local, state and federal jurisdictions to ensure that telehealth visits are performed in compliance with regulations and standards.

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When verifying eligibility and benefits, providers must verify that the member's plan covers telehealth visits prior to rendering services virtually. Additionally, 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. 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 service 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

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.

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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 https://www.cdc.gov/coronavirus.

COVID-19 Lab Test Coding

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

Procedure Codes	Description
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (Effective 5/20/2020)
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (Effective 6/25/2020)
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed (Effective 6/25/2020)
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected (Effective 8/10/20)
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum (Effective 8/10/20)
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected (Effective 10/6/20)
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected (Effective 10/6/20)
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

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Procedure Codes	Description
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen (Effective 8/10/20)
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer (Effective 8/10/20)
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative (Effective 9/10/20)
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
87426	Severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) (Effective 6/25/2020)
87428	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; adenovirus enteric types 40/41; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B (Effective 11/10/2020)
87635	Infectious agent detection by (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) [COVID-19] (Do not use this procedure for Medicare members)
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique (Effective 10/6/20)
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique (Effective 10/6/20)
87811	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) (Effective 10/6/20)
D0604	Antigen testing for a public health related pathogen, including coronavirus (Effective 1/1/2021)
D0605	Antibody testing for a public health related pathogen, including coronavirus (Effective 1/1/2021)
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source. (Effective 3/1/2020)

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Procedure Codes	Description
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of an HHA, any specimen source. (Effective 3/1/2020)
U0001	Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Test Panel (Use only for tests performed by CDC)
U0002	Private labs (e.g. Quest) 2019-nCoV Coronavirus, SARS-CoV-2/2019- nCoV (COVID-19) (Use for Medicare members or Commercial members)
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R
U0005	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date and time of specimen collection. (List separately in addition to either HCPCS code U0003 or U0004) (Effective 1/1/2021)

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

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

Monoclonal Antibody Therapy Administration	
Procedure Codes	Description
M0243	Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring
M0239	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring

Monoclonal Antibody Therapy Drug Supply	
Procedure Codes	Description
Q0243	Injection, casirivimab and imdevimab, 2400 mg (Provided at no cost and should not billed on a claim)
Q0239	Injection, bamlanivimab-xxxx, 700 mg (Provided at no cost and should not billed on a claim)

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Virginia Medicaid Member and Out-of-Pocket Costs

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

Prescription Drug Coverage and Mail Order Pharmacy

It's a good idea for members to refill their prescriptions online and have them delivered by mail.

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

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

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

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

Monitoring Drug Supply Chains

Currently, Kaiser Permanente is not experiencing any significant drug shortages related to this coronavirus. 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.

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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 if members suspect or were exposed to the coronavirus or are under investigation for exposure to COVID-19. Beginning August 1, 2021, medically necessary treatment of COVID-19 will be covered according to the member's plan as outlined in the ***Member/Patient Costs and COVID-19 Cost-Sharing Waivers*** section of this article.

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

Case Scenario	Use ICD-10 DX Code
Concern about a possible exposure to COVID-19, but ruled out after evaluation	Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out
Actual or suspected exposure to someone who is infected with COVID-19; Person under investigation	Z20.822: Contract with and (suspected) exposure to COVID-19 (Effective 1/1/2021) Z20.828: Contact with and (suspected) exposure to other viral communicable diseases
Asymptomatic Patient screened for COVID-19	Z11.52: Encounter for screening for COVID-19 (Effective 1/1/2021) Z11.59: Encounter for screening for other viral diseases
Confirmed COVID-19	U07.1: 2019-nCoV acute respiratory disease
Case of acute bronchitis confirmed as due to COVID-19	U07.1: 2019-nCoV acute respiratory disease and J20.8: Acute bronchitis due to other specified organisms
Cases of Bronchitis not otherwise specified (NOS) due to the COVID-19	U07.1: 2019-nCoV acute respiratory disease and J40: Bronchitis, not specified as acute or chronic
Cases of lower respiratory infection, not otherwise specified (NOS) or an acute respiratory infection, NOS associated with confirmed COVID-19	U07.1: 2019-nCoV acute respiratory disease and J22: Unspecified acute lower respiratory infection
Cases of respiratory infection, NOS due to COVID-19	U07.1: 2019-nCoV acute respiratory disease and J98.8: Other specified respiratory disorders
Cases of ARDS (Acute Respiratory Distress Syndrome) due to COVID-19	U07.1: 2019-nCoV acute respiratory disease and J80: Acute respiratory distress syndrome

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

COVID-19 Vaccinations

Kaiser Permanente will cover the administration of any FDA-approved COVID-19 vaccine at no cost-share to all commercial and Medicaid members (see "Medicare Reimbursement" section below). Providers may bill for the administration of the vaccine but not the cost of the vaccine as they are provided at no cost by the Federal government. No authorization is required for the administration of COVID-19 vaccinations.

