KAISER PERMANENTE®

Provider Update

News for Kaiser Permanente Washington Contracted Providers • December 2023

Celebrating a successful year for our contracted network partners

KAISER PERMANENTE WOULD LIKE TO CELEBRATE our network partner participants in our valued-based quality programs who have provided high-quality, affordable care to our members over the past year. In alignment with Kaiser Permanente's mission and values, you have served over 61,000 members, including more than 10,000 Medicare members and over 51,000 commercial members.

Our Network Quality Reward Program, led by Mirian Aguirre, MPH and Bradley Pope, MD, has achieved phenomenal results this year. Our team has worked with 19 Medical groups, encompassing a total of 124 medical centers across the state, which is 34 more medical centers than last year. These centers include 9,670 providers with very high performance ratings.

This program also has leveraged the collaboration of Washington Permanente Medical Group with these medical centers on many areas of care, including opioid safety, care management, implementation of our Advanced Care at Home program, and a pilot of our Curbside Consultation program.

We are also investing resources to improve our data connectivity with our partners, which will further improve the care coordination of our members.

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Provider Update is published quarterly for Kaiser Permanente contracted providers. Send story ideas and comments to Provider Communications.

BUSINESS OFFICE NEWS

2024 Calendar

EFT deposit and check mail dates

Provider reimbursement checks are scheduled to be deposited ACH or mailed on the following dates. Mailed checks should arrive within approximately three business days.

JANUARY	1, 19, 25	**JULY**	5, 11, 18, 25
FEBRUARY	1, 7, 15, 23, 29	**AUGUST**	1, 7, 15, 22, 29
MARCH	7, 14, 21, 28	**SEPTEMBER**	6, 12, 19, 26
APRIL	4, 11, 18, 25	**OCTOBER**	7, 10, 17, 24, 31
MAY	7, 9, 16, 23, 31	**NOVEMBER**	7, 14, 21, 29
JUNE	6, 13, 20, 27	**DECEMBER**	5, 12, 19, 27

Kaiser Permanente holidays

NEW YEAR'S DAY
Monday, January 1

MARTIN LUTHER KING JR. DAY
Monday, January 15

PRESIDENTS' DAY
Monday, February 19

MEMORIAL DAY
Monday, May 27

INDEPENDENCE DAY
Thursday, July 4

LABOR DAY
Monday, September 2

THANKSGIVING
Thursday, November 28

CHRISTMAS
Wednesday, December 25

PROVIDER NEWS

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A successful year for our contracted network partners

2023 Commercial Milestones

All our participant groups reached the NCQA All line of business 50th percentile or higher in the following areas:

- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Retinal exams for diabetes patients
- Statin use for diabetes patients

2023 Medicare Milestones

All our participants reached Medicare 5 stars (excellent performance) in the following measures:

- Breast cancer screening
- Colorectal cancer screening
- Retinal exam for diabetes patients

All our participants reached Medicare 4 stars (good performance) or higher in the following measures:

- Medication adherence for cholesterol, diabetes, and hypertension
- Statin use for diabetes patients

We want to thank our Network Quality Reward Program participants for their efforts in improving the care of our members. We look forward with anticipation to ongoing patient-centered collaboration in 2024!

Provider Update to be discontinued

We are changing over to a single format for our monthly newsletter. Beginning January 2024, we will use the Provider eNews as our monthly newsletter.

You may still access previous editions of the Provider Update on our provider site.

Washington State chooses CAQH as its credentialing vendor

The Office of the Insurance Commissioner (OIC) asked OneHealthPort (OHP) to lead a working group to recommend future vendors for the ongoing credentialing activities required by RCW 48.43.790(1)(a). The working group recommended CAQH as the credentialing vendor for WA State, and that health plans contract directly with CAQH. As a result, OHP has formally issued a notice of non-renewal of its master contract with Medversant, effectively ending the agreement effective December 31, 2023.

We are currently contracted with CAQH and able to pull applications from their database. You can learn more about CAQH on their website.

