OUR ADVANCED CARE PROGRAM:
HOME-BASED CARE FOR THE CHRONICALLY ILL

“Prior to 1936, the common infections selectively killed those already sick, weakened, and maimed from other causes. People rarely died of the diseases from which they suffered. In the past four decades, however, technology has reversed that situation, adding years to sick rather than healthy lives. The resulting increase in the prevalence of chronic disease and disability represents the failure of our success. The extent to which our life-saving advances have outstripped our health – preserving technology must be recognized and the trend reversed – and it can be – if we are to improve rather than worsen people’s health.” - Ernest M. Gruenberg

“We are facing a change in the complexion of the patient population that we will be treating over the next century,” says William Schwab, MD, PhD, AGSF, chief of geriatrics for the Ohio Permanente Medical Group. The population and lifespan of the chronically ill is increasing. At the same time, the tax base supporting the elderly and the chronically ill is decreasing. But it is important to remember that this increasing number of the chronically ill is not a disaster; on the contrary, it’s a success.

However, this success is creating strain on a system that is designed for the acute care of acute illness. One percent of Kaiser Permanente of Ohio’s membership accounts for 25% of the healthcare costs. For many of these members, the resource utilization is appropriate and a result of the burden of their illnesses. However, for a significant fraction of these high utilization members, the problem is neither poor medical care nor burden of illness, but that the care is delivered in a manner that is inappropriate and ineffective for that particular patient due to the biopsychosocial context in which the illness occurs. “A significant percentage of patients who are resource intensive are using resources out of proportion to the burden of their illness,” Schwab says. “When this happens, it makes sense to have a multidisciplinary treatment approach to address the biopsychosocial factors associated with these types of illnesses.”

But how do we design and deliver care that is appropriate, patient centered, and most effective at Kaiser Permanente?

(continued on page 2)
INTRODUCING OUR ADVANCED CARE PANEL (ACP) PROGRAM

The ACP pilot program began in October 2007. More than 560 members were initially identified as eligible for the panel. The most common diagnoses for these members included hypertension, diabetes mellitus, and cardiac disease.

HOW ACP WORKS

Kaiser Permanente members are identified as potentially appropriate for the ACP program in two ways:

- Via comprehensive reports obtained from Kaiser Permanente’s Likelihood of Hospitalization (LOH) database
- Via a referral from the member’s primary care physician

Once the member is identified as potentially appropriate, the member is contacted and offered a place on the panel. If the member agrees, the ACP physician makes a visit to the member’s home for a full evaluation. The results of the member’s evaluation will then be discussed by the physician and the rest of the ACP team at the next biweekly team meeting. After the team meeting, the final plan of care, including frequency of review and visits, is clearly outlined and defined. Goals of care and advanced directives are then discussed with the member. The ACP member is then seen in the comfort of their own home and/or discussed by the ACP team approximately 12 times a year.

MEET THE ADVANCED CARE PANEL (ACP) AT KAISER PERMANENTE OF OHIO

- William Schwab, MD, PhD, AGSF
  - Responsible for: diagnosis, plan of care, follow up, monitoring outcomes, disease management, member education, and counseling
- Willa Pugh, RN
  - Responsible for: nursing interventions as appropriate, follow up on intervention and monitoring outcomes, disease management, member education, and counseling
- Sharon Hauser, PharmD (Pharmacy)
  - Responsible for: monitoring for appropriate utilization of medications, follow up and monitoring medication outcomes, disease management, member education, and counseling
- Kathleen Skerl, LISW (Social Work)
  - Responsible for: psychosocial assessment and intervention, follow up on intervention outcomes, coordination with community and outside resources, member education, and counseling
- Kathy Mortach, LPN (Office-Based Scheduler)
  - Responsible for: assisting with whatever needs to be done for the ACP to function at a high level, acting as an accessory brain to the panel members, serving as the “den mother” of the team.
- Phone-based Behavioral Health

(continued from page 1)

WHAT DO YOU THINK OF THE PROVIDER CONNECTION NEWSLETTER?

We would appreciate your feedback. Please visit providersurvey.mcmurry.com by June 15, 2010, to take a quick online survey. If you prefer, you can fill out a hard copy of the survey, included on page 15 of this issue, and return it to us, postmarked or faxed no later than June 15, 2010. Enter your name and contact information at the end of the survey and you’ll be entered in a drawing for a $75 gift certificate to the Olive Garden® Restaurant.

(continued on page 3)
IS THE ACP PROGRAM A SUCCESS?

A recent article in the New England Journal of Medicine states: “In [Kaiser Permanente’s] Ohio region, the 1% of patients who were identified by predictive models as accounting for 27% of [Kaiser Permanente’s] total costs were referred to a high-risk clinic in which a geriatrician-led multidisciplinary team provided home care for a small panel of 150 patients. As compared with similar patients receiving usual care, high-risk clinic patients had fewer hospitalizations, fewer emergency department visits, and lower hospital expenses.”

Not everyone who enters the ACP program will have successful outcomes. Additionally, the ACP program is not appropriate for all of our members who are chronically ill. Member buy-in is critical to the success of the program, and the patient and care team goals must coincide. But the early results indicate that the program is working to improve the health outcomes of our chronically ill patients, while remaining cost effective to the organization.