Medicare Reimbursement COVID-19 Vaccinations and Monoclonal Antibody Therapy –
Original Medicare will reimbursement COVID-19 vaccine administration and monoclonal antibody therapy administration (MAB) costs. Therefore, claims for COVID-19 vaccination and MAB administration should be submitted to Original Medicare via the appropriate Medicare Administrative Contractors directly and not to Kaiser Permanente. This provision is for COVID-19 vaccination and MAB administration only. All other Medicare Advantage claims including COVID-19 screening, testing, diagnosis and treatment will continue to be submitted to Kaiser Permanente for reimbursement. For additional information, go to:

- https://www.cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration
- https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion#Payment

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All COVID-19 vaccine administration costs should be billed using the following codes:

Procedure Codes	Description
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **first dose (Pfizer)**
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **second dose (Pfizer)**
0011A	Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **first dose (Moderna)**
0012A	Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **second dose (Moderna)**
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1(ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose **(AstraZeneca)**
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1(ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; second dose **(AstraZeneca)**
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; **single dose (Janssen)**
D1701	SARSCOV2 COVID-19 VAC Administration mRNA 30mcg/0.3mL IM DOSE 1 **(Pfizer) Effective 3/15/2021**
D1702	SARSCOV2 COVID-19 VAC Administration mRNA 30mcg/0.3mL IM DOSE 2 **(Pfizer) Effective 3/15/2021**
D1703	SARSCOV2 COVID-19 VAC Administration mRNA 100mcg/0.5mL IM DOSE 1 **(Moderna) Effective 3/15/2021**
D1704	SARSCOV2 COVID-19 VAC Administration mRNA 100mcg/0.5mL IM DOSE 2 **(Moderna) Effective 3/15/2021**

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Procedure Codes	Description
D1705	SARSCOV2 COVID-19 VAC Administration rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1 **(AstraZeneca) Effective 3/15/2021**
D1706	SARSCOV2 COVID-19 VAC Administration rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2 **(AstraZeneca) Effective 3/15/2021**
D1707	SARSCOV2 COVID-19 VAC Administration Ad26 5x1010 VP/.5mL IM SINGLE DOSE **(Janssen) Effective 3/15/2021**

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

Continue to Encourage Social Distancing

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 **providers.kp.org/mas**. You may also visit **kp.org** for continued updates.

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

2021 Utilization Management Affirmative Statement

Kaiser Permanente practitioners and health care professionals make decisions about the care and services, which are provided based on the member's clinical needs, appropriateness of the 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.

2021 Practitioner/Provider Utilization Management Notification

Utilization Management/Resource Stewardship Program

At Kaiser Permanente our Utilization Management (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 UM 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 Pre-authorization and Post Service Review. UM is organized around three Service Areas: Baltimore, District of Columbia/Suburban Maryland (DCSM) and Northern Virginia (NOVA). UM activities in 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, requests for DME, and home care services. Nurses work collaboratively with licensed, board-certified UM physician managers and practitioners to safely and effectively execute 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.

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The UMOC staff also assist with the following:

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

Access to Utilization Management Criteria

There are several ways to access the Utilization Management (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 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 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

2021 Utilization Management 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.

In the absence of applicable criteria or MCPs, the UM staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioner bases their determination on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of individual patients (e.g., age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. The approved UM criteria sets, and guidelines are listed below.

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 17*

Types of UM Criteria in Use:

A. Behavioral Health UM Criteria

- **Nationally recognized UM criteria**
    - Milliman Care Guidelines (MCG)
    - Community Mental Health and Rehabilitation Services (CMHRS) Manual for Virginia Premier's Behavior Health Services
    - American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder (SUD)
    - Addiction Recovery and Treatment Services (ARTS)
- **Internally developed UM criteria**
    - Medical Coverage Policy (MCP)

B. Non-Behavioral UM Criteria

- **Nationally recognized UM criteria**
    - MCG
    - CMS Coverage Database for National (NCD) and Local Coverage Determination (LCD) for DME and supplies
    - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines
    - InterQual for transplant services
- **Internally developed UM criteria**
    - MCP
    - National Transplant Services (NTS) Transplant Patient Selection Criteria

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 18*

Behavioral Health

Referral Service Type Approved criteria sets are used in order of hierarchy.	Commercial & Exchange Jurisdiction	Medicare	Medicaid (VA Medicaid and FAMIS)	Medicaid (MD HealthChoice)
Behavioral Health: SUD specifically *All levels, i.e., IP, OP, RTC, PHP, IOP	MCG ASAM-Maryland	MCG	ASAM-Maryland	Not Applicable
Behavioral Health: Inpatient	MCG	MCG	MCG	Not Applicable
Behavioral Health: Outpatient *Excludes SUD	MCP MCG	NCD-LCD	MCG	Not Applicable
Behavioral Health: Partial Hospitalization *Excludes SUD	MCG	NCD-LCD	MCG	Not Applicable
Behavioral Health: **CMHRS Covered Services:** 1. Mental Health Case Management 2. Therapeutic Day Treatment (TDT) for Children/Assessment 3. Day Treatment/Partial Hospitalization for Adults/Assessment 4. Crisis Intervention 5. Intensive Community Treatment/Assessment 6. Mental Health Skill-Building Services 7. Intensive In-Home/Assessment 8. Psychosocial Rehab 9. Crisis Stabilization 10. Behavioral Therapy/Assessment 11. Mental Health Peer Support Services or Family Support Partners – Individual 12. Mental Health Peer Support Services or Family Support Partners - Group	Not Applicable	Not Applicable	CMHRS	Not Applicable

