network news

Produced by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.,
with the Mid-Atlantic Permanente Medical Group, P.C.
Website: providers.kaiserpermanente.org/mas

DECEMBER 2016

FOR PRACTITIONERS & PROVIDERS OF KAISER PERMANENTE

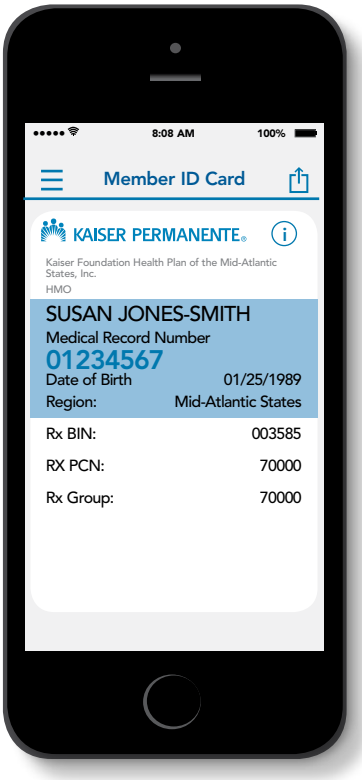
Digital membership cards

Kaiser Permanente – Mid-Atlantic States has introduced a digital membership card – an electronic version of the physical membership card that eligible* Kaiser Permanente members can access via the Kaiser Permanente app on their smartphones.

The digital membership card does not replace the physical membership card, which we will continue to distribute and accept.

During an initial internal promotional period, we will encourage Kaiser Permanente physicians, providers, and staff who are also members to use the digital membership card. We plan to promote it to all members later this year.

* Until further notice, the digital membership card is not available to members in certain plans including Medicare, Medicaid, out-of-area, Flexible Choice Three Tier Point-of-Service, and FAMIS.



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Members will be able to use the digital membership card for services such as checking in for appointments and prescription pickup at Kaiser Permanente and participating affiliate facilities. Members also will have the ability to display digital membership cards for their family members and dependents on their mobile devices, and can email a copy of their digital membership cards to participating providers.

When a member presents for service with a digital membership card, your check-in procedure should remain the same. Your staff should validate membership as they currently do. Remember to record the medical record number and to ask the member to show a photo ID.

If you should have any questions about the new digital membership card, please email Provider Relations at Provider.Relations@kp.org.

New fax numbers

Earlier this year, we transitioned from using local fax numbers to toll free numbers. The old "301-388" prefix fax numbers are no longer in service. Please use our new fax numbers listed below.

Department/unit	Current fax number
Provider Relations	
Provider Relations	(855) 414-2623
Provider Appeals/Disputes	(855) 414-2622
Field Operations Representatives	(855) 414-2620
Online Affiliate	(855) 414-2624
Provider Contracting	
Interested Provider Applications	(855) 414-2621
Utilization Management Operations Center (UMOC)	
Referral/Authorization Request	800-660-2019 (no change)
Behavioral Health	866-311-0052 (no change)
Behavioral Health UM	(855) 414-1703
Pre-Auth Clinical Info	(855) 414-1693
Home Health	(855) 414-1695
Rehabilitation Therapy Utilization Coordinator (RTUC)/Physical Therapy	(855) 414-1698
Clinical Trials	(855) 414-1692
Continuity of Care	(855) 414-1699
Emergency Care Management (ECM)	(855) 414-2634
Continuing Care HUB	(855) 414-1691
Inpatient Continuing Care	
Baltimore	(855) 414-1702
DC/Southern Maryland	(855) 414-1704
Northern Virginia	(855) 414-2659
SNF/Acute Rehabilitation	(855) 414-1707

Kaiser Permanente ClaimsConnect is here!

Our new claims processing system, Kaiser Permanente ClaimsConnect, has been up and running since February 8, 2016 and claims are now being processed by our centralized National Claims Administration (NCA).