“With the ACP, we’ve reduced utilization of resources while maintaining quality care without denying access to care,” Schwab says. “The ultimate goal of the ACP is to reduce inappropriate and unnecessary resource utilization among our chronically ill population by improving access, quality, and coordination of care.”

Despite utilizing 3 full time ACP staff members to see a small panel of patients, Kaiser Permanente of Ohio has seen a significant return on investment, as evidenced by the metrics in the chart below.

DO YOU HAVE A PATIENT THAT COULD BENEFIT FROM THE ACP PROGRAM?

Kaiser Permanente members using a community-based Primary Care Physician may be eligible for the ACP program. However, when a member is deemed eligible and agrees to enter the ACP program, all of that member’s medical care will transfer to Dr. William Schwab, and he will become their new Primary Care Physician. This requirement is due to the intensity of the ACP program and the difficulty of coordination of care between multiple physicians for this patient population.

If you have a Kaiser Permanente member that would be a good candidate for the program or if you have additional questions, please contact Kathy Mortach, LPN for further information. She can be reached by phone at 440-953-5731 or via e-mail at Kathy.Mortach@kp.org.


<table>
<thead>
<tr>
<th>Pre-Intervention Data (6 months prior)</th>
<th>Comparator</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood of hospitalization score</td>
<td>41.9</td>
<td>41.8</td>
</tr>
<tr>
<td>Depression diagnosis (%)</td>
<td>24.7%</td>
<td>17.6%</td>
</tr>
<tr>
<td>ED utilization (%)</td>
<td>33.3%</td>
<td>35.2%</td>
</tr>
<tr>
<td>Inpatient admission (%)</td>
<td>37.0%</td>
<td>37.0%</td>
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<tr>
<td>Inpatient admission cost</td>
<td>$2,335</td>
<td>$2,412</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Post-Intervention Data* (those with 6 months enrollment in the ACP)</th>
<th>Comparator</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient admission (%)</td>
<td>26.8%</td>
<td>17.4%</td>
</tr>
<tr>
<td>ED utilization without hospital admission (%)</td>
<td>21.1%</td>
<td>17.4%</td>
</tr>
<tr>
<td>30-day readmission (%)</td>
<td>9.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Inpatient admission cost</td>
<td>$4,171</td>
<td>$2,837</td>
</tr>
</tbody>
</table>

*Statistical significance has not yet been achieved due to the low event rate.
UTILIZATION MANAGEMENT

On February 1, 2010, Kaiser Permanente of Ohio modified its Utilization Management pre-certification list. This modification may significantly impact the way that you interact with Kaiser Permanente. A number of services that were previously included on either the Auto Authorization or Auto Pay lists, as contained in Section 4.7.4 of the Kaiser Permanente Provider Manual, now require pre-certification. For specific changes and new contact information, based upon the member’s Kaiser Permanente Health Plan product, please see page 6.

QUICK REFERENCE GUIDE AND AUTO AUTH/AUTO PAY LISTS


A hard copy of the new Pre-certification and Mandatory Authorization Quick Reference Guide was mailed to all of our contracted provider offices on December 31, 2009. A printable version of the new guide can be found in the Pre-authorizations section on our Community Provider Web site at providers.kp.org/oh.

Updated Auto Authorization and Auto Pay lists are also available for downloading and/or printing from the Pre-authorizations section on our Community Provider Web site. If you did not receive the new Quick Reference Guide or if you do not have access to these materials online, you may contact your Network Associate or the Kaiser Permanente Network Development department at 1-800-441-9742, option 4, to request hard copies.

(continued on page 5)
Behavioral Health Care

<table>
<thead>
<tr>
<th>Accessibility Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent, Life threatening</td>
</tr>
<tr>
<td>Non-life-threatening emergency: Severe crisis, not life-threatening but with potential to become so, without intervention</td>
</tr>
<tr>
<td>Urgent needs: Severe crisis, not life-threatening, including impaired ability to function in normal roles due to symptoms</td>
</tr>
<tr>
<td>Routine office visits: All other problems and symptoms not meeting definition of emergent or urgent; may have been present over time</td>
</tr>
</tbody>
</table>

ACCESSIBILITY STANDARDS

PROVIDER MANUAL DEFINITION CHANGES

Please note, as described in the first paragraph of Section 4.4 Utilization Management of the Kaiser Permanente Provider Manual, the terms “Referral, Authorization, Preauthorization and Pre-certification” are no longer interchangeable. The use of the term Preauthorization has been discontinued. Revised definitions for the other terms are as follows:

- **Referral:**
  A prospective, written recommendation by a Plan Provider for medical care, equipment and/or supplies. A referral is not approved until it is authorized by Kaiser Permanente.

- **Pre-certification:**
  A determination by Kaiser Permanente that an admission, extension of stay or other health care service has been reviewed and, based upon the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

- **Authorization:**
  Kaiser Permanente’s approval for the provision of Covered Benefits to Members by persons designated to provide such approval pursuant to Kaiser Permanente’s Utilization Management Programs and in the manner specified as described in Section 4 of the Provider Manual. Further, “Authorization” also means the document or electronic documentation indicating Kaiser Permanente’s approval, as the context requires. “Authorized” means provided pursuant to and in compliance with an Authorization.

