

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 2013

FOR PRACTITIONERS & PROVIDERS OF KAISER PERMANENTE

Kaiser Permanente Mid-Atlantic Region Specialty Hubs

Over the past couple of years Kaiser Permanente of the Mid-Atlantic Region have been developing "Specialty Hubs" in order to provide enhanced care to Kaiser Permanente members. A "Hub" is a full service medical office building, with the capability to provide comprehensive outpatient services for more complex conditions. The "Specialty Hubs" contain the following services:

- Full range of primary and specialty care departments
- Oncology and Infusion services able to treat patients on an outpatient basis
- Minor Injury and Urgent Care facilities
- Clinical Decision Units to provide outpatient observation services to the urgent care clinic
- Ambulatory Surgery Centers able to perform outpatient operations
- Outpatient procedure suites able to offer complex diagnostic and therapeutic interventions
- Full radiology capability, including CT, MRI and interventional radiology

There are Kaiser Permanente "Specialty Hubs" that offer fast and convenient quality care to our Kaiser Permanente members in Maryland, Virginia and Washington, D.C.

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Maryland Specialty Hubs



Gaithersburg Medical Center
655 Watkins Mill Road
Gaithersburg, MD 20879 (240) 632-4000



Largo Medical Center
1221 Mercantile
Largo, MD 20774
(301) 618-5500



South Baltimore County Medical Center
1701 Twin Springs Road
Halethorpe, MD 21227
(410) 737-5000

Virginia Specialty Hub



Tysons Corner Medical Center
8008 Westpark Drive
McLean, VA 22102
(703) 287-6400

Washington, D.C. Specialty Hub



Capitol Hill Medical Center
700 2nd Street; NE
Washington, DC 20002
(202) 346-3000

For more information about our Specialty Hubs and other locations and services offered, visit us at kaiserpermanente.org.



New Medical Coverage Policy for enteral formula, equipment, and supplies

A new Medical Coverage Policy defines the coverage and details for ordering nutritional enteral formulas, and related equipment and supplies. Additionally, the policy defines the difference between enteral or nutritional formulas and medical foods. Generally, nutritional formulas are composed of standard carbohydrates, proteins, and fats for persons who can metabolize regular food but have inadequate oral nutrition; Medical Foods are food substitutes for persons who have an inborn or an acquired inability to metabolize regular food. Medical Foods are covered per mandate in all three KPMAS jurisdictions as well as the Medicare and Federal employee lines of business, with variation.

The table on page 4 outlines the coverage variations for the for KPMAS members. For commercial and Medicaid members, please refer to the member's coverage documents to verify their specific covered services. For Federal and Medicare members, please refer to Medicare Coverage Database for specific coverage conditions.

Please contact Provider Relations to verify your member's coverage and plan location. For clinical guidance on either nutritional formulas or medical foods please contact:

Claudia K. Donovan, M.D.
Physician Manager, Referral Management
Mid-Atlantic Permanente Group
11921-B Bournfield Way
Silver Spring, MD 20904
KP paging line: (703) 359-7460
Claudia.K.Donovan@kp.org

If you would like to receive a hard copy of the Medical Coverage Policy, UM criteria or protocol, please contact the Utilization Management Operations Center at 1-800-810-4766 and follow the prompts.

Kaiser Permanente Physician Reviewers are available during business hours 8:00 am to 5:00 p.m., Monday to Friday except holidays to speak with practitioners to discuss pre-service or concurrent medical necessity (adverse) decisions. Please call the Utilization Management Operations Center (UMOC) at 1-800-810-4766 and select the appropriate prompt # or contact the Kaiser Permanente Page Operator at 1-888-989-1144.



Enteral formula, equipment, and supplies	Commercial: District of Columbia, Maryland and Virginia Jurisdictions	Federal members	Medicare members
Nutritional formulas delivered via enteral system	✘	✔	✔
Nutritional formulas for oral intake	✘	✘	✘
Equipment such as feeding pumps and tubing for enteral delivery of formula	✔	✔	✔
Supplies such as feeding bags and syringes	✔	✔	✔
Medical foods for inborn/congenital errors of metabolism	✔	✔	✔
Medical foods for acquired conditions of metabolism/absorption	✔ Covered for Maryland situs plans ONLY ✘ Not covered for Virginia or DC situs plans	✔	✔

✔ Denotes may be covered ✘ Denotes usually NOT covered



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

- By its very nature, the condition must be considered by the physician in evaluating the patient's chief complaint; 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
NOTE: stable on simvastin
- Hypothyroidism
NOTE: stable, synthroid, labs ordered
- A-FIB
NOTE: patient taking warafin

GERD

GERD is a non-systemic Medicare Risk diagnosis that is frequently not documented sufficiently. This means that providers must document the evaluation or treatment of the condition.

Note: The condition need not be treated, evaluation is sufficient

Examples of supporting documentation for the coding of the GERD evaluation.

- NOTE: 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.



Medical Coverage Policies update III — September 2013

Medical Coverage Policies (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. The policies are reviewed and updated annually, reviewed for approval by the Regional Utilization Management Committee (RUMC), and filed with the Maryland Insurance Administration. These MCPs are applicable only to commercial members.