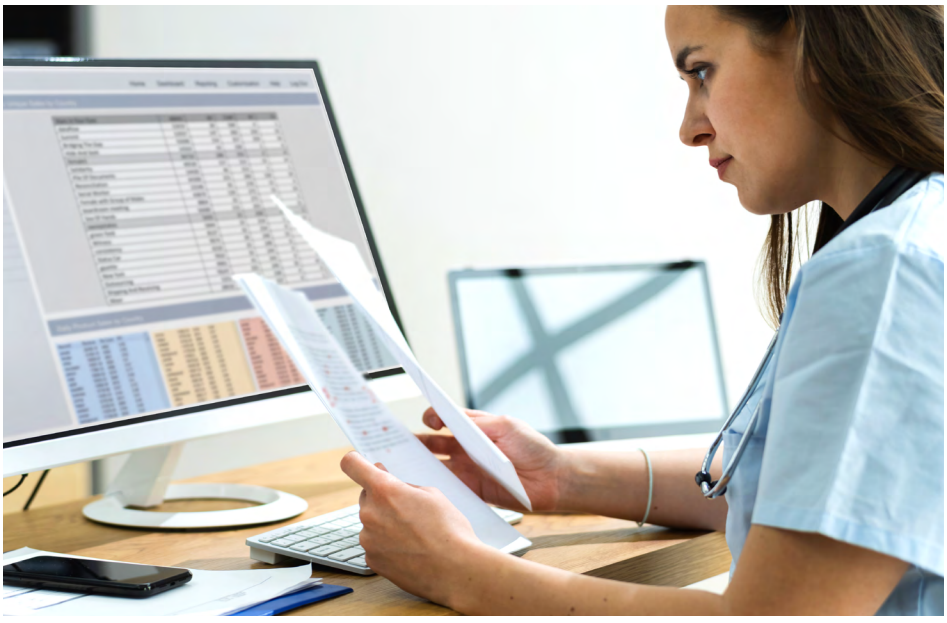
New approach aims to educate and reduce evaluation and management billing errors

THE PROPER CODING of Evaluation and Management (E/M) services is a well-known challenge for many providers. Because providers are faced with the difficult task of determining which level of CPT code appropriately reflects the complexity of the visit, E/M coding constitutes a high percentage of mistakes compared to coding for other services.

To help providers and their offices facilitate correct coding, Kaiser Permanente has contracted with Optum to implement their Coding Advisor solution.

Coding Advisor will review the use of E/M codes, psychotherapy assessments, the billing of Modifier 25 and other codes for providers submitting claims to Kaiser Permanente. The program's aim is to identify cases where providers are billing in one of these areas significantly more often than other providers in the same specialty, as per their primary taxonomy. From this analysis, Coding Advisor provides useful data insights to the provider community, maximizes coding efficiency and accuracy through education, and reduces the burdens associated with traditional audits.

Beginning February 2024, Coding Advisor will initiate an outreach campaign to qualifying providers who are submitting claims to Kaiser Permanente. This campaign will consist of a series of communications which may include outbound notification letters, education based telephone calls, and clearinghouse level claim status messaging.



Throughout the course of this program, Coding Advisor will continue to monitor billing practices and will periodically send updated report(s). They may contact your practice with the intention of identifying any coding discrepancies and to perform one-on-one coding education. All correspondences will be sent to you from Optum.

If you have questions, please call Optum Coding Advisor's Customer Support at 844-592-7009, Option 3, Monday through Friday between 8:00 a.m. and 4:00 p.m. CT.

Improving access to Behavioral Health Care

BEGINNING JANUARY 1, 2024, Licensed Mental Health Counselors (LMHCs) and Licensed Marriage and Family Therapists (LMFTs) will be eligible to serve Medicare members and start billing for services due to the new statutory benefit category established by the Consolidated Appropriations Act (CAA) 2023. As a result, LMHCs and LMFTs will be added to our Medicare Advantage networks.

Take action

If needed, LMFT/LMHC providers who choose to opt out of Medicare should update their provider demographic profile to ensure we can maintain an accurate Provider Directory. Please visit our Practice Changes page on the Kaiser Permanente provider site for instructions on how to submit provider updates.

Some Kaiser Permanente ID cards will look different next year

Starting January 1, 2024, some of our Kaiser Permanente member cards will include the employer group's logo on the front of the card. This logo does not indicate a new network, but rather, a representation of the employer group.

