Kaiser Permanente ClaimsConnect is Coming!

Beginning Monday, February 8, 2016, we will implement a new and improved claims processing system, Kaiser Permanente ClaimsConnect. This system change will coincide with an operational change in which we will begin processing all Mid-Atlantic States claims out of a centralized Kaiser Permanente National Claims Administration (NCA).

This will mean some changes in how you currently file claims with us. See the table on the next page for claims submission changes. Please note that there are no changes for the Self-Funded plan and the 2nd and 3rd tiers of the Flexible Choice plan. Also, there are no changes to how you submit claims electronically.

Beginning in 2016, we will be replacing our member ID cards with the updated address. No need to be alarmed if the address is not updated, please continue to send your paper claims to the address on the next page.
Plans | Paper claims containing any dates of service or admission dates prior to February 8, 2016 | Paper claims with the earliest date of service or admission date being on or after February 8, 2016
---|---|---
HMO plans | Kaiser Permanente PO Box 6233 Rockville, MD 20849-6233 | Mid-Atlantic Claims Administration Kaiser Permanente PO Box 371860 Denver, CO 80237-9998
Self-Funded (EPO) | Kaiser Permanente Insurance Company (KPIC) Self-Funded Claims Administration PO Box 30547 Salt Lake City, UT 84130-0547 | No changes
Flexible Choice (2nd PPO & 3rd OON Tiers Only) | Kaiser Permanente Insurance Company (KPIC) PO Box 261130 Plano, TX 75026 | No changes

In addition, provider disputes and appeals submission addresses will change. Provider disputes and appeals submitted in writing with the earliest date of service or admission date being on or after Monday, February 8, 2016 will need to be sent to:

Mid-Atlantic Claims Administration
Kaiser Permanente
PO Box 371860
Denver, CO 80237-9998

Provider disputes and appeals containing any dates of service or admission dates prior to February 8, 2016 should be sent to our current appeals address at:

Kaiser Permanente
Provider Relations – 2 East
2101 East Jefferson Street
Rockville, MD 20852

This transition supports our goal to provide you with timely and accurate payments by upgrading to a more modern, efficient system, and integrating resources and expertise into one location. We are working closely to ensure that our service standards remain consistent throughout the transition.

Along with these changes, beginning March 30, 2016, providers will be able to view claims and check claim statuses electronically through our Kaiser Permanente Online Affiliate site. If you have not already registered for access to Kaiser Permanente Online Affiliate, please do so at providers.kaiserpermanente.org/mas under “Online Affiliate Registration.”

For additional information on Kaiser Permanente ClaimsConnect and NCA, please visit providers.kaiserpermanente.org/mas to review our Frequently Asked Questions under News and Announcements.
Clinical practice guidelines

Clinical practice guidelines are systematically designed tools to assist participating practitioners and patient decisions regarding specific medical conditions and preventive care. Guidelines are informational and are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by participating practitioners in any particular set of circumstances for each patient.

KPMAS has adopted and implemented evidence-based Clinical Practice Guidelines. These guidelines cover preventive, acute, and chronic care. Preventive care guidelines include, but not limited to, breast, cervical, and colorectal cancer screening, immunizations, obesity, and prenatal and pediatric care. Clinical practice guidelines address the primary care management of common diagnoses, such as adult and pediatric asthma, diabetes mellitus, hypertension, attention deficit hyperactivity disorder, coronary artery disease, and adult depression.

The following clinical practice guidelines are approved and are available to practitioners and providers. These guidelines apply to members in our commercial, Medicare, Maryland Medicaid, Virginia Medicaid, and Marketplace products.

- Adult diabetes
- Adult hypertension
- Breast cancer screening
- Cervical cancer screening
- Child/adolescent attention-deficit/hyperactivity disorder
- Children, adolescents and adult asthma
- Colorectal cancer screening
- Coronary artery disease secondary prevention
- Diagnosis and treatment of depression in adults
- Heart failure
- HIV-STD screening and prevention
- Osteoporosis/fracture prevention
- Prenatal preventive services *New for 2016*
- Preventive care services for adults (age 18-64) and older adults (age 65+)
- Preventive care services for children and Adolescents *New for 2016*
- Prostate cancer screening
- Tobacco cessation

Guidelines can be found online at providers. Kaiserpermanente.org/mas then click on Provider Information and select Clinical Library. If you need assistance with your site registration, please e-mail Lee.S.Milliner@kp.org or call Lee at (301) 816-6309.