We are pleased to say that we are processing claims at a faster rate and with more efficiency. Although as with any new system implementation, there are always some obstacles to overcome in the beginning. Over the past few months we have been closely monitoring the new process. Here are a few helpful tips to ensure that your claims are efficiently processed and paid:

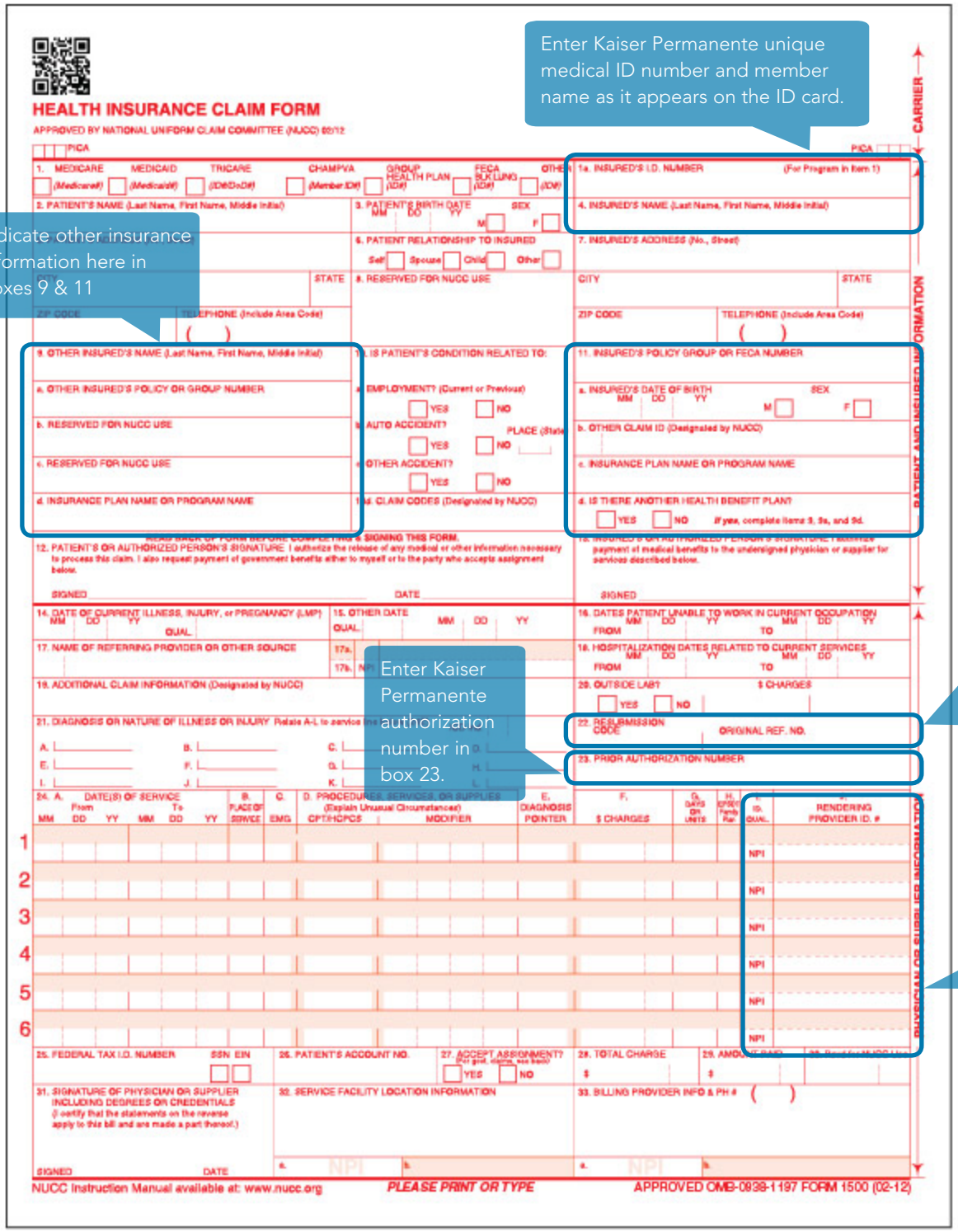
- The best method for claim submission is electronic. It is more efficient and faster than paper claim processing and you will receive a claim acceptance through your clearinghouse. Use the 837P and 837I format. Our electronic payor ID has not changed, it is: 52095.
- For paper claims, use industry standard pre-printed RED claim forms. CMS-1500 (02-12) version for professional claims and UB-04 (CMS-1450) for institutional claims. Color photo copies or copies printed on color printers are not acceptable as the red color and the scaling of the image result in poor quality of the data on the form.
- Be sure to use current valid procedure codes and ICD-10 diagnosis codes.
- Our National Claims processing center receives claims for five different Kaiser Permanente regions and each region has a unique PO Box. Please make sure you send your claim to the correct PO Box for Mid-Atlantic States.

