Kaiser Permanente is pleased to announce the opening of our new Tysons Corner Medical Center located at 8008 Westpark Drive, McLean, Virginia 22102. The new facility is scheduled to open on August 13, 2012.
The Kaiser Permanente Tysons Corner Medical Center will be one of several “Specialty Hubs” providing enhanced care to Kaiser Permanente members. The seven-story 240,000 square foot state-of-the-art facility will be a full service medical office building with the capability to provide comprehensive outpatient services for more complex conditions including:

- Full range of primary and specialty care departments (see below for full list)
- Oncology and Infusion services able to treat patients on an outpatient basis
- Minor Injury and Urgent Care facility
- Clinical Decision Units to provide outpatient observation services to the urgent care clinic
- Ambulatory Surgery Center 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

**Services provided include:**

**Primary Care**
- Adult Medicine
- Internal Medicine
- Obstetrics/Gynecology
- Pediatrics

**Specialties**
- Ambulatory Surgery
- Audiology
- Blood Transfusion
- Cardiology
- Comprehensive Spine Care
- Ear, Nose and Throat
- General Surgery
- Hematology/Oncology
- Infectious Disease
- Infusion Center
- Interventional Pain
- Interventional Radiology
- Nephrology
- Nuclear Medicine
- Orthopedics
- Outpatient Occupational Therapy
- Outpatient Physical Therapy
- Outpatient Procedure Suite
- Peritoneal Dialysis
- Physical Medicine
- Plastic Surgery
- Podiatry
- Pre-Operative Evaluation & Education Center
- Pulmonary
- Spine Surgery

**Hours of Operation:**

**Imaging/Radiology**
- Services include CT scan, fluoroscopy, mammography, MRI, ultrasound, and X-ray
  - 7 days, 24 hours

**Laboratory**
- 7 days, 24 hours

**Ambulatory Surgery Center**
- Hours of operation: Monday to Friday from 6:30 a.m. to 5:30 p.m

**Pharmacy**
- 7 days, 24 hours

**Clinical Decision Unit/Urgent Care**
- 7 days, 24 hours

**Vision Services**
- Optical Center, Ophthalmology and Optometry
  - (Hours to be determined at a later date)

**Other Services**
- Health Education Center
- HIMS
- Member Services

Should you have any questions, please contact Provider Relations at 1 (877) 806-7470 and look for our mailings on up and coming new Medical Centers.
The benefits of referring your patients to Kaiser Permanente for specialty care

Referring your patients to Kaiser Permanente brings the advantages of the integrated care experience to our members as well as to you - the Participating Provider. Members referred to Kaiser Permanente providers for specialty care are seen by Mid-Atlantic Permanente Medical Group P.C. physicians. With our recent expansions in specialty care services, members referred to a specialist within Kaiser Permanente are frequently seen more quickly than those referred to a specialist within our Participating Provider Network. In addition, all services rendered at a Kaiser Permanente medical center including lab, pharmacy, and radiology orders are documented within 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 patient connected with all aspects of the care that he/she receives within Kaiser Permanente. Members may access health information related to their Kaiser Permanente care www.kp.org. Participating PCPs with access to KP HealthConnect® AffiliateLink have real-time access to their patient’s encounters/visits, charts, lab results, and more via the web at www.providers.kp.org/mas.

If you do not have access to KP HealthConnect® AffiliateLink and would like to enroll, you may download an enrollment package at www.providers.kp.org/mas or contact Provider Relations at 1 (877) 806-7470 for assistance.

Pharmacy updates:
Commercial Formulary management

The Kaiser Permanente Mid-Atlantic States Commercial Formulary is a list of drugs approved for use by the Regional Pharmacy, and Therapeutics (P&T) Committee. The P&T Committee, with expert guidance from various medical specialties, evaluates, appraises, and selects FDA-approved drugs considered to be the most appropriate for use within the region.

The formulary is intended to promote rational, safe, and cost-effective drug therapy in the Mid-Atlantic States Region. The formulary process provides objective, evidence-based evaluation and selection of drugs. Composition of the Committee includes physicians from primary care and specialty departments, pharmacists, and representatives from nursing and quality departments.

Selection of generic medications is based on clinical effectiveness, safety, and therapeutic equivalence to a branded drug in accordance with all applicable federal, state and/or local statutes.

If an FDA AB-rated approved therapeutically equivalent generic medication becomes available, the generic medication is added to formulary without P&T Committee review if the brand name medication is already on the formulary and has been reviewed in the past. Selected generic drugs such as hormonal therapy, narrow therapeutic index drugs, or non-formulary drugs may require a formal review by the P&T Committee before they are added to the drug formulary.

The corresponding brand name drug is deleted from the drug formulary after review and approval by the P&T Committee.

Periodically a list of drugs with potential for significant member and organizational cost savings is targeted for therapeutic conversion. The Clinical Pharmacy in collaboration with the MAPMG Physician Director of Pharmacy and Therapeutics Drug Utilization Management develops a standard process for therapeutic conversion for these agents. This process assures proper communication,
implementation, and education of practitioners, pharmacists and KPMAS members about each drug conversion.

Upon evaluation, if a member qualifies for therapeutic conversion, an order is placed to the pharmacy. The member is informed of the therapeutic conversion and to call the pharmacy to have the prescription filled when they are ready to receive their medication.

If the member does not agree to the substitution, a note is placed in the member’s electronic medical record (EMR) so that the issue of the therapeutic conversion is not revisited.

If the patient had an allergy or adverse reaction to the preferred drug, the preferred product is ineffective or patient refuses, this is documented in patient’s EMR and patient receives the non-preferred product.

Mandatory counseling by the dispensing pharmacist is in place to ensure patient education of the therapeutic conversion occurs at the time of dispensing.

The formulary is dynamic and updated monthly with any additions and/or deletions approved by the Committee. Any FDA-approved drug may be evaluated for formulary addition or deletion, and any physician may request a review of a drug.

In order to request a drug be reviewed by the Regional P&T Committee, the request should be in writing and forwarded to the Co-Chairs of the Committee along with supporting literature and references. Drug formulary addition/deletion requests should include the following:

- Name, strength and dosage form of the drug being requested;
- Reason for the request with clinical references of its safety and effectiveness;
- What drug this would replace on formulary (if any); and
- Contact information of the requesting physician along with their specialty.

Drug addition/deletion request forms are available in the intranet at pithelp.co.kaiserpermanente.org/MAS/documents/phcy_therapeutics/formulary addition deletion_request for the MAPMG providers, and from the web at providers.kaiserpermanente.org/mas/formulary.html for the affiliated providers.

The entire formulary and its processes are reviewed at least annually. Drugs included on the formulary are readily available for prescribing, dispensing, and administration.

Based upon the review, a drug or biological will be classified into one of four categories:

**Formulary drug (F)** – A drug, including specific strengths and dosage forms that has been reviewed and approved based on sound clinical evidence that supports the safe, appropriate, and cost-effective use of the drug. A Formulary drug may be prescribed by all privileged prescribers, except where state laws and/or regulations prohibit.

**Formulary drug with Restriction (FR)** – A formulary drug with prescribing restricted to specific prescribers, e.g. individuals, departments, divisions, teams.