Several other clinical practice guidelines may be found at the above Web site. If you would like to receive a hard copy of these or any other Clinical Practice Guideline, please contact the Provider Relations Department at 1-877-806-7470.
Medical Coverage Policy update IV – Final for 2015

The following Medical Coverage Policies (MCPs) and other criteria were approved and published for use in September – December 2015.

Kaiser Permanente MCPs are developed in collaboration with specialty service chiefs and clinical subject matter experts. MCPs specify clinical criteria supported by current peer reviewed literature and are intended to guide use of health care services such as devices, drugs, and procedures. All polices and other criteria are reviewed and updated annually, and approved by the Regional Utilization Management Committee (RUMC), followed by filing with the Maryland Insurance Administration. MCPs are usually applicable only to commercial members, except where noted.

- **Ambulance and non emergency medical transportation**: defines coverage for both emergency and non emergency care transportation.
- **Bariatric surgery**: a separate Maryland-member-only policy, aligns with Maryland mandated benefits; coverage and requirements for bariatric surgery for the remainder of members (District of Columbia members, Federal employees, and Virginia members) is outlined in a second, separate policy.
- **Benign skin lesion treatment**: outlines coverage limitations for plastic and reconstructive surgery to those procedures that significantly improve physical function
- **Bone stimulator**: new policy defines criteria for electrical and ultrasound bone growth stimulators (DME benefit category)
- **Breast reduction and gynecomastia surgery**: provides surgical indications for both male and female members.
- **Capsule endoscopy**: expanded policy includes evaluation of small bowel neoplasms; clarifies upper (EGD) and lower (colonoscopy) endoscopies
- **Continuous Passive Motion (CPM)**: outlines limitations of CPM coverage for in home use
- **Early Periodic Screening Diagnosis and Treatment (EPSDT)**: notification to all physicians and practitioners that EPSDT program requirements remain in force for all Medicaid members.
• **Home phototherapy**: provides covered indications for severe eczema, psoriasis, and other conditions.

• **MRI Wide bore vs Open**: designates appropriate use of open MRI; applicable to both commercial and Medicare patients.

• **Nutritional support**: Enteral Formula, Equipment and Supplies – expanded policy includes definitions and indications for medical foods.

• **Spinal cord stimulation for pain management**: expanded policy adds condition of neck pain/upper extremity radicular pain as indication, deletes TENS as a failed, qualifying therapy, and adds cognitive behavioral therapy as a failed qualifying therapy.

• **Transcranial Magnetic Stimulation (TMS)**: new coverage policy provides indications and requirements for TMS therapy.

• **Transplant patient care**: Interqual standards for inpatient care were readopted for use for all Kaiser Permanente Mid-Atlantic transplant patients.

• **Transplant patient selection criteria (National)**: Provides criteria for selecting transplant candidates for Heart, Heart-Lung, Kidney, Mechanical Circulatory Device as a bridge to transplant, Pancreas and Pancreas/Kidney, Simultaneous Pancreas / Kidney.

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 policies 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 or MCG guideline, please contact the Utilization Management Operations Center (UMOC) at 1-800-810-4766 and follow the prompts.

If you have questions on criteria or medical application please feel free to contact:

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

For administrative questions concerning criteria or medical coverage policies please contact:

- Robin S. Boltz R.N.
  robin.s.boltz@kp.org

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**Diagnosis coding corner**

**Coding chronic diagnoses**
The ICD-10-CM guidelines state, “Code a chronic condition as often as applicable to the patient’s treatment.” If a patient is seen multiple times for the same condition, code the service on multiple visits. The guidelines also state, “Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions which no longer exist).

**Example:**
A patient was seen in the office for right knee pain. The provider documents that the patient has a history of diabetes prior to gastric bypass.

**The provider codes:** Right knee pain ICD-10-CM M25.561, Diabetes ICD-10-CM E11.9

**Correct codes:** Right knee pain ICD-10-CM M25.561, Personal history of other endocrine nutritional and metabolic disease ICD-10-CM Z86.39, Other specified postprocedural states ICD-10-CM Z98.89.