If you have any questions, please feel free to contact your Network Associate or the Kaiser Permanente Network Development department at 1-800-441-9742, option 4.
Due to the recent changes to our Utilization Management program (see article on page 4), we would like to provide you with specific information regarding pre-certification requirements for our members, based upon their Kaiser Permanente Health Plan product. Also, we have added some new Utilization Management contact phone and fax numbers. For your convenience, contact numbers are included below.

KAISER PERMANENTE COMMERCIAL MEMBERS (ALL NON-MEDICARE PLANS)

Services provided to Kaiser Permanente commercial members that were included on the Auto Auth/Auto Pay lists in the past and now require pre-certification include, but are not limited to:

- Diagnostic Radiology/Imaging including MRI, MRA, CT
- Sleep Studies
- Pain Management
- Chemotherapy
- Nuclear Medicine

Please continue to use the Pre-certification telephone or fax numbers below for obtaining pre-certification for all inpatient admissions and selected outpatient and diagnostic services for non-Medicare members.

Pre-Certification Phone Number: 1-866-433-1333
Pre-Certification Fax Number: 1-877-705-2503

KAISER PERMANENTE MEDICARE MEMBERS

The following services provided to Kaiser Permanente Medicare members require pre-certification.

- Skilled nursing facility admissions, including transfer from inpatient facility to skilled nursing facility
- Bariatric surgery
- Transplant services

Please use the Pre-certification telephone number and new Medicare fax number below for notification and pre-certification of the services listed above.

Medicare Pre-Certification Phone Number: 1-866-433-1333
Medicare Pre-Certification Fax Number: 216-529-5532

Additionally, the following home-based services require notification and/or pre-certification through the Kaiser Permanente Home Health Care Department.

- Home health care services
- Home IV infusion services
- Home rehabilitation services
- Hospice care

Please use the Home Care telephone and fax numbers below to provide notification and request pre-certification for home based services.

Medicare Home Care Phone Number: 1-866-433-1333
Medicare Home Care Fax Numbers: Home Health Care, Home Rehabilitation & Hospice - 216-778-6073 Home IV Infusion - 216-265-6856

To request additional inpatient days for a skilled nursing facility stay, please use the new fax number below to submit concurrent review information for Medicare members receiving care in a skilled nursing facility (SNF).

Medicare SNF Concurrent Review Fax Number: 216-398-3514

All other outpatient services for Medicare members do not require notification or pre-certification.

If you have any questions, please feel free to contact your Network Associate or the Kaiser Permanente Network Development department at 1-800-441-9742, option 4.
ON THE WEB WITH KAISER PERMANENTE

Our Community Provider Web site is designed with you in mind! With just a point & click you can access the latest Kaiser Permanente news, view our drug formularies, download commonly used forms, and much more.

Visit us today at: providers.kp.org/oh

Here is a sample of what is available online….

NEWS AND ANNOUNCEMENTS
Here you’ll find up-to-date information about what is happening at Kaiser Permanente of Ohio, including any changes that may affect how you provide care to our members. The “News and announcements” link is located on the left side of our Web site’s home page. Our most recent announcements include an overview of changes to our Utilization Management program and an introduction to our new vision care provider for 2010, VSP® Vision Care.

KP HEALTHCONNECT ONLINE-AFFILIATE PROGRAM
Online-Affiliate is our interactive program that can be used to access your Kaiser Permanente members’ electronic medical records, eligibility and benefit information, and review and request referrals. Providers are required to log-in to this section of our Web site, in order to protect our member’s privacy and comply with all HIPAA regulations.

If you are interested in using this feature, you will need to complete a User Enrollment Form and a License and User Agreement Form located on our Provider Web site. Once we receive your completed forms, we will send you a Welcome packet containing your log-in information and instructions on how to use Online-Affiliate. Enrollment forms are available in the Forms section of the Web site.

CLINICAL PRACTICE GUIDELINES
Kaiser Permanente Ohio has developed a wide array of Preventive Care and Clinical Practice Guidelines to support your clinical practice in providing quality care for our members. You can access these guidelines on our Web site. Clinical Guidelines are located under the “Provider information” section. Each guideline can be downloaded and printed, as needed.

Clinical Practice Guidelines are updated as changes and additions occur. We will notify you of all guideline updates in the News and announcement section referenced above. If you are not able to access the Preventive Care and Clinical Practice Guidelines online, you may request that hard copies of the guidelines be mailed to your office.

Coming in April/May 2010: Updates to Dementia, Breast Cancer Management, Coronary Artery Disease, Diabetes, Musculoskeletal Pain, Cervical Cancer Screening guidelines, and more.

NEWSLETTERS AND DRUG THERAPY ADVISORY
Our Provider Connection newsletters and monthly Drug Therapy Advisory sheets are now posted online. Current and archived issues of both publications are available for review and download. You can locate them in the “Provider information” section, under “Newsletters.”