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 19*

Virginia Medicaid Behavioral Health and SUD
CMHRS and ARTS

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

CMHRS	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

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 20*

ARTS	UM Criteria
Screening, Brief Interventional and Referral to Treatment (SBIRT)	Medical Necessity Review Not Required
Outpatient	Medical Necessity Review Not Required
Intensive Outpatient	ASAM
Partial Hospitalization Program	ASAM
Residential Treatment	ASAM
Inpatient	ASAM
Opioid Treatment Program (OTP)	Medical Necessity Review Not Required
Preferred Office Based Opioid Treatment (OBOT)	Medical Necessity Review Not Required
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-CHIP-Program-%20%20Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html

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

[4] CMHRS

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 21*

1. ASAM Criteria for SUD

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 January 1, 2020**. MCG criteria is no longer used for Maryland Commercial Members SUD in 2020.

2. 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

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 22*

- **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).

Non-Behavioral Health

Note: Commercial and Exchange includes District of Columbia, Maryland, and Virginia jurisdictions.

Referral Service Type Approved criteria sets are used in order of hierarchy.	**Commercial & Exchange Jurisdiction**	**Medicare**	**Medicaid (VA Medicaid and FAMIS)**	**Medicaid (MD HealthChoice)**
Acute Rehabilitation (inpatient)	MCG	NCD-LCD	MCG	MCG
Ambulance Services	KPMAS MCP	NCD-LCD	KPMAS MCP	KPMAS MCP
Durable Medical Equipment (DME) and Supplies	KPMAS MCP MCG NCD-LCD	NCD-LCD	KPMAS MCP MCG NCD-LCD	KPMAS MCP MCG NCD-LCD
Orthotics and Prosthetics	KPMAS MCP MCG NCD-LCD	NCD-LCD	KPMAS MCP MCG NCD-LCD	KPMAS MCP MCG NCD-LCD
EPSDT	Not Applicable	Not Applicable	EPSDT	EPSDT
Home Health Services	MCG	NCD-LCD	MCG	MCG
Hospice (inpatient and outpatient	MCG	MCG	MCG	MCG
Inpatient Services	MCG	MCG	MCG	MCG
Neonatal Care	MCP/MCG	Not Applicable	MCP/MCG	MCP/MCG
Outpatient Services	KPMAS MCP MCG	NCD-LCD	KPMAS MCP MCG	KPMAS MCP MCG
PT/OT/ST	KPMAS MCP MCG	NCD-LCD KPMAS MCP MCG	KPMAS MCP MCG	KPMAS MCP MCG
Skilled Nursing Facility	MCG	NCD-LCD	MCG VA FAMIS Only*	MCG
Transplant Services	NTS IQ®	NTS IQ®	NTS IQ®	NTS IQ®

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 23*

Key to Abbreviations

- MCP/MCG: NICU and Neonatal Care Admission and Discharge (Revised MCG Neonatal Intensive Care Unit Levels)
- MCG – formerly called Milliman Care Guidelines
- ASAM – American Society of Addiction Medicine
- IQ: InterQual® Criteria
- CMHRS – Community Mental Health Rehabilitative Services Criteria
- IOP: Intensive Outpatient Program
- IP: Inpatient
- MCP: Medical Coverage Policies (locally developed)
- NCD-LCD: Medicare Coverage Policies – National and Local Coverage Determination
- NTS: KP National Transplant Network Services Patient Selection Criteria
- RTC: Residential Treatment Center
- PHP: Partial Hospitalization Program
- SUD: Substance Use Disorder
- OP: Outpatient

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 24*

Non-Behavioral Health

A. MCG Guidelines 25th Edition/13.0 Release[5]

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 25th edition was released on February 28, 2021, after systematic evidence-based review by MCG. The new edition went live in KP-MAS on May 18, 2021. The MCG's care guidelines that are licensed for KPMAS are the following:

- **Ambulatory Care (AC)** - 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.
- **Home Care (HC)** - 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.
- **Behavioral Health Care (BHC)** - 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.
- **Inpatient and Surgical Care (ISC)** - 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.
- **General Recovery Care (GRC)** - provides care guideline when no Inpatient & Surgical Care Optimal Recovery Guideline appears applicable or to assist in care management of complex, multifaceted clinical situations with the purpose to identify and describe evidence-based elements of patient care that will assist in the delivery of quality healthcare and efficient resource management.
- **Recovery Facility Care (RFC)** - address two primary level of care which are inpatient rehabilitation facilities (acute rehabilitation) and Sub-acute/skilled nursing facilities (SNF). The appropriate level of care that which determines patient's placement is correlated to patient's clinical condition, functional status, therapeutic goals, preference and potential to reach optimal functioning and independence. The care guideline provides recovery facility admission care and discharge criteria, including complete discharge plans, coordinating plans for moving patients to and through recovery facilities to other appropriate care settings.
    a. **Inpatient rehabilitation facilities** or **acute rehabilitation** provides highly intensive rehabilitation services for ongoing assessment and management of the patient to achieve optimal functioning while being monitored for changing medical or physical status. The care guideline is intended for patients who require and can tolerate extensive physical rehabilitation, and who demonstrate the ability to make progress in the therapeutic program with access to 24-hour nurse support, close physician monitoring, and frequent intensive rehabilitation services.

