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.

Quality Improvement Program

The Quality Improvement Program defines the scope of quality plans that are measured and monitored. Major plan actions include steps that review quality outcomes, patient safety and service as relates to access, availability and satisfaction for ongoing improvement. The scope of service also include any and all related regulatory/accreditation requirements.

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Kaiser Permanente 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/recredentia ling,
- 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 quality improvement process.

QI Program resources

Data sources may include claims data, medical record data, patient complaints (grievances), case management reports, pharmacy data, satisfaction surveys and quality improvement/performance improvement 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 Quality Improvement 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 Quality Improvement 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 but is not limited to:

- Accreditation Association for Ambulatory Health Care (AAAHC) for Ambulatory Surgery Centers in the KPMAS facilities,
Kaiser Permanente electronic payment and remittance advice centralized enrollment processing

Kaiser Permanente has partnered with CAQH to process Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERAs) enrollments. With this partnership, Kaiser Permanente is moving to a National EFT/ERA enrollment platform. We request that all providers pursuing EFT/ERA enrollments utilize the CAQH web portal for these activities. The portal is available 24 hours a day/seven days a week for first time enrollment or changes.

Enrolling in EFT/ERA will provide the following benefits:
- receive claims payments and remittance data faster and more efficiently,
- reduce processing costs, and
- improve office workflow.

It is easy to get started now:
- Visit solutions.caqh.org for information and to create your secure account, or
- speak with the CAQH EnrollHub Helpline at (844) 815-9763.

Representatives are available 7 a.m. - 9 p.m. EST Monday - Thursday and 7 a.m. - 7 p.m. EST Friday.

If you are already enrolled in ERA & EFT with other insurers, you still must enroll with Kaiser Permanente and select the correct region to receive ERA & EFT.

Kaiser Permanente Regions:
- Kaiser Foundation Health Plan NORTHERN CALIFORNIA REGION.
- Kaiser Foundation Health Plan SOUTHERN CALIFORNIA REGION.
- Kaiser Foundation Health Plan COLORADO.
- Kaiser Foundation Health Plan MID ATLANTIC STATE REGIONS (MD, VA, Washington DC).
- Kaiser Foundation Health Plan NORTHWEST REGION (OR, WA).

Important Note: If you are a provider retrieving ERAs from a clearinghouse, you must remember to also complete the ERA set up with your clearinghouse as well as with Kaiser Permanente via the CAQH EnrollHub.

For enrollment status updates, you may contact Provider Relations at (877) 806-7470. Please allow 7-10 business days from the date that CAQH receives your enrollment request before checking on a status.
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)

**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

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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.

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
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.

• **Video Remote Interpretation (VRI)** – Video Remote Interpreting (VRI) provides on-demand access to American Sign Language & Spoken Language interpretation services at medical centers for members. It meets the need in the care experience of walk-in deaf patient and those in need of urgent care.

• **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 quality 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.

To access organization wide population data on language and race, please access the reports via our Community Provider Portal at providers. kp.org/mas under News and announcements. To obtain your practice level data on language and race, please email the Provider Relations Department at Provider.Relations@kp.org.

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.

Network practitioner termination statement

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.
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.
Maryland HealthChoice access standards and outreach

As Kaiser Permanente Maryland HealthChoice Participating Providers, there are special requirements and outreach activities that you along with us must adhere to per the Maryland Department of Health (MDH). Participating providers are required to adhere to the appointment and access standards for Maryland HealthChoice members as defined by the MDH. This table shows the appointment type and the associated access standard:

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial health assessment appointment (upon enrollment)</td>
<td>Within ninety (90) days of enrollment</td>
</tr>
<tr>
<td>Children under the age of 21</td>
<td>Within thirty (30) days of enrollment</td>
</tr>
<tr>
<td>Maternity care – pregnant or post-partum</td>
<td>Within ten (10) days of enrollment</td>
</tr>
<tr>
<td>Members with Heath Risk Assessment (HRA) that screen positive requiring expedited intervention</td>
<td>Within fifteen (15) days from the date of receipt of the completed HRA.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours of the request</td>
</tr>
<tr>
<td>Emergency services</td>
<td>Available immediately upon request</td>
</tr>
</tbody>
</table>

In addition to meeting appointment and access standards, Participating Providers must effectively manage and implement outreach activities. Kaiser Permanente conducts outreach activities designed to ensure Maryland HealthChoice members get the medical care needed. In addition, Kaiser Permanente provides a dedicated on-boarding process that ensures a quality experience for new Maryland HealthChoice members. Our support and outreach services includes a centralized team within our Clinical Contact Center that manages all outreach activities related to Maryland HealthChoice members, including but not limited to appointment reminders, appointment rescheduling, and member results outreach for events such as positive pregnancy tests.