**Note:** Once the provider documents that the patient has a history of the diabetes, the disease is no longer current, and therefore should not be coded.

**Medical documentation is the key**
The diagnosis code is assigned based on the information available in the medical record.
documentation for that particular date of service in the outpatient setting or the complete inpatient record. The provider should code the specific diagnosis that is documented. If a provider is using a template format which includes the ICD-10 codes in his or her progress note, the codes should be reviewed and updated yearly.

**Coding for acute MI versus old MI**
Chapter 9 of the ICD-10-CM Official Guidelines for Coding and Reporting provides instruction on how the codes are assigned based on your documentation.

- **TIME FRAME** The time frame for acute myocardial infarction codes has changed from 8 weeks or less in ICD-9-CM to 4 weeks or less in ICD-10-CM.
- **SUBSEQUENT** When the patient has a new AMI within the 4 week time frame of the initial AMI, include this information in your documentation.
- **WHEN A NSTEMI EVOLVES TO STEMI** If NSTEMI evolves to STEMI, the STEMI code will be assigned.
- **WHEN THROMBOLYTIC THERAPY IS PERFORMED** If a STEMI converts to NSTEMI due to thrombolytic therapy, it would be coded as a STEMI.
- **AFTERCARE** For encounters after the 4 week time frame and the patient is still receiving care relating to the MI.
- **OLD OR HEALED MYOCARDIAL INFARCTION** Detail whether the MI was old or healed (no longer requiring further care).
- **DOCUMENT THE SITE** Identify the location of the MI. ICD-10-CM Guidelines are clear-cut and specifically state “… MI without the site documented, query the provider”.

**ICD-10 guidelines for sepsis**
For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.

A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

New in 2016: Conditional Prior Authorizations (PAs) on select Medicare Part D medications.

Effective January 1, 2016, additional conditional prior authorizations (PAs) will be placed on the following Medicare Part D medications.

- Amrix (cyclobenzaprine) tablets
- Aubagio (alemtuzumab) tablets
- Cyclobenzaprine tablets
- Daklinza (daclatasvir) tablets
- Esbriet (pirfenidone) capsules
- Fexmid (cyclobenzaprine) tablets
- Kalydeco (ivacaftor) tablets, packet
- Marinol (dronabinol) capsules
- Otezla (apremilast) tablets
- Revatio (sildenafil) suspension
- Stelara (ustekinumab) solution
- Technivie (ombitasvir, paritaprevir, ritonavir) tablets

In order for the drug to pay at the patient’s Part D benefit, each drug requires an associated diagnosis code written on the prescription.

These drugs will not be covered under the Part D benefit – and the patient will be charged the full member rate – when prescribed for an indication not approved by the FDA or CMS Compendia or the diagnosis code is not associated with the prescription.

If the diagnosis information is missing, pharmacy staff may contact you to confirm the associated diagnosis.