[5] Source: Change HealthCare, Job Aid MCG 25th edition Summary of Changes

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b. **Subacute/Skilled Nursing facilities (SNF)** is a level of care intended for patients who require ongoing skilled medical interventions that cannot be provided at a lower level of care and can perform rehabilitation therapy but not at a highly intensive level. It require* provision of ongoing skilled medical treatments and moderate to low-level intensive therapy with focus on skilled nursing interventions, rehabilitation therapy, or a combination of both.

Changes in the MCG 25th edition include:

- **General content enhancements and changes**
  - **Acute Viral Illness Guidelines**: The 25th edition of the Viral Illness, Acute inpatient guidelines (adult and pediatric) include an up-to-date summary and analysis of care for COVID-19 inpatients.
- **Ambulatory Care**
  - **Changes to evidence summary recommendation grades for medications**: Within the specialty medications section, a 3rd possible recommendation grade (RG A3) can be assigned to criteria annotations, medications approved for those indications by a federal regulatory agency but evidence is insufficient or does not demonstrate a net benefit.
  - **Oral medications from specialty medications section** are removed while high-cost parenteral pharmacologic agents guidelines continue to be available.
- **Home Care**
  - **Home Care utilization models**: now displays commercial data-based statistics on average number of home care visits by guideline, visit type (such as RN, PT, OT, therapy assistants (such as PTA, OTA) if appropriate and days since start of care including average minutes/ day by visit type.
  - **Definition for completion of rehabilitation** was added to Stage 3 of the clinical status for most home care guidelines to determine appropriateness or readiness for discharge
  - "**Rehabilitation therapy or equipment coordination**" definition was added with links for physical therapy (PT) referral, occupational therapy (OT) referral, and speech language pathology (SLP) referral to determine referral appropriateness upon admission to home healthcare.

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- **Behavioral Health Care**
    - **Social determinants of health assessment** was added from a pop-up bullet on Guideline Day/Stage 1 in the Recovery Course for all Behavioral Health level of care guidelines and care guidelines for Behavioral Health to assess patients who are at higher risk for an unmet health-related social need upon admission (or soon thereafter.
- **Inpatient & Surgical Care**
    - The term **“A” or "Ambulatory" has been removed from Goal Length of Stay (GLOS)** for medical Optimal Recovery guidelines with a with a link to the pertinent Observation Care guideline to minimize confusion regarding use of the designation "Ambulatory" when referencing the inpatient GLOS.
    - **Social determinants of health assessment** has been added in a pop-up bullet on guideline day 1 in the Optimal Recovery course for all inpatient guidelines to help identify patients at higher risk for an unmet health-related social need upon admission or soon thereafter
    - **Discharge milestones standardized -** the following 4 universal recovery milestones which appear consistently in the final day of the guideline’s Optimal Recovery course have been standardized:
        - Ambulatory or acceptable for next level of care
        - Oral hydration (with a footnote attached)
        - Oral medications or regimen acceptable for next level of care
        - Oral diet or acceptable for next level of care
- **General Recovery Care**
    - **Revisions are made in search results** to enhance the user experience and reduce confusion in guideline selection, which are most evident in the following:
        - Reduction of overlap in search results when searching for ISC/GRC guidelines, where a related GRC guideline will no longer display.
        - The search functionality will now primarily return medical GRC guidelines for diagnosis codes and surgical guidelines for procedure codes to reduce the number of GRC guidelines returned.
    - **Social determinants of health assessment**: added from a pop-up bullet on Stage 1 in the General Recovery course for all problem oriented and body system general recovery guidelines, to help identify patients at higher risk for an unmet health-related social need upon admission or soon thereafter.
- **Recovery Facility Care**
    - Skilled nursing facility (SNF) statistical readmission rates is added **to Recovery Facility Care** which measures the percent of SNF admissions (occurring within 1 day of hospital discharge) that result in a readmission to the hospital within 30 days of prior hospital discharge.

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

The **2021 InterQual Level of Care, April 2021 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.

InterQual Level of Care Criteria Description

1. **InterQual Acute Adult Criteria -** determines 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.
2. **InterQual Acute Pediatric Criteria** - determines 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.
    - 2021 InterQual Level of Care – General Surgical, Acute Criteria – Adult & Pediatrics
    - 2021 InterQual Level of Care – General Medical, Acute Criteria – Adult & Pediatrics
    - InterQual Level of Care Acute Criteria, Pediatric - General Transplant Section (General, Bone Marrow and Stem Cell Transplantation)
        - 2021 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Adult
        - 2021 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Pediatric

C. Medicare Coverage Database for NCD-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.

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 28*

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.

C. EPDST Guidelines

EPSDT is 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 health care treatment 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.

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 29*

Internally Developed UM Criteria

A. NTS Transplant Patient Selection Criteria

The following NTS Transplant Patient Selection Criteria and KPMAS MCPs were approved in February 2021:

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 Policies (MCP)

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.