Participating providers are required to make the necessary outreach to members to ensure the members are seen within the required timeframes for initial health care assessment and evaluation for ongoing health needs (e.g. timeliness of health care visits, screenings, and appointment monitoring). In the event, a member after two (2) unsuccessful attempts are made and documented to bring the member in for care, please contact Provider Relations at (877) 806-7470. The Provider Relations representative will report the care gap concern to the Kaiser Permanente Medicaid office. Medicaid office will engage Case management for assistance. After additional attempts are made to bring members into care are unsuccessful the Medicaid office will notify the local/county health department for assistance.

More information regarding access standards and outreach can be found on our website at providers.kaiserpermanente.org/mas in the Kaiser Permanente Maryland HealthChoice Participating Provider Manual.

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) were approved for use and published in June to July 2017.
Practitioner Medical Coverage Policies

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) were approved in April to August 2017.

We develop MCPs in collaboration with specialty service chiefs and clinical subject matter experts. MCPs specify clinical criteria supported by current peer reviewed literature and are used to guide decisions related to request for health care services such as devices, drugs, and procedures. The policies are reviewed and updated annually, reviewed for approval by the Regional Utilization Management Committee (RUMC), and are periodically reviewed by regulatory and accrediting agencies. Except where noted, our MCPs are primarily applicable only to Commercial members.

New or updated Medical Coverage Policies

1. Blepharoplasty, lid ptosis and brow lift surgery
   Revision date: 04/25/2017
   • Entropion added as a surgical indication for the procedure
   • References were updated

2. Cranial remodeling bands & helmets
   Revision date: 04/25/2017
   • References were updated

3. Fetal echocardiogram
   Revision date: 04/25/2017
   • Maternal indications were updated
   • References were updated

4. Homecare
   Revision date: 04/25/2017
   • References were updated

5. NICU Neonatal care admission & discharge
   Revision date: 04/25/2017
   • Revision made to correct NICU level III (section B, 2g-2h) where a section of NICU level 2 care criteria (section C, NICU Level II, C:1c-g and Section C: 2) were appended in error in the 2016 MCP.
   • References were updated

6. Panniculectomy
   Revision date: 04/25/2017
   • Changes made on Section IV. Restrictions and Limitations: Time period post bariatric surgery and weight stabilization were updated according to new references.
   • References were updated
7. Pectus excavatum pectus excavatum, pectus carinatum and poland’s syndrome surgical correction
Revision date: 04/25/2017
• References were updated

8. Transcranial Magnetic Stimulation (TMS) for depression and chronic migraine
Revision date: 04/25/2017
• References were updated

9. Med necessity for pre authorization of a single visit
Revision date: 03/30/2017
• Updated section III, communication with a specialist
Revision date: 04/25/2017
• Revision of Section E: Documentation requirements on Adverse Decision Notice when using the MCP. This is in response to Maryland Insurance Administration’s compliance audit findings in March, 2017 as a corrective action plan, recommended by Kaiser Permanente Mid-Atlantic States’ Legal Department.

10. Med necessity for pre authorization of multiple visits
Revision date: 03/30/2017
• Updated section III, communication with a specialist
Revision date: 04/25/2017
• Revision of Section E: Documentation requirements on Adverse Decision Notice when using the MCP. This is in response to Maryland Insurance Administration’s compliance audit findings in March, 2017 as a corrective action plan, recommended by Kaiser Permanente Mid-Atlantic States’ Legal Department.

11. Nutritional Support - Enteral Formula, Medical Foods and Feeding equipment and Supplies
Revision date: 06/01/2017
• Federal (FEHBP) members no longer have coverage for enteral nutrition using the CMS coverage criteria. Effective 2017, Federal members have DME, orthotic and prosthetic coverage using MCG guidelines. CMS guidelines for DME (Medicare) covers enteral nutrition under prosthetic benefits.
• References were updated

12. Breast pumps: hospital grade and personal use
Revision date: 06/01/2017
a. Update made on the following:
   i. Section II, B, 2: Hospital grade breast pump
   • The single phase technology breast pump: Medela Lactina is replaced with Medela Symphony two phase technology hospital grade breast pump.
   ii. Section IV, D: Personal use manual breast pump
   • Medela and Ameda manual breast pumps are no longer available for distribution through Kaiser Permanente. The manual pump was replaced with Ameda personal use double electric breast pump.
   b. The use of CMS guidelines on DME items is no longer applicable to Federal employee group.
   c. References were updated.

13. Breast implant removal
Revision date: 06/01/2017
• Update made on section IV: Breast implant-associated anaplastic large cell lymphoma added as a clinical indication for breast implant removal.
• References were updated.

14. Sialendoscopy
Revision date: 06/01/2017
• References were updated.

15. Knee scooter_“New”
Revision: 06/07/2017
• A knee scooter (HCPCS code E0118) is considered a crutch substitute and is not covered. It will be denied as “not reasonable and necessary” as there are other DME mobility devices that can meet the criteria and can be used for mobility. The least restrictive device that will meet the patient’s need for mobility will be provided under the DME benefit.
• Devices that are covered include crutches, standard walkers, rolling walkers, hemi-walkers or other standard ambulatory assist devices such as a standard manual wheelchair, or a hemi-wheelchair.

