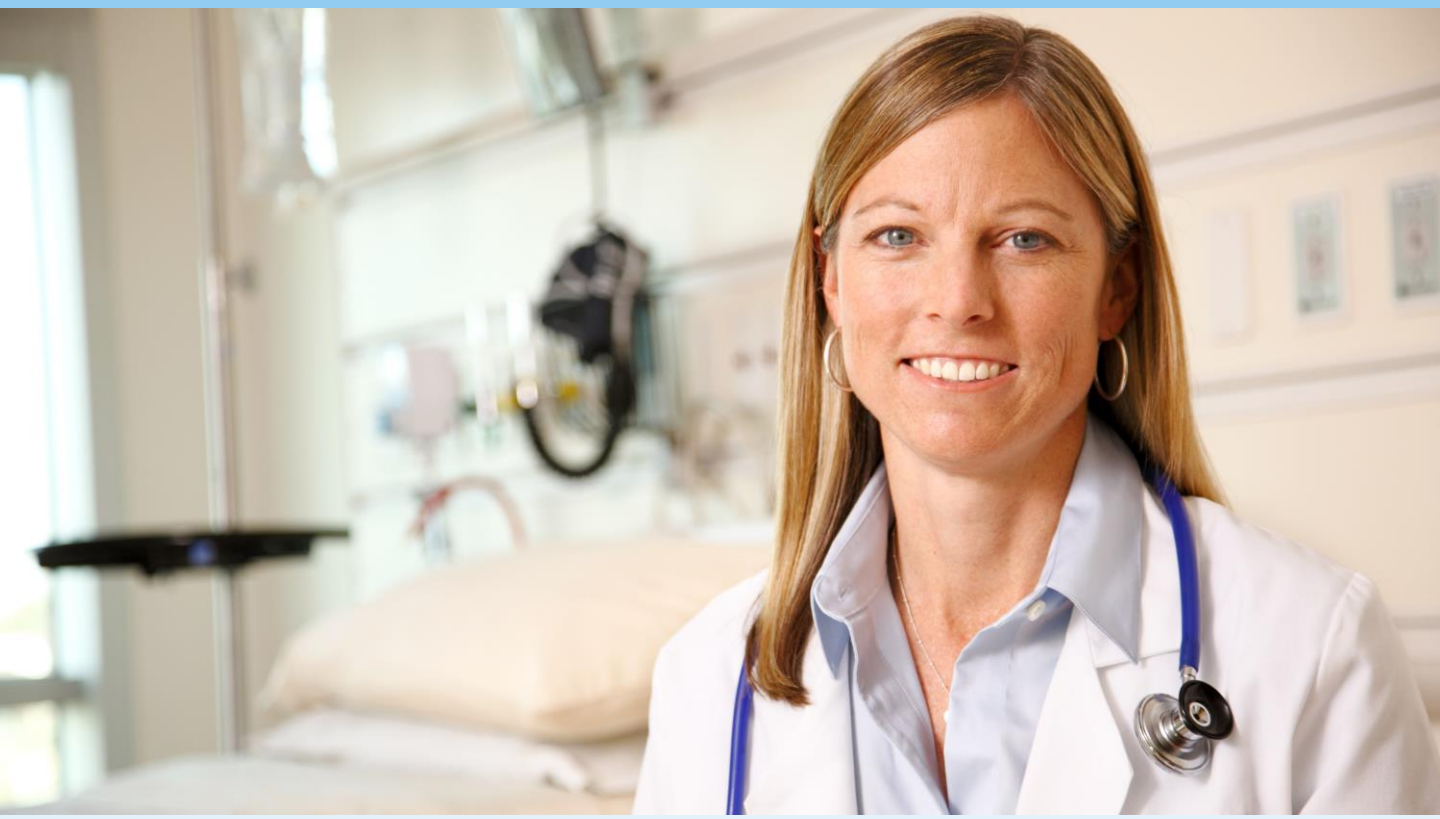
network news

For practitioners and providers of Kaiser Permanente
Produced by Kaiser Foundation Health Plan of the Mid Atlantic States, Inc. in partnership with the Mid Atlantic Permanente Medical Group, P.C.

December 2023



Contents

Optima Health Rebranding to Sentara Health

We want to inform you of a branding change affecting Kaiser Permanente Virginia Medicaid members. Effective January 1, 2024, Optima Health Plan will be rebranded to Sentara Health Plan. Under this new name, they will continue to provide our members with the same excellent service and benefits.

Starting January 1, 2024, Optima Health and Kaiser Permanente VA Medicaid members will be part of Sentara Health and Kaiser Permanente Medicaid plan. There will be no benefit or copay changes as a result of this change, and no action is necessary on your part. You can continue to serve Optima Health and Kaiser Permanente members under the new name of “Sentara Health, Kaiser Permanente.”

Kaiser Permanente and Optima Health are also in the process of notifying our impacted membership of this merger. New membership ID cards will be distributed in the coming weeks and can be used by members at any time beginning in December 2023. For your convenience, a preview of the new Sentara Health Product Member ID card is included below:

Sentara Health Plans

CardinalCare Virginia's Medicaid Program

MEDICAID

KP MEDICAL RECORD NUMBER
5931882
PAAY HULEY,ITZELLE M

MEDICAID ID NUMBER
795135268728

KAISER PERMANENTE

CENTER
CTMC

PRIMARY CARE PHYSICIAN
DAWSON-RICHARDSON,SHANNON M

MedImpact BIN: 003585
MedImpact PCN & Group: 70000

Transportation: (866) 823-8349
Dental/Smiles for Children: (888) 912-3456

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.

kp.org 03100 - Sentara Health Plans

If you have a medical emergency, call 911 or go to the nearest emergency room.

Medical Advice/Appts/Cancel Appts (24 hours a day)		TTY
Northern Virginia	(703) 359-7878	711
Outside Northern Virginia	(800) 777-7904	711

If you are unsure of your condition and require immediate medical advice, call (800) 677-1112.

Member Services Contact Center:		TTY
Northern Virginia and toll free	(855) 249-5025	711
Pharmacy Helpdesk	(800) 788-2949	711
Behavioral Health Access Line	(866) 530-8778	711

Claims for services must be submitted to:
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
PO Box 371860, Denver, CO 80237-9998

Providers: For authorizations, contact Utilization Management at (800) 810-4766.

