Virginia Medicaid and FAMIS Participants

We are pleased to announce that effective November 1, 2013 Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan) participated as a Medicaid Managed Care Organization (MCO) in the Commonwealth of Virginia.

Kaiser Permanente’s mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. Our participation in the Medicaid program is important because it allows us to provide quality care to many of the neediest individuals within the communities, generates positive brand image and public opinion and builds our membership for the future.

Earlier this year, several practices in Virginia became Medicaid Participating Providers with the Mid-Atlantic Permanente Medical Group, P.C. (MAPMG) extending Kaiser Permanente health care services to eligible Virginia Medicaid and FAMIS beneficiaries.

As a Virginia Medicaid and FAMIS Participating Provider, you will play an integral role in the care and coordination of services for Virginia Medicaid and FAMIS members. It is important that you as a provider are familiar with these responsibilities and meet these requirements when providing and/or coordinating services to our members.

To help support you with understanding your responsibilities to our members, we have developed training information as well as a Kaiser Permanente Participating Provider Manual specifically for Virginia Medicaid and FAMIS. Please take the
time and log on to our Community Provider Website at providers.kp.org/mas to access the on-line Virginia Medicaid and FAMIS Participating Provider Training “VA Medicaid Training” and take our Cultural Competent Care Training if you have not done so already. You can also access our Community Provider Website to download the Kaiser Permanente Participating Provider Manual/Virginia Medicaid and FAMIS Programs.

Should you prefer to receive a provider orientation at your office, you can contact Provider Relations to request/schedule an on-site visit by calling 1-877-806-7470.

Tips for documentation and coding diagnoses

All co-morbidities should be listed which the provider has:

- **Managed**: by you or your department
- **Evaluated**: diagnoses, signs, or symptoms being evaluated
- **Assessed**: please consider all chronic diagnoses as part of your assessment during initial and yearly visits
- **Treated**: list all diagnoses treated

When documenting the HCC diagnoses in the progress note, the provider needs to consider whether the diagnosis is systemic or non-systemic for documentation. The differences between a systemic vs. a non-systemic condition are as follows:

**Systemic condition**

- Must recognize and consider condition
- Minimum documentation Requirements:
  - Diagnosis must be listed somewhere in the progress note for that encounter
  - Note: Not necessary to document specific treatment or evaluation of the systemic condition as long as the condition is documented

**Non-systemic condition**

- Must document further evaluation or treatment of the condition
- Minimum documentation requirements:
  - Evaluation or treatment must be documented

* Note: if a non-systemic diagnosis is captured in the diagnosis box, the progress note must support evaluation of the condition. The Condition need not be treated, evaluation is sufficient (i.e., atrial fibrillation stable on warfarin) OR
* “Diagnosis recorded for this visit were addressed and are stable unless otherwise indicated in this note”

If a non-systemic diagnosis is captured in the diagnosis box, the progress note must support evaluation. The provider must address the treatment for non-systemic diseases. The following are examples of diagnoses listed in the assessment with only one sentence which is sufficient documentation for diagnosis capture of a non-systemic condition.

**Documentation examples**

- Hyperlipidemia
  - NOTE: stable patient taking simvastatin
- GERD
  - NOTE: stable on Prilosec

**What should doctors always remember to do?**

- Address all new diagnoses in face to face visits. Remember, email and phone do not count.
- Address all chronic diagnoses at least once a year in a face to face visit.
- Document something about every diagnosis.
Medical Coverage Policies Update IV December 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.

“NEW” Medical Coverage Policies

Continuous Glucose Monitor: Continuous glucose monitors are considered medically necessary in type I diabetic patients on insulin pumps or using insulin analogs four or more times a day who meet the following criteria: working with an endocrinologist and a diabetic educator or nutritionist with documentation of severe recurrent hypoglycemia, severe hypoglycemic unawareness, recurrent hypoglycemic seizures; or a trial of CGM has taken place and treatment plan changes helped but did not resolve the hypoglycemic problem.

