Kaiser Permanente of Georgia Focused on High Quality Care

Kaiser Permanente aims to be a leader in integrated health delivery by making lives better. We strive to provide high quality care by delivering the best care possible with a patient and family-centered focus. Improved care at Kaiser Permanente translates to improved health and better outcomes for the members we serve, helping us accomplish the goal we all want to achieve.

The success of our goals and programs are measured annually utilizing reports from clinical outcomes and member satisfaction sources including:

- National Committee for Quality Assurance (NCQA)
- Health Plan Employer Data and Information Set (HEDIS)
- Consumer Assessment of Health Providers and Systems (CAHPS) Survey

A few of Kaiser Permanente’s 2014 accomplishments include:

- Each year, NCQA awards accreditation status based on triennial survey and annual HEDIS and CAHPS results. Kaiser Foundation Health Plan of Georgia maintained an ‘Excellent’ status, which is the highest level awarded by NCQA. In the state of Georgia, Kaiser has the only commercial HMO and Medicare products designated as ‘Excellent’ plans.
- For the sixth consecutive year, and the seventh time in eight years, J.D. Power and Associates ranked Kaiser Permanente of Georgia the highest in member satisfaction among health plans in the South Atlantic Region, which includes Georgia, North Carolina, and South Carolina.
- Kaiser Foundation Health Plan of Georgia was the top performer, nationally, for 4 HEDIS measures and ranked best in Georgia for over 25 HEDIS measures.

Results of these reports, as well as additional information regarding our commitment to quality are available to our members, TSPMG practitioners and contracted affiliated community providers via our website at www.kp.org under the section titled Measuring Quality.

For a copy of the 2014 Annual Quality Program Evaluation, please contact Tammy Macdonald, Director of Accreditation at 404-587-1084 or at tammy.o.macdonald@kp.org.

Kaiser Permanente Utilization Management Satisfaction Survey

The QRM Department is responsible for processing referrals for general services, home health and DME, targeted review authorizations, and hospital and inpatient concurrent review of care. The QRM staff consists of the Referral Service Coordination and Intake Services, Ambulatory Targeted Review Services and Inpatient Concurrent Review of Care. We are interested in knowing how you think we are doing our job and in how we might better assist you in providing services to our members. Please take the survey on the Provider website. See the Kaiser Permanente Utilization Management Satisfaction Survey on the website at http://providers.kp.org/ga or https://www.surveymonkey.com/s/PSH8F2D. The survey should only take 3-5 minutes to complete. Also, you may write in any comments in the space provided. Your responses will be confidential and we encourage you to be candid with your survey answers and comments. We will use this information to verify that we are meeting patient needs in this area and to make improvements in our program.
Complete Care Program through The Center for Care Partnership

The KPGA Center for Care Partnership (CCP) Complete Care Program exists to improve and maintain the health of our members through high quality, patient centered programs. The programs offered through Complete Care, are patient centered and allow CCP to segment the population and direct individuals to the most appropriate and effective resource.

Complete Care enables us to look at our total population (membership) and provide programs for healthy members, those at risk, the chronically ill and those with catastrophic/end of life needs. Complete Care includes care management programs for Kaiser Permanente members with chronic conditions such as Asthma, Coronary Artery Disease, Depression, Diabetes, Heart Failure and Hypertension. These programs are evidence based and are designed to support practitioners in giving consistent, coordinated care to your chronically ill patients.

Other programs include annual outreach reminders for preventive services and screenings; targeted outreach to high-risk members by our health coaches; and patient educational materials on chronic conditions. Health Education classes, such as our American Diabetes Association (ADA) recognized diabetes self-management education program are available to members in the metropolitan Atlanta area. These programs are developed, maintained, and revised through a collaborative relationship among the department of Center for Care Partnership, the national Kaiser Permanente Care Management Institute (CMI), Primary Care Health Care Teams, clinical pharmacy, and other appropriate departments.

Additional detailed information on Complete Care programs, and the services available, can be found on the KPGA Provider Website in the Affiliated Care Guidelines section, under the heading Population Care, Prevention and Health Promotion.

KPGA Complex Case Management & Disease-Specific Case Management

Kaiser Permanente's complex case management department offers exciting ways to you partner, with us, on your most complex cases to ensure members are getting services necessary to help them thrive. We know that a member with complex healthcare needs or someone newly diagnosed with a serious illness, questions abound - just navigating the healthcare system can be overwhelming and unduly stressful.

This specialized service is provided by Registered Nurses, who are board-certified in case management (CCM®).

To request complex case management service for a member, you may choose any of the following methods:

- Call 770- 603-3932, Monday – Friday, 8:30 a.m. to 5 p.m. (excluding company holidays)

In addition, Case Managers coordinate care for members with HIV, with Sickle Cell disease and pediatric members.

Our Case Managers work closely with the region’s Social Workers who are available to assist your patients in locating community resources, with financial assistance for medical care and with long-term care placement.

New Address for Mailing Claims

On April 1, 2015, Kaiser Permanente claims operations moved from the Georgia Region to shared services located in Denver, Colorado. Migrating claims operations is an organization-wide initiative that integrates geographically dispersed claims functions. The transition supports our mission to provide timely and accurate payments to our health care delivery partners by consolidating resources and expertise in a centralized service location.