Call Medical Advice as soon as possible after you have an emergency hospital admission.

Sentara Health Plans

CardinalCare Virginia's Medicaid Program

FAMIS

KP MEDICAL RECORD NUMBER
46312846
NOORUZI,ARDUNE P

ID NUMBER
578470999919

KAISER PERMANENTE

CENTER
SFMC

PRIMARY CARE PHYSICIAN
HWANG,DAHYE

MedImpact BIN: 003585
MedImpact PCN & Group: 70000

Transportation: (866) 823-8349
Dental/Smiles for Children: (888) 912-3456

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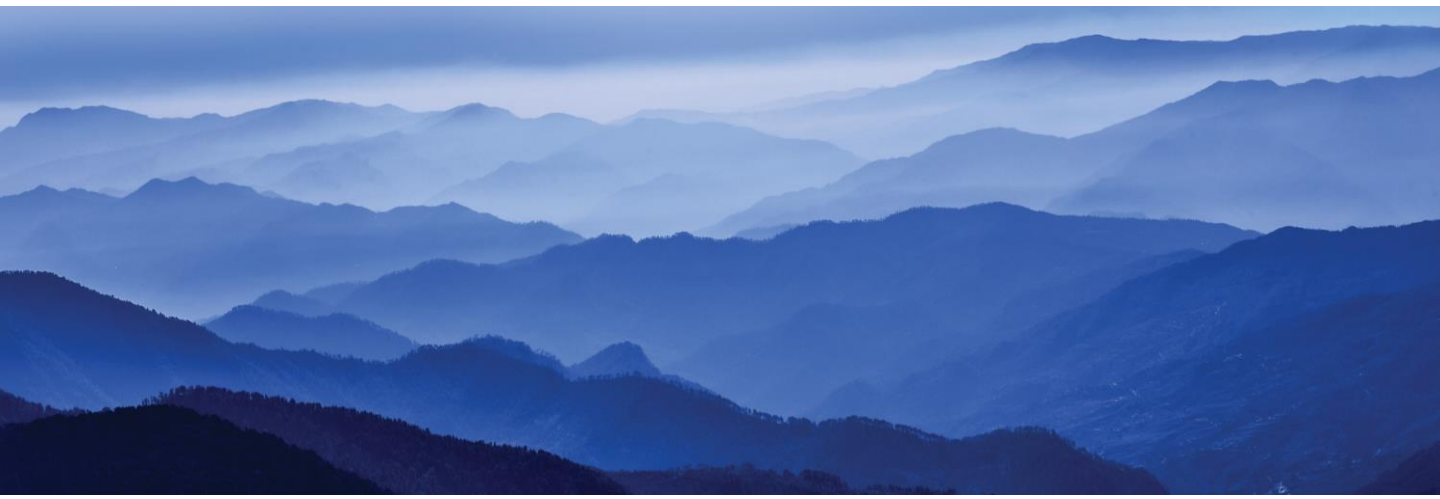


EDC Analyzer Implementation for Maryland Hospitals

Effective January 1, 2024, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and Mid-Atlantic Permanente Medical Group (MAPMG) are making changes regarding review of services for Emergency Department Claim Evaluation and Management (E/M) Codes at Maryland facilities

To ensure coding accuracy and for claims received on or after January 1, 2024, Kaiser Permanente will use the Optum EDC Analyzer tool for outpatient emergency department claims that are submitted with levels 3 through 5 E/M codes 99283 through 99285. For more information on this review, go to www.EDCAnalyzer.com.

The Kaiser Permanente Participating Provider Manual, Section 8.4, details these changes. You may access and/or download the Provider Manual from our Community Provider Portal at www.kp.org/providers/mas.

If you would like reconsideration of a claim adjustment, payment or denial, disputes may be filed online through our Online Affiliate Portal. Non-registered users may register for access to Online Affiliate at www.kp.org/providers/mas.

Thank you for participating with Kaiser Permanente to provide quality healthcare services to our members. If you have any questions, please contact the Provider Experience Department by phone at 877-806-7470 or by email at Provider.Relations@kp.org.

Third Party Liability (TPL) for Medical Support Enforcement Beneficiaries

The Centers for Medicare & Medicaid Services (CMS) has updated third party liability (TPL) requirements regarding medical support enforcement beneficiaries in 42 CFR 433.139(b)(3). **Under these new requirements, Maryland Medicaid must pay and chase claims rendered to a medical support enforcement beneficiary if the provider has (1) first billed the noncustodial parent's insurance and (2) not received payment after 100 days from the date of service.**

The Maryland Department of Health (MDH) has recently notified Medicaid MCOs that they are similarly required to align claims processes with the new medical support enforcement requirements.

Effective November 1, 2023, TPL medical support enforcement beneficiaries claims for Kaiser Permanente Maryland HealthChoice members must be submitted as follows:

- Electronic Submission (Recommended):
  - Complete the 837 through your electronic clearinghouse.
  - Within 24-48 hours of the initial submission, locate the Kaiser Permanente assigned claim number via Online Affiliate.
  - Submit a completed Attestation Form and proof of claim submission to the primary insurer with that claim number via the Request for Information (RFI) process on Online Affiliate. This must be completed no later than 21 calendar days after Kaiser Permanente's receipt of the claim.
    - Institutional Claims – Use "MD Medicaid UB-04 Medical Support Enforcement Third Party Claim Billing Provider Attestation Form"
    - Professional Claims – Use "MD Medicaid CMS-1500 Box 11 – Rejection Reason S Provider Attestation Form"
- Paper Submission:
    - Complete the CMS-1500 or UB-04 billing form as usual.
  - Attach a completed Attestation Form and proof of claim submission to the primary payer with that claim number.
    - Institutional Claims – Use "MD Medicaid UB-04 Medical Support Enforcement Third Party Claim Billing Provider Attestation Form"
    - Professional Claims – Use "MD Medicaid CMS-1500 Box 11 – Rejection Reason S Provider Attestation Form"
    - Mail using the following address:

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

This process is applicable for claims received on or after November 1, 2023. Claims must be submitted at least 100 days after and within 12 months from the date of service. Fully completed Attestation Forms and proof of claim submission to primary payer must be submitted no later than 21 calendar days after Kaiser Permanente's receipt of the claim. Claims and Attestation Forms submitted outside of those windows or those submitted with incorrect or incomplete documentation will be denied.