The following Medical Coverage Policies have been updated with changes noted below:

Cochlear implant

For documented bilateral severe to profound sensorineural hearing loss with documented limited benefit of binaural hearing aids and patient is able to undergo aural rehabilitation.

Capsule endoscopy

For small intestine bleeding of obscure etiology, GI bleeding with negative EGD/colonoscopy, small bowel tumor evaluation, small bowel surveillance with certain genetic conditions, and for evaluation of Crohn's disease in certain circumstances.

Circumcision (excluding newborns)

For infants and children over 2 months of age indications for medically necessary circumcision include documented balanitis, phimosis, paraphimosis, penile post circumcision adhesions and for recurrent UTI's in infants and pre-pubertal children.

Compression garments

Approved for treatment of lymphedema after undergoing a comprehensive lymphedema program and treatment of a venous stasis ulcer.



Cranial remodeling bands and helmets

For infants up to age 1 year who have synostotic plagiocephaly following surgical correction, or moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis (shortening of the sternocleidomastoid muscle) and sleeping positions in infants with no response to repositioning therapy between the ages of 2 and 5 months.

Hyperbaric oxygen

Among approved uses are gas gangrene, necrotizing soft tissue infections, refractory osteomyelitis, soft tissue adionecrosis, osteoradionecrosis, and diabetic wound/ulcers Wagner grade III or higher.

Varicose veins

Documented use of prescription strength (20-40 mm Hg) compression hose for 3 months, size of veins > 3 mm, and documentation of interference with ADLs or job activities.

Vitiligo

Treatments with PUVA and NB-UVB (phototherapy) approved with documentation of failed medical therapy. Excimer laser will only be approved for localized disease unresponsive to medical and phototherapy.

Kaiser Permanente revised Milliman Guidelines NICU Levels

NICU Guidelines: Includes Level III admission criteria, Level II admission criteria, Level I admission criteria and discharge criteria for the NICU.

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Please call the Utilization Management Operations Center (UMOC) at 1-800-810-4766 and select the appropriate prompt # or contact the Kaiser Permanente Page Operator at 1-888-989-1144.

If you have any comments or questions on these updates, please contact:

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Behavioral health programs expansion

As part of our commitment to our members we continually strive to provide better access to care and integrated services within Kaiser Permanente Medical Centers. Over the past two years we've expanded the number of behavioral health providers within Kaiser Permanente across a wide range of expertise. We've also extended service hours into the evening at many of our facilities to better accommodate our members.

We've also expanded behavioral health programs offered across the region to better care for our patients within our medical centers. We opened Intensive Outpatient (IOP) clinics designed to deliver a better continuum of care for discharged patients and provide crisis stabilization at the following medical centers:

- Burke
- Marlow Heights
- Northwest
- Summit

Members referred to a Kaiser Permanente behavioral health provider experience the benefits of coordinated care with the co-location of primary care and specialty care services in one place in a majority of behavioral health locations, all connected through our electronic medical record system. Members registered on kp.org can also e-mail their behavioral health provider's office, view most laboratory results, and refill most prescriptions on-line.

Note to Network Behavioral Health Providers: After an initial consultation, if you determine a Kaiser Permanente Member requires follow-up care you will need to send via fax a proposed treatment plan for the patient to Kaiser Permanente Behavioral Health Utilization Management at (301) 388-1638 or 866-311-0052.

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 results from the consultant/provider in the record.
18. If a consultation is requested, there is a written summary report reflecting the practitioner 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.



New Medicare requirements for Durable Medical Equipment (DME)

The Centers for Medicare and Medicaid Services (CMS) have established new requirements for Medicare patients receiving DME. The Affordable Care Act (ACA) established a face-to-face visit requirement for all patients requiring DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face visit with the patient. If the face-to-face is conducted by a NP, PA or clinical nurse specialist, it must be co-signed by the physician. The visit must occur within the 6 months before the order is written

for the DME. In addition, for any patient needing mobility and assistive devices, CMS requires a Physical Therapy (PT) evaluation is performed. The PT evaluation aids in the decision for ordering the correct assistive device and the appropriate training for use of the device.

For additional information, see www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf

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: 301-388-1700, email Provider.Relations.kp.org, or by mail:

Kaiser Foundation Health Plan of
The Mid-Atlantic States, Inc.
Provider Affairs; 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



<<DATE>>

Tax identification #:
Requestor phone #:
Effective date of change(s):
Requestor:

Reason for the request:

- Address change (practice location or billing)
*identify whether adding or deleting demographic change
- Adding a provider or practitioner to an existing group contract
*identify whether adding or deleting provider

If adding or deleting a provider please include:

- First and last name
- Sex
- Title or degree
- NPI number
- CAQH number
- UPIN or social security number
- Primary specialty with secondary specialty if applicable
- Practice locations w/ phone and fax numbers
- Foreign languages
- If urgent care/ will the provider have a panel of Kaiser Permanente patients.



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