1. **Home Oxygen**
   Effective date: June 24, 2021
   - References were updated
2. **Hyperbaric Oxygen**
   Effective date: June 24, 2021
   - References were updated
3. **Transgender Surgery Commercial MD, VA & Feds**
   Effective date: June 24, 2021
   - References were updated
4. **Transgender Surgery DC Jurisdiction**
   Effective date: June 24, 2021
   - References were updated
5. **Transcranial Magnetic Stimulation (TMS)**
   Effective date: June 24, 2021
   - Section V: Added OCD as an exclusion
   - References were updated
6. **Circumcision Revision**
   Effective date: June 24, 2021
   - References were updated
7. **Purewick NEW 2021**
   Effective date: July 22, 2021

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 30*

8. **Transcutaneous Tibial Nerve Stimulator (TTNS) NEW 2021**
   Effective date: July 22, 2021

9. **External Insulin Pumps and Supplies**
   Effective date: July 22, 2021
   - Section III, C - Coverage
     - Documented frequency of glucose self-*testing on average changed from 4 to 3 to align with prior changes
   - References were updated

10. **Dermal Fillers**
    Effective date: July 22, 2021
    - Section III, D Clinical Indications for Referral – on dermal filler retreatments:
      - Update: retreatments should generally occur after 2 years and for 3-4 injections with 2-year time frame supported by the literature. “Generally” is used as if the plastic surgery evaluation indicates that this is needed before that time frame it may be done but does provide some guidelines for retreatment
    - References were updated

11. **Pelvic Floor Rehabilitation**
    Effective date: July 22, 2021
    - References were updated

12. **Varicose Veins**
    Effective date: July 22, 2021
    - References were updated

13. **Microwave Thermolysis with miraDry System**
    Effective date: July 22, 2021
    - References were updated

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 31*

14. IVF Diagnosis and Treatment

Effective date: August 17, 2021

- Section IV. Definition.
  - A, Infertility - added: # 3: PCOS and # 8: Post-menopausal
  - B: added: "IVF Cycle"
- Section VI, C Initial Specialist Consultation Referral – Female
  - Added: "count" to anterior follicle to assess ovarian functional status.
- Section VIII. Female Treatment, A. Basic Infertility and B. Advanced Reproductive
  - Deleted: reference to IVF number of cycles
  - As per SGF and KP one cycle of IVF to be authorized at a time.
- References were updated

15. Fertility Preservation for Iatrogenic Infertility

Effective date: August 17, 2021

- References were updated

16. External Insulin Pump

Effective date: August 17, 2021

- Section **III, A # 4** of the External Insulin Pump policy – update glucose testing to at least 3x/day – to match the July 2021 @ least 3x per day glucose testing update on **section III, C**

17. Cochlear Implants and Auditory Brain Stem Implants

Effective date: August 17, 2021

- Section VI. B - External Component (speech processor)
- Added: An upgrade of the implant's external component (speech processor) is covered in the 6 months prior to the obsolescence date and not prior to this time.
- References were updated

Access to MCPs ***is only two clicks away in HealthConnect.***

MCPs can be accessed through the **KP Clinical Library** by using the web link below:
https://clm.kp.org/wps/portal/cl/MAS/search_iframe?query=medical+coverage+policy&x=0&y=0.

Click on the Clinical Library section on the right side of the KPHC Home page and then type in "medical coverage policy" in the search box. All medical coverage policies will be displayed.

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

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

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

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

If you have administrative questions concerning accessing or using our criteria, please contact:

Marisa R Dionisio, RN
Marisa.R.Dionisio@kp.org
240-620-7257

2021 Utilization Management 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 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, our member's 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 800-810-4766 and follow prompts to be directed to the call center, available 24 hours, 7 days a week.

UM staff can receive inbound communications regarding UM issues after normal business hours by:

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

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.

2021 UM Accessibility, Communication and Hours of Operations – *Continued from page 33*

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: 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 p.m. except Clinical Trials: Clinical Trials 8 a.m. to 4:30 p.m. Call 800-810-4766 Weekends and Holidays, *except Clinical Trials:* 8:30 a.m. to 5 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 p.m. Call 800-810-4766 Weekends and Holidays: 8:30 a.m. to 5 p.m. for urgent and routine discharge care coordination referrals DME HOTLINE 855-632-8279 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

2021 UM Accessibility, Communication and Hours of Operations – *Continued from page 34*

UM Department Section	Hours of Operation	Core Responsibilities
Continuing Care Hub	Monday through Friday: 8:30 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 a.m. to 5:30 p.m. *Limited Evening hours* 3 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
Skilled Nursing Facility (SNF) and, Rehabilitation Services and Long-Term Acute Care Hospitals (LTACH)	Monday through Friday 8 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 a.m. to 4:30 p.m. Including weekends and major holidays BH Status Line: 301-552-1212 Fax: 855-414-1703	Conduct concurrent review and transition care management services of behavioral health service

2021 UM Accessibility, Communication and Hours of Operations – *Continued from page 35*

UM Department Section	Hours of Operation	Core Responsibilities
UM Outpatient Services – Behavioral Health	Monday to Friday: 8 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
Outpatient Continuing Care: **Complex Case Management** **Renal Case Management** **Virtual Home Care Program (VHCP)**	Monday through Friday 8:30 a.m. to 5 p.m. Excluding weekends and major holidays VHCP: 8 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

2021 Adopting Emerging Technology for Utilization Management 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 the 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.