TPL for Medical Support Enforcement Beneficiaries – *Continued from page 4*

This process is applicable for claims received on or after November 1, 2023. Claims must be submitted at least 100 days after and within 12 months from the date of service. Fully completed Attestation Forms and proof of claim submission to primary payer must be submitted no later than 21 calendar days after Kaiser Permanente's receipt of the claim. Claims and Attestation Forms submitted outside of those windows or those submitted with incorrect or incomplete documentation will be denied.

Kaiser Permanente's Maryland Medicaid Manual has been updated to reflect these changes (Kaiser Permanente Maryland HealthChoice Provider Manual - Section VI). The updated manual and necessary attestation forms are available on our Community Provider Portal at www.kp.org/providers/mas.

If you have any questions or concerns, please call 800-777-7902. We appreciate your support in caring for our members.

2023 Utilization Management Affirmative Statement

Kaiser Permanente practitioners and health care professionals make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of care and service, and existence of health plan coverage. Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. The health plan does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or benefits or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and services or result in underutilization. In order to maintain and improve the health of our members, all practitioners and health professionals should be especially diligent in identifying any potential underutilization of care or service.

2023 Utilization Management Approved Criteria Sets and Guidelines

Measurable, objective and evidence-based decision-making criteria ensure that decisions are fair, impartial and consistent. Kaiser Permanente utilizes and adopts nationally, recognized UM criteria sets, regionally developed Medical Coverage Policies (MCP) and nationally developed Kaiser Permanente Transplant Referral Guidelines. Additionally, the clinical criteria is supported by current peer reviewed literature and evaluated by specialty service chiefs and subject matter experts who are 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 base their determination on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of individual patient (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.

2023 Utilization Management Approved Criteria Sets and Guidelines – *Continued from page 6*

Utilization Management Criteria in Use

A. Behavioral Health UM Criteria

- **Nationally Recognized UM Criteria**
  - Milliman Care Guidelines (MCG) 27th Edition
  - American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder (SUD)
  - Department of Medical Assistance Services (DMAS)
- **Internally Developed UM Criteria**
  - Medical Coverage Policy (MCP)

B. Non-Behavioral Health UM Criteria and Guidelines

- **Nationally Recognized UM Criteria**
  - MCG 27th Edition
  - 2023 InterQual Level of Care Criteria for Transplant-related Services
  - Adult and Pediatric CMS Coverage Database for National (NCD) and Local Coverage Determination (LCD) for DME and Supplies
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines
  - 2022 InterQual Level of Care Criteria for Transplant Services
- **Internally Developed UM Criteria**
  - MCP
  - National Transplant Services (NTS) Transplant Referral Guidelines
- **Guidelines**
  - Center for Medicare and Medicaid Services (CMS) Benefit Policy Manual, Chapter 8 – Coverage of Extended Care (SNF) Services under Hospital Insurance
  - State of Maryland Department of health and Mental Hygiene (DHMH), Maryland Medical Assistance Program, Nursing Home Transmittal #217

Behavioral Health
2023 Utilization Management Criteria

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	MCG	ASAM	Not Applicable
Behavioral Health: Inpatient	MCG	MCG	MCG	Not Applicable
Behavioral Health: Outpatient *Excludes SUD	MCP MCG	MCG	MCG	Not Applicable
Behavioral Health: Partial Hospitalization *Excludes SUD	MCG	MCG	DMAS	Not Applicable
Behavioral Health: MHS Covered Services[4]	Not Applicable	Not Applicable	DMAS	Not Applicable

2023 Utilization Management Approved Criteria Sets and Guidelines – *Continued from page 7*

Virginia Medicaid Behavioral Health and SUD
Mental Health Services (MHS) and Addiction and Recovery Treatment Services (ARTS)

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

Mental Health Services (MHS)	UM Criteria
MH Case Management	Registration Only
MH Peer Support - Individual	DMAS SA after Initial Registration
MH Peer Support-Group	DMAS SA after Initial Registration
Mobile Crisis Response	DMAS Registration
23 Hour Crisis Stabilization	DMAS Registration
Community Stabilization	DMAS SA after Initial Registration
Residential Crisis Stabilization	DMAS after Initial Registration
Assertive Community Treatment	DMAS after Initial Registration
Intensive In-Home	DMAS Service Auth
Therapeutic Day Treatment for Children School Day	DMAS Service Auth
Therapeutic Day Treatment for Children After School	DMAS Service Auth
Partial Hospital Program	DMAS Service Auth
Mental Health Skill Building Services	DMAS Service Auth
Psychosocial Rehab	DMAS Service Auth
Applied Behavior Analysis	DMAS Service Auth
Intensive Outpatient Program	DMAS Service Auth
Functional Family Therapy	DMAS Service Auth
Multisystemic Therapy	DMAS Service Auth

2023 Utilization Management Approved Criteria Sets and Guidelines – *Continued from page 8*

Addiction and Recovery Treatment Services (ARTS)	UM Criteria
ARTS 0.5 Early Intervention/SBIRT	No referral needed
ARTS 1.0 CD Outpatient Services	No referral needed
ARTS 2.1 CD Intensive Outpatient (IOP)	ASAM SA for BH IOP
ARTS 2.5 CD Partial Hospital Program (PHP)	ASAM SA for BH PHP
ARTS 3.1 Clinically Managed Low Intensity Residential	ASAM SA for BH RTC
ARTS 3.3 Clinically Managed Population Specific High Intensity Residential	ASAM SA for BH RTC
ARTS 3.5 Clinically Managed High Intensity Residential	ASAM SA for BH RTC
ARTS 3.7 Medically Monitored Intensive Inpatient	ASAM for Inpatient Service
ARTS 4.0 Medically Managed Intensive Inpatient	ASAM for Inpatient Service
CD OP Med Management - Addiction Medicine	No referral needed
OTP/OBAT Opioid Treatment Program/Preferred Office Based Addiction Treatment	No referral needed
MAT/MOUD - Medication Assisted Treatment/Medication for Opioid Use Disorder	No referral needed
CD Group Therapy	No referral needed
CD Case Management	Registration
ARTS Peer Support	ASAM Service Auth
ARTS Family Support	ASAM Service Auth
Care Coordination	No referral needed