16. Transgender surgery, District of Columbia (only)
Revision date: 06/28/2017
• Covered sexual reassignment surgery procedures: added tracheal shave
• References were updated.

17. Transgender surgery, FEDS (only)
Revision date: 06/28/2017
• References were updated

18. Continuous glucose monitors (devices)
Revision date: 06/28/2017
• References were updated

19. Hyperbaric oxygen
Revision date: 06/28/2017
• Section II, A 6: Clinical Indication: Acute Air added
• Section III S: Exclusions: Thermal Burns deleted
• References were updated

20. Circumcision
Revision date: 07/28/2017
• Section V update – Clinical indication for circumcision referral: Added adult HIV-negative male in a discordant heterosexual relationship (HIV+ female, HIV- male) per recommendation by an Infectious Disease/HIV physician, as part of transmission reducing strategy.
• References were updated.

21. Varicose veins
Revision date: 07/28/2017
• Section I and II: referral to General Surgery for varicose veins’ evaluation and treatment has been deleted
• References were updated

22. Compression bandages and garments, and pneumatic devices
Revision date: 07/28/2017
• Section VII, B, number 4 update: Referral for continuous, 24 hour use of compression bandages and garments has been changed from 2 years to 1 year.
• References were updated.

23. External insulin pump and supplies
Revision date: 07/28/2017
• Section III, D: Coverage criteria update: children with diabetes mellitus
• References were updated

24. Pelvic floor rehabilitation for myofascial pelvic pain
Revision date: 07/28/2017
• Section IV. Excluded Adjunct Therapies – may be done as a separate procedure. Please refer to MCG for guidelines on these therapies.
• References were updated.
• No substantive content change

25. Acupuncture
Revision date: 07/28/2017
• Added Section III. Policy: Coverage - a reference to acupuncture when used as anesthesia for procedures is not covered by the medical coverage policy. Consult the Evidence of Coverage (EOC) to determine the benefit coverage according to the member’s group plan.
• Acupuncture when used for anesthesia will only be covered for the District of Columbia KPIF and Small Group Plans effective in 2018. The benefit change is a response to the objection by DC government during Kaiser Permanente’s benefit form filing, which require KP to cover acupuncture when used as an anesthesia.

26. Mira Dry system “New”
Revision date: 08/29/2017
• miraDry System is a non-invasive third line treatment for primary axillary hyperhidrosis after creams and botox treatment have been tried and documented to have failed.
• miraDry is not approved by FDA for generalized hyperhidrosis or focal hyperhidrosis outside the axillae.
• All other indications for miraDry other than primary axillary hyperhidrosis are considered experimental and investigational and are not covered.
27. Dermal fillers  
Revision date: 08/29/2017  
• References were updated

28. Infertility diagnosis and treatments  
Revision date: 08/29/2017  
• Section V, Patient work up – Added: “Documentation” is required of diagnostic studies on female members by the primary care gynecologist.  
• Section VIII, Female Treatments:  
  B. Advanced Reproductive (infertility) Treatments,  
  » Number 1: IVF – up to 3 cycles, 30 visits per referral. Added: “A cycle of IVF is counted once oocyte retrieval is completed.”  
  » Number 4 – Indications for ICSI. Added: “When IVF is covered.”  
  D. General Instructions, number 3 – Deleted:  

29. Bariatric surgery adults and adolescents  
VA-FED-DC  
Revision date: 08/29/2017  
• Section V, letter C - Surgical inclusion criteria for adult (18 years old and above) with no prior history of bariatric surgery. Added: nicotine/smoke free when beginning the therapeutic program measures  
• Section VI: Initial surgical inclusion for Adolescents – entire criterion modified  
• Section VII, A: Contraindications and limitations – Conditions that will render ineligibility for bariatric surgery. Added: Adults who have not obtained 95% of physical maturity  
• Section VIII, A. 1 and 2 Therapeutic measures to complete prior to referral for initial bariatric surgery  
  » Adolescents. Deleted:  
  » Adults, number 5, b: deleted: Replaced with: “No apparent contraindications from a Behavioral Health perspective noted.”

30. Bariatric surgery adults and adolescents MD  
Revision date: 08/29/2017  
• Section V: Initial surgical inclusion for Adolescents – entire criterion modified.  
• References were updated.

31. Cochlear and auditory brain stem implants  
Revision date: 08/29/2017  
• Section IV, B. Adult Criteria for Cochlear Implants  
  » Definition of Limited benefit from amplification updated from a score of 40% to 50%  
  » Candidacy criteria clarified  
• Section VIII Bilateral implants, Replacements and Upgrades  
  A. Internal Components  
  Section A-2b, deleted  
  B. External Components  
  Added: Replacement or upgrade of external component (speech processor).  
• Section IX. Exclusions and Limitations  
  Added to the non-covered list:  
  A. Replacements or repair of lost parts and B. To diagnose tinnitus, unless the individual meets the sensorineural hearing loss criteria

Access to MCPs is only two clicks away in Health Connect.