2021 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.

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

Communicating Population Care Management 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 understand 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. Multimedia 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, submit a KP HealthConnect "registry update request" in basket message to the P Clinical Content team. 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.

Integration of Care in KPMAS Patient Centered Medical Home

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.

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).

Integration of Care in KPMAS PCMH – *Continued from page 41*

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.

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) days from the date of receipt of the completed HRA
Urgent care	Within twenty-four (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.

Provider Access to Health Education Materials

Kaiser Permanente physicians and network providers have access to all health education materials to provide to patients as part of the After-Visit Summary and secure email communications, or to supplement discussion from patient visit.

Content can be viewed through the centralized internal "Clinical Library" which is an electronic inventory of health education information that can be used for all visit types. Health education content and links to education videos are also embedded into KP HealthConnect for inclusion in member After Visit Summary, sent via secure messaging, or mailed directly to patient's addresses. For health education programs, providers can:

- Direct members to kp.org/appointments to register for classes.
- Use KP HealthConnect, After Visit Summaries, or hard copy flyers to provide members with information on how to self-register for programs.

Additional information on health education programs, tools, and resources is available by:

- Visiting kp.org/healthyliving/mas.
- Contacting the Health Education automated line 301-816-6565 or toll-free at 800-444-6696.

Member Rights and Responsibilities: Our Commitment to Each Other

Kaiser Permanente is committed to providing you and your family with quality health care services. In a spirit of partnership with you, here are the rights and responsibilities we share in the delivery of your health care services.

Member rights

As a member of Kaiser Permanente, you have the right to do the following:

RECEIVE INFORMATION THAT EMPOWERS YOU TO BE INVOLVED IN HEALTH CARE DECISION MAKING

This includes your right to do the following:

a. Actively participate in discussions and decisions regarding your health care options.

b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved – no matter what the cost is or what your benefits are.

c. Receive relevant information and education that helps promote your safety in the course of treatment.

d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.

Member Rights and Responsibilities – *Continued from page 45*

e. Refuse treatment, provided that you accept the responsibility for and consequences of your decision.

f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an advance directive, a durable power of attorney for health, a living will, or another health care treatment directive. You can rescind or modify these documents at any time.

g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.

h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your authorized representative will be asked to provide written permission before your records are released, unless otherwise permitted by law.

RECEIVE INFORMATION ABOUT KAISER PERMANENTE AND YOUR PLAN

This includes your right to the following:

a. Receive the information you need to choose or change your primary care physician, including the names, professional levels and credentials of the doctors assisting or treating you.

b. Receive information about Kaiser Permanente, our services, our practitioners and providers, and the rights and responsibilities you have as a member. You also can make recommendations regarding Kaiser Permanente’s member rights and responsibility policies.

c. Receive information about financial arrangements with physicians that could affect the use of services you might need.

d. Receive emergency services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

e. Receive covered, urgently needed services when traveling outside the Kaiser Permanente service area.

f. Receive information about what services are covered and what you will have to pay and examine an explanation of any bills for services that are not covered.

g. File a complaint, a grievance, or an appeal about Kaiser Permanente, or the care you received, without fear of retribution or discrimination; expect problems to be fairly examined; and receive an acknowledgement and a resolution in a timely manner.

RECEIVE PROFESSIONAL CARE AND SERVICE

This includes your right to the following:

a. See plan providers; get covered health care services; and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring and professional manner.

Member Rights and Responsibilities – *Continued from page 46*

b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.

c. Be treated with respect and dignity.

d. Request that a staff member be present as a chaperone during medical appointments or tests.

e. Receive and exercise your rights and responsibilities without any discrimination based on age; gender; sexual orientation; race; ethnicity; religion; disability; medical condition; national origin; educational background; reading skills; ability to speak or read English; or economic or health status, including any mental or physical disability you may have.

f. Request interpreter services in your primary language at no charge.

g. Receive health care in facilities that are environmentally safe and accessible to all.

Member responsibilities

As a member of Kaiser Permanente, you have the responsibility to do the following:

PROMOTE YOUR OWN GOOD HEALTH

a. Be active in your health care and engage in healthy habits.

b. Select a primary care physician. You may choose a doctor who practices in the specialty of internal medicine, pediatrics, or family practice as your primary care physician.

c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.

d. Work with us to help you understand your health problems and develop mutually agreed-upon treatment goals.

e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.

f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.

g. Schedule the health care appointments your physician or health care professional recommends.

h. Keep scheduled appointments or cancel appointments with as much notice as possible.

i. Inform us if you no longer live or work within the plan service area.

Member Rights and Responsibilities – *Continued from page 47*

KNOW AND UNDERSTAND YOUR PLAN AND BENEFITS

a. Read about your health care benefits and become familiar with them. Detailed information about your plan, benefits and covered services is available in your contract. Call us when you have questions or concerns.

b. Pay your plan premiums and bring payment with you when your visit requires a copayment, coinsurance, or deductible.

c. Let us know if you have any questions, concerns, problems, or suggestions.

d. Inform us if you have any other health insurance or prescription drug coverage.

e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our plan.