To identify the member's network, please look at the upper right corner of the card for the network designation. Please see the illustration below for an example of one of the Kaiser Permanente member cards you might see next year.

Kaiser Permanente's CoreSelect provider network discontinued

EFFECTIVE JANUARY 1, 2024, Kaiser Permanente is discontinuing the CoreSelect provider network, thus streamlining the number of networks and supporting a better member and provider experience.

All continuing Kaiser Permanente Individual and Family (KPIF) members who utilize the CoreSelect network will automatically transition to the Core provider network as of January 1, 2024.

Providers who are in the CoreSelect network are also part of the Core network, so members will not lose access to their current providers because of this network change. Members' print and digital cards will be updated to note the Core network in the upper right corner, and their member number will remain the same. There are no specific actions required by members or providers for this network change.

We appreciate your support in ensuring a seamless transition for our impacted KPIF members.

Note: The Connect provider network will remain active for KPIF Virtual Plus plans in King, Kitsap, Pierce, Snohomish, Spokane and Thurston counties.

Recent letters to providers

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) have issued the following notices:

Network discontinuation

CoreSelect network discontinuation notice (PDF)

Effective January 1, 2024, Kaiser Foundation Health Plan of Washington will discontinue the HMO commercial network CoreSelect.

Reason for the discontinuation: Streamlining the number of networks will better support our members and provider groups.

Payment policy changes

Sinuplasty billed with functional endoscopic sinus surgery (FESS) (PDF)

Effective February 1, 2024, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) **will not** separately reimburse for sinuplasty when billed with a Functional Endoscopic Sinus Surgery (FESS) procedure for the same member on the same date of service by the same provider.

ICD-10 cm diagnosis code combinations (PDF)

Effective February 1, 2024, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) **will not** separately reimburse services billed with diagnosis codes that are mutually exclusive when billed for the same member by the same provider on the same date of service.

Step therapy requirement

Medicare Part B drugs requiring step therapy (PDF)

Effective March 1, 2024, step therapy will be required for the non-preferred Medicare Part B drugs listed in Table 1.

Changes to medical necessity review criteria

Effective January 1, 2024

Changes to medical necessity review criteria for fractional flow reserve (FFR) (PDF)

Changes to medical necessity review criteria for lumbar and cervical MRI (PDF)

Changes to medical necessity review criteria for bariatric surgery (PDF)

Changes to medical necessity review criteria for continuous glucose monitors (PDF)

Changes to medical necessity review criteria for transition of care (PDF)

Effective February 1, 2024

Changes to medical necessity review criteria for Myocardial Perfusion Imaging (MPI) (PDF)

Changes to medical necessity review criteria for prescription hearing aids (PDF)

Changes to medical necessity review criteria for breast cancer index (PDF)

Changes to medical necessity review criteria for sinus surgery (PDF)

Changes to medical necessity review criteria for Clarifix® (PDF)

Changes to medical necessity review criteria for Endobronchial Ultrasound (PDF)

Changes to medical necessity review criteria for brain mapping (PDF)

Updated prior authorization criteria

The following notices are regarding products that are on or will be added to the non-Medicare list of office-administered drugs requiring prior authorization:

Effective March 1, 2024

Oncology products updated prior authorization criteria (PDF)

Pegcetacoplan (syfovre) updated prior authorization criteria (PDF)

The criteria for pegcetacoplan (Syfovre) will be updated to include a quantity limit.

Pasireotide (signifor lar) will require prior authorization approval (PDF)

Updated prior authorization criteria for Ranibizumab (Lucentis) (PDF)

The criteria ranibizumab (Lucentis) will be updated to reflect the preferred biosimilar, ranibizumab-nuna (Byooviz). This change does not affect current authorizations for Lucentis; however, any new authorization is subject to the criteria below.

Medicare Part B drugs requiring prior authorization (PDF)

Gabapentinoid safety in patients on opioids

CLINICAL QUESTION

Does the risk of co-prescribing opioids and gabapentinoids outweigh the benefit?

Why did we choose this topic?

