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 at 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 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 providers.kp.org/mas or contact Provider Relations at 1 (877) 806-7470 for assistance.
Pharmacy updates:
drug formulary management

The Kaiser Permanente Mid-Atlantic States (KPMAS) has multiple drug formularies to promote rational, safe and cost-effective drug use for our Commercial, Medicare, Medicaid and Exchange members.

Each drug formulary is a list of preferred drugs approved for use by the KPMAS Regional Pharmacy and Therapeutics (P&T) Committee. The KPMAS 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.

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*Based on State Regulations, the Medicaid formularies will also include specific legend drugs and specific over-the-counter (OTC) items; DHMH = Department of Health and Mental Hygiene.
The KPMAS P&T Committee is comprised of physicians from primary care and specialty departments, pharmacists, and representatives from nursing and quality departments who review objective, evidence-based evaluations for the purpose of adding and/or deleting drugs from the drug formulary (preferred drug list).

The KPMAS P&T Committee promotes the use of generic drugs 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 and therapeutically equivalent generic drug becomes available, the generic drug is added to the drug formulary without KPMAS P&T Committee review if the brand name drug is already on the drug formulary and has been reviewed in the past. The corresponding brand name drug is deleted from the drug formulary after review and approval by the KPMAS P&T Committee. Selected generic drugs such as hormonal therapy, narrow therapeutic index drugs, or non-formulary drugs may require a formal review by the KPMAS P&T Committee before they are added to the drug formulary.

**Therapeutic conversions**

Periodically a list of drugs with potential for significant member and organizational cost savings is targeted for therapeutic conversion. The KPMAS Clinical Pharmacy Team, in collaboration with the MAPMG Physician Director of P&T Drug Utilization Management, develops a standard process for therapeutic conversion for these agents.

This process assures proper communication, implementation, and education of healthcare providers, 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 asked to call the pharmacy to have the prescription filled when they are ready.

If the member does not agree to the therapeutic conversion, has an allergy or adverse reaction to the preferred drug, or the preferred product is ineffective for the member’s treatment, a note is placed in the member’s electronic medical record (EMR) so that the issue of the therapeutic conversion is not revisited.

Members who are converted to a new drug will be counseled by the dispensing pharmacist and provided patient education at the time of drug pick-up.

**KPMAS formulary review (addition/deletion)**

The drug formularies for each line of business and their corresponding pharmaceutical management processes are reviewed at least annually.

The KPMAS drug formularies are dynamic and updated regularly (monthly) with any additions and/or deletions approved by the KPMAS P&T Committee. Any FDA-approved drug may be evaluated for drug formulary addition or deletion, and any physician or member may request a review of a drug.

In order to request that a drug be reviewed by the KPMAS P&T Committee, a drug Addition/Deletion request form is completed by the requestor and forwarded to the Co-Chairs of the KPMAS P&T 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 on the KPMAS intranet for MAPMG providers, and from the Community Provider portal for affiliated providers.
Based upon the KPMAS P&T Committee review, a drug or biological will be classified into an appropriate category:

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

B. **Formulary drug with Criteria or Guidelines (FC)** - A formulary drug that includes specific criteria for prescribing and/or dispensing. Prescribers may prescribe these drugs as long as criteria are met, and the specific criteria are documented in the medical record. Criteria must be measurable and operationally practical.

C. **Formulary drug with Restrictions (FR)** - A formulary drug with prescribing restricted to specific prescribers, e.g. specialty departments.

D. **Non-formulary drug (NF)** - A drug not officially accepted for inclusion into the drug formulary. This includes: drugs that have been reviewed but not accepted to the drug formulary; new drugs not yet reviewed for addition to the drug formulary; a brand, strength, or dosage form of a drug not approved for addition to the formulary.

E. **Non-formulary drug with Criteria or Guidelines (NFC)** - A drug that has not been accepted to the formulary, though drug rider coverage for this drug meets specific criteria for use. The specific criteria are documented on the prescription.

F. **Non-formulary drug with Restrictions (NFR)** - A drug that has been reviewed, but not accepted into the formulary. Drug rider coverage for this drug meets specific restrictions for use when prescriptions are written by or are written in consultation with the specific prescribers, e.g. specialty, departments.

Affiliated providers can keep current with drugs on all KPMAS drug formularies by visiting the affiliated provider website and MAPMG providers can search all KPMAS formularies via the intranet.

