Kaiser Permanente is listening!

The Provider Relations Department at Kaiser Permanente strives to provide the highest level of customer service to our network providers. To ensure we are meeting the goals and expectations of our customers, we will be rolling out two specific provider-focused satisfaction surveys. Kaiser Permanente and the provider relations department relies on accurate responses and everyone’s input to assess and improve the products and services to participating providers in the community. Specifics regarding each survey are as follows:

SURVEY 1 – Participating provider satisfaction survey
Through this survey, you can help us evaluate practitioner and provider end-to-end operational, health plan, and care coordination satisfaction with Kaiser Permanente. You will have the opportunity to share your opinions of Kaiser Permanente as a health plan and as a provider in five key areas of contracting, outreach & education, claims, provider inquiries, and medical review & care coordination. The anticipated delivery date to our provider network is June 30th 2009; your participation would be greatly appreciated.

SURVEY 2 -- Kaiser Permanente HealthConnect AffiliateLink survey and the community provider website
By July 15, 2009, the 700+ provider groups enrolled in the Kaiser Permanente Online AffiliateLink will be receiving this survey instrument evaluating the provider end-user’s overall satisfaction in using AffiliateLink and the provider website.
For those who are unfamiliar with this online provider tool, “AffiliateLink” features allow Kaiser Permanente providers and medical staff to: review member demographics, verify insurance coverage, view benefit information, view a member’s clinical information, review and create referrals, and bridge time-sensitive communications with Kaiser Permanente. For any further questions regarding this tool or enrollment questions, please visit our provider website at www.providers.kp.org/mas or call the Provider Relations helpline at 1 (877) 806-7470. Your office manager or staff in the billing department might be the appropriate staff to complete these surveys. Please note that the surveys are 100% anonymous. We know that your time is valuable and greatly appreciate your willingness to participate in these very important studies to assess your satisfaction with Kaiser Permanente. If you have any questions or concerns, please call the provider relations helpline at 1 (877) 806-7470.

Kaiser Permanente Medical Financial Assistance (MFA) program

If Medicare members do not qualify for “extra help”, they may apply for MFA. Certain income and asset requirements must be met. Members must apply for Member Financial Assistance by contacting member services who can order the application form via the “Order Publication weblink” in Resource Central. Members must complete the application which is processed by Patient Financial Services. If the member application is accepted, then an award letter is sent to the member. The member must utilize a KP Medical Center and must present the original “embossed” MFA Award letter and ID to receive financial assistance for service. For help or information, please call Member Services at 1-888-777-5536 and TTY for 1-866-513-0008.

For additional questions about the Medicare Part D changes for 2009, contact your membership services at 301-468-6000.

Note: If a member receives “extra help” paying drug costs, there won’t be a coverage gap and the member will pay a small or no co-payment once catastrophic coverage is reached.
Managing ambulance resources in the mid atlantic states

How on-scene time affects ambulance resources?
Kaiser Permanente and American Medical Response have been working closely over the past several years to improve the availability and responsiveness of ambulance transportation. There are two committees tasked with monitoring the quality of ambulance transportation service and ensuring that the appropriate ambulances are available to meet the needs of Kaiser Permanente members. The National Joint Steering Committee (NJSC) and the Local Joint Steering Committee (LJSC) are comprised of representatives of both organizations. The National Joint Steering Committee provides strategic direction and guidance of the National Medical Transportation Agreement between AMR and Kaiser Permanente. The Local Joint Steering Committee oversees the conduct of ambulance services in the Mid Atlantic service area. The LJSC is comprised of members from various Kaiser Permanente departments including Provider Contracting, Utilization Management, Medical Leadership and Executive Leadership. AMR representation includes Account and Network Management, Operations, Division and National Executive Leadership. The LJSC monitors a number of performance matrices including compliance to the standards established for ambulance vehicle response times, telephone performance, protocols compliance and the clinical quality of services being provided to Kaiser Permanente members. Over the coming months the Local Joint Steering Committee will be publishing a series of newsletters in an effort to improve the overall performance of Ambulance services in the Mid Atlantic service area. The newsletters will cover a range of topics from changes in federal regulations affecting ambulance services, ambulance paperwork requirements, medical necessity requirements, physician medical necessity (PCS) requirements and Vehicle Response Time (VRT) expectations. This month’s topic, Reducing Ambulance On Scene Times (OST), will highlight a few of the problem areas that contribute to extended on-scene times and what steps we can take to help reduce that number and increase the availability of ambulance resources.