**Non-Formulary drug (NF)** – A drug that has not been formally accepted for inclusion on the KPMAS drug formulary. This includes: drugs that have been reviewed but denied acceptance on the drug formulary; new drugs not yet reviewed for addition to the formulary; a brand, strength, or dosage form of a drug not approved for addition to the formulary; formulary drugs for which prescribing or eligibility criteria or restriction are NOT met (e.g., weight management medication for a patient whose BMI = 22).

**Non-Formulary with Restrictions (NFR)** – A drug that has been reviewed, but acceptance on the formulary has been denied. Drug-rider coverage for this drug meets specific restrictions for use when prescriptions are written for or are written in consultation with the specific prescribers, e.g. individuals, departments, divisions, health care teams.
Affiliated providers can keep current with drugs on the KPMAS Formulary by visiting providers.kaiserpermanente.org/mas/formulary.html, and our MAPMG providers can search the formulary in the intranet at http://pithelp.co.kp.org/MAS/formulary.html. A printed copy of the formulary is available upon request from the Provider Relations department at 1-877-806-7470 or through the web for the affiliated providers at providers.kaiserpermanente.org/mas/formulary.html and for the MAPMG providers in the intranet at http://pithelp.co.kp.org/MAS/formulary.html.

**Formulary changes and medication updates**
The Regional P & T Committee publishes formulary decisions to ensure that the providers are kept informed with the most recent updates of the formulary. Electronic copies of the formulary changes are available on the web at providers.kaiserpermanente.org/html/cpp_mas/formularydecisions.html

**Non-Formulary Exception Process**
The non-formulary exception process provides physicians and patients with access to non-formulary drugs and facilitates prescription drug coverage of medically necessary, non-formulary drugs as determined by the prescribing practitioner.

Patients can obtain a non-formulary drug outside of the exception process at any time by paying full price for the drug, when the provider deems it is not medically necessary and not harmful, but agrees to prescribe based on patient demand.

**Highlights of the non-formulary exception Process:**
- Non-formulary drugs should be used only if the patient fails to respond to formulary drug therapy, or has special circumstances requiring the use of a non-formulary drug.
- The practitioner makes the final decision regarding what drug is appropriate for the member. If the appropriate drug is not on the formulary and is deemed medically necessary by the practitioner, he/she documents the reason for the medical necessity in the patient’s medical record and on the pharmacy prescription order. This documentation is transferred with the prescription to the Kaiser Permanente pharmacy or network pharmacy for appropriate dispensing.
- If a network practitioner writes for a non-formulary drug without the appropriate exception reason documented, they should expect a telephone call from a pharmacist to suggest a formulary alternative or to obtain an exception reason, so the same documentation may take place. This allows Kaiser Permanente to track the use of non-formulary agents and decide whether they should be re-evaluated for formulary inclusion.

Some reasons why a physician may grant an exception include allergy/adverse reaction to formulary product, or treatment failure on formulary drug. Once the physician chooses a non-formulary exception code, the prescription will be covered at the appropriate co-payment.
If the physician determines the non-formulary prescription is not medically necessary, the physician will discuss the formulary alternatives available with the member. If the member insists on the non-formulary product but an appropriate formulary alternative is available, the physician may prescribe the non-formulary drug and document appropriately:

- The physician will document the non-formulary prescription as a patient request/demand, although not medically necessary.
- The drug will not be covered under the pharmacy benefit.
- Patient will pay full price for the drug if a non-formulary prescription is not ordered through the KPHealthConnect®, there is no exception reason documented, and the member presents to a Kaiser Permanente pharmacy to fill the prescription, the following steps will occur:
  - The pharmacist will contact the prescribing practitioner to determine the formulary alternative or the non-formulary exception reason.
  - If an appropriate reason for exception is obtained from the prescribing practitioner, the appropriate co-pay will be applied.
  - If the reason for exception is not obtained, then the member may get the non-formulary medication filled by paying full price for the drug.
  - The member may request a review of their case through Member Services.

Medicare Part D drug formulary and tiering exception process

On January 1, 2012, Kaiser Permanente implemented a new Medicare Prescription Drug Benefit design for Direct Pay Medicare Part D members (approximately 50% of Kaiser Permanente's Medicare population). This new benefit design is based on a tiered cost-sharing structure for pharmacy benefits.

Each Part D drug on the formulary is assigned a drug tier level. The list below are the drug tiers for Direct Pay Medicare Part D members:

- Tier 1 — Preferred generic drugs
- Tier 2 — Non-preferred generic drugs
- Tier 3 — Preferred brand-name drugs
- Tier 4 — Non-preferred brand-name drugs
- Tier 5 — Specialty-tier drugs
- Tier 6 — Injectable Part D vaccines

The Center for Medicare and Medicaid Services (CMS) requires that a Health Plan with a tiered cost-sharing structure allow members to request a tiering exception. A tiering exception allows Direct Pay Medicare members to obtain a non-preferred brand drug at the more favorable co-pay that is applicable to drugs in the preferred brand drug tier.

If the physician prescribes a non-formulary prescription drug requested by a patient with network pharmacy benefit, without indicating a non-formulary exception and the member goes to a network pharmacy to fill the prescription, the member may do the following:

- Ask the pharmacist to request a formulary alternative or call the Pharmacy Benefit Manager to start the process for a non-formulary exception;
- Get the non-formulary medication filled and pay the standard retail price; or Contact Kaiser Permanente Member Services at 1-877-218-7750 and request a non-formulary exception review.

The cost of prescriptions may vary depending upon the type of drug and the member’s particular pharmacy benefit. If members have questions about their pharmacy benefits, please refer them to the Kaiser Permanente Member Services, or their Evidence of Coverage document that they received at the beginning of this renewal year.

You may also find copay information related to prescriptions drugs on the following link: businessnet.kaiserpermanente.org/health/plans/mid/assisteemployees/supportmaterials
A tiering exception applies only to drugs in the non-preferred brand tier (Tier 4). The following criteria must be met before a member can request a tiering exception:

The request must be for a drug to be placed into the preferred brand drug tier (i.e., Tier 3) for a lower copay,

A generic counterpart is NOT available for the non-preferred brand drug, At least one other drug in the same class is available on the preferred brand tier.

Kaiser Permanente members or their provider may initiate a tiering exception request by calling Kaiser Permanente Mid-Atlantic Member Services at 1-888-777-5536, or via a written request to the following address/fax number:

Kaiser Permanente of the Mid-Atlantic States Appeals and Correspondence Department. 2101 East Jefferson Street. Rockville, MD 20852 Fax: 301-816-6192

Members may find more details at www.kaiserpermanente.org\seniormedrx or by contacting Kaiser Permanente Member Services at the number above. Members may also refer to their Evidence of Coverage and other plan materials for more details.

Once the tiering exception request is received, it will be reviewed by Kaiser Permanente Clinical Pharmacy Services. Prescribing providers may receive a fax or phone call suggesting a drug from the preferred tier or requesting to provide documentation to support the tiering exception. Prescribing providers are asked to promptly respond to these requests with all required information to facilitate the timely delivery of medications to the patient. A tiering exception may be granted when the provider has clearly documented:

• The preferred drug will not be as effective as the requested drug in the non-preferred tier, or
• The preferred drug will have adverse effects for the member.