A printed copy of each drug formulary is available upon request from the Provider Relations department at 1-877-806-7470, via the affiliated provider website or via the intranet for MAPMG providers.
Quantity limits or quotas
The KPMAS P&T Committee may set quantity or refill limits for drugs in the following circumstances:
• medication safety concerns;
• potential for waste or diversion associated with high cost; or
• drug shortage situations.

These limits will be reviewed annually or as appropriate, such as in the setting of a drug shortage.

The drug formulary also lists drugs for which quantity limits apply as described in the Evidence of Coverage. Drugs with established quantity limits are marked with abbreviation “QL” in the drug formulary list.

Prior authorization and exclusions to the formulary
For VA Medicaid and FAMIS formularies, the following drug classes will have a Prior Authorization (PA). The criteria for the PA will be reviewed at least annually by KPMAS P&T Committee:
• Agents when used for weight loss; and
• Agents when used as growth hormones.

For MD HealthChoice formulary, the following drug class will have a Prior Authorization (PA). The criteria for the PA will be reviewed at least annually by KPMAS P&T Committee:
• Agents when used as growth hormones.

The following are excluded from the VA Medicaid, VA FAMIS and MD HealthChoice formularies:
• Agents when used to promote fertility;
• Agents when used for cosmetic purposes or hair growth; and
• Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the FDA.

Formulary changes and drug updates
The KPMAS P&T Committee publishes drug formulary decisions for all lines of business to ensure that health care providers are kept informed with the most recent updates to each drug formulary. These updates are published monthly on the affiliated provider website and the MAPMG intranet.

A printed copy of each drug formulary is available upon request from the Provider Relations department at 1-877-806-7470, via the affiliated provider website or via the intranet for MAPMG providers.

Non-formulary exceptions process
The non-formulary exceptions process provides providers and members with access to non-formulary drugs and facilitates prescription drug coverage of medically necessary, non-formulary drugs as determined by the prescribing provider.

Members can obtain a non-formulary drug outside of the exception process at any time by paying full price for the drug, when the prescribing provider deems it is not medically necessary and not harmful, but agrees to prescribe based on patient demand.
Please note that Medicare members can request a tiering exception and Exchange members have an open formulary.

**Highlights of the non-formulary exceptions 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 provider makes the final decision regarding what drug is appropriate for the member. If the appropriate drug is not on the drug formulary and is deemed medically necessary by the provider, 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 an affiliated (network) provider prescribes 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 a non-formulary exception reason in order for the same documentation to take place. This allows Kaiser Permanente to track the use of non-formulary agents and decide whether they should be re-evaluated for drug formulary inclusion.

Some reasons why a provider may grant an exception to the formulary include:

- allergy/adverse reaction to formulary product; or
- treatment failure to a formulary drug.

Once the provider chooses a non-formulary exception reason, the prescription will be covered at the appropriate co-payment.

If the provider determines that the non-formulary drug is not medically necessary, the provider will discuss the available formulary alternatives with the member. If the member insists on the non-formulary
drug but an appropriate formulary alternative is available, the provider may still prescribe the non-formulary drug and document appropriately:

a. The provider will document the non-formulary drug as a patient request/demand, although not medically necessary. The drug will not be covered under the pharmacy benefit.

b. The member will pay full price for the drug if a non-formulary drug is not ordered through KP HealthConnect, there is no exception reason documented, and the member presents to a Kaiser Permanente pharmacy to fill the prescription. In this case, the following steps will occur:

1. The pharmacist will contact the prescribing provider to discuss a formulary alternative or obtain the non-formulary exception reason.
2. If an appropriate non-formulary exception reason is obtained, the appropriate co-pay will be applied.
3. If a non-formulary exception reason is not obtained, then the member may get the non-formulary drug filled by paying full price for the drug.
4. The member may request a review of their case through Member Services.

If the provider prescribes a non-formulary drug requested by a patient with the 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;
• Receive the non-formulary drug and pay the standard retail price;
• Contact KPMAS Member Services at 1-877-218-7750 and request a non-formulary exception review.

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

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.