Please see the attached table for FDA-approved indications for the new medications with Conditional Prior Authorizations.
<table>
<thead>
<tr>
<th>Medications with Conditional prior authorizations</th>
<th>Indications approved by the FDA or CMS compendia(^{b})</th>
<th>Suggested alternatives/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Otezla (apremilast)</strong>&lt;br&gt;30 mg tablets, Starter Pack (10 mg, 20 mg, 30 mg tablets)</td>
<td>• Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy&lt;br&gt;• Active psoriatic arthritis</td>
<td>• Methotrexate oral&lt;br&gt;• Methotrexate injection</td>
</tr>
<tr>
<td><strong>Amrix (cyclobenzaprine)</strong>&lt;br&gt;15 mg, 30 mg extended-release capsules</td>
<td>• Short-term relief of muscle spasms associated with acute, painful musculoskeletal conditions as an adjunct to rest and physical therapy</td>
<td>• Acetaminophen&lt;br&gt;• Anercream 4%, 5%&lt;br&gt;• NSAIDs (meloxicam)&lt;br&gt;• Topical Capsaicin</td>
</tr>
<tr>
<td><strong>Cyclobenzaprine</strong>&lt;br&gt;5 mg, 7.5 mg, 10 mg tablets</td>
<td><strong>NOT to exceed 21 day supply(^{c})</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Fexmid (cyclobenzaprine)</strong>&lt;br&gt;7.5 mg tablets</td>
<td>• Cystic fibrosis (CF) in patients age 2 years and older who have one of the following mutations in CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R.&lt;br&gt;• CF in patients age 2 years and older who have an R117H mutation in CFTR gene (not effective in patients with CF who are homozygous for the F508del mutation in the CFTR gene)</td>
<td>Supportive Care:&lt;br&gt;• Dornase alfa (Pulmozyme)&lt;br&gt;• Hypertonic saline&lt;br&gt;• Nebulized/inhaled antibiotics&lt;br&gt;• Bronchodilators&lt;br&gt;• Pancreatic enzyme supplements&lt;br&gt;Covered only for confirmed R117H mutation</td>
</tr>
<tr>
<td><strong>Kalydeco (ivacaftor)</strong>&lt;br&gt;150 mg tablets, 75 mg packet</td>
<td>• Idiopathic pulmonary fibrosis (IPF)</td>
<td>Second-line to Ofev (nintedanib)&lt;br&gt;Covered only for confirmed IPF</td>
</tr>
<tr>
<td><strong>Esbriet (pirfenidone)</strong>&lt;br&gt;267 mg capsules</td>
<td>• Pulmonary arterial hypertension (PAH)</td>
<td>• Sildenafil (generic Revatio) tablets</td>
</tr>
<tr>
<td><strong>Revatio (sildenafil)</strong>&lt;br&gt;10 mg/mL suspension</td>
<td>• Relapsing forms of multiple sclerosis</td>
<td>• Extavia (interferon beta-1b)</td>
</tr>
<tr>
<td><strong>Aubagio (alemtuzumab)</strong>&lt;br&gt;7 mg, 15 mg tablets</td>
<td>• Anorexia associated with weight loss in patients with AIDS&lt;br&gt;• Nausea/vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments</td>
<td>• Ondansetron (generic Zofran)&lt;br&gt;• Emend (aprepitant)&lt;br&gt;No alternatives for weight loss associated with AIDS; covered only for confirmed associated weight loss</td>
</tr>
<tr>
<td><strong>Marinol (dronabinol)</strong>&lt;br&gt;2.5 mg, 5 mg, 10 mg capsules</td>
<td>• Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy&lt;br&gt;• Active psoriatic arthritis alone or in combination with methotrexate</td>
<td>• Methotrexate (oral, injection)&lt;br&gt;• Humira (adalimumab)&lt;br&gt;• Enbrel (etanercept)&lt;br&gt;• Remicade (infliximab)&lt;br&gt;• Cosentyx (secukinumab)</td>
</tr>
<tr>
<td><strong>Stelara (ustekinumab)</strong>&lt;br&gt;45 mg/0.5 mL, 90 mg/mL solution</td>
<td>• Chronic hepatitis C virus (HCV) genotype 4 infection without cirrhosis, in combination with ribavirin</td>
<td>Covered only for confirmed genotype 4 infection</td>
</tr>
<tr>
<td><strong>Technivie (ombitasvir, paritaprevir, ritonavir)</strong>&lt;br&gt;12.5 mg/75 mg/50 mg tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Daklinza (daclatasvir)</strong>&lt;br&gt;30 mg, 60 mg tablets</td>
<td>• Chronic HCV genotype 1, 2, and 3 infection, in combination with sofosbuvir</td>
<td>Covered only for confirmed genotype 1, 2, and 3 infection</td>
</tr>
</tbody>
</table>

\(^a\) Please note, all medications must have an associated diagnosis code AND prescribed for FDA-approved indications in order for Medicare Part D medications to properly adjudicate.

\(^b\) Medicare will not cover off-label uses.

\(^c\) Only approved for short-term therapy due to lack of evidence on effectiveness with prolonged use.
Medicare Part D Medications with an existing conditional prior authorizations

- Adcirca, Cialis (tadalafil)
- Baclofen (Gaboflen/Lioresal) IT
- Botox (onabotulinumtoxinA)
- Carisoprodol products
- Dysport (abobotulinumtoxinA)
- Flector (diclofenac) patch
- Harvoni (ledipasvir/sofosbuvir)
- Hydrocodone (Zohydro)
- Lidoderm (lidocaine) patch
- Nuvigil (armodafinil)
- Olysio (simeprevir)
- Provigil (modafinil)
- Retin-A/Avita (tretinoin)
- Somatotropin Products (e.g., genotropin, humatrope, norditropin, omnitrope, serostim)
- Sovaldi (sofosbuvir)
- Transmucosal Immediate-release Fentanyl (TIRF)
- Xeomin (incobotulinumtoxinA)

Pharmaceutical management information and updates

The Kaiser Permanente Mid-Atlantic States 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 at 1-877-806-7470.
Systemic versus non-systemic diagnoses

In a recent review of Medicare diagnoses, it was determined that frequently providers code for diagnoses without documenting the supporting documentation in the medical record.