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] Department of Medical Assistance Services (DMAS) criteria for Mental Health Services (MHS) formerly called as CMHRS- Community Mental Health Rehabilitative Services)

2023 Utilization Management Approved Criteria Sets and Guidelines – *Continued from page 9*

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 (Maryland HealthChoice)**
Acute Rehabilitation (Inpatient)	MCG	MCG	MCG	MCG
Ambulance Services	KP-MAS MCP	NCD-LCD	KP-MAS MCP	KP-MAS MCP
DME and Supplies	KP-MAS MCP MCG NCD-LCD	NCD-LCD	KP-MAS MCP MCG NCD-LCD	KP-MAS MCP MCG NCD-LCD
Orthotics and Prosthetics	KP-MAS MCP MCG NCD-LCD	NCD-LCD	KP-MAS MCP MCG NCD-LCD	KP-MAS MCP MCG NCD-LCD
EPSDT Services	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	KP-MAS MCP MCG	NCD-LCD	KP-MAS MCP MCG	KP-MAS MCP MCG
PT/OT/Speech	KP-MAS MCP MCG	NCD-LCD KP-MAS MCP MCG	KP-MAS MCP MCG	KP-MAS MCP MCG
Skilled Nursing Facility	MCG	CMS Chapter 8 Benefit Policy Manual	Medicaid Transmittal # 217	Medicaid Transmittal # 217
Transplant Services	NTS IQ®	NTS IQ®	NTS IQ®	NTS IQ®

2023 Utilization Management Approved Criteria Sets and Guidelines – *Continued from page 10*

Key to Abbreviations

• MCP/MCG™: NICU and Neonatal Care Admission and Discharge (Revised MCG® Neonatal Intensive Care Unit Levels) • MCG™: formerly called Milliman Care Guideline • ASAM: American Society of Addiction Medicine • IQ: InterQual® Criteria • Mental Health Services Criteria: formerly Community Mental Health Rehabilitative Services (CMHRS) Criteria • IOP: Intensive Outpatient Program	• 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 • IP: Inpatient

New/Emerging Technologies, Transplant Referral Guidelines, and Medical Coverage Policy Update: 2023

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) and Transplant Patient Selection Criteria were approved between **August 2023 to October 2023.**

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.

New and Emerging Technologies

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): August 4, 2023
Approved by the Regional Utilization Management Committee (RUMC): August 24, 2023

INTC Presentation Date	**National Interregional New Technology Committee (INTC) Conclusion** **http://cl.kp.org/pkc/national/cpg/intc/specialty.html**	**KP-MAS Recommendation - Adopt the use of technology** **Sufficient evidence**	**KP-MAS Recommendation – Do not recommend** **Inconclusive or Insufficient evidence**
Sufficient evidence: Quality and quantity of evidence is good, should be used in most cases where indications are met.			
Insufficient evidence: Quality and/or quantity is low or moderate, further research or trials are needed. Can be used in selected cases but not for general use for this diagnosis or indication.			
6/17/2022	Nodify Blood Tests for Pulmonary Nodules		X
6/17/2022	Functional Electrical Stimulation (FES) for Foot Drop due to MS		X
6/24/2022	Implantable Vagus Nerve Stimulation for Stroke Rehabilitation		X
6/24/2022	Intraosseous Radiofrequency Basivertebral Nerve Ablation for the Treatment of Adults with Chronic Vertebrogenic Low Back Pain		X
7/11/2022	ConfirmMDx for Prostate Cancer	X	
7/11/2022	Prolaris for Prostate Cancer		X

New and Emerging Technologies - *Continued from page 12*

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): September 1, 2023
Approved by the Regional Utilization Management Committee (RUMC): September 27, 2023

INTC Presentation Date	National Interregional New Technology Committee (INTC) Conclusion http://cl.kp.org/pkc/national/cpg/intc/specialty.html	KP-MAS Recommendation - Adopt the use of technology Sufficient evidence	KP-MAS Recommendation – Do not recommend Inconclusive or Insufficient evidence
Sufficient evidence: Quality and quantity of evidence is good, should be used in most cases where indications are met.			
Insufficient evidence: Quality and/or quantity is low or moderate, further research or trials are needed. Can be used in selected cases but not for general use for this diagnosis or indication.			
7/14/2022	TAT Mobile Pelvic Floor Muscle Training (PFMT) Application for Stress Urinary Incontinence		X There is low certainty in the body of evidence that using the TAT mobile application improves symptoms severity and quality of life in women with stress urinary incontinence
8/5/2022	Lumipulse G-beta Amyloid Ratio for Suspect Alzheimer's Disease		X The existing evidence for the clinical utility of the test is of insufficient quantity and quality. There is no direct evidence for the clinical utility of this test
8/5/2022	Fluorescence Imaging for Parathyroid Gland Identification during Thyroid or Parathyroid Surgery	X Quality and quantity of evidence is good. This technology will reduce surgical morbidity and improve outcomes. It is becoming standard of care	
9/23/2022	Robot-Assisted Skin and Nipple Sparing Mastectomy for Prevention and Treatment of Breast Cancer		X There is low certainty in the body of evidence that robot-assisted nipple-sparing mastectomy is as safe as conventional nipple-sparing mastectomy techniques.

New and Emerging Technologies - *Continued from page 13*

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): September 1, 2023
Approved by the Regional Utilization Management Committee (RUMC): September 27, 2023

INTC Presentation Date	National Interregional New Technology Committee (INTC) Conclusion http://cl.kp.org/pkc/national/cpg/intc/specialty.html	KP-MAS Recommendation - Adopt the use of technology Sufficient evidence	KP-MAS Recommendation – Do not recommend Inconclusive or Insufficient evidence
Sufficient evidence: Quality and quantity of evidence is good, should be used in most cases where indications are met.			
Insufficient evidence: Quality and/or quantity is low or moderate, further research or trials are needed. Can be used in selected cases but not for general use for this diagnosis or indication.			
9/23/2022	Robot-Assisted Bronchoscopy for Minimally Invasive Peripheral Lung Biopsy	X Robotic-assisted bronchoscopy is being implemented throughout the country. Our experience has been that this is superior to electromagnetic bronchoscopy and radial ultrasound bronchoscopy when used without robotic assistance for better biopsy yield of peripheral lung lesions.	
10/20/2022	Virtual Reality for Chronic Pain		X Do not recommend. Insufficient evidence for approval. The quality of the research is low. Can be used in select cases but not for general use for this indication