**Websites to bookmark**

MAPMG providers:

- KPMAS Drug Formularies (all lines of business)
  » pithelp.co.kp.org/MAS/formulary.html
- Drug Formulary Addition and Deletion Request Form:
  » pithelp.co.kp.org/MAS/documents/phcy_therapeutics/DrugFormularyAdditionAndDeletionRequestForm.pdf

Affiliated Providers via the Community Provider Portal:

- KPMAS Drug Formularies (all lines of business) including a request for a printed copy
  » providers.kaiserpermanente.org/html/cpp_mas/formulary.html?
- Drug Formulary Addition and Deletion Request Form
  » providers.kaiserpermanente.org/html/cpp_mas/formulary.html?
- General Information on Members’ Prescription Co-payment and Coinsurance
  » providers.kaiserpermanente.org/mas/providertools.html

* You will be asked to sign in with your user ID and password to access the co-payment and coinsurance information.
* If you do not have access to KP HealthConnect AffiliateLink and would like to gain access, please contact provider relations at 1-877-806-7470 Monday through Friday, 9 a.m. to 5 p.m., EST for assistance.
Medicare Part D drug formulary and tiering exception process

The Kaiser Permanente Medicare Prescription Drug Benefit design for Direct Pay Medicare Part D members (approximately 50% of Kaiser Permanente’s Medicare population) is based on a tiered cost-sharing structure for pharmacy benefits.

Each Part D drug on the drug formulary is assigned a drug tier or level. Below lists the drug tiers for Direct Pay Medicare Part D members:

- **Tier 1** — Preferred generic drugs (select chronic condition drugs)
- **Tier 2** — Non-preferred generic drugs (all other generics)
- **Tier 3** — Preferred brand-name drugs
- **Tier 4** — Non-preferred brand-name drugs (all other brands)
- **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.

A tiering exception applies to drugs in the non-preferred generic brand tier (Tier 2) and 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 generic drug in Tier 2 to be placed into the preferred generic drug tier (i.e., Tier 1) at the lower Tier 1 preferred generic copay;
- The request must be for a brand drug in Tier 4 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; or
- At least one other drug in the same class is available on the preferred tier.

Medicare Part D members cannot ask for tiering exceptions for Tier 3 or Tier 5 drugs.

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 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 the Kaiser Permanente Pharmacy Benefit Prior Authorization Help Desk Pharmacist. 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 drugs 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.
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
  » Medicare or Medicaid sanctions, or any investigation for a federal healthcare program
  » Medical malpractice action
• 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
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 a telephonic interpreter.
- **Translation services.** Some member materials are available in the member’s preferred language.
- **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.
- **Braille or large print.** Blind or vision impaired members can request for documents in Braille or large print or in audio format.
- **Telecommunications Relay Service (TRS).** If members are deaf, hard of hearing, or speech impaired, we have the Telecommunications Relay Service (TRS) access numbers that they can use to make an appointment or talk with an advice nurse or member services representative or with you.
- **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.** Health education materials can be made available in languages other than English by request. To access Spanish language information and many educational resources go to kp.org/espanol or kp.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 Kaiser Permanente 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.

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

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.
CLAS standards

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Principal standard
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, leadership, and workforce
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and language assistance
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, continuous improvement, and accountability
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Note: The standards are organized by four themes.
• Principal Standard
• Governance, Leadership and Workforce (Standards 2-4)
• Communication and Language Assistance (Standards 5-8)
• Engagement, Continuous Improvement and Accountability (Standard 9-15)

U.S. Department of Health & Human Services, Office of Minority Health (OMH).
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.
Privacy and security

Distribution errors can have serious consequences

Every day we use email, for both business reasons and personal use. It’s become such a part of our regular routine that we don’t give it much thought. But when we stop paying attention we can make mistakes, and some mistakes can have serious consequences.

For example, your email system may automatically populate the “To” field after you type in just a few letters. Have you ever hit “Send” only to realize you just sent something to a perfect stranger – or an entire distribution list of strangers? If the contents are sensitive or private – or contain Protected Health Information (PHI), this is more than an “oops” moment.

When you forward or reply to an email that contains PHI, always consider whether or not the recipients need that information to do their job. If not, consider creating a new message that only contains the information needed by the recipients, or if you forward or reply to an email with an attachment that contains PHI, delete the attachment before sending the response if the recipients do not need that information to do their job.

Whenever you need to send anything sensitive, proprietary or non-public information, always encrypt. But encryption is no magic bullet. Encryption protects the information in transit, but if you send the email to the wrong recipient, that recipient will still be able to decrypt it.

Under HIPAA, whenever PHI is sent or handed to the wrong individual, it is considered an impermissible disclosure. Besides the email errors described above, other examples of impermissible disclosures include:

• handing a prescription, after-visit summary, pre-op instructions, or discharge instructions to the wrong individual;
• faxing to the wrong number;
• mailing information intended for two different individuals in one envelope;
• mailing information to the wrong address (if it is opened);
• leaving a detailed message on the wrong patient’s answering machine; and
• sending patient secure messages to the wrong patient, or when it contains another patient’s information.