NO ACCESS TO OUR WEB SITE? NO PROBLEM.
We know that not all practitioner/provider offices have access to the Internet. If you or your office staff would like to receive printed copies of any forms, guidelines, or documents referenced in this article or anywhere else in this newsletter, please contact your Network Associate or the Kaiser Permanente Network Development department at 1-800-441-9742 (toll free), option 4. We will be happy to mail them to your office.
EDI CLAIMS
Electronic claims submission (EDI) continues to grow at Kaiser Permanente, allowing us to improve our turnaround time for processing claims. Since electronic claims do not have to be scanned or manually keyed, turnaround times have improved for EDI claims.

In addition to electronic remittances, we now offer the option of having your payments deposited via an electronic funds transfer (EFT). Now you can submit claims to Kaiser Permanente and receive remittance advice and payment without handling a sheet of paper!

SUBMITTING SECONDARY CLAIMS VIA EDI
Kaiser Permanente of Ohio does and will continue to welcome electronic secondary claims submission. To process the claims correctly, we need the detail of the primary payment. Therefore, we require that providers adhere to the Coordination of Benefit (COB) guidelines specified in the HIPAA Implementation Guide section 1.4.2. The claim must report all applicable claim level adjustment amounts (Loop 2320) as well as service line level adjustment amounts (Loop 2430). Claims without this information will have to be denied and further information will be requested.

SUBMITTING CLAIMS FOR DUALLY COVERED MEMBERS
When a Kaiser Permanente member is covered under two Kaiser Permanente benefit plans, please submit the claim once. Our Claims Operations team will pay under both plans so you will receive remittance advice and payment under both the primary and secondary Kaiser Permanente coverage.

837P CODING ALERT
If you submit via 837P, and have received a denial due to the lack of a rendering provider on your claim, please confirm with your EDI team which loop the rendering provider information was populated into.
- Loop 2310A indicates the referring provider.
- Loop 2310B indicates the rendering provider.

We’ve had a spate of claims submitted with a referring provider, but no rendering provider. Since we must process claims according to the information given, even if we suspect an error we are required to deny the claim back to you for resubmission, delaying your claims payment.

PREPARING FOR THE FUTURE
On January 16, 2009, Health and Human Services announced the final rules for the 5010 Transactions sets for electronically submitted claims and the ICD-10 code sets. Kaiser Permanente has begun a national project to ensure we are prepared to begin accepting and processing both the 5010 transaction sets and the ICD-10 codes on schedule. We are on track for full compliance.

TO SET UP ELECTRONIC CLAIMS SUBMISSION (837 TRANSACTIONS):
Contact your EDI clearinghouse to submit claims to Kaiser Permanente of Ohio through one of our contracted clearinghouses using the appropriate Payer ID. There’s no need for you to contact Kaiser Permanente to begin submitting your claims via EDI. We’re ready to accept electronic claims whenever you submit them.

<table>
<thead>
<tr>
<th>CLEARINGHOUSE</th>
<th>PAYER ID FOR KAISER PERMANENTE OF OHIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>RelayHealth</td>
<td>RH007</td>
</tr>
<tr>
<td>Emdeon: including</td>
<td>34092</td>
</tr>
<tr>
<td>• Consult, Inc.</td>
<td></td>
</tr>
<tr>
<td>• eTactics, Inc.</td>
<td></td>
</tr>
<tr>
<td>McKesson via Emdeon</td>
<td>2259</td>
</tr>
<tr>
<td>Quadax</td>
<td>Contact clearinghouse directly</td>
</tr>
<tr>
<td>Capario (Medavant)</td>
<td>KS005</td>
</tr>
</tbody>
</table>

You can also submit claims and member inquiries to us via the Availity multi-payer web portal. For more information, please see the Availity article on page 17 or contact the Network Development Department at 1-800-441-9742, option 4.

(continued on page 9)
TO SET UP ELECTRONIC REMITTANCE ADVICE (835 TRANSACTIONS):

Contact our Network Development Department or the EDI Coordinator for the 835 Provider Setup Information form. Complete this form, and email or fax it to our EDI Coordinator. This form is also available in the “Forms” section of our Community Provider Web site at providers.kp.org/oh. The 835 setup can usually be completed without any further requests for information.

TO SET UP ELECTRONIC PAYMENT:

Contact our Network Development Department or EDI Coordinator to retrieve the EFT Provider Setup form. This document is also available in the “Forms” section of our Community Provider Web site at providers.kp.org/oh. Complete this document and mail a signed copy to our EDI Coordinator with the required attachments.

Elizabeth Estep, EDI Coordinator:
Phone: 216-227-4956
Email: elizabeth.f.estep@kp.org

Or mail to:
Elizabeth Estep,
Kaiser Permanente,
14600 Detroit Avenue,
7th Floor
Lakewood, OH 44107

QUESTIONS…

If you have any questions, please contact Network Development at 1-800-441-9742, option 4 or refer to the “Claims” section of Community Provider Web site at providers.kp.org/oh.

Kaiser Permanente®

Claims Corner
(continued from page 8)
Kaiser Permanente has developed two drug formularies, Commercial and Medicare Part D, to be used by all contracted Kaiser Permanente providers.