Drospirenone-containing oral contraceptives: Updating labeling changes and risk of blood clots

The FDA has completed its review of recent observational studies regarding the risk of blood clots in women taking drospirenone-containing oral contraceptives (OCPs). FDA states that these drugs may be associated with a higher risk for venous thromboembolism (VTE) than other progestin-containing pills. This information will be added to the drug labels for drospirenone-containing products (see attachment A for a table of all oral contraceptives which contain drospirenone).

Drospirenone is a synthetic version of the female hormone, progesterone, found in some oral contraceptive pills also approved to treat symptoms
of premenstrual dysphoric disorder (PMDD) and to treat moderate acne in women who choose to use an oral form of contraception. Two products (Beyaz and Safyral) contain levomefolate calcium in addition to the contraceptive hormones, and may also be used to improve folate levels in women who choose to use an oral form of contraception.

Venous thromboembolism is already known to be a rare but serious potential side effect of taking any (OCP) containing a progestin and estrogen. The risk of VTE in users of oral contraception is low, although it is higher than the risk of VTE in women who do not use OCPs. The risk of VTE in pregnant women (about 5 to 20 cases per 10,000 women) is even higher than that in women who use OCPs.

The drug labels for all combination OCPs currently include warnings regarding the potential risk of VTE and describe additional factors that increase this risk (such as age, obesity, smoking or a history of blood clots). Usually the risk of VTE is highest during the first year after starting to use a combination OCP.

Study summary
FDA was aware of two published studies in 2011 that evaluated the risk of VTE in women who use OCPs that contain drospirenone. The two published studies compared the risk of clots in women taking OCPs with the progestin drospirenone to similar women taking OCPs containing a different progestin called levonorgestrel. These two studies reported that there is a greater risk of VTE associated with OCPs that contain drospirenone. This risk was reported to be up to 2 to 3 times greater than the risk of VTE associated with using levonorgestrel-containing pills.

Conflicting information already existed on this potential increased risk. Two previously published studies, which were conducted at the request of FDA or the European regulatory agencies after drug approval, did not report any difference in risk of VTEs between the drospirenone-containing products and products containing levonorgestrel or other progestins. However, two publications in 2009 reported that the risk of VTEs is higher in women using a drospirenone-containing product than in women who use levonorgestrel-containing products. These four earlier studies were already described in the labeling for drospirenone-containing OCPs.

The recent studies reviewed by FDA did not provide consistent estimates of the comparative risk of VTE between OCPs that do and do not contain drospirenone. These studies did not account for important known and unknown patient characteristics that may influence prescribing and that likely affect the risk of VTE.

Though it is unclear whether the increased risk of VTE seen in some of the epidemiologic studies is actually due to use of drospirenone-containing OCPs, on April 10, 2012, FDA updated the drug labels for Beyaz, Safyral, Yasmin and Yaz to report that some epidemiologic studies reported as high as a three-fold increase in the risk of VTE for drospirenone-containing products when compared to products containing levonorgestrel or some other progestins, whereas other epidemiological studies found no additional risk of VTE with drospirenone-containing products.

The labels also will include a summary of the previously released results of an FDA-funded study of the risk of VTE.

Prescribers should discuss all potential risks including VTE with their female patients who are request an oral contraceptive agent and consider the risks and benefits of drospirenone-containing OCPs and a individual woman’s risk for developing significant VTE before prescribing these products. The FDA recommends that women who are over age 35 and smoke should not take any type of combination birth control pill (including those containing drospirenone), due to an increased risk of serious cardiovascular events. The risk of VTE also increases with age and smoking. Other women who should not take combination OCPs include those with a history of thrombosis, heart attack, or
stroke or those who are pregnant or think they may be pregnant.

Additional information can be found at the following link below:
- Data Summary: www.fda.gov/Drugs/DrugSafety/ucm299305.htm
- Yasmin label update: www.accessdata.fda.gov/drugsatfda_docs/label/2012/021098s022lbl.pdf
- Beyaz label update: www.accessdata.fda.gov/drugsatfda_docs/label/2012/022532s004lbl.pdf

### Approved oral contraceptives containing drospirenone

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beyaz</td>
<td>Drospirenone 3 mg, ethinyl estradiol 0.02 mg and levomefolate calcium 0.451 mg</td>
</tr>
<tr>
<td>Drospirenone and ethinyl estradiol</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.03 mg</td>
</tr>
<tr>
<td>Drospirenone and ethinyl estradiol</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.02 mg</td>
</tr>
<tr>
<td>Gianvi</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.02 mg</td>
</tr>
<tr>
<td>Loryna</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.02 mg</td>
</tr>
<tr>
<td>Ocella – KPMAS Formulary</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.03 mg</td>
</tr>
<tr>
<td>Safyral</td>
<td>Drospirenone 3 mg, ethinyl estradiol 0.03 mg, and levomefolate calcium 0.451 mg</td>
</tr>
<tr>
<td>Syeda</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.03 mg</td>
</tr>
<tr>
<td>Yasmin – KPMAS Formulary</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.03 mg</td>
</tr>
<tr>
<td>Yaz</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.02 mg</td>
</tr>
<tr>
<td>Zarah</td>
<td>Drospirenone 3 mg and ethinyl estradiol 0.03 mg</td>
</tr>
</tbody>
</table>

### New warning and contraindication for blood pressure medicines containing Aliskiren

The FDA recently alerted health professionals to the increased risk of renal impairment, hypotension, and hyperkalemia associated with concomitant use of aliskiren-containing products and angiotensin converting enzyme inhibitors (ACEIs) or angiotensin receptor blockers (ARBs) in patients with diabetes or renal impairment.

Aliskiren is a renin inhibitor used to treat hypertension by lowering blood pressure and is found as a single agent product (Tekturna) as well as a combination product (see attachment A for a table of medications containing aliskiren).

The labels for aliskiren drugs are being updated based on preliminary data from the, “Aliskiren trial in Type 2 Diabetes Using Cardio-Renal Endpoints (ALTITUDE)”, trial which was terminated after 27 months for lack of efficacy.

The purpose of ALTITUDE was to determine whether aliskiren (compared to placebo), on top of conventional treatment with an ACEI or ARB, reduces death and disease caused by the heart, the circulatory system and the kidney in patients with type 2 diabetes and renal disease. The primary efficacy outcome was the time to the first event of the primary composite.
endpoint, which consisted of cardiovascular death, resuscitated sudden death, non-fatal myocardial infarction, non-fatal stroke, unplanned hospitalization for heart failure, onset of end-stage renal disease, renal death, and doubling of serum creatinine concentration from baseline sustained for at least one month.

In ALTITUDE, the risks of renal impairment, hypotension, and hyperkalemia in a group of patients taking aliskiren plus an ARB or ACEI increased relative to a group of patients taking placebo plus an ARB or ACEI. The preliminary data from ALTITUDE also demonstrated a slight excess of cardiovascular events (death or stroke) in the aliskiren group; however, FDA has reached no definite conclusion regarding an actual link between these drugs and death or stroke. As a result of the ALTITUDE trial, Novartis has announced it will no longer manufacture Valturna after July 20, 2012.