The co-prescribing of gabapentin and opioids has gained attention due to emerging evidence of increased risk of respiratory depression and overdose associated with their concurrent use.

Recommendations

- When prescribing gabapentinoids, be aware of the risk of misuse/abuse and monitor accordingly (e.g., frequent early fills).
- Carefully evaluate the risks and benefits of combined use of opioids and gabapentinoids. Patients at increased risk of adverse events are the elderly, those with underlying lung disease, and those on concomitant CNS depressants. If risks outweigh benefits, taper one of the agents.
- Use alternative neuropathic medications when possible: duloxetine, tricyclic antidepressants (TCAs) in patients aged < 65 years, topical lidocaine (for localized pain).
- For patients continued on opioids and gabapentinoids, there should be clear documentation of the rationale for continuing this combination as well as an ongoing monitoring plan. Documentation should also include that the patient was educated on the risks (respiratory depression, increased risk of overdose).
- Monitor renal function for patients on gabapentinoids (SCr at minimum once a year) and renally adjust dose as appropriate.

Background

- Gabapentinoids, gabapentin and pregabalin, are anticonvulsants commonly prescribed for neuropathic pain, including diabetic neuropathy, fibromyalgia/central sensitivity, and post-herpetic neuralgia.
- Pharmacologically, they inhibit α2δ-1 voltage-gated calcium channels in the CNS, decreasing the release of excitatory neurotransmitters, and contributing to their analgesic and antiepileptic effects.
- Both medications are primarily excreted in the urine and require renal dose adjustments.

Gabapentinoid misuse, abuse

- There is a growing prevalence of gabapentinoid misuse and abuse. Postmortem toxicology reports detected gabapentin in almost 1 in 10 U.S. overdose deaths between 2019 and 2020 in a CDC report that analyzed unintentional drug overdoses in 23 states and the District of Columbia.[1]
- Federally, pregabalin is a schedule V controlled substance, whereas gabapentin is non-controlled. However, several states have tightened regulations on gabapentin, including 15 states requiring gabapentin reporting on the Prescription Drug Monitoring Program (PDMP), and 7 states reclassifying gabapentin as a controlled substance (schedule V). In Washington state, gabapentin is not a controlled substance nor is it reported on the PDMP.[2]
- One study showed the prevalence of gabapentinoid misuse/abuse in the general population as 1.1% for gabapentin and 0.5% for pregabalin. The prevalence was higher in patients with opioid use disorder (15–22% for gabapentin; 3–68% for pregabalin).[3]

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Gabapentinoid safety in patients on opioids

- Gabapentinoid abuse typically involves taking large amounts (median: gabapentin 3,600 mg and pregabalin 2,100 mg) as a single dose.[3]
- Risk factors for gabapentinoid abuse: young age, underlying psychiatric comorbidities, substance use disorder (especially opioid use disorder), and benzodiazepine use.

Gabapentinoids and respiratory depression

- Between 2012 and 2017, the FDA received 49 reports of gabapentinoid-induced respiratory depression including 12 deaths, all of which occurred in persons with at least one respiratory risk factor. Respiratory risk factors include lung disease, age-related loss of lung function (i.e., in the elderly), and the use of opioid or other CNS depressants.[4]
- In December 2019, the FDA issued a warning about serious breathing problems with gabapentinoids in patients with underlying respiratory risk factors.[4]
- A case control study by Gomez and colleagues found that concomitant gabapentin and opioid use was associated with a 49% increased risk of dying from an opioid overdose compared with opioids alone.[5]
  - In the dose-response analysis, exposure to a moderate dose (900–1,799 mg daily) or high dose (1,800 mg daily or more) of gabapentin was associated with nearly 60% increased odds of opioid-related death compared to exposure to opioids alone. Exposure to a low gabapentin dose was not significantly associated with increased odds of opioid-related death.
- A retrospective cohort study by Bykov and colleagues evaluating 441 overdose events in 5.5 million patients in the perioperative setting found an absolute risk of 1.4 per 10,000 patients with gabapentinoid exposure and 0.7 per 10,000 in patients receiving opioids only.[6]

How could this change my practice?