The medications included in the Kaiser Permanente drug formularies are determined by a group of Kaiser Permanente physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics (P&T) Committee. Formulary medications covered under the Medicare Part D drug benefit must also be approved by the Centers for Medicare and Medicaid Services (CMS).

The P&T Committee meets regularly to evaluate and choose medications that are most effective, safe, and useful in caring for our members. Frequently, several drugs will work equally well for a medical condition. In such cases, the Committee considers other factors – such as safety, unique value, and cost – to determine those medications that offer the best value for our members.

The P&T Committee reviews and updates the formularies throughout the year and notifies our providers, pharmacists, and other clinicians about any changes.

Kaiser Permanente HMO and Medicare plans use a closed drug formulary. Only medications included in each plan’s drug formulary are covered under the member’s prescription drug benefit. Members who choose to purchase a nonformulary medication should expect to pay the full retail cost of the medication. Some of our members are enrolled in our Added Choice® Point of Service (POS) Plan in which nonformulary drugs may be covered, but require a higher copayment.

Prescription drug coverage may vary, based upon the member’s health benefit plan. Not all Kaiser Permanente health plans include prescription drug coverage. Additionally, some prescription drug coverage may exclude certain drugs, cover drugs at varying levels based upon drug cost, or limit the amount of the drug the member can receive with a prescription or copayment. Members should consult their Evidence of Coverage (EOC) or call the Customer Relations Department at 1-800-686-7100 (toll free) or 1-877-676-6677 (TTY for the deaf, hard of hearing, or speech impaired) for specific prescription drug coverage information.

Requesting coverage of a nonformulary or criteria-restricted medication for an individual HMO or Medicare member

The formularies are designed to meet the needs of the majority of our members. However, there are instances when the use of a nonformulary drug is necessary. Prescriptions for nonformulary medications may be filled at Kaiser Permanente pharmacies. The member should expect to pay the full retail cost unless the prescribing practitioner has obtained approval for the nonformulary medication or the member has a benefit that provides coverage at a higher nonformulary copayment. There may be a delay in filling the prescription because the pharmacy may need to place a special order. Coverage of certain formulary medications may also be subject to restrictions established by the Regional P&T Committee.

Nonformulary medications may be covered under the Formulary Exception Policy in the same manner as formulary drugs if:

- Formulary medications have proven ineffective; or
- The formulary medication causes or is reasonably expected by the plan physician to cause harmful or adverse reactions

All nonformulary medications require authorization through Kaiser Permanente’s Pharmacy Utilization Management Department prior to dispensing to assure coverage by the member’s drug benefit.

To seek approval for coverage of a nonformulary drug for a member, prescribing practitioners must complete the Request for Drug Coverage form.

The Request for Drug Coverage form is available –

- By calling:
  - Pharmacy Utilization Management 216-524-5003 or 1-866-524-5003 (toll free)
  - MedImpact 1-800-788-2949 (toll free)
  - Any Kaiser Permanente Medical Office Pharmacy
- On our Community Provider Web site, at providers.kp.org/oh/viewforms.html
- In your Practitioner/Provider Manual

The purpose of completing the form is to document the medical necessity for using a nonformulary medication. Whenever possible, providers should complete the form using specific laboratory data, physical exam findings, and other supporting documentation.

(continued on page 11)
Our Kaiser Permanente Drug Formularies
(continued from page 10)

Instructions for completing the Request for Drug Coverage form:

1. Complete all requested information. When requesting coverage of a COX-2 Inhibitor, please use the specific form for these drugs. All other medications should be requested using the standard Request for Drug Coverage form.
2. Submit a separate form for each patient and for each drug you wish to have reviewed.
3. Keep a copy for your records.
4. Fax the form to: Kaiser Permanente Pharmacy Utilization Management Service
   216-635-4500 or 1-866-635-4500 (toll free)
OR Mail to: Kaiser Permanente Pharmacy Utilization Management Service
   5500 Lancaster Drive
   Brooklyn, OH 44131

Each request will be reviewed by the Pharmacy Utilization Management staff against established criteria that has been approved by the Regional Pharmacy and Therapeutics Committee and the appropriate department chiefs of the Ohio Permanente Medical Group (OPMG). Approvals may be granted only if the practitioner can document the ineffectiveness of formulary alternatives or the reasonable expectation of harm to the patient from the use of formulary medications. In most cases, patients must have failed at least two formulary alternatives or have experienced adverse effects from the use of the formulary medications. If a request does not meet the criteria, a pharmacist will recommend formulary alternatives to the requesting practitioner. However, if the requesting practitioner disagrees with these recommendations, the request will be sent to a Pharmacy Utilization Management Physician for a decision. A response will be faxed to the requesting practitioner and the member will be notified by mail. In most cases, approvals will be given an unlimited authorization date so that the practitioner will not be required to resubmit a request every year.

For expedited requests, include “Expedited Request” on faxed form. A secondary method would be to call Pharmacy Utilization Management at 216-524-5003 or 1-866-524-5003. For weekend and holiday expedited requests, please call one of the numbers above and follow the instructions given. For members with the commercial drug formulary benefit, the expedited process can take up to 72 hours. For members with the Medicare Part D drug formulary benefit, the expedited process can take up to 24 hours. To make an expedited request, one of the following criteria must be met:

- The drug is necessary to complete a specific course of therapy after discharge from an acute care facility.
- The time frame required for a standard review would compromise the member’s life, health, or functional status.
- The drug requires administration in a time frame that will not be met using the standard process.