The following recommendations are being added to the drug labels for aliskiren-containing products as of 4/20/12:

A new contraindication against the use of aliskiren with ARBs or ACEIs in patients with diabetes because of the risk of renal impairment, hypotension, and hyperkalemia.

A warning to avoid use of aliskiren with ARBs or ACEIs in patients with moderate to severe renal impairment (i.e., where glomerular filtration rate [GFR] < 60 mL/min).

Based on results from the ALTITUDE trial, aliskiren-containing medications are contraindicated for use in patients with Type 2 diabetes who are concomitantly treated with an ACEI or ARB and aliskiren-containing medications should be used cautiously in patients with GFR < 60 mL/min due to the risk of renal impairment, hypotension and hyperkalemia.

The FDA will evaluate the final trial results as well as results from other aliskiren trials and will communicate any new information when it becomes available.

Additional information can be found at the following link below:

Dear Healthcare Provider Letter from Novartis re: aliskiren-containing medication labeling updates and pending removal of Valturna from the market: www.pharma.us.novartis.com/assets/pdf/Tekturna_Quo_Site_for_Professionals.pdf

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### Medications containing aliskiren

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Components</th>
<th>KPMAS Formulary status (commercial / MPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amturnide</td>
<td>aliskiren hemifumarate, amlodipine besylate, and HCTZ</td>
<td>NF / Non-Preferred Brands Tier 4</td>
</tr>
<tr>
<td>Tekturna</td>
<td>aliskiren hemifumarate</td>
<td>NF / Non-Preferred Brands Tier 4</td>
</tr>
<tr>
<td>Tekturna HCT</td>
<td>aliskiren hemifumarate and hydrochlorothiazide</td>
<td>NF / Non-Preferred Brands Tier 4</td>
</tr>
<tr>
<td>Tekamlo</td>
<td>aliskiren hemifumarate and amlodipine besylate</td>
<td>NF / Non-Preferred Brands Tier 4</td>
</tr>
<tr>
<td>Valturna*</td>
<td>aliskiren hemifumarate and valsartan*</td>
<td>NF / Non-Preferred Brands Tier 4</td>
</tr>
</tbody>
</table>

MPD: Medicare Part D; NF = non-formulary;*Novartis will be removing Valturna from the US Market on July 20, 2012 based on the ALTITUDE study results
Diversity

Members have the right to free language services for health care needs. We provide free language services including:

- **24-hour access to an interpreter.** When members call to make an appointment or talk to their personal physician, if needed, we will connect them to the Language Line.® The Language Line provides health care interpreters for more than 170 languages over the phone.

- **Bilingual physicians and staff.** In some medical centers and facilities, we have bilingual physicians and staff to assist members with their health care needs. They can call Member Services or search online in the medical staff directory at kaiserpermanente.org.

- **TTY access.** If members are hearing- or speech impaired, we have TTY access numbers that they can use to make an appointment or to talk with an advice nurse or Member Services representative.

- **Sign language interpreter services.** These services are available for appointments. In general, advance notice of two or three business days is required to arrange for a sign language interpreter; availability cannot be guaranteed without sufficient notice.

- **Educational materials.** Selected health promotion materials are available in foreign languages upon request. To access Spanish language information and many educational resources go to kaiserpermanente.org/espanol or kaiserpermanente.org to access La Guía en Español (the Guide in Spanish). Members can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in La Guía en Español.

- **Prescription labels.** Upon request, the KPMAS pharmacist can provide prescription labels in Spanish for most medications filled at the KaiserPermanente Pharmacy.

At Kaiser Permanente, we are committed to providing superior health care to our members regardless of their race, ethnic background or language preference. Efforts are being made to collect race, ethnicity and language data through our electronic medical record system, HealthConnect®. We believe that by understanding our members’ cultural and language preferences, we can more easily customize our care delivery and Health Plan services to meet our members’ specific needs.

Currently, when visiting a medical center, members should be asked for their demographic information. It is entirely the member’s choice whether to provide us with demographic information. The information is confidential and will be used only to improve the quality of care. The information will also enable us to respond to required reporting regulations that ensure nondiscrimination in the delivery of health care.

We are seeking support from our practitioners and providers to assist us with the member demographic data collection initiative. We would appreciate your support with the data collection by asking that you and your staff check the member’s medical record to ensure the member demographic data is being captured. If the data is not captured, please take the time to collect this data from the member. The amount of time needed to collect this data is minimal and only needs to be collected once. Recommendation for best practices for collecting data is during the rooming procedure.

In conclusion, research has shown that medical treatment is more effective when the patient’s race, ethnicity and primary language are considered.
**CLAS standards**

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language
are collected in health records, integrated into the organization's management information systems, and periodically updated.

11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Note: The standards are organized by three themes.
- Culturally Competent Care (Standards 1-3)
- Language Access Services (Standards 4-7)
- Organizational Supports for Cultural Competence (Standards 8-14)

Minimum necessary - How much is too much?

With the widespread use of Kaiser Permanente HealthConnect® and other electronic health records, we have an abundance of information at our fingertips. But how much information do you really need to do your job?

It’s important to know the answer to this question, because HIPAA requires providers to access, use, and disclose only the minimum amount of information necessary to do their job. If you access, use, or disclose more than the minimum necessary you are violating a member’s right to privacy.

What to ask yourself when you are determining how much is too much.

Do I need protected health information (PHI) to do my job in certain situations?

- If you can accomplish your task without accessing, using, or disclosing PHI, then do not access PHI just because it is readily available.

If you need PHI, what specific information do you need right now?

- If you are completing a form that asks only for name, medical record number (MRN), and home address, you do not need to access any medical information.
- If you need to reauthorize a durable medical equipment (DME) order, you do not necessarily need to access information about a person’s Social Security number.

Think about what information you really need to fulfill your duties, and only access, use, or disclose that specific information.

What if the information I need is in a place where I can’t help but see other PHI that I don’t need?

- Sometimes you can’t avoid being exposed to confidential information you don’t really need. Make a good faith effort to access, use, or disclose only what you need.

What if I am not entirely sure what I may need? For example, if I am treating a patient, I may think I only need his vaccination history, but as I review his chart, I may find I am concerned about possible medication allergies. Can I then look at that information as well?

- Yes. In the course of fulfilling your duties you may need to expand the amount of PHI you are accessing to provide the necessary level of service and care. Just be sure that if you are asked, you can clearly explain why accessing, using, or disclosing that information was necessary to fulfill your duties.

Remember, only the minimum necessary information must be accessed, used or disclosed to accomplish your job.

Before you access PHI, ask yourself:

- Do I need to know this information to do my job?
- If the answer to this question is “no,” do not access, use, or share the information.

If the answer is yes, then ask:

- What is the minimum amount of necessary information I need to get the job done?
- If you have determined that you need to use or share the information to do your job, then you need to determine what the minimum amount of information is to accomplish the task or purpose.
Practitioner and provider quality assurance and credentialing

The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners under contract with the Mid-Atlantic Permanente Medical Group (MAPMG) and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KPMAS) are qualified, appropriately educated, trained, and competent.