Click on the Clinical Library section on the right side of the KPHC Home page and then type in “medical coverage policy” in the search box. All medical coverage policies will be displayed.

UM Standards clinical criteria

1. MCG 21st edition – an evidence-based clinical guideline that span the continuum of care was approved and will continue to be the best practices criteria and content for healthcare professionals, supporting clinical decisions and easing patient transitions between healthcare settings for Commercial and Medicaid members in Maryland and Virginia, in the following settings:

Care guidelines:  
• Ambulatory Care  
• Behavioral Health Guidelines  
• General Recovery Guidelines  
• Home Care  
• Inpatient and Surgical Care  
• Recovery Facility Care
2. Utilization management criteria for durable medical equipment (DME), orthotics, and prosthetics
   • UM will continue to use Centers for Medicare and Medicaid Services (CMS): National and Local Coverage Determinations as the primary criteria for Medicare Cost and Medicare Advantage members;
   • UM will only use CMS National and Local Coverage Determinations for DME, orthotic, and prosthetic devices and services for Commercial and Medicaid members in Maryland and Virginia in the absence of MCG or medical coverage policy.
   • The Medicare Coverage Database can be accessed at cms.gov/medicare-coverage-database.

3. McKesson’s Interqual 2017 criteria was approved as the ongoing evidence-based clinical decision criteria to manage transplant related care of adult and pediatric transplant patients. You may obtain a copy of these Interqual standards by contacting the Utilization Management Operations Center (UMOC) at (800) 810-4766.

4. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements of the federal government will continue to be in use for Medicaid members in Maryland and Virginia. The federal mandated services include screening, vision, dental, hearing, and diagnostic services and the health care services treatment for all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures. The federal requirements for children under age 21 who are enrolled in Medicaid may be found at Medicaid.gov, search EPSDT.

   Please contact the Utilization Management Operations Center (UMOC) at (800) 810-4766 to receive a copy of the UM guideline or criteria related to a referral.

   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).

   If you have clinical questions on use of our criteria, please feel free to contact:
   Claudia Donovan M.D.
   Physician Referral Reviewer
   Claudia.K.Donovan@kp.org

   If you have administrative questions concerning accessing or using our criteria, please contact:
   Marisa R Dionisio, RN
   Marisa.R.Dionisio@kp.org
   (301) 816-6689

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Provider access to health education materials

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

Content can be viewed through the centralized internal “clinical library” which is an electronic inventory of health education information 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
• Provide members with information on how to self-register through KP HealthConnect After Visit Summary or hard copy flyers

Additional information on health education programs, tools, and resources is available by:

• Visiting kp.org/healthyliving
• Contacting the Health Education automated line (301) 816-6565 or (800) 444-6696.
Practitioner/Provider UM notification

Utilization Management/Resource Stewardship Program

At Kaiser Permanente our Utilization Management (UM) program is a collaborative effort between the Medical Group and Health Plan leadership and staff designed to help our members receive the right care, in the right place, at the right time.

The scope of the UM program encompasses quality management and resource stewardship across the care continuum. It consists of five major categories: Concurrent Review, Continuing Care, Transitions Care, Case Management, and Referral Management (which includes Preauthorization and Post Service Review). The Utilization Management (UM) Department is organized around three Service Areas (Baltimore, District of Columbia/Suburban Maryland (DCSM), and Northern Virginia (NOVA)). The UM activities within each Service Area include inpatient utilization review and management; transitions care; complex case management (CCM), Skilled Nursing Facility (SNF) and acute rehabilitation utilization management.

Throughout these service areas, UM staff partner with the health care team to deliver medical, surgical, and behavioral health care services to Kaiser Permanente Mid-Atlantic States (KPMAS) members. The Utilization Management Operations Center (UMOC) is a centralized telephonic Utilization Management (UM) and Referral Management hub designed to assist Mid-Atlantic Permanente Medical Group (MAPMG) practitioners, community-based practitioners, and applicable KPMAS staff to coordinate health care services for KPMAS members.

Registered Nurses and Durable Medical Equipment Coordinators review and process outpatient referrals, requests for durable medical equipment and home care services. Nurses work collaboratively with licensed, board-certified UM Physician Managers and Practitioners to safely and effectively execute completion of the referral management process within specified time frames depending upon the type and nature of the referral.

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 (800) 810-4766 and follow the appropriate prompts.
The Utilization Management Operations Center (UMOC) staff can also assist with the following:
• Provide information regarding utilization management processes
• Check the status of a referral or an authorization
• Provide, free of charge, copies of the specific criteria/guidelines utilized for decision making
• Answer questions regarding a benefit denial decision

All Practitioners have the opportunity to discuss any non-behavioral health and/or behavioral health Utilization management (UM) medical necessity denial (adverse) decision 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 through Friday except on holidays, to speak with 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. Medical necessity denial decisions can be discussed with the UM Physician by calling the Utilization Management Operations Center (UMOC) at (800) 810-4766 and select the appropriate prompt # of the Kaiser Permanente Page Operator at (888) 989-1144.