Nutritional support: enteral formula, equipment, and supplies: Medical equipment and supplies are covered for all members when the member meets criteria for enteral feeding. Supplies may be single or multiple use. Supplies and equipment are covered regardless of whether or not the formula is covered. Pumps require documentation that a pump is medically necessary, i.e., gravity feeding is not satisfactory due to aspiration, diarrhea, or dumping syndrome.

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

- **Ambulance**: Coverage for ambulettes is provided if by doing so will result in improved ability to provide continuity and coordination of care. Please see MCP for complete details.
- **Bariatric surgery**: Revision surgery criteria updated so that each case will be considered on a case by case basis for patients who have undergone a previous restrictive and malabsorptive procedure (Roux-en-Y, gastric sleeve). Lap band is only a restrictive method for weight control. Patient must meet weight
requirements (BMI > 40 or BMI 35-39 with a co-morbidity) and undergo a six (6) month weight loss surgery program. VA/Fed/DC bariatric surgery patients must be nicotine free to start program.

- **Benign skin lesions**: Covered only when symptomatic and treatment has been attempted before referral as indicated.

- **Breast reduction**: Covered if a patient’s weight is stable, bra size is stable, other causes for macromastia are ruled out, documentation of chronic skin infections, effect on lifestyle, pain, grooving of shoulder and attempts at relief of pain by PT or nsaid have been attempted. Patient must be one year or more postpartum and have stopped breast feeding for six (6) or more months.

- **Continuous passive motion devices**: Approved only after total knee, total shoulder replacement or major joint surgery where PT is unavailable. Requires review by orthopedic service chief.

- **Home phototherapy**: For psoriasis and mycosis fungoides with documented improvement by dermatology and need for continuous treatment. Referral made only by dermatology when medically appropriate.

- **Kaiser Permanente revised Milliman guidelines NICU levels**: Modified Milliman criteria for NICU includes Level III admission criteria, Level II admission criteria, Level I admission criteria and discharge criteria for NICU.

- **Spinal cord stimulator**: Indicated after multiple modalities have not been effective for relief of chronic pain of the lumbar spine, complex regional pain syndrome and angina. Behavioral Health clearance is required. Cervical spinal cord stimulators are rarely indicated and will require review.

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

Claudia K. Donovan, M.D.
Physician Manager, Referral Management
Mid-Atlantic Permanente Group
11921-A Bournefield Way
Silver Spring, MD 20904
KP paging line: (703) 359-7460
Claudia.K.Donovan@kp.org
The Affordable Care Act referrals

What does this patient need?
The Affordable Care Act has created many changes that impact referrals to specialists for a Kaiser patient. We have many new patients who have never had health care and need some direction.

PLEASE
• Enter only the number of visits a patient will likely need in a 90 day period. If we authorize less than the requested amount, the member gets a partial denial/partial approval letter which will be confusing to the member.
• Consider sending your patient to the Kaiser Permanente MAPMG [Mid-Atlantic Medical Group] specialist! We have hired many specialists from some of the top residencies and fellowships. Appointment access is almost always less than 2 weeks. Call (301) 879-6238 to see if we have a specialty service near your practice.
• Remind your Kaiser patients that our new hubs are open 24 hours a day for urgent adult and pediatric care, radiology (including MRI and CT), pharmacy, and lab. No appointment is required for any of these services, and the patient will have a much shorter wait time than the nearest emergency room.

KP HealthConnect AffiliateLink

All services rendered at a Kaiser Permanente are documented in KP HealthConnect, our state-of-the-art electronic medical record and care management system. The electronic capabilities and technology available through KP HealthConnect allow us to keep you and the member connected with all aspects of the care he or she receives within Kaiser Permanente. Participating specialty care physicians with access to KP HealthConnect encounters/visits, charts, laboratory results, and more via the web at providers.kaiserpermanente.org/mas. Kaiser Permanente members may also access information about their care including lab results, radiology, and pharmacy by logging on at www.kp.org.

If you do not have access to KP HealthConnect AffiliateLink and would like to enroll, you may download an enrollment package at providers.kaiserpermanente.org/mas or contact Kaiser Permanente Provider Relations at 1-877-806-7470, for assistance.
New technology

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

The Kaiser Permanente Interregional New Technologies Committee (INTC) met and reviewed new and emerging technologies that are pertinent to the Kaiser Permanente Mid-Atlantic States (KPMAS) delivery system. The new technologies listed below were reviewed and approved by the local Technology Review and Implementation Committee (TRIC). The following is a brief synopsis that summarizes New Technology: Summary of New Technology conclusions regarding the reviews.