All participating practitioners must be able to deliver health care according to KPMAS standards of care and all appropriate state and federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA) and KPMAS.

Provider responsibilities

Provider responsibilities in the credentialing process include:

• Submission of a completed application and all required documentation before a contract is signed.
• Producing accurate and timely information to ensure proper evaluation of the credentialing application.
• Provision of updates or changes to an Application within 30 days including:
  * Voluntary or involuntary medical license suspension, revocation, restriction, or report filed
  * Voluntary or involuntary hospital privileges reduced, suspended, revoked, or denied
  * Any disciplinary action taken by a Hospital, HMO, group practice, or any other health provider organization
• Provision of a current certificate of insurance when initiating a credentialing application. A certificate of insurance must also be submitted at annual renewal.
• Cooperation with pre-credentialing site and medical record-keeping review process
• Provide a minimum of 90 days notification to health plan of intent to terminate contract.

Provider rights

Provider rights in the credentialing process include:

• Reviewing the information contained in his or her credentials file.
• Correcting erroneous information contained in his or her credentials file.
• Being informed, upon request, of the status of their application.
• Appealing decisions of the credentialing committee if he/she has been denied re-credentialing, has had their participating status changed, been placed under a performance improvement plan, or had any adverse action taken against them.

These rights may be exercised by contacting the Kaiser Permanente Practitioner and Provider Quality Assurance Department by phone 301-816-5853, fax 301-816-7133, or mail:

Kaiser Permanente
Practitioner and Provider Quality Assurance
6 West
2101 East Jefferson Street
Rockville, MD 20852

Board certification policy

If not already board certified, all Kaiser Permanente physicians and contracted physicians and podiatrists who work for us are required to obtain a board certification in their contracted specialty by an organization recognized by the American Board of Medical Specialties or the American Podiatric Medical Association. KPMAS accepts the following boards:

• American Board of Medical Specialties (ABMS)
• American Podiatric Medical Association (APMA)
Kaiser Permanente physicians and network physicians and podiatrists must obtain and maintain specialty board certification in an ABMS (American Board of Medical Specialties) or APMA (American Podiatric Medical Association) recognized specialty throughout the life of their contract or employment with Kaiser Permanente. Failure to obtain board certification within 5 years of the original contract or employment date will result in removal/termination of credentials.

Physicians and podiatrists whose certification lapses during the course of their contract or employment will be given two years following the expiration of their board certification to obtain recertification. (This does not apply to hourly Kaiser Permanente physicians). Physicians who were practicing in a specialty prior to the establishment of board certification of that specialty are exempt from this policy with respect to that specialty.

In addition, physicians who move from MAPMG into the network or from the network into MAPMG shall for the purposes of the application of this policy be considered to have a single start date for affiliation with KPMAS.

Practitioner/Provider UM Notification

Utilization Management/Resource Stewardship Program

Our Utilization Management (UM) or Resource Stewardship program is a collaborative effort between the Medical Group and Health Plan staff at Kaiser Permanente designed to help our members receive the right care and the right resources in a timely manner.

The scope of the UM program encompasses quality management and resource stewardship across the care continuum. It consists of five major categories: Concurrent Review, Transition Care Management also known as Discharge Planning, Case Management, Referral Management/Preauthorization, and Post Service Review. The Utilization Management (UM) Department is organized around three Service Areas (Baltimore, District of Columbia/ Suburban Maryland (DC/SM), and Northern Virginia (NOVA). The UM activities within each Service Area include inpatient case management and complex case management (CCM) and SNF utilization management.

Collectively, these areas implement the UM Program for medical, surgical, and behavioral health care rendered to Kaiser Permanente Mid-Atlantic States (KPMAS) members. The Utilization Management Operations Center (UMOC) is a centralized telephonic Utilization Management (UM) and Referral Management Service Center designed to assist Mid-Atlantic Permanente Medical Group (MAPMG) practitioners, community-based practitioners, and applicable KPMAS staff in coordinating health care services for KPMAS members.

Registered Nurses review and process outpatient referrals, requests for durable medical equipment and home care services, and coordinate emergency care and out of area admissions. Registered Nurses work collaboratively with licensed, board-certified UM Physician Managers and Practitioners in managing the patient’s medical, surgical, or behavioral health care through telephonic utilization review of requested services and equipment, and by coordinating care across the continuum. Referrals requiring medical necessity review are reviewed by Board Certified UM Medical Directors (UM Physicians) who are certified Medical Directors by the State of Maryland.
Practitioners and providers may contact the Utilization Management Operations Center (UMOC) toll-free number for any inquiries and questions regarding UM issues and processes at 1-800-810-4766 and follow the appropriate prompts.

The Utilization Management Operations Center (UMOC) staff can also assist you with the following:

- Provide information regarding utilization management processes
- Check the status of referral or an authorization
- Provide copies of criteria/guidelines utilized for decision making
- Answer questions regarding a benefit denial decision

All Practitioners have the opportunity to discuss any non-behavioral health and or/behavioral health Utilization management (UM) medical necessity denial (adverse) decisions with a Kaiser Permanente Physician Reviewer (UM Physicians).

Kaiser Permanente Physician Reviewers are always available during business hours 8:00 am to 5:00 pm, Monday to Friday except holidays to speak with all practitioners to discuss pre-service or concurrent medical necessity decisions. Practitioners are notified about adverse decisions through verbal or electronic notification followed by a written letter. If you wish to discuss any medical necessity denial decisions with a UM Physician, call the Utilization Management Operations Center (UMOC) at 1-800-810-4766 and select the appropriate prompt # or the Kaiser Permanente Page Operator at 1-888-989-1144.

**UM Criteria/Guidelines and Medical Coverage Policies (MCPs)**

KPMAS UM utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, regionally developed medical coverage policies, and locally produced specialty medical coverage policies. Additionally, the opinions of subject matter experts, certified in the specific field of medical practice, are sought in the guideline development process.

KPMAS adheres to Medicare rules and regulations for medical necessity determinations for applicable services such as skilled nursing facility (SNF), acute rehabilitation, home health, hospice, DME, prosthetics and orthotics, ambulance transportation for all Medicare beneficiaries and for commercial members as noted in their Evidence of Coverage (EOC).

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 by Regional Utilization Management Committee, and filed with the state of Maryland.

**Access to UM criteria**

There are several ways to access the UM criteria sets, national guidelines and medical coverage policies:

- UM approved criteria sets and medical coverage policies can be accessed by any UM staff and physicians through KP HealthConnect®, Clinical Library and Mid-Atlantic States Knowledge Base (MASK)
- The Utilization Management Operations Center (UMOC) can be reached during business hours to request copies of UM criteria or MCPs, or to reach a Utilization Management Physician regarding UM medical coverage policies and medical necessity decisions
- Milliman Care Guidelines are used by UM staff and physicians for review of inpatient and Behavioral Health inpatient and outpatient reviews.
- InterQual criteria are used by UM staff and physicians for outpatient procedures and rehabilitation, and review of inpatient skilled nursing facility and acute rehabilitation admission and continued stay, and home health services.
- Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD)
applicable for Medicare members and DME for commercial members are accessible through the Centers for Medicare and Medicaid Services (CMS) website.

