

Provider Bulletin

Control Number:	110120
Date:	November 6, 2020
Subject:	Kaiser Foundation Health Plan of Washington Options, Inc. and First Choice Health: Summit PPO Network For Large Group Employers
Author:	John Prassas (Kaiser Permanente) and Bob Hinman (First Choice Health Network)
Effective Date:	January 1, 2021

Kaiser Foundation Health Plan of Washington Options, Inc (KFHPWAO) is pleased to announce its intention to launch a new Summit PPO plan for large business groups (LGB) effective January 1, 2021.

The Summit PPO will be offered to large business groups based in any of these 6 counties: King, Snohomish, Pierce, Kitsap, Thurston and Spokane. The provider network (for in-network benefits) offered to such LBG employees and dependents will span KFHPWAO’s 18 county service area in Washington state (please see color coded maps below).

Summit PPO is a tiered provider network. It identifies and groups physicians, healthcare professionals, ancillary providers and facilities into specific tiers in which different Coinsurance and Copayment amounts apply as a means of managing cost, utilization and quality. KFHPWAO does not use the Summit PPO tiered network to limit access to any certain categories of providers or facilities.

The network in the six blue color-coded counties for **TIER 1** will consist of **ONLY** those providers owned by or directly contracted with Kaiser Foundation Health Plan of Washington.

SUMMIT PPO – TIER 1

Preferred, In Network, Six County Service Area: King, Kitsap, Pierce, Snohomish, Spokane, Thurston
BLUE Counties represent Kaiser Permanente Only



FCHN providers should request prior authorizations for services. Depending on the member’s benefit plan, prior authorization requests may be denied, approved at the in-network benefit level, or approved at the out-of-network benefit level.

FCHN providers can check to see if the procedure and/or service CPT code needs a pre-authorization, needs medical necessity review, and what records to send with the request.

Pre-authorization code check: <https://wa-provider.kaiserpermanente.org/home/pre-auth/search>

Medical Necessity Reviews

If prior authorization is not obtained, Kaiser Foundation Health Plan of Washington will perform post-service medical necessity reviews of claims for services that are listed in the Kaiser Foundation Health Plan of Washington Clinical Review Criteria. These criteria can be found in the Referrals and Clinical Review section of the Provider Manual (link above).

Will these changes affect claims payment?

KPWA will make the medical necessity determination at the time the claim is adjudicated and either pay or deny the claim. In the event the services rendered do not meet medical necessity criteria, the following will occur:

- If the rendering provider is in the KFHPWAO network, the claim will be denied as provider write-off.
- If the provider is out of the KFHPWAO network, the claim will be denied as member responsibility.

To ensure payment, you have the option of requesting medical necessity review prior to providing services on the above referenced Clinical Review Criteria list.

Subject to the provisions of your provider contract, including obtaining a member’s prior written agreement to be financially responsible for the specific non-covered service, providers may bill a member for non-covered Services. For additional help or questions please contact the Provider Assistance Unit at 1-888-767-4670.

Member ID Cards



Kaiser Foundation Health Plan of Washington will issue ID Cards to members as groups enroll. A sample ID card is shown for your reference.

For questions regarding your FCHN contractual agreement, email Provider Relations at ProviderRelations@fchn.com.