UM Criteria/Guidelines and Medical Coverage Policies (MCPs)
Kaiser Permanente Mid-Atlantic States (KPMAS) UM utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, and regionally developed medical coverage policies. Development, adoption and review of medical coverage criteria includes a comprehensive compilation of current evidence, expert opinion, national association guidelines and policy statements, state and federal regulatory mandates regarding coverage, and a consensus of licensed board certified physician specialists within KPMAS.

For all Medicare beneficiaries, KPMAS adheres to Medicare rules and regulations in addition to National Coverage Determination (NCD) and Local Coverage Determination (LCD) for medical necessity determinations for services such as for skilled nursing facility (SNF), home health, Durable Medical Equipment (DME), prosthetics and orthotics, ambulance transportation. UM uses MCG criteria, (formerly called Milliman Care guidelines) to make determinations for acute inpatient.

For Commercial members, UM uses MCG criteria and Medical Coverage Policies (MCP's).
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 Kaiser Permanente physicians through KP HealthConnect®, Clinical Library and Mid-Atlantic States Knowledge Base (MASK)
- Contracted network and community physicians and providers can access KP HealthConnect and Clinical Library with their Affiliate Link access.
- Hard copies of the criteria or Medical Coverage Policy or rule or protocol are available free of charge. To receive a copy of the UM guideline or criteria related to a referral, please contact the Utilization Management Operations Center (UMOC) at (800) 810-4766.
- The above number can also be used to reach a Utilization Management Physician to discuss UM medical coverage policies related to medical necessity decisions.
- Emerging technology, and regionally-based medical technology assessment reports are communicated internally through the KPMAS Clinical Library, KP HealthConnect® messaging and through regional emails. Current standings on new technologies related to medical necessity decisions can be discussed with a Utilization Management Physician at the Utilization Management Operations Center at (800) 810-4766.

Types of UM criteria

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, hospice and home health services for Commercial and Medicaid Members.

Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are applicable criteria for Medicare members and are accessible through the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Database website.

The National Transplant Network Services (NTS) patient selection criteria and InterQual patient care criteria are used for solid organ and bone marrow transplant services for all members, including Medicare. Copies of these criteria can be obtained free of charge by calling UMOC at (800) 810-4766.

Medical Coverage Policies developed by KP Mid-Atlantic region are used primarily for commercial members to augment the MCG or Medicare criteria, as applicable in the absence of MCG guideline.

For new technology and the new application of existing technology to include medical, behavioral healthcare procedures, pharmaceuticals and devices which may not yet be fully formulated as criteria, Kaiser Permanente conducts continuously scheduled evaluations of emerging technologies and uses. These reports are posted in the KP Clinical Library and MASK.

Accessibility of UM operations

Accessibility is important to our members and providers. Kaiser Permanente Mid-Atlantic States (KPMAS) Utilization Management (UM) 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 Utilization Management Operations Center’s (UMOC) telephonic toll free number, UMOC’s facsimile, or through Kaiser Permanente Health Connect messaging system. 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 below describes the access and hours of operations for UM services.

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<thead>
<tr>
<th>UM Department Section</th>
<th>Hours of Operation</th>
<th>Core Responsibilities</th>
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<tbody>
<tr>
<td>Emergency Care Management - Clinical Call Center Department</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 • Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities • Assist with repatriations from hospital to hospital • Support all cardiac transfers for level of care needed</td>
</tr>
<tr>
<td>Utilization Management Operations Center: outpatient, specialty referrals and clinical research trials</td>
<td>Monday through Friday: 8 a.m. to 4:30 p.m. Weekends and Holidays: 8:30 a.m. to 5 p.m. for Urgent and emergent referrals and care coordination referrals</td>
<td>• Conduct pre-service review of specialty referrals (outpatient and inpatient) to include external clinical trial requests • Weekends and holidays pre-service review of urgent/emergent referrals except clinical research trials</td>
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<tr>
<td>Utilization Management Operations Center: • Durable Medical Equipment (DME) • Home Care • Rehabilitative Therapies • Physical, Occupational and Speech Therapies</td>
<td>Monday through Friday: 8:30 a.m. to 5 p.m. Weekends and Holidays: 8:30 a.m. to 5 p.m. for Urgent and routine discharge care coordination referrals</td>
<td>• Conduct pre-service and concurrent review of home care, durable medical equipment, physical therapy, occupational therapy and speech therapy • Post-service review provided to Kaiser Permanente members outside a Kaiser Permanente medical facility</td>
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<tr>
<td>UM Department Section</td>
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<tr>
<td>Non Behavioral Health located at affiliated hospitals</td>
<td>Monday through Friday Weekends and Holidays 8:30 a.m. to 5 p.m.</td>
<td>• Conduct concurrent review and transition care management</td>
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<td>Skilled Nursing Facility (SNF) and, rehabilitation services and Long Term Acute Care Hospitals (LTACH)</td>
<td>Monday through Friday 8 a.m. to 4:30 p.m. Excluding major holidays</td>
<td>• Conduct concurrent review and transition care management for members in the acute rehab and SNF settings</td>
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<tr>
<td>UM Hospital Services – Behavioral Health located at affiliated hospitals</td>
<td>Monday through Friday: 8 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>
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<tr>
<td>UM Outpatient Services – Behavioral Health</td>
<td>Monday through Friday: 8 a.m. to 4:30 p.m. Excluding major holidays</td>
<td>• Conduct pre-service and concurrent review of behavioral outpatient services</td>
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<tr>
<td>Outpatient continuing care, complex case management and renal 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>
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**Utilization management affirmative statement**