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

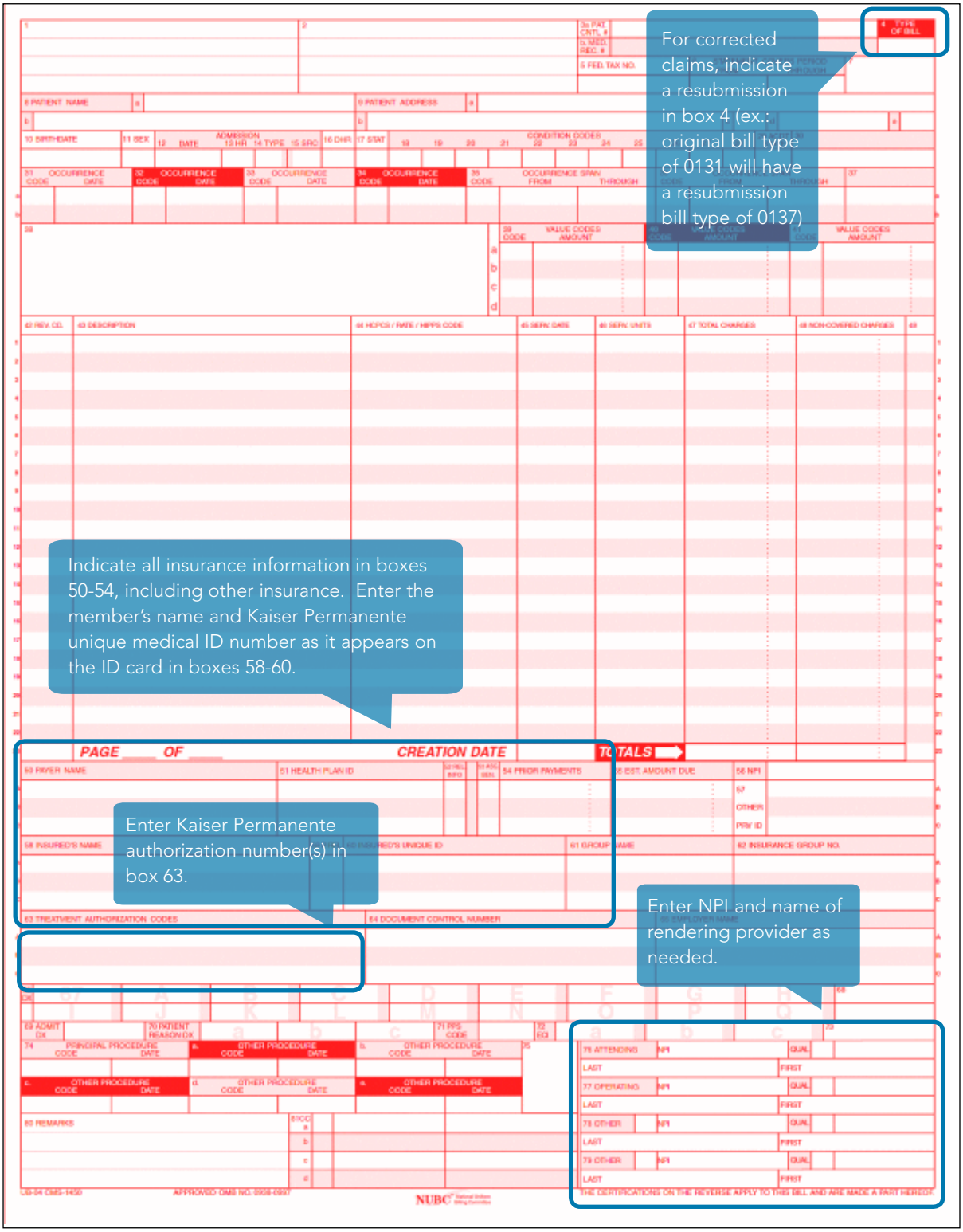
- List the member's name and unique medical record number as it appears on the Kaiser Permanente medical ID card.
- Other insurance (i.e. Medicare): For CMS-1500, use boxes 9 and 11 to indicate the other health benefit plan. For UB-04, other insurance information should be entered into boxes 50-54 and insured's information into boxes 58-60. Include the EOB/EOMB along with the claim.
- If you are submitting additional information for a claim, please include the assigned claim number, Kaiser Permanente member ID number, date of service, and billed amount to help identify which claim the additional information is associated with.
- When submitting a corrected claim, identify the claim using the correct submission type: CMS-1500 forms – use "7" for Resubmission Code in box 22 and Kaiser assigned claim number in Original Ref. No. field in box 22. UB-04 – indicate a resubmission for Type of Bill in box 4 (ex.: original bill type of 0131 will have a resubmission bill type of 0137)
- Rendering provider information: CMS-1500 – only the NPI is required in box 24J. UB-04 – submit NPI and name as needed in boxes 76-79.
- For professional claims billing consultation codes: Effective January 1, 2010, consultation codes are no longer payable by Medicare. CMS has advised physicians to use the appropriate new or established patient evaluation and management (E/M) code that represents where the visit occurs and that identifies the complexity of the visit performed. (For example: a new patient seen in the office would be billed the corresponding code in the 99201-99205 range and for a patient seen inpatient after admission would be billed the corresponding code in the 99231-99233 range.)
- Non-claims correspondence (disputes, appeals): Indicate on a cover sheet, the reason for the correspondence, member name, Kaiser Permanente medical ID number, and associated Kaiser Permanente claim number. This will aide in the processing of the correspondence.