If you are responsible for or become aware of a distribution error, report it to your manager or compliance office immediately for investigation and analysis. Under HIPAA, such distribution errors could require you to notify the affected individual and/or a federal or state regulatory agency.

There are several things you can do to prevent distributions errors:

• Reviewing distribution lists prior to hitting “send.”
• Checking and double checking documents prior to handing them over or placing them in an envelope, to make sure the right documents are going to the intended recipient.
• Confirming and checking fax numbers prior to sending.
• Reviewing information to be disclosed to ensure that the disclosure includes only the PHI needed for the intended purpose (e.g. if a report includes MRNs, do you also need to include patient names).

Think about all of the resources involved in investigating and correcting this one mistake – and think before you act.
Member rights and responsibilities

As a member of Kaiser Permanente you have the right to:

1. Receive information that empowers you to be involved in health care decision making. This includes your right to:
   a. Actively participate in discussions and decisions regarding your health care options.
   b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are.
   c. Receive relevant information and education that helps promote your safety in the course of treatment.
   d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.
   e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
   f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time.
   g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
   h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your authorized representative will be asked to provide written permission before your records are released, unless otherwise permitted by law.

2. Receive information about Kaiser Permanente and your plan. This includes your right to:
   a. Receive information in languages other than English, in large print or other alternative formats.
   b. Receive the information you need to choose or change your Primary Care Physician, including the name, professional level, and credentials of the doctors assisting or treating you.
   c. Receive information about Kaiser Permanente, our services, our practitioners and providers, and the rights and responsibilities you have as a member. You also can make recommendations regarding Kaiser Permanente’s member rights and responsibility policies.
   d. Receive information about financial arrangements with physicians that could affect the use of services you might need.
   e. Receive emergency services or Part D drug when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
f. Receive covered urgently needed services when traveling outside Kaiser Permanente’s service area.

g. Receive information about what services are covered and what you will have to pay and to examine an explanation of any bills for services that are not covered.

h. File a complaint, grievance or appeal about Kaiser Permanente, Part D drug or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.

3. Receive professional care and service. This includes your right to:

a. See plan providers, get covered health care services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.

b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.

c. Be treated with respect and dignity.

d. Request that a staff member be present as a chaperone during medical appointments or tests.

e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status including any mental or physical disability you may have.

f. Request interpreter services in your primary language at no charge.

g. Receive health care in facilities that are environmentally safe and accessible to all.

c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.

d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals.

e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.

f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.

3. Know and understand your plan and benefits:

a. Read about your health care benefits and become familiar with them. Detailed information about your plan, benefits and covered services is available in your Evidence of Coverage. Call us when you have questions or concerns.

b. Pay your plan premiums and bring payment with you when your visit requires a copayment, coinsurance or deductible.

c. Let us know if you have any questions, concerns, problems or suggestions.

d. Inform us if you have any other health insurance or prescription drug coverage.

e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our plan.

3. Promote respect and safety for others:

a. Extend the same courtesy and respect to others that you expect when seeking health care services.

b. Assure a safe environment for other members, staff, and physicians by not threatening or harming others.
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 utilization 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 free of charge
- 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 8:30 a.m. to 5 p.m., 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, Durable Medical Equipment (DME), prosthetics and orthotics, ambulance transportation for all Medicare beneficiaries. For Commercial members, UM uses Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD) and MCP’s for Durable Medical Equipment (DME) and for prosthetics and orthotics.

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 free of charge, or to reach a Utilization Management Physician regarding UM medical coverage policies and medical necessity decisions.
- MCG Guidelines, formerly called Milliman Care Guidelines, are used by UM staff and physicians for review of both Non-Behavioral Health and Behavioral Health inpatient and outpatient admission and continued stay, outpatient procedures and outpatient rehabilitation, 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. National Transplant Network services Selection criteria and InterQual criteria for transplant and hematology/oncology is used for transplant services. Copies of these criteria can be obtained free of charge by calling UMOC at 1-800-810-4766.
- Community based or network providers have access to the Kaiser Permanente Medical Coverage Policies through the Community Provider 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 free of charge, 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.

Kaiser Permanente practitioners and health plan professionals make decisions about which care and services are provided are based on the member’s clinical needs, the appropriateness of the care and service, and the existence of health plan coverage.