- Community based or network providers have access to the Kaiser Permanente Medical Coverage Policies through the MAPMG website portal.
- Medical Coverage Policies, emerging technology, and regionally-based medical technology assessment reports are communicated internally through the KPMAS Clinical Library, HealthConnect® messaging capabilities and through regional emails.

If you would like to receive a hard copy of the criteria or Medical Coverage Policy or rule or protocol, please contact the Utilization Management Operations Center (UMOC) at 1-800-810-4766.

**Utilization Management Affirmation Statement for Health Plan staff and Practitioners**

The staff of the health plan (Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.) administer benefits, ensure compliance with laws and regulations, screen for quality of care, review how care and services are used, arrange for the member’s ongoing care, and help organize the many facets of their care.

Decisions made by the health plan about which care and services are provided are based on the member’s clinical needs, the appropriateness of the care and service, and health plan coverage.

The health plan 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 care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and service. 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.

**Accessibility of UM Operations**

Accessibility is important to our members and providers. The Kaiser Permanente Utilization Management Department ensures that all members and providers have access to UM staff, physicians and managers.

UM staff is available eight hours a day during normal business hours for inbound calls regarding UM issues. UM staff can receive inbound communication regarding UM issues after normal business hours and can send outbound communication regarding UM inquiries during normal business hours.

Communication with deaf, hard of hearing or speech-impaired members is handled through Telecommunications Device for the Deaf (TDD) or teletypewriter (TTY) services. TDD/TTY is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties.

Utilization Management Operations Center (UMOC) staff has a speed dial button on their phones to facilitate sending and receiving messages with the deaf, hearing or speech impaired. Additionally, a separate TDD/TTY line for deaf, hard of hearing, or speech impaired KPMAS member is available through Member Services. Members are informed of the access to TDD/TTY through the Member's ID card, the Member's evidence of coverage handbook, and the annual subscriber's notice. Non English speaking members may discuss UM related issues, requests and concerns through the KPMAS language assistance program offered by an interpreter, bilingual staff, or the language assistance line. UMOC staff has the Language Line programmed into their phones to enhance timely communication with non English speaking members. Language assistance services are provided to members free of charge. The table on the next page describes the access and hours of operations for UM services.
<table>
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<tr>
<th>UM Department section</th>
<th>Hours of operation</th>
<th>Core responsibilities</th>
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| Utilization Management Operations Center (UMOC): Emergency Care Management           | 24 hours/day, 7 days/week, including holidays                                                                   | • Receive inbound communication regarding UM issues after business hours  
• Process transfer requests for Members who need to be moved to a different level of care including emergency rooms, inpatient facilities, and Kaiser Permanente Medical Office Buildings  
• Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities or physicians  
• Facilitate Repatriation from Emergency room to Hospital  
• Assist with Repatriations from Hospital to Hospital  
• Support all cardiac transfers for level of care needed  
• Facilitate Behavioral Health admissions  
• Facilitate urgent/emergent ambulance transports |
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| Patient Care Coordinators (PCCs)                                                    | Monday to Friday, weekends and holidays, 8:30 a.m. to 5 p.m. | • Conduct concurrent review and transition care management  
  • Conduct repatriation of members to KP Hospitals with Medical Group Physicians and KPMAS on-site reviewers or contracted facilities  
  • Complete arrangements for placement of Members to lower level of care facilities when needed |
| Non Behavioral Health                                                                | Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding major holidays | • Conduct concurrent review and transition care management for members in the acute rehab and SNF settings |
| Onsite reviews conducted at the following hospitals:                                 | Monday to Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct concurrent review and transition care management services of Behavioral Health Service |
| • Holy Cross Hospital                                                                 | Monday to Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct Pre-service and concurrent review of Behavioral Health Outpatient services |
| • Washington Hospital Center                                                           | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members |
| • Children’s National Medical Center                                                   | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Screen Members for Home Health, Palliative Care or Hospice  
  • Coordinate acute rehab, SNF, Home Health referrals  
  • Arrange SNF to SNF transfers, LTC to SNF referrals, Community to SNF or Acute Rehab Placement |
| • Greater Baltimore Medical Center                                                     | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct concurrent review and transition care management for members in the acute rehab and SNF settings |
| • St. Agnes Hospital                                                                  | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct concurrent review and transition care management services of Behavioral Health Service |
| • Fairfax INOVA Hospital                                                               | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct Pre-service and concurrent review of Behavioral Health Outpatient services |
| • Virginia Hospital Center                                                             | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members |
| Skilled Nursing Facility (SNF) and Rehabilitation Services                           | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct concurrent review and transition care management for members in the acute rehab and SNF settings |
| UM Hospital Services – Behavioral Health                                             | Monday to Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct concurrent review and transition care management services of Behavioral Health Service |
| UM Outpatient Services – Behavioral Health                                            | Monday to Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct Pre-service and concurrent review of Behavioral Health Outpatient services |
| Complex Case Management                                                               | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members |
| Renal Case Management                                                                 | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Screen Members for Home Health, Palliative Care or Hospice  
  • Coordinate acute rehab, SNF, Home Health referrals  
  • Arrange SNF to SNF transfers, LTC to SNF referrals, Community to SNF or Acute Rehab Placement |
| Continuing Care Hub (Virtual Medical Office for SNF Rounders and Home Based Palliative Care Physicians) | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct concurrent review and transition care management for members in the acute rehab and SNF settings |
|                                                                                      | Monday to Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct concurrent review and transition care management services of Behavioral Health Service |
|                                                                                      | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct Pre-service and concurrent review of Behavioral Health Outpatient services |
|                                                                                      | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members |
|                                                                                      | Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays | • Screen Members for Home Health, Palliative Care or Hospice  
  • Coordinate acute rehab, SNF, Home Health referrals  
  • Arrange SNF to SNF transfers, LTC to SNF referrals, Community to SNF or Acute Rehab Placement |
Documentation of coordination of care with primary care physicians (PCPs)

Kaiser Permanente continues to be a leader in promoting the integration of behavioral and medical health care and views care coordination between Behavioral Health and Primary Care to be a critical aspect of treatment.

Behavioral Health providers are asked to obtain the member’s consent to communicate the following to the patient’s PCP within seven (7) days of the beginning of treatment:
- Date of initial service
- Patient’s diagnosis and brief assessment of their findings
- Treatment plan and recommendations
- Medications prescribed

If you are not sure how to contact the member’s PCP, you may mail or fax treatment information to the following address and we will make sure the PCP gets your report.

Kaiser Permanente
Regional HIMS
6526 Belcrest Road, Suite 207
Hyattsville, Maryland 20782
FAX: (301) 209-6065

Network practitioner terminations

Consultant agrees to provide Kaiser Permanente ninety (90) days written notice of termination date. In addition, the Consultant agrees to complete any active course of care to Members in active treatment for a chronic or acute medical condition or through the post partum period (for members in their second or third trimester of pregnancy). There must be a proper referral and the member must request in writing (addressed to Kaiser Permanente) to continue receiving Consultant Services for 90 days or through the active course of care (whichever is lesser) from Consultant. This does not apply in the event of termination for cause and/or if prohibited by applicable federal and/or state law. The Consultant agrees to assist Kaiser Permanente in identifying Members who have the right to continue receiving Consultant Services after the Agreement terminates, and Kaiser Permanente shall notify such Members of this right.