Breast MRI for preoperative evaluation

INTC brief synopsis

• There is sufficient evidence to determine that breast MRI is generally not medically appropriate for routine preoperative evaluation of early stage invasive breast cancer. There is evidence that preoperative MRI increases mastectomy rates without demonstrating improvement in other health outcomes.
• There is insufficient evidence to determine whether breast MRI is medically appropriate for selective preoperative evaluation of patients diagnosed with lobular carcinoma and/or heterogeneously or extremely dense breasts. The evidence is of insufficient quantity and quality.

KPMAS coverage position
Breast MRI for preoperative evaluation of patients with early invasive breast cancer, lobular breast cancer, and heterogenous or dense breasts is considered experimental and investigational and not a covered benefit.

Gene expression profiling for Stage II colon cancer

INTC brief synopsis

• There is insufficient evidence to determine whether gene expression profiling (GEP) is a medically appropriate test for patients with stage II colon cancer who are considering chemotherapy treatment.
• The existing evidence regarding how GEPs impact patient management and/or health outcomes is of insufficient quantity and quality. The evidence base currently consists of over 20 studies examining analytic and clinical validity, including several studies that evaluate the five commercially available tests; however there are no studies demonstrating clinical utility or improvement in health outcomes. This field is rapidly evolving and the INTC will continue to monitor this topic.
• For patients with stage II colon cancer, the decision about whether or not to have adjuvant chemotherapy is not clear and is usually based on clinical and pathological risk factors for recurrence. Gene expression profiling (GEP) may assist clinicians assess the probability of recurrence and/or benefit from adjuvant chemotherapy.
KPMAS coverage position
- Gene Expression Profiling (GEP) to assess appropriateness of adjuvant chemotherapy for Stage II colon cancer is considered experimental and investigational and not a covered benefit at this time.

Genetics strategy: operational challenges and opportunities

INTC brief synopsis
- Experts from the regions are currently working together on genetic services and in January 2013, an interregional group participated in a Genetics Services Business and Systems Stakeholder Summit. Presenters at the summit provided an overview of the current and future market of genetics. The NPC is also working on the formation of a genetics SST, which will develop contracts to help enable high quality, affordable care is consistent across regions.

KPMAS coverage position
- Not applicable—refer to KPMAS Medical Coverage Policy on Genetic Counseling and Genetic Testing for coverage determinations.

PCA3 urine testing for prostate cancer

INTC brief synopsis
- There is insufficient evidence to determine whether PCA3 testing is medically appropriate for the diagnosis of prostate cancer for men with elevated PSA and/or an abnormal DRE who are candidates for initial or repeat prostate biopsy.
- There is insufficient evidence to determine whether PCA testing is medically appropriate for identifying low risk/indolent patients who may be candidates for active surveillance for men with a positive prostate biopsy.
- The evidence base currently consists of over 40 observational studies examining diagnostic accuracy; however there are no studies demonstrating clinical utility or improvement in health outcomes.

Stepping into GRADE - rating the quality of evidence

INTC brief synopsis
- Grading of Recommendations, Assessment, Development and Evaluation (GRADE) is a systematic, explicit, and transparent framework and process that separates the evaluation of the quality of the evidence from determining the strength of the recommendation. When the framework is utilized, the evidence summary is based on predetermined and specific outcomes.
- It was suggested that the strength of GRADE is that it is subjective and is a framework that allows for transparency in evaluating quality of the evidence. When using GRADE, the process should involve clinical experts. After working through the process a GRADE score is provided for each outcome. An example by Ibargoyen-Roteta et al. from 2010 was provided as an example where GRADE was utilized in assessing a new technology.1

KPMAS coverage position
- Not Applicable for establishing a coverage determination. Use of GRADE is encouraged during the technology assessment of new technologies being considered for adoption into patient care and health care delivery.