As a reminder, the documentation needs to be supportive of what was considered for that diagnosis or how it may have affected treatment of the patient. Below are instructions based on the diagnosis type, either systemic diagnosis documentation requirements or non-systemic diagnosis documentation requirements.

**Systemic condition**
Diagnosis can be coded even in the absence of expressly documented active treatment, evaluation or intervention by the physician

**Definition of a systemic condition**
A condition is always present, even though it may have been stabilized; AND
- The condition affects a major body part; AND
- The provider indicates he/she considered the condition by documenting the diagnosis in the progress note.

Examples of systemic diagnoses are: diabetes mellitus and any documented manifestations, rheumatoid arthritis, coronary artery disease, congestive heart failure, hypertension, and chronic kidney disease etc.

**Non-systemic condition example**
If a non-systemic diagnosis is coded, the progress note must support the evaluation.

**Documentation examples**
- **Hyperlipidemia**
  - Stable on simvastin
- **Hypothyroidism**
  - Stable, synthroid, labs ordered
- **A-FIB**
  - Patient taking warafin
GERD
GERD is a Non-systemic Medicare Risk diagnosis that is frequently not documented insufficiently. This means that providers must document the evaluation or treatment of the condition.
• The condition need not be treated, evaluation is sufficient.

Documentation examples
• GERD stable on Prilosec, or
• Refill placed for Prilosec for GERD

Providers should at minimum state whether or not the GERD is stable or link the medication with the diagnosis.

Provider access to health education materials
KP 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).

Utilization management affirmation 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.
Correction: Department fax number updates

Effective February 24, 2016, all fax numbers with the “301-388” prefix will be changing. We are moving to toll free numbers. The current fax numbers will no longer be available as of February 24, 2016. Below is a table of departments/areas with current fax numbers and new fax numbers.

<table>
<thead>
<tr>
<th>Department/unit</th>
<th>Old fax number</th>
<th>New fax number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>(301) 388-1700</td>
<td>(855) 414-2623</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>(301) 388-1698</td>
<td>(855) 414-2622</td>
</tr>
<tr>
<td>Field Operations Representatives</td>
<td>(301) 388-1699</td>
<td>(855) 414-2620</td>
</tr>
<tr>
<td>Online Affiliate</td>
<td>(301) 388-1695</td>
<td>(855) 414-2624</td>
</tr>
<tr>
<td>Provider Contracting</td>
<td>(301) 388-1690</td>
<td>(855) 414-2621</td>
</tr>
<tr>
<td>Interested Provider Applications</td>
<td>(301) 388-1631</td>
<td>(855) 414-1708</td>
</tr>
<tr>
<td>Home Health</td>
<td>(301) 388-1632</td>
<td>(855) 414-1695</td>
</tr>
<tr>
<td>Rehabilitation Therapy Utilization Coordinator</td>
<td>(301) 388-1633</td>
<td>(855) 414-1698</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>(301) 388-1638</td>
<td>866-311-0052</td>
</tr>
<tr>
<td>Continuing Care Hub</td>
<td>(301) 388-1758</td>
<td>(855) 414-1691</td>
</tr>
<tr>
<td>Emergency Care Management (ECM)</td>
<td>(301) 388-1639</td>
<td>(855) 414-2634</td>
</tr>
<tr>
<td>Inpatient UM Team</td>
<td>(301) 388-1636</td>
<td>(855) 414-1704</td>
</tr>
<tr>
<td>SNF/Acute Rehab Patient Coordinators</td>
<td>(301) 388-1753</td>
<td>(855) 414-1707</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td></td>
<td>(855) 414-1692</td>
</tr>
<tr>
<td>Pre-Auth Clinical Info</td>
<td></td>
<td>(855) 414-1693</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td></td>
<td>(855) 414-1699</td>
</tr>
</tbody>
</table>