- There is evidence that concurrent use of opioids and gabapentinoids can result in increased risk of adverse events, including respiratory depression. Patients at increased risk include the elderly, those with underlying lung disease, and those using concomitant CNS depressants.
- For patients already on gabapentinoids, assess for efficacy of the medication. If a patient is reporting no benefit/unclear benefit, then recommend tapering down and reassessing.
- Be sure to consider the use of gabapentinoids in risk/benefit discussions at each chronic opioid therapy visit.
- Consider consulting a pain management clinic for assistance with tapering as well as treatment plan recommendations.

References

1. Mattson CL, Chowdhury F, Gilson TP. Notes from the Field: Trends in Gabapentin Detection and Involvement in Drug Overdose Deaths - 23 States and the District of Columbia, 2019-2020. *MMWR Morb Mortal Wkly Rep.* 2022;71(19):664-666. Published 2022 May 13. doi:10.15585/mmwr.mm7119a3
2. Karavolis ZA, Su AB, Peckham AM. State-level response to gabapentin misuse in the United States: Implications and future direction. *Am J Health Syst Pharm.* 2022;79(9):e143-e148. doi:10.1093/ajhp/zxab486
3. Evoy KE, Morrison MD, Saklad SR. Abuse and Misuse of Pregabalin and Gabapentin. *Drugs.* 2017;77(4):403-426. doi:10.1007/s40265-017-0700-x
4. U.S. Food and Drug Administration. FDA warns about serious breathing problems with seizure and nerve pain medicines gabapentin (Neurontin, Gralise, Horizant) and pregabalin (Lyrica, Lyrica CR). December 19, 2019.
5. Gomes T, Juurlink DN, Antoniou T, Mamdani MM, Paterson JM, van den Brink W. Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case-control study. *PLoS Med.* 2017;14(10):e1002396. Published 2017 Oct 3. doi:10.1371/journal.pmed.1002396
6. Bykov K, Bateman BT, Franklin JM, Vine SM, Patorno E. Association of Gabapentinoids With the Risk of Opioid-Related Adverse Events in Surgical Patients in the United States. *JAMA Netw Open.* 2020;3(12):e2031647. Published 2020 Dec 1. doi:10.1001/jamanetworkopen.2020.31647

Related resources

Non-specific Back Pain Guideline

Chronic Opioid Therapy Safety Guideline

Questions?

Mena Raouf, PharmD, BCPS, Pharmacy Pain Management

Edwin Lojeski, DO, Pain Management

ARTICLES OF INTEREST

Kaiser Permanente Washington Health Research Institute

- **A simple solution to help catch cervical cancer early.** Research finds that mailing HPV test kits directly to patients increases cervical cancer screening rates. Read more
- **Can preventing hearing loss reduce dementia risk?** New research from Linda McEvoy, PhD, helps explain how hearing loss affects the brain. Read more
- **HIV/AIDS research advances through Pamela Shaw's work.** Shaw's project to reduce the impact of errors in data was just honored with an NIH MERIT award. Read more

7-day supply limit for new starts* on Z-drugs for Kaiser Permanente commercial plans

TO PROMOTE THE SAFE USE of non-Benzodiazepine Sedative-Hypnotics (Z-drugs) Kaiser Permanente is adding a 7-day supply quantity limit for patients new to Z-drug therapy. Z-drugs include zolpidem, zaleplon, and eszopiclone products.

Data supporting the long-term effectiveness of z-drugs for sleep/insomnia indications is weak and the evidence for potential harm is strong. Sleep studies have shown that sleep patterns return to pre-treatment levels after only a few weeks of regular use. Z-drugs are not recommended for long-term use due to the risks of physical and psychological dependence, tolerance, potential for severe withdrawal symptoms, potential for rebound insomnia, and persistent adverse side effects. Physical dependence rapidly occurs within 2 weeks of continuous use.

The addition of this 7-day supply limit will help reduce the risk for physical and psychological dependence on these medications as well as to decrease excess supply of medications in the community.

7-Day Supply Limit Update

A new 7-day supply limit for non-benzodiazepine sedative-hypnotics (z-drugs) for the initial new start dispense will go into effect January 1, 2024, for Kaiser Permanente members with commercial (non-Medicare) plans. Any prescriptions for these medications requesting a larger than 7-day supply dispense will require a clinical review by the Pharmacy Benefit Help Desk.