On the next page are sample claim forms that highlight the key areas listed above. For additional information on Kaiser Permanente ClaimsConnect and NCA, you can visit our Community Provider Portal at providers.kaiserpermanente.org/mas or contact Provider Relations at 1-877-806-7470.

Sample UB-04 (CMS-1450)



Sample CMS-1500 (02-12) form



Pharmaceutical management information and updates

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

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

The formularies are updated monthly with additions and/or deletions approved by the Regional P&T Committee. The most recent information on drug formulary updates or changes can be accessed via the online Community Provider Portal for affiliated practitioners available at **providers.kaiserpermanente.org/html/cpp_mas/formulary.html**. To view the P&T Memos, you will be redirected to the KPMAS Clinical Library, a secured network, and asked to sign in and/or register for access.

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

Did you know…

Did you miss the last Network News? Participating Providers can find these newsletters on our provider website simply by going to providers.kaiserpermanente.org and clicking on "Provider Information" and "Newsletters". While you are there check out our News and Announcements section for any new updates or changes!

Medical Coverage Policy update III 2016

The following Medical Coverage Policies (MCPs) were approved and published for use in July to September 2016.

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 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 the Maryland Insurance Administration and other regulatory and accrediting agencies. Except where noted, our MCPs are primarily applicable only to commercial members.

New or Updated Medical Coverage Policy

- **Circumcision –** coverage provided for up to one year after adoption
  - * Steroid regimen clarified
  - * Reasons for delay of circumcision identified

- **Cochlear Implants guideline for coverage of implants**
  - * Audiology requirements updated
  - * References updated

- **Compression Bandages and Garments and Pneumatic Devices**
  - * Added language to address pneumatic compression components to meet MCG criteria (Section VIII)
  - * PT evaluation needed every two years for review before ordering new garments
  - * References updated

- **Dermal Fillers "New"**
  - * Allows the use of dermal fillers for lipodystrophy and other medical disorder.