PROMOTE RESPECT AND SAFETY FOR OTHERS

a. Extend the same courtesy and respect to others that you expect when seeking health care services.

b. Ensure a safe environment for other members, staff and physicians by not threatening or harming others.

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-Virginia Premier VA Medicaid	Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List
Maryland HealthChoice	Maryland HealthChoice Preferred Drug List Note: some drugs used for Mental Health and Substance Abuse Disorders are excluded from the KPMAS Drug Formulary, but covered by Maryland Department of Health on the Maryland Medicaid Fee-for-Service Preferred Drug List
Marketplace Exchanges	KPMAS District of Columbia, Maryland and Virginia Marketplace Formulary

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

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

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

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 49*

This process assures proper communication, implementation and education of health care 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).

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 50*

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 877-806-7470, via the affiliated provider website or via the intranet for MAPMG providers.

Pharmacy Updates: Drug Formulary Management – *Continued from page 51*

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 and/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
- Criteria established by the 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.

Prior authorizations or step therapy may require periodic review for renewal as the evidence-based criteria may be updated due to changes in guidelines or regulatory mandates.

Pharmacy Updates: Drug Formulary Management – *Continued from page 52*

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 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.
- 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.

Pharmacy Updates: Drug Formulary Management – *Continued from page 53*

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 877-218-7750 and request a non-formulary exception review.

Pharmacy Updates: Drug Formulary Management – *Continued from page 54*

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 https://providers.kaiserpermanente.org/html/cpp_mas/pharmacytoc.html?

- You will be asked to sign in with your user ID and password to access the co-payment and coinsurance information.
- If you do not have access to KPMAS Clinical Library and would like to gain access, please contact Provider Experience at 877-806-7470 Monday through Friday, 9 a.m. to 5 p.m., Eastern Time for assistance.

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

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.

Medicare Part D Drug Formulary and Tiering Exception Process – *Continued from page 56*

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

Kaiser Permanente
Appeal & Grievance Operations
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736

Members may find more details at 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.

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 Advantage Plan members can call toll free: 888-777-5536, 866-513-0008 TTY, 8 a.m. to 8 p.m., 7 days a week.

Member Complaint Procedures – *Continued from page 57*

Written compliments or complaints should be sent to:

Kaiser Permanente
Appeal & Grievance Operations
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736

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.

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).
- Fax: 404-949-5001
- 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
Appeal & Grievance Operations
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736

Member Complaint Procedures – *Continued from page 58*

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.

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 Advantage Plan members can call toll free: 888-777-5536, 866-513-0008 TTY, 8 a.m. to 8 p.m., 7 days a week.

CLAS 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

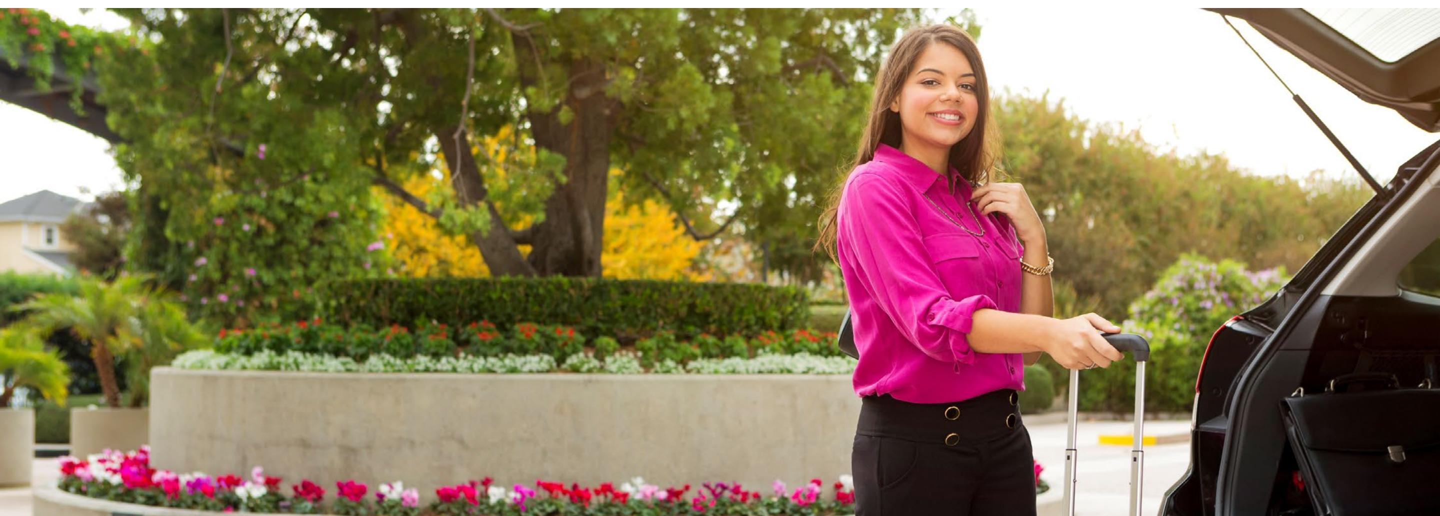
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

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.