New and Emerging Technologies - *Continued from page 14*

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): September 25, 2023
Approved by the Regional Utilization Management Committee (RUMC): October 25, 2023

INTC Presentation Date	National Interregional New Technology Committee (INTC) Conclusion http://cl.kp.org/pkc/national/cpg/intc/specialty.html	KP-MAS Recommendation - Adopt the use of technology Sufficient evidence	KP-MAS Recommendation – Do not recommend Inconclusive or Insufficient evidence
Sufficient evidence: Quality and quantity of evidence is good, should be used in most cases where indications are met.			
Insufficient evidence: Quality and/or quantity is low or moderate, further research or trials are needed. Can be used in selected cases but not for general use for this diagnosis or indication.			
11/18/2022 SCPMG	Micro-Ultrasound (ExactVu) for Prostate Cancer Biopsy and Detection of Prostate Cancer		X
11/18/2022 SCPMG	Electroceutical Coin (eCoin, Valencia Technologies Corp) Tibial Nerve Neurostimulator for Urgency Urination/Overactive Bladder		X
11/30/2022 National	Kardia to Detect Afib and Monitor the Corrected QTc Interval		X
11/30/2022 National	Laparoscopic Radiofrequency Ablation for Symptomatic Uterine Fibroids (Acessa)		X
11/30/2022 National	Transcervical Radiofrequency Ablation Procedure for Uterine Fibroids (Sonata®)		X

New and Updated Medical Coverage Policies

1. Cardiac Rehabilitation

Effective date: 08/24/2023

- Utilization Alert was updated
- References were updated

2. Breast Reduction and Gynecomastia Surgery

Effective date: 08/24/2023

- Grammatical edit – not content change
- Utilization Alert was updated
- References were updated

3. Breast Pump

Effective date: 08/24/2023

- Utilization Alert was updated
- References were updated

4. SpaceOAR

Effective date: 08/24/2023

- Utilization Alert was updated
- References were updated

5. Ambulance Transportation and Non-Emergency Transportation

Effective date: 08/24/2023

- Utilization Alert was updated
- References were updated
- Section V. Indications for Air Ambulance
    - B. Hospital to Hospital Air Transport – added “neurointerventional care” to example of specialized medical services.

Medical Coverage Policy Update: 2023 - *Continued from page 16*

6. Ambulance Transportation and Non-Emergency Transportation

Effective date: 09/27/2023

- Word "coverage" replaced with "medical necessity" statements.
- Statement "require approval by MAPMG" replaced with the word "authorization."
- Section V. Clinical Guidelines for Air Ambulance
- Outline edited for clarity

7. Benign Skin Lesion Treatment

Effective date: 08/24/2023

- Utilization Alert was updated
- References were updated

8. Continuous Passive Motion (CPM)

Effective date: 08/24/2023

- Utilization Alert was updated
- References were updated

9. Orthosis: Spinal & Soft Goods_NEW

Effective date: 08/24/2023

- Utilization Alert was updated
- References were updated

10. Orthosis: Upper Extremity & Soft Goods_NEW

Effective date: 08/24/2023

11. Orthosis: Lower Extremity & Soft Goods_NEW

Effective date: 08/24/2023

12. Orthotics – Knee, Foot, and Ankle_RETIRED

Effective date: 09/27/2023

13. Hypoglossal Nerve Stimulator for OSA_NEW

Effective date: 09/27/2023

14. High Frequency Flutter Valves and Oscillator Vest (HFOV)

Effective date: 09/27/2023

- References were updated
- Section III, E-1: HFCWO – clinical indications that are considered as investigational or experimental and not covered:
  - *"without the diagnosis of bronchiectasis"* added to chronic obstructive pulmonary disease (COPD) and chronic bronchitis.

15. Endobronchial Valve

Effective date: 09/27/2023

- References were updated

Medical Coverage Policy Update: 2023 - *Continued from page 17*

16. Morbid Obesity/Bariatric Surgery, Adolescents and Adult

Effective date: 09/27/2023

- Utilization Alert was updated
- References were updated
- Section III. Diagnosis – Edited
  - Changed *"Morbid obesity uncontrolled by non-surgical therapies with failure of past attempts at long-term weight reduction"* to *"Severe obesity uncontrolled…"*
- Section IV. Definition
  - *"Morbid obesity"* replaced with *"Severe obesity*" – defined as:
    - Severe obesity means a body mass index (BMI) >/= 35 kg/m^2, regardless of presence, absence, or severity of co-morbidities and should be considered for individuals BMI of 30-34.9 kg/m^2 with diabetes mellitus type 1 or type 2.
- Section V. Surgical inclusion criteria for adult (18 years old and above) patients with no prior history of bariatric surgery
  - A & B replaced with the following:
    - *A. BMI >/= prior to preoperative preparatory program; or*
    - *B. BMI equal to or greater than 30-34.9 kg/m2 prior to preoperative preparatory program with diabetes mellitus type 1 or type 2; AND*
    - C. *"Being nicotine/smoke free when beginning therapeutic program"* replaced with *"Being nicotine/smoke free three months prior to beginning the "Bariatric Surgery" therapeutic program."*
- Section VI. Initial surgical inclusion criteria for adolescents if not excluded by EOC
  - Deleted – *B. Patient will need a psychiatric comprehensive evaluation and a nutrition program prior to being considered for bariatric surgery.*
- Section VII. Contraindication and Limitation
  - *C. High surgical risks including HbA1C > 7%* replaced with the following:
    - *C. High surgical risks including HbA1C > 9% or per bariatric surgeon's discretion.*
- Section VIII. Therapeutic measures to complete prior to referral for initial bariatric surgery – updated
- Section IX
  - Deleted: *Section IX. Surgical criteria measures for all patients who have had previous restrictive bariatric surgery.*
  - Replaced with: *Section IX. Repeat or revision surgical criteria measures for patients who have had previous restrictive sleeve gastrectomy surgery or previous restrictive and malabsorptive weight reduction surgery.*
- Section X. Repeat or revision surgical criteria measures for patients who have had previous restrictive sleeve gastrectomy surgery or previous restrictive and malabsorptive weight reduction surgery – entire section deleted