- **External Insulin Pumps and Supplies**
  - * Member criteria for insulin pump clarified to include adults with (Type 1 or Type 2 or gestational) diabetes (Section III A).
  - * References updated

- **Habilitative Services including Applied Behavioral Analysis (ABA) for Maryland**
  - * Habilitative benefits clarified for Maryland jurisdiction

- **Infertility Diagnosis and Treatment**
  - * Updated criteria for Prolactin: only required if there are not regular menses,.
  - * ICSI and assisted hatching criteria updated
  - * References updated

- **Pelvic Floor Rehabilitation for myofascial pelvic pain**
  * Added pelvic floor therapy clinical indication descriptions for GU symptom and chronic pelvic pain.
  * References updated

- **Pre-Implantation Genetic Diagnosis (PGD)**
  * Updated clinical indication to include one or both parents who are known carriers for autosomal recessive conditions.
  * References updated

- **Varicose Veins**
  * Updated clinical indications for treatment of varicose veins that meet criteria for medical necessity.
  * There are no substantial changes.
  * References updated

- **Vitiligo Treatment**
  * Criteria for treatments of vitiligo described
  * References updated

- **Retirement of Medical Coverage Policy: Cell Free DNA**
  * Switched to use MCG criteria

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

If you would like to receive a hard copy of a Medical Coverage Policy please contact the Utilization Management Operations Center (UMOC) at 1-800-810-4766 and follow the prompts.

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

Claudia Donovan M.D.
Physician Referral Reviewer
Claudia.K.Donovan@kp.org

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

Marilyn Balcita, RN
marilyn.balcita@kp.org
(301) 816-6133

Diagnosis and documentation coding tips

There must be supporting documentation of evaluation or treatment of non-systemic conditions in your office note. If a non-systemic diagnosis is captured in your assessment, the progress note must support evaluation of the condition during the encounter visit.

Coding Guidelines for Probable, Questionable, or Rule out diagnoses
Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/ visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Authentication Requirements
Every office note must be signed and legible with the author's full name, credentials and date of signature.

Diagnosis Coding Guideline for active diagnoses
Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Source: cdc.gov/nchs/data/icd10/icdguide.pdf

Documentation of coordination of care with primary care physicians (PCPs)

Kaiser Permanente continues to be a leader in promoting the integration of behavioral and medical health care and views care coordination between Behavioral Health and Primary Care to be a critical aspect of treatment.

Behavioral Health providers are asked to obtain the member's consent to communicate the following to the patient's PCP within seven (7) days of the beginning of treatment:

- Date of initial service
- Patient's diagnosis and brief assessment of their findings
- Treatment plan and recommendations
- Medications prescribed

If you are not sure how to contact the member's PCP, you may mail or fax treatment information to the following address and we will make sure the PCP gets your report:

Kaiser Permanente
Regional HIMS
6526 Belcrest Road, Suite 207
Hyattsville, Maryland 20782
Fax: (301) 209-6065

New technology

Gregory Alexander, M.D., F.A.A.F.P
Physician Director, Referrals and Medical Policies

The Kaiser Permanente Technology Review and Implementation Committee (TRIC) reviews new and emerging technologies that are pertinent to the Kaiser Permanente Mid-Atlantic States (KPMAS) delivery system. The comments and recommendations made for adoption of the new technologies listed on the next page were approved by the committee in June 2016. Kaiser Permanente only cover procedures or services that have **sufficient evidence basis**.

Laparoscopic Magnetic Sphincter

Augmentation for GERD – LINX

- There is insufficient evidence to determine whether the LINX Reflux Management System is medically appropriate for the management of patients with treatment-refractory GERD

Artificial Cervical Disc Replacement

- There is insufficient evidence to determine that artificial cervical disc replacement is a medically appropriate treatment option for any patient with degenerative disc disease. It is currently offered to select patients who have failed non-surgical therapies when recommended by an appropriate specialist in spine surgery. Case by case review must be performed prior to authorization by orthopedic spine surgery service chief.