Appeal Process

If coverage is denied, the prescribing practitioner can appeal the decision in two ways:

1. The prescribing practitioner can submit written comments, documents, records, or any other information that may be required for the reconsideration process and mail it to:
   Kaiser Permanente Appeals Unit
   P.O. Box 93764
   Cleveland, OH 44101-5764

2. The prescribing practitioner can contact the Kaiser Permanente Appeals Unit at 216-635-4664 or 1-888-479-5333 (toll free). The prescribing practitioner will be notified in writing as to the outcome of the appeal. Additionally, the member who has been denied coverage may file an appeal by contacting Customer Relations at 216-621-7100 or 1-800-686-7100 (toll free). Medicare members may call 1-800-493-6004 (toll free) or 1-866-513-9966 (TTY for the deaf, hard of hearing, or speech impaired).
PRACTITIONER/PROVIDER APPEALS

Contracted practitioners and providers have the right to appeal any decision made by Kaiser Permanente to deny reimbursement for services rendered, or any decision to deny a pre-authorization or a referral based on medical necessity. The following information is an overview of the Kaiser Permanente Provider Appeal Process.

Note: This process pertains to denials for payment or preauthorization only. This process does NOT pertain to claims payment disputes that are related to bundling/unbundling, or over- or under-payments.

APPEAL PROCESS OF PRE-SERVICE DENIALS

The requesting practitioner/provider may submit a written appeal request to the Kaiser Permanente Appeals Unit at the following address:

Kaiser Permanente
Appeals Unit
P.O. Box 93764
Cleveland, OH 44101-5764

Or fax the appeal request to: 216-635-4673

Appeal requests must be received within the same timeframes that are offered to our members. These timeframes are:

- Commercial members (per the Department of Labor [DOL] and the National Committee for Quality Assurance [NCQA]): within 180 calendar days of receipt of the initial adverse determination.
- Medicare members (per the Centers for Medicare and Medicaid Services [CMS]): within 60 calendar days of receipt of the initial adverse determination.
- Federal Employee members (per the Office of Personnel Management [OPM]): within six months of receipt of the initial adverse determination.

The Kaiser Permanente Appeals Unit review nurse will review the documentation and contact the appealing practitioner/provider for additional information if needed.

The appeal will be reviewed by either the Medical Advisory Council (MAC) for medical necessity denials, or the Benefits Advisory Council (BAC) for benefit denials within 30 calendar days of receipt of the appeal request.

An appropriate physician or behavioral health clinician makes all decisions for medical appropriateness. Physicians participating on the Medical Advisory Council shall not have been involved in the initial determination or be subordinates of a physician involved in the initial determination. For urgently needed services, the appeal will be reviewed by a physician of similar or like specialty as expeditiously as the health condition requires, but no later than 72 hours.

If the initial denial is overturned, the Appeals Unit staff will contact the practitioner/provider and the member in writing within 30 calendar days of the request (telephonically for urgently needed services within 72 hours), and will process the request per department procedures.

If the initial denial is upheld, the Appeals Unit staff will contact the practitioner/provider and the member in writing within 30 calendar days of receipt of the request (telephonically for urgently needed services within 72 hours), informing them of the rationale for the decision and providing information on any further appeal rights. For Medicare members: if the initial denial is upheld, the case will automatically be forwarded to Medicare’s Independent Review Entity for the final determination.

APPEAL PROCESS OF POST-SERVICE DENIALS

(Provider Submissions)

All providers/practitioners have the opportunity to appeal for denied payment of unauthorized services rendered to members, when the member is not financially responsible for charges incurred. If the member has been billed for services, the member must submit their own appeal request. All appeals for payment will be responded to within 90 calendar days from receipt. Please note that this process only applies to those claims that have been denied based on the absence of prior authorization where authorization is required. This process does NOT apply to claims payment disputes.

The provider/practitioner may submit a written appeal request to the Kaiser Permanente Appeals Unit. Please feel free to include pertinent clinical information; however, medical necessity is NOT a guarantee for payment for services requiring prior authorization. Send the appeal along with any supporting documentation to:

Kaiser Permanente
Appeals Unit
P.O. Box 93764
Cleveland, OH 44101-5764

Or fax the information to: 216-635-4673

(continued on page 13)
Practitioner/Provider Appeals
(continued from page 12)

Appeal requests must be received within the same timeframes as for Pre-Service Appeals (as described on page 12). The appropriate physician advisor or behavioral health clinician involved in a previous decision will not review the appeal request at a subsequent level.

A decision is made within 90 calendar days of receipt of the appeal request. The practitioner/provider is notified, in writing, when the denial is upheld.

The Appeals Unit staff communicates an overturn decision to the Kaiser Permanente Claims Department. Reprocessing of the claim will be performed within 30 days of the decision and will serve as notice of the overturn.