Kaiser Permanente practitioners and health care professionals make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of care and service, and 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.
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
2101 East Jefferson Street, 6 West
Rockville, MD 20852.

Referring members for dialysis

When referring members for dialysis, please remember to utilize Kaiser Permanente participating facilities. For a list of participating facilities, please visit Kaiser Permanente’s Online Provider directory at kp.org.
Palliative Care and Hospice access for your patients

The continuum of Palliative Care and Hospice services available for members offers both internal and external services. The Palliative Care philosophy is an interdisciplinary approach to support members with a deteriorating medical condition with focus on pain & symptom management, emotional support, clarification of goals and advance care planning. Hospice services are focused on those with a terminal condition, prognosis of 6 months or less and a shift from aggressive treatments to comfort oriented care.

The following three internal Palliative Care service lines can be referred directly through Orders Entry within KPHC.

• Inpatient Palliative Care (IPC) consultation service is provided at core hospitals. The model includes an interdisciplinary team service comprised of a palliative care physician, nurse and social worker. The team meets with member and family to assess their understanding of the illness, to discuss realistic outcomes of treatments and to identify goals of care. The team also addresses pain and symptom management and provides consultation to hospital physicians and staff on end of life care.

• Skilled Nursing Facility Palliative Care service is a nurse consultation model available to members in the Mid-Atlantic service area in which the palliative care nurse works closely with the SNFs health care team. Members in the SNF setting are similar to those in the in-patient setting in terms of medical complexity and social needs, therefore the goals of this model are similar to the IPC consult model.

• Advanced Illness Care Coordination (AICC) service is a clinical social work consultation model involving sessions with members and families with goals for each meeting such as advance care planning, emotional support, community resources and conversations related to end-of-life. The overall result is increased member and family understanding of the illness, ultimately fostering more informed choices. The AICC model has demonstrated increased hospice utilization and length of stay as well as improved quality of life for individuals facing advance illness and end of life situations.

• External services include hospice services and home palliative care services as offered by multiple contracted home health agencies. Home palliative care services are based upon the skilled home care benefit and include in-home services for nursing, social work, physical/occupational therapy and home health aide. Hospice services are provided by local hospice agencies throughout Mid-Atlantic. Please contact the Continuing Care HUB at (301) 562-6683 for assistance with hospice or home palliative care services and referrals.

Advance Directives

An Advance Directive is a legal document which allows members to make treatment preferences for serious or sudden health events. It also lets the member identify the health care surrogate. For additional details on Advance Directives and Advance Care Planning and Life Care Planning services, please visit: kp.org/lifecareplan.
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 Marketplace 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.

<table>
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<tr>
<th>Line of business</th>
<th>Applicable drug formulary</th>
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<tr>
<td>Commercial</td>
<td>KPMAS Commercial Drug Formulary</td>
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<tr>
<td>Medicare Part D</td>
<td>Medicare Part D Drug Formulary</td>
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<tr>
<td>VA Medicaid</td>
<td>Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List</td>
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<tr>
<td>VA FAMIS</td>
<td>Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List</td>
</tr>
<tr>
<td>MD HealthChoice</td>
<td>Maryland HealthChoice Preferred Drug List Note: some drugs used for Mental Health, Substance Abuse Disorders and HIV/AIDS are excluded from the KPMAS Drug Formulary, but covered by Maryland Department of Health on the Maryland Medicaid Fee-For-Service Preferred Drug List</td>
</tr>
<tr>
<td>Marketplace Exchanges</td>
<td>KPMAS District of Columbia, Maryland and Virginia Marketplace Formulary</td>
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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. Updates to the drug formularies are available on the KPMAS intranet for MAPMG providers and on the KPMAS Clinical Library (Patient Care Resources --> Drug Information --> Formulary) for affiliated providers. Providers are encouraged to review the drug formulary changes online regularly.