Medical Coverage Policy Update: 2023 - *Continued from page 18*

16. Morbid Obesity/Bariatric Surgery, Adolescents and Adult (Continued)

Effective date: 09/27/2023

- Utilization Alert was updated
- References were updated
- Section XII. Surgical methods for weight loss
  - Revised from:
    A. Biliopancreatic bypass with duodenal switch;
    B. Laparoscopic adjustable gastric banding (e.g., lap band);
    C. Open or laparoscopic roux-en-Y gastric bypass;
    D. Laparoscopic sleeve gastrectomy (LSG); and
    E. Open sleeve gastrectomy
  - Replaced with:
    A. Biliopancreatic bypass with duodenal switch; and
    B. Roux-en-Y gastric bypass; and
    C. Sleeve gastrectomy; and
    D. Single Anastomosis duodenal-ileal bypass with sleeve gastrectomy
- Section XIII. Surgical methods for weight loss considered as experimental or investigational – Entire section deleted
- Section XIV. External bariatric surgery coverage policy – New section added

17. Preimplantation Genetic Test (PGT)

Effective date: 09/27/2023

- References were updated
- Section V. Added the following as an **exclusion** for PGT:
  - PGT for nonmedical gender selection and/or nonmedical traits
  - PGT for multifactorial inheritance disorders
  - PGT for hereditary mutations which manifest in adulthood (e.g., BRCA testing)
  - PGT for screening of conditions with incomplete penetrance or significant variability of expression (e.g., Alzheimer's disease, cancer predisposition)
  - Screening for polygenic risk (PGT-P)

18. Spinal Cord Stimulation for Pain Management

Effective date: 09/27/2023

- References were updated

19. Wound Supplies

Effective date: 09/27/2023

- References were updated

20. Nutritional Support

Effective date: 09/27/2023

- References were updated
- New Section VI added: *Adult and Pediatric Enteral Formulas and Medical Foods for DC Situs Members*

Medical Coverage Policy Update: 2023 - *Continued from page 19*

21. Continuous Glucose Monitor

Effective date: 10/03/2023

- **Update: Adults and Peds**
  - Insulin injection edited from a minimum of 3x/daily to at least once daily or an insulin pump for Commercial members.
  - Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person or telehealth visit with the beneficiary to evaluate their diabetes control and determined that criteria (1)-(4) above are met.
- **Section III. A – Clinical Indications for Adult**
  - #1 c. Currently monitoring blood glucose at least 3 or more times daily or has documented willingness to monitor blood sugars continuously through a CGM trial.
  - #1 d. Prior to initial continuous glucose monitor use, patient is managed by the ordering provider for at least 6 months with at least 3 documented diabetes encounters with the ordering provider within 6 months.
  - #2 a-b. On chronic insulin treatment (any dose) AND there is specific documentation of:
    a. Severe dexterity impairment (inability to use standard blood glucose monitor); or
    b. Severe vision impairment (severe, uncorrectable vision impairment, resulting in the inability to read standard blood glucose meter).
- **Section III. B – Clinical Indications for Peds**
  - **Deleted #1 c-d and #2 a-d**
    - #1 c. Child or caregiver performs blood glucose testing at least 3 or more times daily or has documented willingness to monitor blood sugars continuously through a CGM trial;
    - #1 d. Documented consistent encounters with an endocrinologist every 6 months, over the last 6-12 months and in-between phone contact with diabetes educator for a patient with an established diagnosis of Type 1 Diabetes;
    - #2 a-d. Member is 17 years old or younger and has a diagnosis of Type 1 Diabetes Mellitus on chronic insulin treatment (any dose) AND specific documentations.
- **Section III. D #1 – Exclusions**
  - Deleted: Use of a CGM device that does not provide the option of a DME Receiver (e.g., Freestyle Libre 3) is not considered to be medically necessary at this time
  - Added as an exclusion: Smart devices used to receive glucose readings

22. Phrenic Nerve Stimulator_NEW

Effective date: 10/25/2023

23. Acupuncture

Effective date: 10/25/2023

- References were updated

Medical Coverage Policy Update: 2023 - *Continued from page 20*

24. Vitiligo Treatment

Effective date: 10/25/2023

- References were updated
- Section II. C #3 – Vitiligo Treatment Exclusion
  - Deleted: Janus kinase (JAK) inhibitors

25. Continuous Passive Motion (CPM) Machines

Effective date: 10/25/2023

- Section III. A: Clinical indications for referral – statement revised
  - A. CPM may be indicated and covered for repeat of high-risk surgery, post manipulation of shoulder, knee, elbow, and other joints.
    - Added: *"in conjunction with physical therapy"*
    - Deleted: *"only if active physical therapy services are not available"*

26. Habilitative Services – Small Group and KPIF VA Jurisdiction

Effective date: 10/25/2023

- References were updated
- Section II. A and B: Visit Limit for KPIF and Small Group
  - Deleted: *"contract year"*

27. Habilitative Services – DC Jurisdiction

Effective date: 10/25/2023

- References were updated

28. Habilitative Services – MD Jurisdiction

Effective date: 10/25/2023

- References were updated
- Section II. A and B: Habilitative Services
  - Added: *"coverage of habilitative services is without visit, dollar, nor age limit"*
  - Deleted: *"age limit"*

Access to MCPs is only two clicks away in Health Connect.

Medical Coverage Policies 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.