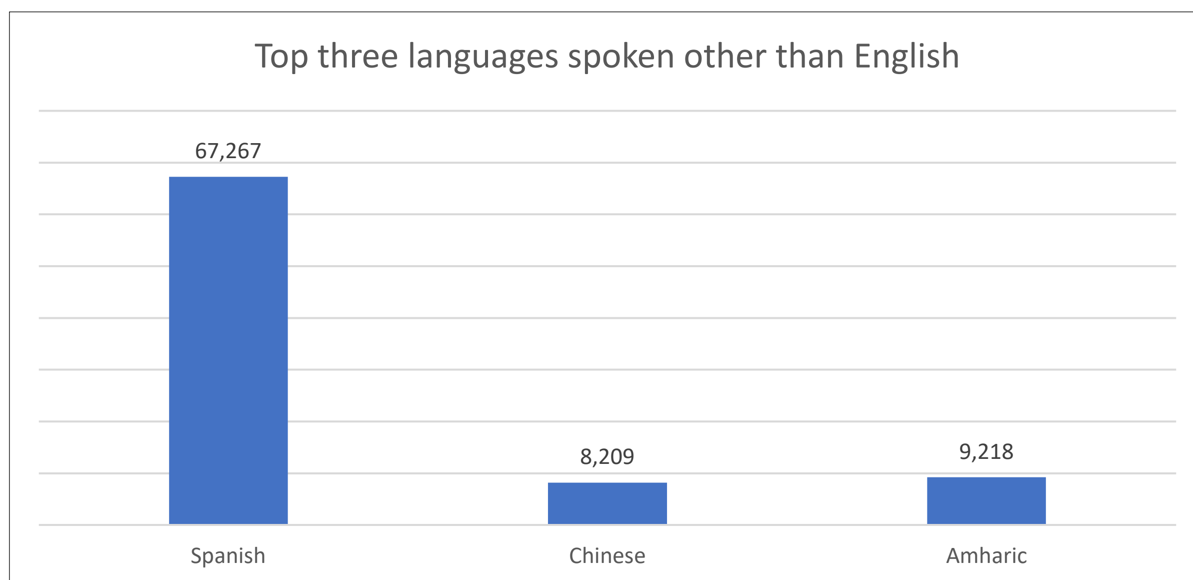
CLAS Standards – *Continued from page 60*

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, 2020 – December 31, 2020. 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.

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.

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.

Diversity – *Continued from page 62*

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 **kp.org/providers/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**.

Referring Patients to KP 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 AffiliateLink have real-time access to their patient's encounters/ visits, charts, lab results and more via the web at **kp.org/providers/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 **kp.org/providers/mas** or contact Provider Experience at 877-806-7470 for assistance.

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

Advanced 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: **kp.org/lifecareplan**.

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.

Keeping Your Provider Data Updated

Be sure to submit any changes to your practice to Kaiser Permanente. Keeping Kaiser Permanente updated will ensure that our provider directory and data systems are accurate and help us to provide an excellent healthcare experience to our members. To access our provider directory online, go to kp.org. For your convenience, a sample form letter can be found on our Community Provider Portal at kp.org/providers/mas and on the following page. Utilize the sample to submit updates throughout the year.

Updates may be submitted to Provider Experience via:

Fax: 855-414-2623
Email: Provider.Demographics@kp.org
Mail: Kaiser Permanente
Provider Experience
2101 East Jefferson St., 2 East
Rockville, MD 20852

Sample Provider Data Update Form Letter

Company Letterhead Logo

<<Date>>
Requestor:
Requestor's Correspondence Address:
Requestor's Phone #:
Requestor's Email:
Tax ID#:
Effective date of change(s):
Reason for the request:

***PLEASE DELETE SECTIONS NOT NEEDED**

Address change (Specify if practice location or billing address is changing)

- Specify if adding or deleting address
- Include **old** and **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, **Tax ID** and **NPI**)
- Billing/Payment Address/Tax ID/NPI
- Management Correspondence Address (include Phone & Fax Number

Practice location addition

- Include **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, **Tax ID** and **NPI of Location**)
- Billing/Payment Address/Tax ID/NPI

Adding a provider to or deleting a provider from an existing group

- Specify if adding or deleting provider
- Include the information listed below if adding or deleting a provider:
    - First Name, Middle Initial, and Last Name
    - Gender
    - Title (*MD, CRP, CRNP, PA etc.)*
    - Date of Birth
    - NPI #
    - CAQH #
    - UPIN or SSN
    - Medicare #
    - Medicaid Participation State(*s*)
    - Medicaid #
    - Practicing Specialty
    - **Practicing Location(s) (*include phone & fax numbers*)**
        - Indicate whether practicing location is hospital based or office based
    - Billing/Payment Address (*include W-9*)
    - Management Correspondence Address (*include phone & fax number*)
    - Hospital Privileges
    - Foreign Languages
    - Effective Date
    - Provider Panel Status: Open or Closed
- ***A copy of provider licenses in all practicing states is required***

Changing the Tax Identification Number and/or the name of an existing group

- Include **old** and **new** tax ID number and/or group name
- Include effective date of the new tax ID number and/or group name
- Include NPI number
- Include a signed and dated copy of the new W-9
- Billing/Payment Address
- Management Correspondence Address (include phone & fax number)

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

KAISER PERMANENTE®