The impact of obesity on knee arthroplasty for osteoarthritis of the knee

INTC brief synopsis
- The evidence summary will be provided to the Orthopedic Joint Specialty Groups.
- Studies have shown an increase in prevalence of osteoarthritis of the knee with increasing BMI. Excess weight increases the load on the knee, resulting in increased pain and functional impairment.

potentially overwhelming the articular cartilage, leading to further damage. Weight management interventions such as behavior modification, diet, exercise, pharmacological and surgical treatments are considered. Surgery in the obese population is technically more challenging and can carry added risk of complications. The objective of this review was to determine the impact of obesity on clinical, functional, and patient-specific outcomes after knee surgery for osteoarthritis of the knee. In addition, to identify the optimal BMI threshold, if one exists, in which knee surgery would be contraindicated.

KPMAS coverage position

• TRIC supports the current practice of MAPMG orthopedic surgeons generally not performing total knee replacements on patients with BMI’s over 40, performing total knee replacements on selected patients with BMI 35 to 39 who have limited comorbid conditions, and encouraging morbidly obese patients to attain a BMI of 35 or less before performance of total knee replacement to optimize outcomes from performance of total knee replacements.

Whole exome sequencing

INTC brief synopsis

• Whole exome sequencing (WES), which selectively targets the protein-coding regions of the genome, is a rapidly evolving approach to the molecular diagnostic strategy of single-gene disorders and other clinical conditions. At present, internal clinical and laboratory genetics expertise is not consistently available across all PMGs in the program. The INTC recommends that KP develop additional mechanisms for inter-regional expertise and consultation as well as data/EMR infrastructure regarding WES and other emerging genetic technologies.

• The current evidence base consists of six case-series studies (>10 patients) and 22 smaller studies of individual families or patients. The larger patient series studies reported a diagnostic yield from 10 to 54%. Of these studies, two studies noted changes in management or clinically actionable results for some patients. Other than these studies reporting on diagnostic yield, there are no systematic studies reporting clinical outcomes of WES.

• Studies on WES typically focus on conditions with significant genetic heterogeneity, phenotypes that are consistent with many different conditions (i.e., phenotypic overlap), and conditions for which a genetic test is not clinically available. Limitations of WES include a diagnostic yield <100%, lack of coverage of intronic sequences and gene regulatory regions, higher error rates compared to other sequencing methods, difficulty in determining causative variants, and potential errors in variant databases.

KPMAS coverage position

• Requests for performance of whole exome sequencing for diagnosis of genetic disorders will be assessed on a case by case basis with KPMAS Genetics counselors, the incoming physician clinical genetics specialist and with genetics specialists in TPMG as indicated.

Radiofrequency ablation for Barrett’s esophagus

INTC brief synopsis

• There is sufficient evidence to determine that radiofrequency ablation is a medically appropriate treatment option for high-grade dysplastic Barrett’s esophagus.

• There is insufficient evidence to determine whether radiofrequency ablation is a medically appropriate treatment for nondysplastic Barrett’s esophagus, indefinite for dysplasia Barrett’s esophagus, or low-grade dysplastic Barrett’s esophagus.

KPMAS coverage position

• Radiofrequency ablation for high grade dysplastic Barrett’s esophagus is considered medically necessary and appropriate and a covered benefit.

• Radiofrequency ablation for indications other than high grade dysplastic Barrett’s esophagus will be reviewed on a case by case basis for medical necessity and appropriateness by Utilization Management with the Gastroenterology Service Chief of the member’s service delivery area.
**Fecal transplantation for clostridium difficile infection**

**INTC brief synopsis**
- There is insufficient evidence to determine whether fecal transplantation is a medically appropriate treatment option for any patient with lab-confirmed Clostridium difficile infection. The existing evidence is of insufficient quantity and quality.
- The existing evidence base consists of 1 randomized study and 10 case series studies including a total of 297 patients. There is very low quality evidence regarding the safety of fecal transplantation although few adverse events are reported. Low quality of evidence may be acceptable given the lack of alternative effective treatments.
- Efforts are ongoing within KP to obtain a program wide treatment IND and coordinated efforts by the IR GI Chiefs Group are supported rather than each region obtaining separate INDs.