Ambulance on-scene times
How does ambulance on-scene time (OST) affect ambulance availability and response times?
Ambulance OST is the measurement taken from the time an ambulance arrives at the facility until the ambulance begins transporting a patient to their destination. In most cases the time should average between 20 and 30 minutes. The LJSC has reviewed the last six months of ambulance transportation data in the Mid Atlantic States and determined that in a number of cases the OST has averaged in excess of 45 minutes. This can and does have an adverse impact on the availability of the ambulances in the network that services Kaiser Permanente members by unnecessarily delaying an ambulance on scene and extending their total time on task.

How can I impact the ambulance OST times in my facility?
The LJSC has identified several key drivers that are affecting the OST and your attention to these will assist in improving the availability of Ambulance resources throughout the region:
• Have transport paperwork completed prior to crew’s arrival.
• Ensure that necessary signatures are obtained prior to crew’s arrival.
• Ensure that the patient is prepared for Transport, IV’s disconnected where appropriate – medication administration completed prior to arrival.
• Pt’s belongings packaged.
• Notify the Kaiser Permanente Utilization Management Operations Center if patient condition changes prior to ambulance crew arrival.
Improving your documentation is critical in today’s healthcare environment

Kaiser has documentation and coding standards consistent with industry standards which all internal and those external providers contracting with Kaiser are expected to meet. In the 4th Quarter of 2008, the Kaiser Permanente Health Information Management Services (HIMS) staff conducted its bi-annual Network Provider assessment, which included reviewing both the ICD9 and CPT codes submitted and the documentation for the patient encounter. Providers with panel sizes of > 50 Kaiser Members were reviewed. Results of the audit presented an overall 66.3% accuracy rate. Diagnoses codes had a 64.1% accuracy rate, and Evaluation and Management (E/M) codes fared a bit better at accuracy rate of 68.5%. Congratulations go to Dr. Pinto in Baltimore who had a 100% accuracy rate across the board.

Major findings throughout the assessment identified:

- Practitioners over coded the E/M by at least one level. The documentation of all the elements must be present in order to substantiate the Evaluation and Management codes used. A review of 2-9 body systems or organ systems must be documented in the medical record in order to substantiate a high level history
- Diagnoses were commonly noted in the documentation but not recorded as an ICD9 code resulting in under coding.
- There was a lack of specificity in the diagnoses listed.

Medical record documentation is required to report pertinent facts, findings and observations about an individual’s physical or mental health history, examinations, tests, treatments and outcomes. Documentation should chronologically sequence the care of the patient. Appropriate documentation is essential to substantiate services as medically necessary. For a service to be deemed medically necessary, most payers require that the services and/or supplies be:

- In accordance with standards of good medical practice
- Consistent with the diagnosis, and
- Delivered at the most appropriate level of care

Basic documentation standards include:

- The medical record should be complete and legible. The documentation of each patient encounter should include: reason for the encounter (chief complaint) and relevant history, physical examination findings, and prior diagnostic test results; assessment, clinical impression or diagnosis; plan for care (including discharge plan, if appropriate); and legible date and identification of the observer.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient’s progress, response to and change in treatment, and revision of diagnosis should be documented.
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.”

Kaiser Permanente HIMS staff will continue to review and monitor documentation and coding requirements on a bi-annual basis. We appreciate your cooperation in submitting the documentation and/or allowing our coding staff to review the records on-site. We are committed to high quality documentation standards and coding compliance.
Medicare Plus members with Part D: benefit changes for 2009

By: Paula Greenberg, Pharmacy Project Manager, Perry L. Mackrill, R.Ph, Regional Pharmacy Training Coordinator; Reviewed by: Susan Downard R.Ph, Pharmacy Benefits and Business Consultant

Good news! This year’s Medicare Part D changes are primarily focused on threshold amounts and cost shares. We continue to have a three-tier Medicare Part D drug benefit for Medicare Plus members with Part D. All Regions share a national Medicare Part D Formulary (CMS approved 9/16/08) posted on www.kp.org/seniormedrx.