APPEAL PROCESS FOR APPEALS RELATED TO DENIED MEDICARE PART D PRESCRIPTION DRUGS (PRE- OR POST-SERVICE)

Prescribing practitioners have the right to appeal any decision made by Kaiser Permanente to deny coverage of a Part D prescription drug benefit. The process for filing an appeal remains the same as under “Appeals Process of Pre-Service Denials” and “Appeals Process of Post-Service Denials.” However, the timeframes for rendering a decision for Medicare Part D appeals are as follows:

- Seven calendar days for standard pre- or post-service requests
- 72 hours for expedited appeal requests

Additionally, in the event that the decision is to uphold the initial denial, members will be instructed on how to proceed with an external review through Maximus Federal Services. Unlike the automatic submission to Medicare’s Independent Review Entity of all upholds of Part C services, the member must request an external review of Part D denials in writing. The redetermination notice will instruct the member as to the process and timeframe for requesting an external review.

Should you have any questions regarding the Appeal Process, please feel free to contact the Kaiser Permanente Appeals Unit at 216-635-4664, or toll free at 1-888-479-5333.
Kaiser Permanente wants our members to be satisfied with our services, our facilities, and our physicians. Customer Relations welcomes any member commentary, compliments, or complaints, regarding our medical services or administrative procedures. If members are dissatisfied for any reason, they can contact us in writing or by calling Customer Relations at 1-800-686-7100 (toll free) or 1-877-676-6677 (TTY for the deaf, hard of hearing, or speech impaired).

For written complaints or grievances:
Customer Relations
Kaiser Foundation Health Plan of Ohio
P.O. Box 5309
Cleveland, OH 44101

The member, or the member’s authorized representative, must sign all written complaints or grievances. An authorized representative may be any person that the member authorizes in writing to act on his/her behalf.

All complaints or grievances are reviewed by a neutral party, up to and including the President of Kaiser Foundation Health Plan of Ohio, or the President and Medical Director of the Ohio Permanente Medical Group. Customer Relations will acknowledge receipt of complaint or grievance within 5 business days and will respond in writing to formal written complaints or grievances within 30 days. The member will be notified if additional time is required.

For verbal complaints or grievances:

**NON-MEDICARE**

- Monday through Thursday: 8:15 a.m. to 5:00 p.m.
- Friday: 9:00 a.m. to 5:00 p.m.
- 216-621-7100 or 1-800-686-7100 (toll free)
- 1-877-676-6677 (TTY for the deaf, hard of hearing, or speech impaired)

**MEDICARE**

- 8:00 a.m. – 8:00 p.m., 7 days a week (including holidays)
- 1-800-493-6004 (toll free)
- 1-866-513-9966 (TTY for the deaf, hard of hearing, or speech impaired)

Members who call after regular office hours may leave a message, and a representative will return their call the next business day.

Kaiser Permanente of Ohio strives to provide services in a way that embraces all members, including those with limited English language or reading skills. Information pertaining to member complaints or grievances may be available in alternate formats. If your patient has special needs, questions or concerns, they may contact our Customer Relations Department at the phone numbers listed above for additional assistance.
Kaiser Permanente of Ohio wants you to get the most out of the Provider Connection, our network provider newsletter. One of the ways we can make sure this happens is to hear from you.

Let us know your thoughts about the Provider Connection by completing this survey. At the end of the survey, you can enter your name for a chance to win a $75 gift certificate to the Olive Garden® Restaurant.

1. When you receive the Provider Connection, how often do you read it?
   - □ Never read it
   - □ Read it occasionally
   - □ Read every issue

2. When you receive the Provider Connection, how much of it do you read?
   - □ Skim through it without reading any articles
   - □ Read a few articles that sound interesting
   - □ Read all the articles

3. Please rate the following topics on how important they are to you personally.
   (1 being not important to you and 5 being very important to you)

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<th>Information on:</th>
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<td>New Kaiser Permanente affiliated practitioners</td>
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</table>

4. In general, are the articles in the Provider Connection informative and relevant to your practice?
   - □ Yes
   - □ No

5. What do you do with the newsletter after reading it?
   - □ Keep it for reference
   - □ Discard or recycle
   - □ Pass it along to another person in your office
The current Provider Connection newsletter and past issues are available electronically on our Community Provider Web site, providers.kp.org/oh. You can read, download or print any of the newsletters, as needed.

6. Have you visited our Community Provider Web site, providers.kp.org/oh?
   - Yes
   - No

7. Do you read, download or print the Provider Connection from our Community Providers Web site?
   - Yes
   - No

8. Would you prefer to:
   - Receive a printed version of the Provider Connection in the mail
   - Receive an e-mail reminder when the latest issue of the Provider Connection is posted on the Web site
   - Access the Provider Connection on the Web site without an e-mail reminder

9. Where do you work?
   - Primary Care Office (PCP)
   - Specialty Care Office (SCP)
   - Multi-specialty Care Office (both PCP & SCP)
   - Hospital
   - Ancillary Care Facility

10. What is your responsibility?
    - Physician
    - Other healthcare professional
    - Practice or office management
    - Finance, billing or claims
    - Managed care, authorization or referrals
    - Administration
    - Other

Thank you for completing this survey. If you would like to be entered into a raffle for a chance to win a $75 gift certificate to the Olive Garden® Restaurant, please fill out the contact information below and return by June 15, 2010. (Please print)

Name: ____________________________________________________________

Address: _______________________________________________________________________________________________________

_________________________________________________________________________________________________________

Phone: _______________________________________________________________________________________________________

E-mail: _______________________________________________________________________________________________________

Completed surveys may be mailed to: Kaiser Permanente of Ohio, Network Development
1001 Lakeside Dr., Suite 1200
Cleveland, OH 44114

Or fax both sides of the survey to: 216-479-5550
A FRESH LOOK!