**KPMAS coverage position**
- KPMAS will follow guidelines established by Kaiser Inter-regional Gastroenterology Chiefs and by National Transplant Network.

**Implantable eye device (Argus II) for retinitis pigmentosa**

**INTC brief synopsis**
- There is insufficient evidence to determine whether the implantable eye device (Argus II) is a medically appropriate treatment option for any patient with retinitis pigmentosa (RP). The existing evidence is of insufficient quantity and quality.
- Existing published data consists of one prospective, unmasked, single arm trial of 30 patients with severe RP. While the data show statistically significant improvement of some visual tasks, it is not known whether these improvements translate into real life benefit. There are safety concerns regarding adverse effects related to surgery and implantation of the device (17 serious adverse events were reported, affecting 30% of patients).

**KPMAS coverage position**
- The Argus II Implantable Eye Device for Retinitis Pigmentosa is considered experimental and investigational and is not a covered benefit.
- All referral requests for Argus II Implantable Eye Device for Retinitis Pigmentosa will be reviewed with Ophthalmology Service Chiefs in NoVa and DCSM in collaboration with their staff retinal subspecialists.

**Propofol computer-assisted delivery system (SEDASYS)**

**INTC brief synopsis**
- There is insufficient evidence to determine whether computer-assisted personalized sedation is medically appropriate for patients undergoing routine colonoscopy or upper endoscopy. The existing evidence regarding how computer-assisted personalized sedation (SEDASYS®) effectively manages propofol sedation during routine colonoscopy and upper endoscopy procedures is of insufficient quantity and quality. Additional safety data is needed.

**KPMAS coverage position**
- Propofol Computer-Assisted Delivery System (SEDASYS) is not covered in KPMAS because it is considered investigational and experimental and thereby excluded from coverage.
- This Technology Assessment was shared with Service Chiefs in Anesthesiology and Gastroenterology and there were no communications from the Service Chiefs that indicated disagreement with the conclusions of the INTC.

**MRI-ultrasound fusion for targeted prostate biopsy**

**INTC brief synopsis**
- There is insufficient evidence to determine whether there is any additional diagnostic yield from MRI-targeted prostate biopsy using MRI-US software registration fusion or whether this procedure results in improved mortality or survival compared to systematic biopsy.
- The existing evidence on MRI-targeted biopsy using MRI-US software registration fusion consists of 20 relatively small observational studies.
including from 13 to 649 patients using 6 different MRI-US systems. Although there is a small and growing body of evidence that suggests that MRI-targeted biopsy using MRI-US software registration fusion increases diagnostic yield over systematic biopsy (including clinically significant cancer), there are no studies reporting long-term clinical outcomes such as mortality or survival. The definitions of clinically significant prostate cancer also varied across studies.

**KPMAS coverage position**

- MRI-Ultrasound Fusion for Targeted Prostate Biopsy is not covered in KPMAS because it is considered investigational and experimental and thereby excluded from coverage.

- This Technology Assessment was shared with Service Chiefs in Urology and there were no communications from the Service Chiefs that indicated disagreement with the conclusions of the INTC.

- A Urology Service Chief did indicate that the technology may be clinically appropriate for a very limited subset of men with rising PSA’s and repeated negative traditional biopsies performed by Transrectal Ultrasound guidance. Therefore an exception to the policy may be granted should a member meeting the noted criteria be presented to Referral Management in which case Referral Management will request an ad hoc review with Urology Service Chiefs.

**Minimally Invasive lumbar decompression (MILD®) for lumbar stenosis**

**INTC brief synopsis**

- There is insufficient evidence to determine whether minimally invasive lumbar decompression (mild®) is a medically appropriate treatment option for patients with spinal stenosis. The existing evidence is of insufficient quantity and quality.

- The body of evidence currently consists of 1 small RCT including 38 patients and 10 case series studies including a total of 463 patients. All studies have short-term follow-up, and one study suggests that the effects may not be long term. There is a lack of well-designed studies comparing mild® to standard treatment for lumbar spinal stenosis. The committee suggests potential candidates should be part of an IRB trial with a well-designed protocol, appropriate informed consent, and structured long-term follow-up.