Summarized below are the new amounts for the Medicare Plus with Part D for 2009:

- Initial coverage up to $2700 in Total Drug Costs (TDC). TDC is the accumulation of what Kaiser Permanente (or any other Part D plans) charges for Part D covered drugs (i.e., Full Member Rate).
- Coverage gap up to $4350 in Total Out-Of-Pocket (TrOOP). TrOOP is the accumulation of what members paid out-of-pocket (or paid by others on their behalf) for covered Part D drugs.
- Catastrophic Coverage begins once TrOOP is over $4350 until the end of the calendar year.

Medicare Member Notification
As required by the Centers for Medicare and Medicaid Services (CMS) Medicare Plus Members with Part D have been notified of any Part D and other Medicare changes through materials they received as part of the 2009 Annual Notice of Changes mailing in October.

Medicare Part D Vaccine Policy Reminder
Kaiser Permanente must account for injectable Part D vaccines and vaccine administration. Members are responsible for the cost shares, which count toward their Part D accumulations according to CMS guidelines. Part D covered vaccines include vaccines such as Hepatitis A, Diphtheria/Tetanus and Zostavax® (for shingles). Here are some key points to remember:

- Medicare Plus members with Part D who receive injections at the medical offices will not be charged at the time of service.
- These members will receive a bill for the appropriate Part D cost share depending on their coverage level at the time of service. (Payment will count toward the member’s TrOOP).
- Costs for Part D vaccines (at KP Member Rate) will apply automatically to the member’s TDC accumulation.
- Part D claims adjudication and reconciliation will occur during HealthTrans and retroactive billing processes.
- Members will see these line items in their Explanation of Benefits.
- Part D vaccine costs are subject to change.
- Coverage for Part B covered vaccines (influenza, pneumococcal, and Hepatitis B for intermediate to high-risk patients) is not affected by this change.

Extra help from Medicare
Kaiser Permanente Medicare Plus members with Part D may be eligible for financial assistance programs such as Extra Help from Medicare (also called “Low Income Subsidy”). If they qualify, members may have reduced or no co-payment for their prescription drug coverage. Medicare members interested in Extra Help from Medicare can call the Social Security Administration toll free at 1-800-772-1213 (TTY: 1-800-325-0778) or visit the website at www.socialsecurity.gov for information.
Clinical practice guidelines

The following clinical practice guidelines have recently been approved and are available on the clinical library and MAPMG online web sites.

Asthma – child, teen and adult
• Major changes from prior guidelines:
• Child/teen and adult age groups combined.
• Adopted the expert panel report 3 (EPR3): Guidelines for the diagnosis and management of asthma.
  * New approaches to assessment and monitoring (control vs. severity; current impairment, future risk; 3 age groups vs. 2).
  * Patient education (self-management/monitoring; Asthma action plan importance; expansion of patient education opportunities).
  * Control of environmental factors and other conditions (single environmental change actions insufficient; common co-morbidities include allergic rhinitis, GERD, sinusitis, sleep obstructive asthma, obesity, and depression).
• Treatment expanded (from adults and children 0-4 to age groups 0-5, 5-11, and 12 and up; expanded from 4 treatment steps to 6 steps).

Abdominal aortic aneurysm (AAA) screening
Major change from prior guideline: Added a section on AAA screening for adults with a family history of AAA.

Colorectal cancer screening
Major changes from prior guideline:
• Lowered upper age limit from 80 to 75 provided there is a history of routine screening (if not, upper age limit is 80).
• Colonoscopy added as an acceptable screening type for asymptomatic, average-risk adults.
• Standard guaiac FOBT was moved to a less-preferred screening option for asymptomatic, average-risk adults.
• Added recommendations for adults with a family history of advanced adenomas before age 60 (colonoscopy beginning at age 50).