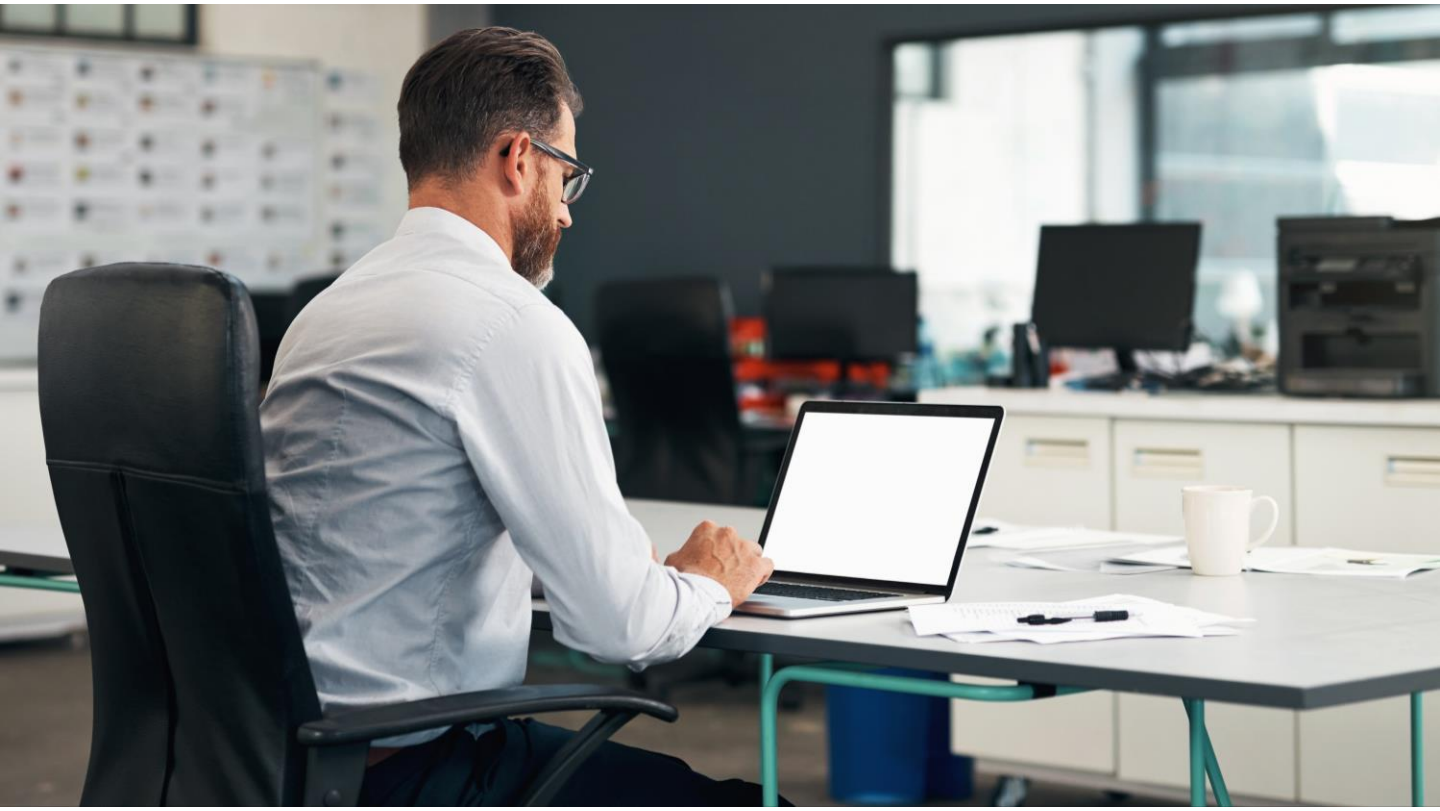
All Practitioners have the opportunity to discuss any non-behavioral health and or/behavioral health Utilization Management (UM) medical necessity denial (adverse) decisions with a Kaiser Permanente Physician reviewer (UM Physicians).

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

Christine Assia, M.D.
Physician Director of Medical Policies, Benefits and Technology Assessment
Emergency Physician, Advanced Urgent Care/ECM/UMOC
Christine.C.Assia@kp.org

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

Marisa R Dionisio, RN
Marisa.R.Dionisio@kp.org



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.

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.

Member Rights and Responsibilities – *Continued from page 23*

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.

Member Rights and Responsibilities – *Continued from page 24*

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.

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 25*

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

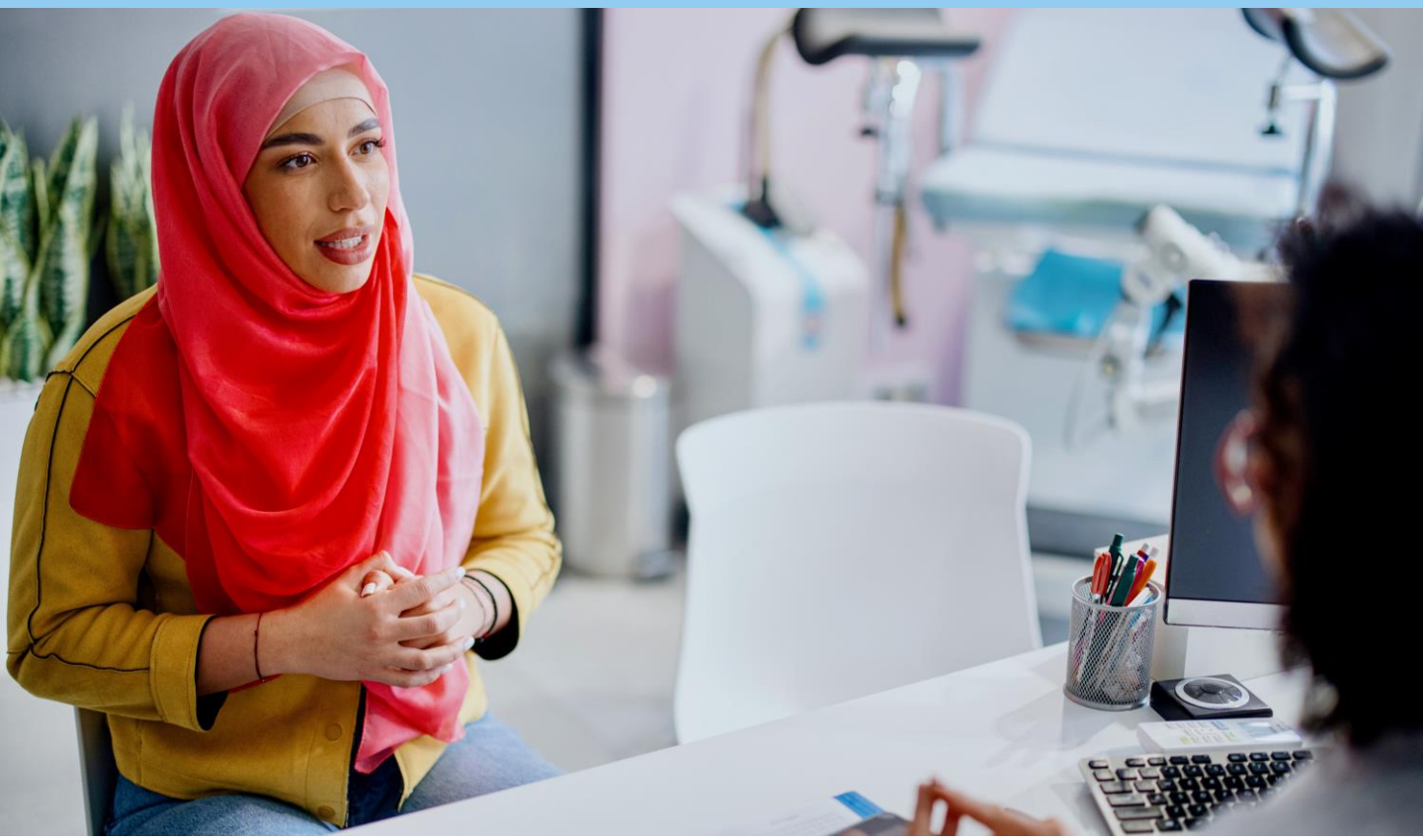
a. Extend the same courtesy and respect to others that you expect when seeking health care services.