Whole Body Cryotherapy for Musculoskeletal Pain

- There is insufficient evidence to determine whether whole body cryotherapy is medically appropriate for any patient with musculoskeletal pain from any musculoskeletal disorder.

Vagus Nerve Blocking (Maestro System VBLOC) for Treating Morbid Obesity

- There is insufficient evidence to determine whether VBLOC is a medically appropriate treatment option for morbid obesity.

UroLift System (NeoTract Inc.) for Treatment of Benign Prostatic Hypertrophy

- There is sufficient evidence that UroLift is a medically appropriate option for the management of patients for short-term relief with lower urinary tract symptoms (LUTS) due to benign prostatic hyperplasia (BPH). UroLift procedure is a covered surgical procedure when performed by a Kaiser Urologist or when performed by a contracted and credentialed urologist after review by the Kaiser Permanente Urology Service Chief.

Per Oral Endoscopic Myotomy (POEM) for Achalasia

- There is insufficient evidence to determine whether POEM is medically appropriate for any patient due to the unanimity of coverage stance between Medicare, MCG, and INTC. Any exceptions for coverage of performance of POEM at a tertiary care center must be reviewed by the General Surgery Service Chief.

Intra-gastric Balloon for Treating Morbid Obesity

- There is insufficient evidence to determine whether the intra-gastric balloon (IGB) is a medically appropriate treatment option for morbid obesity.

For clinical comments or questions on these updates, please contact Dr. Gregory Alexander via the Kaiser Permanente Paging Operator at (888) 989-1144.

Keeping the provider directory up to date

Please use the sample letter format on the next page to update us with any changes you may have through out the year. It is very important that we have the most accurate information when we pull our data for the directory.

Changes may be made by fax to: (855) 414-2623, email Provider.Relations@kp.org, or by mail:

Kaiser Foundation Health Plan of
The Mid-Atlantic States, Inc.
Provider Relations; Flr 2 East
2101 East Jefferson St.
Rockville, MD 20852

If you would like to request a provider directory please contact Member Services at:

- Within the Washington, D.C., metro area call (301) 468-6000, (301) 879-6380 TTY
- All other areas outside of Washington, D.C., metro area call 1-877-777-7902, 1-800-700-4901 TTY

Company Logo or Letterhead

<<Date>>

Requestor:
Requestor's Correspondence Address:
Requestor's Phone #:
Email:
Tax ID#:
Effective date of change(s):

Reason for the request:

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 and NPI)
- Billing/Payment Address
- Management Correspondence Address (include Phone & Fax Number)

Adding a provider to an existing group or deleting a provider from an existing group
- Specify if adding or deleting provider
- Include the below listed information if adding or deleting a provider:
  * First Name, Middle initial, and Last Name
  * Gender
  * Title or Degree
  * NPI #
  * CAQH #
  * UPIN or SSN
  * Medicare #
  * Medicaid Participation State(s)
  * Medicaid #
  * Primary Specialty (include secondary specialty if applicable)
  * Practice location (include Phone & Fax Number)
  * Billing/Payment Address
  * Management Correspondence Address (include Phone & Fax Number)
  * Foreign Languages
  * Effective date

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 a signed and dated copy of the new W-9
- Billing/Payment Address
- Management Correspondence Address (include Phone & Fax Number)

***Email your letter to the Provider Relations Department at Provider.Relations@kp.org or fax to (855) 414-2623.*

Medical record documentation standards

Medical record documentation standards are based on and adopted from several risk management and quality improvement sources. Medical record documentation is required to report pertinent facts, findings, and observations about an individual's physical or mental health history (including present illnesses and/or chronic conditions and past medical, surgical and social histories), examinations, tests, treatments, and outcomes.

The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. Payers have a contractual obligation to enrollees and may require reasonable documentation that services are consistent with coverage provided.