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 KPMAS Clinical Library (Patient Care Resources --> Drug Information --> Formulary) 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 KPMAS Clinical Library (Patient Care Resources --> Drug Information --> Formulary) and MAPMG providers can search all KPMAS formularies via the intranet. Providers are encouraged to check their respective websites regularly for any changes or updates.

A printed copy of each drug formulary is available upon request from the Provider Relations department at (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;

• Agents when used as growth hormones; and

• Agents used for Hepatitis C treatment.

• Agents when used for management of heterozygous familial hypercholesterolemia, homozygous familial hypercholesterolemia or clinical ASCVD, otherwise known as PCSK9 inhibitors

• All long acting opioids, all Fentanyl products, any short acting opioid prescribed for > 7 day supply and > 14 days in 60 days, individual opioid > 90 morphine milligram equivalents (MME), cumulative opioid daily dose > 120 MME/day

• Benzodiazepine-Opioid concurrent use

• Buprenorphine mono or combination oral therapy used for management of Substance Use Disorders and prescribed by physicians other than a “Gold Card” physician (physicians specialized in the management of substance use disorders and recognized as “Gold Card” physicians by Virginia Department of Medical Assistance Services).

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;
• Agents used for Hepatitis C treatment;
• GLP-1 agonists, DPP-4 inhibitors and SGLT2 inhibitors used for the treatment of Diabetes Mellitus Type 2;
• Agents when used for management of heterozygous familial hypercholesterolemia, homozygous familial hypercholesterolemia or clinical ASCVD, otherwise known as PCSK9 inhibitors;
• Any long-acting opioids, all fentanyl products and any opioid (short- and long-acting) exceeding 90 MME/day

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.

For Commercial formulary, the following drug class will have a Prior Authorization (PA):
• Agents when used for management of heterozygous familial hypercholesterolemia, homozygous familial hypercholesterolemia or clinical ASCVD, otherwise known as PCSK9 inhibitors.

**Step Therapy**

KPMAS shall notify the appropriate state departments prior to the implementation of any step therapy criteria or protocols. All step therapy criteria or protocols will be reviewed and approved by the KPMAS Pharmacy and Therapeutics Committee.

**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 (877) 806-7470, via the KPMAS Clinical Library 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 Marketplace 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:
• 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.
• 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:
  * The pharmacist will contact the prescribing provider to discuss a formulary alternative or obtain the non-formulary exception reason.
  * If an appropriate non-formulary exception reason is obtained, the appropriate co-pay will be applied.
  * 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.
  * 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 (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 KPMAS Clinical Library (Patient Care Resources --> Drug Information --> Pharmacy Prescription Benefit Grid Summary).

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) can be located at: pithelp.appl.kp.org/MAS/formulary.html
• The Drug Formulary Addition and Deletion Request Form can be accessed at pithelp.appl.kp.org/MAS/phcy_therpeutics.html

**Affiliated Providers**
• Via KPMAS Clinical Library at providers. kaiserpermanente.org/html/cpp_mas/pharmacytoc.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 KPMAS Clinical Library and would like to gain access, please contact provider relations at (877) 806-7470 Monday through Friday, 9 a.m. to 5 p.m., EST for assistance.
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 (800) 777-7902, (toll free), (301) 879-6380, TTY.
- Medicare Plus Plan members can call toll free: (888) 777-5536, (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 E. Jefferson St.,
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 (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: (800) 777-7904, (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 (877) 261-8807 (toll free) 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) 468-2270, (800) 492-6116 (toll free) (800) 735-2258 (toll free TTY) (410) 468-2270 or (410) 468-2260 (fax) mdinsurance.state.md.us

In Virginia
• Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560, (804) 371-9032 (Richmond metropolitan area) 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, (800) 552-7945 (toll free) TDD (804) 371-9206 scc.virginia.gov
• The Office of Licensure and Certification Department of Health 9960 Mayland Drive, Suite 401 Richmond, VA 23233-1463 (804) 367-2106, (800) 955-1819 (toll free) (804) 527-4503 (fax) 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) 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 opm.gov

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

As a member of Kaiser Permanente, you have the responsibility to:

1. Promote your own good health:
a. Be active in your health care and engage in healthy habits.
b. Select a Primary Care Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Physician.
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.
g. Schedule the health care appointments your physician or health care professional recommends.
h. Keep scheduled appointments or cancel appointments with as much notice as possible.
i. Inform us if you no longer live or work within the plan service area.

2. 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.
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 (877) 806-7470 for assistance.

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 (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 (866) 223-2347. A message will prompt the member or caregiver to state their name, phone number, and the Kaiser Permanente 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.
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 — 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 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 (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.
Communicating PCM programs to practitioners

Kaiser Permanente Mid-Atlantic States population care management programs (PCM) help you to monitor and manage your patients with chronic conditions. Members with diabetes, asthma, coronary artery disease, chronic kidney disease, hypertension, ADHD, and/or depression are enrolled into care management programs. 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, secure messages, and/or phone calls periodically, including care gap reminders. Multi-media 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 online tools; best practice alerts, smart sets, and health maintenance alerts within KP HealthConnect®; and direct patient management for our highest risk members by our Care Management Program.