KPMAS members, who have pre-authorized care scheduled with a practitioner who terminates will be allowed to continue care with the practitioner if the appropriate UM physician determines that the same care cannot be provided by a contracted practitioner. Should the patient have continued care needs with terminating specialty care practitioner, they should contact their personal physician, to assist in coordinating this care.
Communicating PCM programs to practitioners

Kaiser Permanente Mid-Atlantic States (KPMAS) care management programs help you to monitor and manage your patients with chronic conditions. Members with diabetes, asthma, coronary artery disease, chronic kidney disease, hypertension, and/or depression are enrolled into care management programs through a registry.

These programs are designed to engage your patients to help care for themselves, better understand their condition(s), update them on new information about their disease, and help manage their disease with assistance from your health care team and the population care management department. This information and education is designed to reinforce your treatment plan for your patient.

Members in these programs receive mailings when they are initially identified as having one of these conditions and mailings and/or phone calls periodically thereafter, including care gap reminders. The mailings and additional multimedia resources introduce the programs and provide education on topics such as the latest information on managing their condition, physical activity, tobacco cessation, medication adherence, planning for visits and knowing what to expect, and coping with multiple diseases. You receive member-level information to help you manage your panel, and quality process and outcome information to help you improve your practice. In addition, you receive tools for you and your team, including posters and pocket cards; best practice alerts, smart sets, and health maintenance alerts within KP HealthConnect®; and direct patient management for our highest risk members by a Nurse Practitioner.

Your patients do not have to enroll in the programs; they are automatically identified into a registry. If you have patients who have not been identified for program inclusion, or who have been identified as having a condition but do not actually have the condition, you can "activate" or "inactivate" them from the program using the CarePOINT "Modify Population" Module or sending a KPHC staff message to the Population Care pool. Community providers who want to add or remove members from the program can send an e-mail to CarePOINT-MAS@kaiserpermanente.org with their contact information to receive a call back to garner the patient’s PHI. Or, call our message line anytime at (703) 536-1465 in the Washington Metro area or (410) 933-7739 in the Baltimore area. Members can choose not to participate or can self-enroll by calling our message line anytime at (703) 536-1465 in the Washington Metro area or (410) 933-7739 in the Baltimore area. For TTY access, dial 711.
Case management

The Case Management services of Kaiser Permanente Mid-Atlantic States strive to empower members to achieve the highest possible health outcomes by coordinating health care services across the continuum of care.

Our case managers provide members with the following types of assistance: coordination of care due to complex medical conditions, support related to a newly diagnosed medical problem, advice and referrals for a range of issues impacting one’s health care, as well as close monitoring of members who have experienced a recent increase in hospital admissions or urgent care visits. Also, proactive calls may be made by the case management team to remind members of important health screenings, talk about the gaps in care, or remind the member when it’s time to come in and see a practitioner for a health assessment.

KP HealthConnect® referrals should be made to case management using e-Consult and in accordance with the referral guidelines that are outlined therein. Practitioners without access to KP HealthConnect® may refer by calling the Self-Referral line 301-321-5126 or toll free at 1-866-223-2347 including the main reason for referral. Referrals will then be reviewed and directed to the most appropriate case management resource.

Please note that the Self-Referral phone line is available for any member who would like to be evaluated for enrollment in the Case Management program. The member or caregiver may call either the 301-321-5126 or the toll free number at 1-866-223-2347. A message will prompt the member or caregiver to state their name, phone number, and the Kaiser medical record number. Most importantly, please tell us the main reason why the member would like to have their very own case manager- It’s that easy! The member or caregiver will then be contacted by telephone within one to two business days to begin an enrollment process. Enrollment in any of the case management programs including the Complex Case Management is voluntary and may be discontinued by the member at any time.

Focus on EDI

Did you know you can receive payments deposited into your account within 48 hours of a check cycle? Kaiser Permanente now has Electronic Funds Transfer (EFT). The pre-requisites are as follows:

1. You must submit claims electronically
2. You must receive remittances electronically

There is no cost for EFT.

**Steps:**

1. If you have an EDI vendor, contact them and enable electronic remittances for Kaiser Foundation Health Plan of the Mid Atlantic States.

2. If you do not have an EDI vendor you may choose from one of our preferred EDI vendors:
   - Emdeon: www.emdeon.com
     Sales: 866-924-4634
   - Relay Health
     www.relayhealth.com
     Sales: 866-RELAY-ME (866.735.2963)
   - Capario
     www.capario.com
     Sales: 800-586-6870
   - Office Ally
     www.officeally.com
     Sales: 866-575-4120
   - RealMed Corporation
     www.RealMed.com
     Sales: 877-REALMED (877-732-5633)
   - Ingenix
     www.ingenix.com
     800-765-6713
3. Contact your provider relations representative for an EFT application. You may also download the EFT application at providers.kaiserpermanente.org/html/cpp_mas/forms.htm

4. Complete and forward EFT application to Provider Affairs for processing.
   Kaiser Permanente Provider Affairs
   EFT Coordinator
   2101 East Jefferson Street, 2 East
   Rockville, MD 20852
   877-806-7470

Are you utilizing Kaiser Permanente EDI Suite? Kaiser Permanente’s EDI suite is designed to save time and money and shorten your revenue cycle.

**Kaiser Permanente EDI Suite**

**Electronic claim submission (837)** – Send claims at the speed of light. Faster, cleaner submissions mean faster adjudication. Save time, postage and paper resources. Eco friendly option.

**Electronic remittance (835)** – Receive payment information at the speed of light. Save time with automatic posting of payments and paper resources. Eco friendly option.

**Automatic claim status notification (277U)** – Receive automatic claim status notification upon receipt then every 14 days until release. No more waiting on the phone for claim status information. Save time and money.

**Electronic funds transfer (EFT)** – Receive payments within 48 hours of a check cycle. No more lost checks, save paper and printing resources. Eco friendly option

**Medicare Crossover** – Medicare primary claims automatically forwarded to Kaiser Permanente for processing. No need to send secondary Medicare claims to Kaiser Mid Atlantic after 09/09/2011.

**Tip**

Some providers submit paper because they believe Kaiser requires the referral attached to the claim. We can reinforce our policy that the physical referral is not required and is stored electronically in our adjudication system and to send these claims electronically.

Contact your provider relations representative for additional information.
We encourage members to let us know about the excellent care they receive as a member of Kaiser Permanente or about any concerns or problems they have experienced. Member Services representatives are dedicated to answering questions about members’ health plan benefits, available services, and the facilities where they can receive care. For example, they can explain how to make members first medical appointment, what to do if members move or need care while traveling, or how to replace an ID card. They can also help members file a claim for emergency and urgent care services, both in and outside of our service area, or file an appeal. Also, members always have the right to file a compliment or complaint with Kaiser Permanente.