Osteoporosis/fracture prevention guideline
Major changes from prior guideline:
• Added a recommended retesting interval for women not on treatment for 5 years, but is flexible based on risk factors.
• Added a section strongly recommending the fracture risk assessment tool (FRAX) to assess absolute fracture risk in adults before treatment initiation and recommendations for pharmacologic treatment based on the 10-year probability of hip fracture.
• Added screening for Vitamin D deficiency.
• Increased daily calcium recommendations from 800 IU/day to 1,000 IU/day.
• Added postmenopausal women with a FRAX 10-year risk of hip fracture ≥ 3% as a category for recommending Alendronate (10 mg/day or 70 mg/week).
• Added a section on third-line drug therapy when other modalities are contraindicated or not tolerated: Zoledronic acid (IV 5 mg/annually) for postmenopausal women over age 65 with high risk or Teriparatide by daily injection for high risk women only after specialist evaluation.
• Added a section on treatment for men: Alendronate (10 mg/day or 70 mg/week) for men aged 70 or older with osteoporosis or FRAX 10-year risk of hip fracture ≥ 3% and pharmacologic treatment is optional in men under age 70 who are diagnosed with osteoporosis but without a FRAX 10-year risk of hip fracture ≥ 3%.
• Lowered the daily dose of prednisone or equivalent from ≥ 7.5 to ≥ 5 mg/day and added FRAX 10-year risk of hip fracture ≥ 3% as a guideline for initiating first-line therapy for men/women taking corticosteroid therapy. Teriparatide is an option in these patients not tolerant of or responsive to other agents only after specialist evaluation.

To find guidelines on Clinical Library (cl.kp.org), follow this path: Clinical library MidAtlantic >> Clinical guidelines >> Mid-Atlantic States guidelines >> Clinical practice guidelines.

On MAPMG online (www.mapmgonline.com), select the guidelines group from the Group Navigation pulldown on the left, then select Documents in the left column.

Several other clinical practice guidelines, e.g., breast cancer and diabetes, also may be found at the above websites. To obtain hard copies, please contact Betina Pereira at (301) 816-7122 or Betina.J.Pereira@kp.org.
MEMORANDUM

To: Kaiser Permanente Network Physicians
Date: April 23, 2009

Subject: Medicare Part D Formulary 2009 - Information Regarding Prescription Raptiva Injection and Part D Coverage: Notice to MD’s on FDA Safety Recall of Raptiva

From: Carol Forster, MD
MAPMG Physician Director, Pharmacy and Therapeutics, Formulary Management
KPMAS Regional Pharmacy Services

SITUATION:

As part of our due diligence to inform all concerned of Medicare Part D Formulary Changes, the following notification called “Medicare Part D Formulary 2009 - Information Regarding Prescription Raptiva® Injection and Part D Coverage” is requested by CMS to be sent to all Providers. Additionally, a copy of the provision of notice is included for reference.

BACKGROUND:

In an FDA Statement released April 8, 2009, Genetech announced that it has begun a voluntary, phased U.S. market withdrawal of their product Raptiva® (efalizumab), a biologic injectable used to treat moderate-to-severe chronic plaque psoriasis and which is usually self-injected.

ASSESSMENT:

Prescribers are being asked not to initiate Raptiva® treatment for any new patients. Prescribers should immediately begin discussing with patients currently using Raptiva® on how to transition to alternative therapies. The FDA strongly recommends that patients work with their health care professional to transition to alternative therapies for psoriasis. By June 8, 2009, Raptiva® will no longer be available in the United States.

RECOMMENDATIONS for Preferred alternatives:

The four biologics FDA-approved for the treatment of moderate to severe psoriasis on the Kaiser Permanente Mid-Atlantic States Commercial and MPD Formularies with prescribing restrictions and with guidelines are:

- adalimumab (Humira®)
- alefacept (Amevive®)
- etanercept (Enbrel®)
- infliximab (Remicade®)

If there are any questions, please contact your primary care clinical pharmacist.

Confidential & Proprietary – For Kaiser Permanente Use Only
Out with the old, in with the new: No more provider add/change forms. Here is a sample letter for submitting your provider changes.

**SAMPLE LETTER**

Company Logo or Letterhead

<<DATE>>

Tax Identification #: 
Email Address: 
Effective date of change(s): 
Requestor: 

Reason for the request: 

- Address change (practice location or billing)  
  *identify whether adding or deleting demographic change 
- Adding a provider or practitioner to an existing group contract  
  *identify whether adding or deleting provider 

If adding or deleting a provider please include: 

- First and Last Name 
- Sex 
- Title or Degree 
- NPI number 
- CAQH number 
- UPIN or Social Security number 
- Primary Specialty with Secondary Specialty if applicable 
- Practice Locations w/ Phone and Fax numbers 
- Foreign Languages