Kaiser Permanente does not make decisions regarding hiring, promoting or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. The health plan does not specifically reward, hire, promote or terminate practitioners or other individuals for issuing denials of coverage, or benefits, or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and services or result in underutilization. In order to maintain and improve the health of our members, all practitioners and health professionals should be especially diligent in identifying any potential underutilization of care or service.

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 collect or toll-free calls regarding UM issues. UM staff can receive inbound communication regarding UM issues after normal business hours through UMOC telephonic toll free number, UMOC facsimile, or Kaiser Permanente Health Connect messaging system, and can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. Staff is identified by name, title and organization name when they initiate or return calls regarding UM issues.

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>
<thead>
<tr>
<th>UM services</th>
<th>Hours of operation</th>
<th>Core responsibilities</th>
</tr>
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<tbody>
<tr>
<td>Emergency Care Management - Clinical Call Center</td>
<td>24 hours/day, 7 days/week, including holidays</td>
<td>• 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</td>
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<td></td>
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<td>• Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities</td>
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<td></td>
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<td>• Assist with Repatriations from Hospital to Hospital</td>
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<td>• Support all cardiac transfers for level of care needed</td>
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<tr>
<td>Outpatient Services: Utilization Management Operations Center - Specialty Referrals and Clinical Research Trials</td>
<td>Monday through Friday, 8 a.m. to 5 p.m.; weekends and holidays: 11 a.m. to 1 p.m. for urgent and emergent referrals only</td>
<td>• Conduct pre-service review of outpatient or inpatient services to include clinical trials</td>
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<tr>
<td></td>
<td></td>
<td>• Weekends and holidays pre-service review of urgent/emergent referrals except clinical research trials</td>
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<tr>
<td>Durable Medical Equipment (DME), Home Care, Rehabilitative Therapy Utilization Management Operations Center</td>
<td>Monday through Friday, 8:30 a.m. to 5 p.m., weekends and holidays: 11 a.m. to 1 p.m., for urgent referrals</td>
<td>• Conduct pre-service and concurrent review of Home Care, Durable Medical Equipment, Physical Therapy, Occupational Therapy and Speech Therapy, and post-service review provided to Kaiser members outside a Kaiser medical facility</td>
</tr>
<tr>
<td>UM Hospital Services - Non Behavioral Health</td>
<td>Monday through Friday, weekends and holidays, 8:30 a.m. to 5:00 p.m.</td>
<td>• Conduct concurrent review and transition care management</td>
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<tr>
<td>Skilled Nursing Facility (SNF) and Rehabilitation Services</td>
<td>Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays</td>
<td>• Conduct concurrent review and transition care management for members in the acute rehab and SNF settings</td>
</tr>
<tr>
<td>UM Hospital Services – Behavioral Health</td>
<td>Monday through Friday, weekends and holidays, 8:00 a.m. to 4:30 p.m., excluding major holidays</td>
<td>• Conduct concurrent review and transition care management services of behavioral health service</td>
</tr>
<tr>
<td>UM Outpatient Services – Behavioral Health</td>
<td>Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays</td>
<td>• Conduct Pre-service and concurrent review of behavioral health outpatient services</td>
</tr>
<tr>
<td>CareConnect/Complex Case Management</td>
<td>Monday through Friday, 8:30 a.m. to 5 p.m., excluding major holidays</td>
<td>• Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members</td>
</tr>
<tr>
<td>Renal Case Management</td>
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</tr>
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</table>
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.
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: 1-866-924-4634
   - Relay Health
     www.relayhealth.com
     Sales: 1-866-RELAY-ME (1-866.735.2963)
   - Capario
     www.capario.com
     Sales: 1-800-586-6870
   - Office Ally
     www.officeally.com
     Sales: 1-866-575-4120
   - RealMed Corporation
     www.RealMed.com
     Sales: 1-877-REALMED (877-732-5633)
   - Ingenix
     www.ingenix.com
     1-800-765-6713

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.html.

4. Complete and forward EFT application to Provider Affairs for processing to:

   Kaiser Permanente
   Provider Affairs EFT Coordinator
   2101 East Jefferson Street, 2 East
   Rockville, MD 20852
   1-877-806-7470

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.
Member complaint procedures

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.
- 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.

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, 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 toll free 1-800-777-7904 (TTY 711).