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

Diversity

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

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



Diversity – *Continued from page 27*

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

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

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

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

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

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

Pharmacy Updates – Formulary Information

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

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

The formularies are updated monthly with additions and/or deletions approved by the Regional P&T Committee. The most recent information on drug formulary updates or changes can be accessed via the online Community Provider Portal for affiliated practitioners available at https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/pharmacy#formulary. To view the P&T Memos, you will be redirected to the KPMAS Clinical Library, a secured network, and asked to sign in and/or register for access. Once logged in, click on “Browse” to see available resources (Go to Clinical Specialties>Pharmacy>Drug Information>Pharmacy and Therapeutic Committee Decisions).

A printed copy of each drug formulary is available upon request from the Provider Relations department, which can be contacted via email at Provider.Relations@KP.org.

Hazardous Drug Compounding Outsourcing to Network Compounding Pharmacy

Effective 11/01/2023, there are updated USP 800 and USP 797 standards regarding requirements for pharmacies that compound hazardous drugs (HD). USP 800 provides standards for safe handling of HDs to minimize the risk of exposure to health care personnel, patients, and the environment.

Due to these changes, Kaiser Permanente Mid-Atlantic States (KPMAS) region has identified a list of nonsterile compounds (see below) which can no longer be prepared at our Kaiser Permanente outpatient pharmacies. Kaiser Permanente is working to secure a preferred vendor to outsource the preparation of these HD drug compounds.

In the interim, **East Pines Pharmacy** is able to prepare these HD compounds for our members (**Address:** 6003 66th Ave, Riverdale, MD 20737; **Phone:** 301-459-6211; **Fax:** 301-459-6217). They are located in Riverdale, Maryland but can ship these HD compounds to Maryland, Virginia, and the District of Columbia. The prescription may be ordered electronically (if applicable) or faxed to East Pines pharmacy. Once the prescription is received, East Pines Pharmacy will reach out to the member to obtain necessary payment, delivery, or other information as needed for order processing. Alternatively, upon request, the member may take the hard copy prescription to a pharmacy of their choice and may submit for reimbursement (this will depend on their coverage plan).

Prescriber Required Actions:

1. Please send ALL refills and new-start prescriptions for an HD compound to a network pharmacy (such as East Pines Pharmacy), effective 11/01/2023.
2. Please note - updated information regarding preferred vendor will be sent in a future communication.

Hazardous Drug Outsource Compounds List

1. amphotericin B – chloramphenicol – hydrocortisone – sulfamethoxazole otic capsules (CSmF/HC capsules for the ear)
2. amphotericin B – chloramphenicol – hydrocortisone otic capsules (CF/HC capsules for the ear)
3. azathioprine 10 mg/mL oral suspension
4. clonazepam 0.1 mg/mL oral suspension
5. spironolactone – HCTZ 5mg/5mg/mL oral suspension
6. tacrolimus 1 mg/mL oral suspension
7. temozolomide 10mg/ml oral suspension
8. testosterone propionate 2% in petroleum ointment topical
9. topiramate 6 mg/mL oral suspension
10. thioguanine 20 mg/mL oral suspension
11. hydroxyurea 100 mg/mL suspension

For any questions, please contact Kaiser Permanente pharmacy at 1-800-733-6345.

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 discussions 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 the member After Visit Summary, sent via secure messaging, or mailed directly to the patient’s address. For health education programs, providers can:

- Refer or direct book members into some health education programs through the KP Consult system.
- 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 at 301-816-6565 or toll-free at 800-444-6696

Provider Directory Validation Surveys

The Kaiser Permanente provider directory validation survey is designed to adhere to the Center for Medicare and Medicaid Services (CMS) regulations and the new Consolidated Appropriations Act of 2021, also known as the No Surprises Act. The objectives of both are to ensure that members have access to accurate provider information. The survey not only addresses directory accuracy but also accuracy of our other provider data systems.

In accordance with these regulations, provider data must be validated at least every 90 days. Therefore, Kaiser Permanente sends this provider directory validation survey each quarter, and providers are required to respond. Instructions are contained along with the survey, and **providers are reminded to return all pages with their response before the stated deadline.**

If you have any questions or concerns, please contact Provider Experience at 1-877-806-7470 or email us at provider.demographics@kp.org with the subject line: “Provider Directory Validation.”

Thank you for communicating all data changes in a timely manner. We appreciate your cooperation!

Keeping Your Provider Data Updated

Keeping Kaiser Permanente updated with changes, adds, and terminations to your practice will ensure that our directory and data systems are accurate and help us provide an excellent healthcare experience to our members.

It is imperative that you ensure your information is current by notifying us in a timely manner of demographic changes, provider terminations, and/or provider additions to your practice. **If a provider is being added to your practice, your information must be communicated and updated in our system before treating our members.**

Please utilize the provider update form to submit updates throughout the year. For your convenience, the form can be found on the following page as well as on our Community Provider Portal at the following link:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/mas/ever/sample-add-change-letter-en.pdf.

These 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)