Validation may include the following information:

- Location of service.
- Medical necessity and appropriateness of diagnostic and/or therapeutic services.
- Services provided have been correctly coded and reported based on supporting documentation in the medical record.

Kaiser Permanente of Mid-Atlantic States has adopted the following medical record documentation standards.

1. All entries are legible.
2. All entries are authenticated by the author with signature, credentials and date of entry.
3. Medication allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
4. There is an immunization summary for patients 18 years and younger.
5. There is a problem list w/significant illnesses and conditions listed in the medical record.
6. Chronic conditions and significant illnesses are listed.
7. Past surgical history is documented or noted as "none" on the problem list or face sheet.
8. Family history is documented or noted as "none" on the problem list or face sheet.
9. For patients 14 years and older, there is documentation of the following in either the progress note or face sheet.
   a. Alcohol use or lack thereof
   b. Substance use or lack thereof
   c. Tobacco use or lack thereof
   d. Sexual behavior
10. There is a chief complaint documented for each encounter visit.

11. There is a history of present illness documented for each encounter visit.
12. There is an examination documented in the progress note relevant to the chief complaint.
13. There is a treatment plan documented for each encounter visit.
14. Follow-up instructions are documented in the encounter and include follow-up instructions and time frame for follow-up.
15. For laboratory orders written during the encounter, the results indicate signature and date of ordering provider's review.
16. Radiology orders written during the encounter being reviewed, the results indicate signature and date of ordering provider's review.
17. If a referral or order for services (procedure or diagnostic testing-internal or external) is requested during the encounter being reviewed, there is a written report or resultsfrom the consultant/provider in the record.
18. If a consultation is requested, there is a written summary report reflecting thepractitioner review with date of review and signature.
19. Abbreviations used within the encounter are listed on the approved "Abbreviation List" located in the physician's office.

Annual Kaiser Permanente HealthConnect AffiliateLink SOX compliance survey

Kaiser Permanente is committed to protecting the health record information of our members. As part of this commitment, we conduct an annual review of all community providers and end-users that access Kaiser Permanente HealthConnect AffiliateLink to coordinate health care services for our members.

If you and/or your practice received a survey, please complete it by the date indicated on the survey. This survey should be completed by your Group Administrator or other authorized representative. Completed surveys should be faxed to (855) 414-2623.

If you have questions or need assistance with the survey, please contact Sirena Perkins at (301) 816-7193 for assistance. For anyone needing to enroll for Kaiser Permanente HealthConnect AffiliateLink access please visit our provider website at providers.kaiserpermanente.org/mas to register online.

Amended medical records

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

- **Late Entry –** A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.

- **Example –** A late entry following treatment of multiple trauma might add: "The left foot was noted to be abraded laterally. John Doe MD 06/15/15"
- **Addendum –** An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.
- **Example –** An addendum could note: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette. John Doe MD 06/15/15"

- **Correction –** When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Sources: Section 1833(e) Title XVIII of the Social Security Act (No Documentation); Section 1842(a)(1)(c) of the Social Security Act (Carrier Audits); Section 1862(a)(1)(A) of Title XVIII of the Social Security Act (Medical Necessity)

Provider access to health education materials

Kaiser Permanente physicians and network providers have access to all health education materials to provide to patients as part of the After Visit Summary or to supplement discussion from 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 is also embedded into KP HealthConnect for inclusion in member After Visit Summary or sent via secure messaging. For health education programs, providers can:

- Refer or direct book members into health education programs through eConsult system
- Provide members with information on how to self-register through KP HealthConnect After Visit Summary or hard copy flyers

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

- Visiting kp.org/healthyliving
- Contacting the Health Education automated line (301) 816-6565 or 1-800-444-6696 (toll free)

Access and availability

Quarterly, Kaiser Permanente conducts access and availability survey's to ensure members' have appropriate and timely access to services. The survey assesses provider appointment access and availability with routine care, urgent care and after-hours care. Your participation is critical in helping us identify areas that need improvement and ensuring access and availability standards are being met.

Thank you for your participation.

KAISER PERMANENTE®

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