After business hours, call an advice nurse
- Within the Washington, D.C., metro area, call (703) 359-7878, (703) 359-7878 (TTY 711).
- 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, 1-800-492-6116 (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: www.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**
- Department of HealthCare Finance
  Office of the Health Care Ombudsman and Bill of Rights
  899 North Capital Street, N.E., 6th Floor
  Washington, DC 20002
  (202) 724-7491,
  (202) 535-1216 (fax)
  www.healthcareombudsman.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.
- 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.
Quality program information

Our vision at Kaiser Permanente is to be a leader in total health by making lives better. Learn more about how we:
- evaluate the quality of care you will receive as a Kaiser Permanente member,
- take steps to ensure the safety of our members,
- protect your privacy and prevent fraud, and
- make it easy for you to report quality and safety concerns.

QI Program

The QI Program defines the processes that are measured and monitored. Major plan components include processes involved with quality outcomes, patient safety and service as it pertains to access, availability and satisfaction. The scope of service also includes any and all regulatory requirements. KPMAS has determined that areas in which our members receive care and service should be monitored and evaluated for opportunities for improvement. These areas include (but are not limited to):
- credentialing/recredentialing,
- satisfaction survey,
- complaints and appeals,
- hospitals,
- urgent care centers,
- ambulatory services,
- ambulatory surgery centers,
- hospices,
- skilled nursing facilities, and
- drug and alcohol dependency facilities.

The areas listed encompass the care and services delivered by our network practitioners and providers. Network providers of care to our
members include primary care providers and specialists. Behavioral health providers are fully integrated into the QI process.

QI Program resources

Data sources may include claims data, medical record data, patient complaints (grievances), case management reports, pharmacy data, satisfaction surveys and QI projects.

Research analysts, quality program staff and Information System (IS) staff may use data elements to develop a reporting format that is reviewed and evaluated by the QI Committee.

The QI Committee uses data to make recommendations for interventions aimed towards improvement.

Any member-specific or provider-specific data is considered confidential and treated according to KPMAS policy. These policies are fully congruent with HIPAA regulations. The appropriate sources receive feedback with findings, conclusions and recommendations.

The QI Program staff prepares a yearly evaluation of the program and presents it to the QI Committee for review. The following year’s program is built from this evaluation.

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 you 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 that we participate with includes:

- Accreditation Association for Ambulatory Health Care (AAAHC) for Ambulatory Surgery Centers in the KPMAS facilities,
- National Committee for Quality Assurance (NCQA) for health plan accreditation status,
- Healthcare Effectiveness Data and Information Set (HEDIS) for clinical effectiveness of care and measures of performance, and
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure health plan member satisfaction.

Kaiser Permanente has maintained an “Excellent Accreditation” from 2004 to 2016 for Commercial and Medicare health plan products 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 or request a copy of the quality program or information, including a report of our progress toward quality improvement goals, call Member Services.
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.
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)
- American Osteopathic Association (AOA) Directory of Osteopathic Physicians
- American Board of Oral and Maxillofacial Surgeons
- American Midwifery Certification Board
- ANCC Certification for Nurse Practitioners
- NCCPA Certification for Physician Assistants
- Pediatric Nursing Certification Board
- American Academy of Nurse Practitioners
- American Association of Nurse Anesthetists

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.

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.
Provider access to health education materials

KP physicians and network providers have access to all health education materials to provide to patients as part of After Visit Summary or to supplement discussion from patient visit.

- MAPMG physicians can view materials through a centralized internal “clinical library” with electronic inventory of health education materials that can be used for all visit types. Health education content is also embedded into KP HealthConnect for inclusion in member After Visit Summary or sent via secure messaging. For health education programs, providers can:
  » refer or direct book members into health education programs through eConsult system, and
  » provide members with information on how to self-register through KP HealthConnect After Visit Summary or hard copy flyers.
- Network providers can access the physician network portal to download and print health education materials. Participating providers receive information about health education programs through Network News.

Additional information on health education programs, tools, and resources is available by:
- visiting Kp.org/healthyliving, or
- contacting the Health Education automated line (301) 816-6565 or 1-800-444-6696 (toll free).

Provider and practitioner satisfaction survey

August to September 2014, the Kaiser Permanente Provider and Practitioner Satisfaction: Continuity of Care/Utilization Management survey will be accessible online at these links:
- Primary care practitioners: kp.qualtrics.com/SE/?SID=SV_ea3p7NUw5H5w4Qt
- Specialty care practitioners: kp.qualtrics.com/SE/?SID=SV_eKf6HLGvLhQ5iX

Please copy and paste this link to your browser and respond to the two simple questions about your perception of the patient transition and utilization services you use. Or, you can find the link in the August 2014 Newsletter: providers.kaiserpermanente.org/mas/newsletters.html

Note: Your responses remain completely anonymous.