Notable exceptions to this quantity limit include use in or as part of an active cancer treatment plan or the individual is in hospice program, end-of-life care, or palliative care program.

What does this mean for prescribers and members?

Kaiser Permanente members starting on z-drug therapy will receive a maximum of 7-days supply during their initial fill and subsequent fills until they are no longer considered a new start* on therapy. Any authorized remainder on the prescription will still be available as needed through the refill process.

Prescribers may receive outreach to confirm or clarify if the member is eligible for the exception criteria.

Resources for clinicians

Insomnia (PDF)

Benzodiazepine and Z-Drug safety (PDF)

** New Start is defined as having less than or equal to a 7-day supply of a non-benzodiazepine sedative-hypnotic (z-drug) within the last 180 days.*

Kaiser Permanente 2023 drug formularies

THE KAISER PERMANENTE DRUG FORMULARIES are the cornerstone of medication therapy, quality assurance, and cost containment. The formularies are developed by the Pharmacy and Therapeutics (P&T) Committee.

You can find formulary decision highlights from the most recent P&T Committee meetings on the Kaiser Permanente provider website.

Kaiser Permanente has 7 formularies

The table below outlines some of the major differences in these formularies. A closed formulary design describes a formulary in which preferred medications are covered and non-preferred (non-formulary) medications are generally not covered. Coverage of non-preferred medications is available through an exception process. An open formulary design describes a formulary in which both preferred and non-preferred medications are covered; however, preferred medications are available at a lower cost share for patients.

How to view the Kaiser Permanente formularies

- On the Kaiser Permanente provider website.
- On ePocrates, register free of charge.

If you have questions about formulary status of a drug or prior authorization, please contact our Pharmacy Drug Benefit Help Desk toll-free at 800-729-1174 or by fax toll-free at 866-510-1765.

Medicare Part D Formulary updates

Notifications about drug removals from the Medicare Part D Formulary are now posted online on the pharmacy page of our provider website.

MEDICARE	INDIVIDUAL & FAMILY / SMALL GROUP	LARGE GROUP AND FEDERAL EMPLOYEE HEALTH BENEFIT				
Closed Design	**Open Design**	**Closed Design**	**Closed Design**	**Open Design**	**Open Design**	**Open Design**
Six tiers: • Preferred generic • Non-preferred generic • Preferred brand • Non-preferred brand • Specialty • Injectable Part D vaccines	**Four tiers:** • Preferred generic • Preferred brand • Specialty • Non-preferred generic & brand **PLUS:** • Self-administered oncology • Medical benefit	**Two tiers:** • Preferred generic • Preferred brand	**Three tiers:** • Preferred generic • Preferred brand • Preferred specialty	**Three tiers:** • Preferred generic • Preferred brand • Non-preferred	**Four tiers:** • Preferred generic • Preferred brand • Non-preferred generic & brand • Specialty	**Five tiers:** • Preferred generic • Preferred brand • Non-preferred generic & brand • Preferred specialty • Non-preferred specialty

Save these dates

Kaiser Permanente Washington offers a variety of continuing medical education courses throughout the year, detailed on our CME catalog page.

HURT, TIRED, AND STUCK: STRATEGIES FOR CENTRAL SENSITIVITY

Thursday, February 15, 2024 (Virtual)

Introduction to Central Sensitivity Syndrome, Illness Anxiety and Somatization, Non-pharmacologic Treatment of Chronic Pain, Managing High-risk Medications, Psychopharmacology Through CSS Lens, Ambiguous Headache, Pelvic Pain, Chronic Back and Neck Pain, Itch, Movement as Medicine

MENTAL HEALTH AND WELLNESS FOR PRIMARY CARE

Wednesday, May 15, 2024 (Virtual)

Topics to include: ADHD, Mental Health and Substance Use Disorder, Anxiety and Depression, Adult Autism, Nutrition, Mindphone Case Vignettes, Geropsychiatry

Register

Check out the CME catalog page to register and get course details.

Contact

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