Clinical practice guidelines are systematically designed tools to assist practitioners with specific medical conditions and preventive care. Guidelines are informational and not designed as a substitute for a practitioner’s clinical judgment. Guidelines can be found online at Providers.KaiserPermanente.org/mas then click on Provider Information and select Clinical Library or call (877) 806-7470.

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. Community providers who want to add or remove members from the program can 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. Relay access, 711.
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 Board of Foot and Ankle Surgery (ABFAS)
- 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 completion of training 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.

Integration of care in KPMAS Patient Centered Medical Home (PCMH)

The concept of a “Patient Centered Medical Home” incorporates a commitment of primary care practitioners to work closely with patients and their families to provide whole-person oriented care that is continuous, well-coordinated, effective, culturally competent and tailored to meet the needs of each patient. The PCMH model develops relationships between primary care practitioners and providers, their patients and their patients’ families. In the PCMH model, primary care teams promote cohesive coordinated care by integrating the diverse, collaborative services a patient may need. This integrative approach allows primary care practitioners to work with their patients in making healthcare decisions. These decisions are based on the fullest understanding of information in the context of a patient’s values and preferences.

Appropriate care coordination depends in large measure on the complexity of needs of each individual patient or population of patients. Factors that increase complexity of care include multiple chronic care conditions, acute physical health problems, the social vulnerability of the patient, and the involvement of a large number of primary and specialty care practitioners and providers involved in the patient’s care. Patients’ preferences and self-care management abilities can also affect the need for support and care coordination.

The medical home team or PMCH Health Care Team (HCT), that may consist of nurses, pharmacists, nurse practitioners, medical assistants, case managers, educators, behavioral health therapists, social workers, care coordinators, and others, is led by the primary care physician who
takes the lead in working with the patient to define their needs, develop and update plans of care, and coordinate care plans with the PCMH HCT.

Care coordination, within the KPMAS PCMH model, includes the following components:

**Determining and updating care coordination needs:** Coordination needs are based on a patient’s individual health care needs and treatment recommendations and care plan that reflect physical, psychological, and social factors. Coordination needs are also determined by the patient’s current health and health history; functional status; self-management knowledge and behaviors; and need for support services.

**Create and update a proactive plan of care:** Establish and maintain a plan of care, jointly created and managed by patients, their families and/or caregivers, and their health care team led by the primary care physician. The patient-centered plan of care outlines the patient’s current and long term needs and goals for care, identifies coordination needs, and addresses potential gaps. The care plan anticipates routine needs and tracks current progress towards patient goals using evidence-based medicine.

**Communication:** allows for the exchange of information, preferences, goals, and experiences among participants in a patient’s care. Including communication across clinical resources and facilities and leveraging access to direct scheduling and referral systems. Communication about care needs may take place in person, by phone, in writing, and/or electronically. Communication is especially critical during transitions in care. Primary care practitioners and providers are included in the transfer of information during transitions. Examples of transition include from the inpatient hospital or skilled nursing facility (SNF) to the ambulatory setting (i.e. physician's office).

**Align resources with population needs:** assess the needs of populations to identify and address gaps and disparities in services and care. Care coordination and feedback from practitioners, providers and patients should be used to identify opportunities for improvement (i.e. smoking cessation, weight management, self-management for diabetes, or health coaching).

KPMAS’ PCMH model of care is designed to improve the quality, appropriateness, timeliness, and efficiency of care coordination including clinical decisions and care plans. An overall performance goal is to improve the quality and efficiency of health care for members with complex and chronic conditions.

To provide the care our PCMH vision requires, our primary care providers play a pivotal role in guiding the PCMH HCT to provide timely, comprehensive, well-coordinated care.

KPMAS is responsible for identifying patients who qualify for its disease management and complex case management programs, notifying the PCMH HCT of qualifying members, and maintaining a tracking mechanism to monitor these members. Notification to the PCMH HCT is conducted for each patient when they qualify for the disease management or complex case management programs, if they are identified outside of the PCMH. The PMCH HCT and care coordinators of respective disease management or complex case management use KPMAS electronic health record (KP HealthConnect) to document care plans and provide that information as needed to coordinate patient care. In addition, patients, their family members, or anyone on the health care team, may refer a patient for complex case management or disease management programs.

Network providers, Kaiser Permanente Members/ Caregivers can take advantage of these services by calling the Case management Referral Telephone Line at (301) 321-5126, or toll free (866) 223-2347, 24 hours a day, 7 days a week. Messages are checked Monday-Friday during business hours by our case managers.
KP Online affiliate reminder

KP Online Affiliate allows providers to view and check member eligibility and benefits, referral status, claims status and our member’s medical records. When first registering for access to KP Online Affiliate please remember to download our first-time user instructions and follow all steps, complete steps 1-5 to avoid delays in activating your account. Thank you.