**PROVIDER CONNECTION GOES “GREEN”…**

*Provider Connection* has a new look! We’ve spruced up our design, changed our masthead and added new colors and text styles. Additionally, we’ve gone “green” by printing this newsletter on recycled, eco-friendly paper. At Kaiser Permanente, we continually strive towards improving the environment, and to make the link between the health of our members, the communities we serve and our planet.

We hope you like the new look! If you have any comments or suggestions, please submit them to our editor, Julie Franklin, via e-mail at julie.m.franklin@kp.org or by phone at 216-479-5095.

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**ADMINISTRATIVE SIMPLIFICATION FOR YOUR OFFICE**

**A MULTI-PAYER WEB PORTAL FOR PROVIDERS OF HEALTH CARE IN OHIO**

Ohio’s health plans, including Kaiser Permanente of Ohio, are collaborating with Availity, one of the nation’s leading health information networks, to deliver a multi-payer Web portal to Ohio providers of care. The Availity® Health Information Network will provide you with free access to the state’s leading health plans for the exchange of administrative information in real-time.

The portal offers the following transactions:

- Eligibility and Benefits
- Claim Status
- Web-Entered Claims
- Authorizations and Referrals*

(*Not available for all participating plans, including Kaiser Permanente of Ohio)

**COLLABORATING FOR SUCCESS**

This collaboration among health plans, America’s Health Insurance Programs, Availity, and the Blue Cross and Blue Shield Association is designed to simplify the exchange of real-time information with health plans through Availity’s secure provider Web portal. A free service for participating providers, the portal helps providers of care improve service to patients and streamline the health care claims process.

Availity will provide your practice with the necessary training to get up and running—and offers integration options with numerous practice management systems so you can leverage your existing investment.

Over time, the founding partners of the Ohio administrative simplification program will measure provider adoption and gather information on the widespread use of electronic tools. Through these evaluative efforts, your experiences can influence the development of similar portals – both here in Ohio and across the country.

Availity optimizes information exchange between multiple health care stakeholders through a single, secure network. The Availity Health Information Network encompasses administrative, financial, and clinical services, supporting both real-time and batch exchange via the Web, business-to-business (B2B) integration, and electronic data interchange (EDI).

All providers in the state of Ohio are eligible to participate. For more information, including an online demonstration, please visit availity.com.
We need your help in keeping our provider information accurate and up-to-date. Remember to notify Kaiser Permanente in advance of any changes to your practice, such as the addition of a new practitioner or a change in office location. For practitioner terminations, please notify us at least 30 days in advance of the termination to ensure continuity of patient care is not affected. Thank you.

Please welcome the following practitioners as Kaiser Permanente affiliated providers:

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<tr>
<th>PRACTITIONER</th>
<th>NETWORK</th>
<th>SPECIALTY</th>
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<tr>
<td>Russell A. Blair, MD</td>
<td>Lake</td>
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<td>Leonard L. Brzozowski, MD</td>
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<td>Russell A. Blair, MD</td>
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<td>Navdeep Kaur, MD</td>
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<td>Rajinikanth Seshan, MD</td>
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<td>Teresa K. Larsen, DO</td>
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<td>Thomas G. Smith, MD</td>
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<td>Richard E. Hammond, DPM</td>
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<td>Gaurang Shah, MD</td>
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<tr>
<td>Anca M. Barbu, MD</td>
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<tr>
<td>Michael Broniatowski, MD</td>
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<td>Fred B. Pearlman, DO</td>
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<td>Isabelle E. Lane, DO</td>
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<td>Eric J. Paul, DPM</td>
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<td>Louise A. Kolarik, MD</td>
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<td>Shakeel A. Bahadur, MD</td>
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<td>Mark J. Hudak, MD</td>
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<td>Erick C. Lear, LISW</td>
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<td>David C. Brinkman-Sull, PhD</td>
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<td>Elliot D. Schprechtman, MD</td>
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<td>Ratnaja Katneni, MD</td>
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<td>Lara Burrows, MD</td>
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<td>Roger J. Hudgins, MD</td>
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<td>James M. Lewis, MD</td>
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<tr>
<td>Mary K. Murray, MD</td>
<td>Summit</td>
<td>Surgical Oncology</td>
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The following practitioners are no longer Kaiser Permanente affiliated providers:

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<td>Wissam E. Khoury, DPM</td>
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### New Kaiser Permanente affiliated physicians

(continued from page 18)

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<tr>
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<td>Samir J. Shaia, DO</td>
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In this issue:

- Speak Up: Provider Connection Survey
- Our Advanced Care Program
- Utilization Management Program Updates
- A Fresh Look! Provider Connection goes “Green”

and more...