Member Assistance and Resource Specialists are available at most Kaiser Permanente medical office buildings administration offices, or members can call Member Services Monday through Friday, 7:30 a.m. to 5:30 p.m.
- Within the Washington, DC metro area, call 301-468-6000 (301-879-6380, TTY)
- Outside the Washington, DC metro area, call 1-800-777-7902 (toll free) (301-879-6380, TTY)

Written compliments or complaints should be sent to:
Kaiser Permanente Member Services
Correspondence Unit
2101 East Jefferson Street
Rockville, MD 20852

All complaints are investigated and resolved by a Member Services representative through coordinating with the appropriate departments.

Members have the right to file an appeal if they disagree with the health plan’s decision not to authorize medical services or drugs or not to pay for a claim.

**Medically urgent situations**

Expedited appeals are available for medically urgent situations. In these cases, call Member Services. An expedited external review may be requested at the same time as an internal review.

- Medicare Plus Plan members can call toll free: 1-888-777-5536 (1-866-513-0008, TTY) 8 a.m. to 8 p.m., 7 days a week.
Monday through Friday, 7:30 a.m. to 5:30 p.m.
• Within the Washington, DC metro area, call 301-468-6000 (301-879-6380, TTY)
• Outside the Washington, DC metro area, call 1-800-777-7902 (toll free) (301-879-6380, TTY)

After business hours, call an advice nurse
• Within the Washington, D.C., metro area, call 703-359-7878 (703-359-7616, TTY)
• Outside the Washington, D.C., metro area, call toll free: 1-800-777-7902. (1-800-700-4901, TTY)

Members must exhaust the internal appeal process before requesting an external review/appeal. However, an external review/appeal may be requested simultaneously with an expedited internal review/appeal when:
• services are denied based on experimental/investigational may be expedited with written notice by the treating physician that services would be less effective if not initiated promptly
• the denial involves medical necessity, appropriateness, healthcare setting, level of care, or effectiveness denials.
• the health plan fails to render a standard internal appeal determination within 30 (pre-service) or 60 (post-service) days and the member has not requested or agreed to a delay.

Members may also initiate an appeal for non-urgent services in writing. When doing so, please include:
• The member’s name and medical record number.
• A description of the service or claim that was denied.
• Why members believe the health plan should authorize the service or pay the claim.
• A copy of the denial notice members received.

Send members’ appeal to:
Kaiser Permanente Member Services
Appeals Unit
2101 East Jefferson Street
Rockville, MD 20852

Any member request will be acknowledged by an appeals analyst who will inform each member of any additional information that is needed and help obtain the information. The analyst will conduct research, and prepare the members’ request for review by the appeals/grievances committee. The analyst will also inform the member of the health plan’s decision regarding the members’ appeal/grievance request along with any additional levels of review available to members. Detailed information on procedures for sharing compliments and complaints or for filing an appeal/grievance is provided in the members’ Evidence of Coverage.

Other assistance
We are committed to ensuring that member concerns are fairly and properly heard and resolved. Members have the right to contact one of the following regulatory agencies to file a complaint about care or services that they believe have not been satisfactorily addressed by the health plan.

In Maryland
• Health Education and Advocacy Unit
  Consumer Protection Division
  Office of the Attorney General
  200 St. Paul Place
  Baltimore, MD 21202
  1-877-261-8807 (toll free)
  Web: www.oag.state.md.us
  E-mail: consumer@oag.state.md.us
• Maryland Insurance Administration
  Appeals and Grievance Unit
  200 St. Paul Place, Suite 2700
  Baltimore, MD 21202
  410-468-2000, 800-492-6116 (toll free)
  1-800-735-2258 (toll free TTY)
  410-468-2270 or 410-468-2260 (fax)
  Web: www.mdinsurance.state.md.us

In Virginia
• Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  1-877-310-6560 (toll free)
  804-371-9032 (Richmond metropolitan area)
  Web: state.va.uswww.scc.virginia.gov/division/boi/webpages/boiombudman.asp
  E-mail: ombudsman@scc.virginia.gov
• State Corporation Commission
  Bureau of Insurance, Life and Health Division
  P.O. Box 1157
  Richmond, VA 23218
  804-371-9691, 1-800-552-7945 (toll free)
  TDD 804-371-9206
  Web: www.scc.virginia.gov

• The Office of Licensure and Certification
  Department of Health
  9960 Mayland Drive, Suite 401
  Richmond, VA 23233-1463
  804-367-2106, 1-800-955-1819 (toll free)
  804-527-4503 (fax)
  Web: www.vdh.state.va.us/olc/
  E-mail: mchip@vdh.virginia.gov

In the District of Columbia
• Grievance and Appeals Coordinator
  Office of the General Counsel
  District of Columbia Department of Health
  899 North Capitol St., NE
  4th Floor, Suite 4119
  Washington, D.C. 20002
  202-442-5979
  202-442-4797 (fax)
  Web: www.dchealth.dc.gov

For federal employees
• United States Office of Personnel Management
  Insurance Services Programs
  Health Insurance Group 3
  1900 E St., NW
  Washington, D.C. 20415-3630
  202-606-0755
  Web: www.opm.gov

How to contact us
Member Services — Practitioners, providers or members can speak with a Member Services representative if assistance is needed with, or have questions about, the health plan or specific benefits. A Member Services representative is available Monday through Friday, 7:30 a.m. to 5:30 p.m.
• Within the Washington, D.C., metro area, call 301-468-6000 (301-879-6380, TTY)
• Outside the Washington, D.C., metro area, call toll free: 1-800-777-7902 (1-800-700-4901, TTY)
• Medicare Plus Plan members can call toll free: 1-888-777-5536 (1-866-513-0008, TTY) 8 a.m. to 8 p.m., 7 days a week.

Provider directories
Our provider directories are online at members.kaiserpermanente.org/kpweb/medicalstaffdir/entrypage.do, divided by region. You can also request a printed directory by calling Member Services.
Quality program information

At Kaiser Permanente, we are committed to providing quality, cost effective health care. Our physicians and managers work together to improve care, service, and the overall performance of our organization. We participate in a number of independent reports on quality of care and service so that members have reliable information about the quality of care we deliver, as well as a method for comparing our performance to other health plans in the region.

The quality reporting organizations we participate with are:

- The National Committee for Quality Assurance (NCQA) for health plan accreditation status.
- Health Plan Employer Data and Information Set (HEDIS) for clinical effectiveness of care measures of performance.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey to measure health plan member satisfaction.

KPMAS has maintained an “Excellent Accreditation” from 2004 to 2012 from the National Committee for Quality Assurance (NCQA), the highest award given for service and clinical quality. This award is only given to organizations that meet or exceed NCQA’s rigorous requirements for consumer protection and quality improvement. To see the complete report, visit ncqa.org.

The NCQA is the nation’s leading watchdog for managed care organizations. To find out more about the quality program, request a copy of the quality program or information including a report of our progress toward quality improvement goals from a Member Services representative between Monday through Friday, 7:30 a.m. to 5:30 p.m.

- Within the Washington, DC metro area, call 301-468-6000 (301-879-6380, TTY)
- Outside the Washington, DC metro area, call 1-800-777-7902 (toll free) (301-879-6380, TTY)

Medicare Plus Plan members can call toll free: 1-888-777-5536 (1-866-513-0008, TTY) 8 a.m. to 8 p.m., 7 days a week.