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 throughout 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 (877) 777-7902, (800) 700-4901 TTY
Requestor: ________________________________________________________________________________

Correspondence address: ____________________________________________________________________

Phone __________________________ Email ______________________________________________________

Tax ID __________________________ Effective date of change(s) ___ / ___ / ____

**REASON FOR THE REQUEST**

☐ Address change  ☐ Practice location (☐ Add  ☐ Delete)  ☐ Billing address (☐ Add  ☐ Delete)

Previous address ____________________________________________________________________________

(STREET, CITY, STATE, ZIP, PHONE, FAX AND NPI)

New address ______________________________________________________________________________

(STREET, CITY, STATE, ZIP, PHONE, FAX AND NPI)

☐ Adding a provider to an existing group  ☐ Deleting a provider from an existing group:

First name ___________________________ Middle initial ___ Last name ____________________________

Gender ☐ M ☐ F  Title or Degree ____________________________________________________________  NPI # __________________

CAQH # ____________________________ UPIN or SSN ____________________________________________

Medicare # __________________________ Medicaid # __________________________________________

Medicaid participation State(s) ____________________________

Primary specialty (include secondary specialty if applicable) ______________________________________

Practice location address ________________________________________________________________

(STREET, CITY, STATE, ZIP)

Billing/Payment address ____________________________

Management correspondence address ____________________________

(Street, City, State, Zip)

Foreign languages __________________________________________

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

Previous Tax ID number ____ _______________________ Tax ID number __________________________

Previous Group name ________________________ New group name ______________________________

Effective date ___ / ___ / ____ Please include a signed and dated copy of the new W-9

Billing/Payment address ____________________________

(STREET, CITY, STATE, ZIP)

Management correspondence address ____________________________

(STREET, CITY, STATE, ZIP)

Email your letter to the Provider Relations Department at Provider.Relations@kp.org or fax to (855) 414-2623.
CMS National Coverage Determinations update

The following updates on Medicare benefit coverage are provided to assist you in caring for Kaiser Permanente Medicare members. This list is not inclusive of all Medicare coverage or payment changes and does not include the complete CMS requirements for coverage of each service. Please refer to the Medicare Coverage Database for complete information at cms.gov/medicare-coverage-database.

Single chamber and dual chamber cardiac pacemakers
In February, 2015 CMS initiated reconsideration of coverage indications for single chamber and dual chamber cardiac pacemakers. After multiple notices, CMS stated on December 10, 2015 that coverage indications for single and dual chamber cardiac pacemakers will remain the same as effective on August 13, 2013. The August 2013 notice states that implanted permanent cardiac pacemakers are covered.

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.

If you are selected to participate and receive a survey by mail, we thank you for your participation.
pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible, symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion).

Speech generating devices
On July 29, 2015, CMS issued a National Coverage Determination (NCD) for speech generating devices (SGDs). This determination redefined the scope of coverage for speech generating devices to expand the types of devices that may be covered for qualified beneficiaries. SGDs are defined as DME that provide an individual who has a severe speech impairment with the ability to meet his or her functional, speaking needs. SGDs are devices or software that generate speech and are used solely by the individual who has a severe speech impairment.

With this National Coverage Decision, the scope of benefit for speech-generating devices expanded to now cover SGDs that include the capability to generate email, text, or phone messages to allow the patient to “speak” or communicate remotely. In the notice, CMS expressly states that computers or tablets are generally not considered DME because they are useful even without an illness or injury.

Lung Cancer Screening and Low Dose Computed Tomography
In a Decision Memo released February 5, 2015, CMS added an additional preventive service benefit for lung cancer screening counseling and shared decision making visit. Additionally, CMS added screening for lung cancer with low dose computed tomography (LDCT) once per year for Medicare members who meet all the following criteria: age 55-77, and are either current smokers or have quit smoking within the last 15 years; they have a tobacco history of at least 30 “pack years” (an average of one pack a day for 30 years); and they receive a written order from a physician or qualified non-physician practitioner that meets certain requirements. Subsequent screenings are also covered as preventive services benefits when additional CMS requirements are met.