**KPMAS coverage position**

- This Technology Assessment was shared with Regional Service Chief for Spine Surgery and the Regional Medical Director for Musculoskeletal Conditions and there were no communications.
from the Service Chiefs that indicated disagreement with the conclusions of the INTC.

**Total artificial heart as bridge to transplant**

**INTC brief synopsis**
- There is sufficient evidence to determine that the SynCardia total artificial heart as a bridge to transplant is a medically appropriate treatment option for select patients.
- The body of evidence currently consists of 4 retrospective comparative trials comparing the SynCardia TAH to medical management (1 study, n=130), BIVAD (1 study, n=383), and LVAD (2 studies, n=93) and 7 prospective or retrospective case series studies. There is a paucity of studies comparing TAH with medical management and other mechanical device systems and currently there are no feasible alternatives for patients waiting for heart transplant who would not be a candidate for LVAD. RCTs comparing LVAD to optimal medical management (OMM) report improved survival with continuous flow devices over OMM (REMATCH and INTrEPID studies, 10%-30% survival at 1 year f/u for OMM, 70%-80% survival for LVAD).

**KPMAS coverage position**
- Total Artificial Heart as Bridge to Transport will be covered on a case by case. All referrals for use of this technology must be reviewed with a cardiology service chief and the Medical Director for Transplant Services.

**Accelerated partial breast irradiation using intraoperative radiotherapy in early stage breast cancer**

**INTC brief synopsis**
- There is insufficient evidence to determine whether sole radiation therapy with intraoperative radiotherapy (IORT) is a medically appropriate treatment option for patients with early stage breast cancer who are undergoing breast-conserving surgery (BCS). The existing evidence is of insufficient quality.
- The evidence for IORT as sole radiation treatment relies primarily on a single RCT (TARGIT-A) with limited follow-up. In the most recent report, only 18% of patients in TARGIT-A had accrued at least 5 years of follow-up, which was the primary trial endpoint.

**KPMAS coverage position**
- Accelerated Partial Breast Irradiation using Intraoperative Radiotherapy in Early Stage Breast Cancer is not covered in KPMAS because it is considered investigational and experimental and thereby excluded from coverage.
- This Technology Assessment was shared with Service Chiefs in Radiology, General Surgery and Obstetrics/Gynecology and there were no communications from the Service Chiefs that indicated disagreement with the conclusions of the INTC.

**Gene expression profiling for prostate cancer**

**INTC brief synopsis**
- There is insufficient evidence to determine that gene expression profiling is medically appropriate for any patient with prostate cancer. The existing evidence is of insufficient quantity and quality.
- The body of evidence currently consists of validation studies, and studies reporting on clinical validity and clinical utility are lacking. Study limitations for validation studies include heterogeneity in evaluation protocols and reported outcomes.

**KPMAS coverage position**
- Gene expression profiling for prostate cancer is not covered in KPMAS because it is considered investigational and experimental and thereby excluded from coverage.
- This technology assessment was shared with Service Chiefs in Urology and Oncology and there were no communications from the Service Chiefs that indicated disagreement with the conclusions of the INTC.

If you would like to receive a hard copy of the Interregional New Technologies Committee (INTC) Summary of Emerging Medical and Surgical Treatment (New Technology) Report, please contact Dr. Gregory Alexander or Dr. Claudia Donovan via the Kaiser Permanente Paging Operator at 1-888-989-1144.
Beginning November 1, 2013, Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP) region became a Medicaid Managed Care Organization (MCO) in the Commonwealth of Virginia. Kaiser Permanente’s participation in the Medicaid program is important because it allows us to provide quality care to many of the neediest individuals within the communities we serve. Primary Care Physicians (PCP’s) in our VA Medicaid Participating Provider Network, Section 1902(a)(13)(C) may be entitled to Medicare enhanced rates for physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine for evaluation and management (E&M) services (CPT codes 99201 thru 99499) or vaccine administration services furnished to a Medicaid member in Calendar Years 2013 and 2014.

MCO’s and State Programs, must make increased payments for services furnished by a physician, or under the personal supervision of a physician who self-attests to a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), the American Osteopathic Association (AOA) or the American Board of Allergy and Immunology (ABAI), and then attests that he/she:

- Is Board Certified with such a specialty or subspecialty; or
- Has furnished Evaluation and Management services (CPT codes 99201 thru 99499) and vaccine administration services that equal at least 60% of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

To download Attestation Form please go to www.virginiamedicaid.dmas.virginia.gov/wps/portal
- Under Physician Primary Care Increase click on Physician Primary Care Attestation Form
- Complete form and return to:
  Provider Contracting & Network Management
  Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
  2101 East Jefferson Street
  Rockville, MD 20852

Or you may simply fax the form to (301) 388-1690, attention: Provider Contracting and Network Management/Physician Primary Care Attestation Form.

Importance of correctly completing A URF

When completing a URF Please ensure that the CPT, DX Codes are included on the referral. Also remember that it is essential to include clinical notes. Effective January 1, 2014 when ordering All DMEs a WOPD or information required on the WOPD is required for the vendor to supply the DME. And last but not least do not forget your face to face encounter documentation. (See form on next page).
# Maryland Uniform Consultation Referral Form

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<tr>
<th>Referral Information:</th>
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<tbody>
<tr>
<td>Referral is Valid Until: (Date) _________________ (See Carrier Instruction)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature: (Individual Completing This Form)</th>
<th>Authorizing Signature: (If Required)</th>
</tr>
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</table>

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member’s eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.
KPMAS member prescription benefit information

The cost of members’ prescriptions may vary depending upon the type of product and particular pharmacy benefit, however, providers can find general information on members’ prescription co-payment and coinsurance information by member benefit plan type on the Kaiser Permanente HealthConnect AffiliateLink, accessible via the Community Provider Portal at providers.kaiserpermanente.org/html/cpp_mas/providertools.html.

You will be asked to sign in with your User ID and password to access the co-payment and coinsurance information. If you do not have access to KP HealthConnect AffiliateLink and would like to gain access, please contact Provider Relations at 1-877-806-7470 Monday through Friday, 9:00 a.m. to 5:00 p.m. EST for assistance.

Significant changes for combination prescription acetaminophen products.

Acetaminophen is widely used in over-the-counter (OTC) and prescription products to effectively manage pain and fever; however, acetaminophen overdose is the leading cause of acute liver failure in the United States. In addition, acetaminophen use is now an essential component of the Medicare Part D Overutilization Monitoring System and prescribers must ensure patients do not exceed the FDA-recommended daily maximum dose of acetaminophen.

On January 14, 2011, the Food and Drug Administration (FDA), in conjunction with the Department of Health and Human Services (HHS), published a Notice in the United States Federal Register notifying the public that by January 2014, sponsors of approved prescription drug products containing more than 325 mg of acetaminophen – including manufacturers of butalbital-, hydrocodone- and oxycodone/acetaminophen combination products – have until January 14, 2014 to remove these products from the market, after which they may be subject to action by FDA. The purpose of the market withdrawal is to reduce the risk of overdose and severe liver injury.

The new limit for acetaminophen in combination prescription products is 325 mg in each dosing unit (e.g., capsule, tablet) and a Boxed Warning about the potential for severe liver injury and allergic reactions is now included on the label of all prescription products that contain acetaminophen.

There are no changes to the prescribing recommendations for these products:
• The number of capsules, tablets or dosage units and dosing intervals remain the same.
• The FDA-recommended maximum daily dose of acetaminophen remains at 4,000 mg/day (3,000 mg/day for those 75 years of age and older).

After January 14, 2014 KPMAS pharmacies will no longer dispense >325 mg acetaminophen combination products.

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: (301) 388-1700, 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
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.
Provider Referral Requests

The Kaiser Permanente Utilization Management Operations Center reviews each referral request and determines the number of visits that are medically necessary. When requesting referrals, please only request one visit or the exact number of visits that will be needed for a three (3) month period. Additional visits can be added if medically necessary before approval but if more visits are requested than needed, the member will receive a partial approval/denial letter which has been creating confusion for members as they believe their referral is being denied. To help avoid this, please only request one visit or the exact number of visits necessary.

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.