As a result of the migration, the claims address has changed. The new address is for all claims with the exception of those connected to self-funded plans. Self-funded plans can be easily identified by green membership cards. We recommend filing all claims electronically using Payor ID #21313; if you are unable to file a claim electronically the following is the address to which all other claims mail should be forwarded:

Kaiser Permanente
PO Box 370010
Denver, Colorado 80237-9998
Get to Know Us
The Quality Resource Management (QRM) department professionals are here to assist you in providing the highest quality care to your patients. QRM can assist you with utilization questions and issues with referrals, authorizations and medical necessity, as well as review of elective targeted services. Our physicians and nurses are available to discuss any details including criteria used in making a review decision. The information and medical criteria used for coverage or medical necessity determination are available upon request and provided free of charge.

Notice About Kaiser Permanente’s Utilization Management Program
Kaiser Permanente does not use financial incentives to encourage barriers to care and service. Decisions involving utilization management are based solely on the appropriateness of care and service and the existence of coverage under the member’s benefit plan. We do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, and does not use financial incentives that encourage decisions that result in under-utilization.

Kaiser Permanente is prohibited from making 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.

New Kaiser Permanente Digital Membership Card
Kaiser Permanente has rolled out a Digital Membership Card. It is a digital version of the physical membership card that will be available to Kaiser Permanente members via the KP Mobile App. Members will have the ability to email a copy of their digital membership cards to contracted network providers. The digital membership card is a service enhancement; it does not currently replace the physical card.

When a member presents with a digital membership card for service, your check-in procedure should remain the same. Please continue to verify the member’s eligibility; a membership card does not guarantee a member is currently eligible for benefits with Kaiser Permanente. Remember to record the medical record number and to ask the member to show a photo ID. If your facility requires the swiping or imprinting of a physical card, the front-office staff should ask the member for their physical card.

If the member does not have the physical card, the member can email their card to you, or you can verify eligibility via KP Online-Affiliate (https://provider.kp.org/ga).
Kaiser Permanente of Georgia Appointment Access Standards

Kaiser Permanente of Georgia has established the following access standards:

**Medical Care**
- **Regular and Routine Care:** Appointments should be scheduled within 3 days of the member’s request.
- **Urgent Care:** Appointments should be scheduled within 24 hours of the member’s request, where applicable.
- **After-Hours Care:** After-hours care is available to members seeking immediate care for non-life threatening medical conditions after regular clinic hours, including evenings and weekends. Members can utilize any clinic where after-hours care is offered. Although walk-ins are welcomed, members are encouraged to call the KPGA “Help Line” for a designated appointment time to reduce waiting. Additionally, our members may choose to visit one of our Affiliated Community Urgent Care centers without an appointment.

**Behavioral Health Care**
- **Non-Life Threatening Emergencies:** Appointments should be scheduled within 6 hours of the member’s request.
- **Urgent Care:** Appointments should be scheduled within 48 hours of the member’s request.
- **Routine Care:** Appointments should be scheduled within 10 business days of the member’s request.

**Updated Targeted Review List (effective July 1, 2015)**

Kaiser Permanente released an updated Targeted Review List to be effective July 1, 2015. Please be sure to review it carefully.

Changes were limited to updating six (6) new medications:
- Glyxambi (empagliflozin and linagliptan)
- Hetlioz (tasimelteon)
- Jardiance (empagliflozin)
- Tanzeum (albiglutide)
- Trulicity (dulaglutide)
- Ruconest (C1 inhibitor (recombinant))

Effective January 1, 2016, the following medications will be added to the Targeted Review List:
- Avonex (interteron beta-1a)
- Copaxone (glatiramer acetate)
- Plegridy (peginterferon beta-1a)
- Fabrazyme
- Elocate (Factor 8)

The July 2015 Targeted Review List appears on our provider website at http://providers.kp.org/ga. As a reminder, failure to obtain authorization prior to providing these services listed will result in a denial of payment. If you have questions about these changes, contact Provider Contracting & Network Management at 404-364-4934.

**Standards for Medical Record Documentation**

Kaiser Permanente champions continuity and coordination of patient care by maintaining standards for medical record documentation. As a part of our commitment to quality, Kaiser Permanente’s medical record documentation standards promote timely, detailed, and organized record documentation that ensures effective patient care and confidentiality of patient information in accordance with regulatory Centers for Medicare & Medicaid Services (CMS) and accreditation National Committee for Quality Assurance (NCQA) requirements.

Medical Record Documentation Guidelines 10 Cs:
- Correct
- Comprehensive
- Collaborative
- Patient Centered
- Confidential

For a complete listing of Kaiser Permanente’s medical record documentation standards please visit the provider website at http://providers.kp.org/ga.

Also please see your Provider Manual for information regarding our policies on the confidentiality, availability, and organization of members’ medical records.

If you have any questions, or for a hard copy of the medical record documentation standards, please contact the Quality and Clinical Risk Management Department at 404-364-4858.
International Classification of Diseases (ICD) is a coding system used for inpatient and outpatient diagnoses and inpatient procedures. ICD-9 is the current version used in the United States when billing for health care services.

On January 16, 2009, the Department of Health and Human Services released the Final HIPAA Administrative Mandate to Adopt Version 10 (ICD-10.) The compliance date for implementation of the ICD-10 Coding System is October 1, 2015.

What this means for providers?
• Providers will not be able to continue to report ICD-9-CM codes for services provided on or after October 1, 2015
• ICD-10-CM (diagnoses) will be used by all providers in every health care setting
• ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures
• ICD-10-PCS will not be used on physician claims, even those for inpatient visits

For more information:
On our provider portal we have additional information regarding the implementation of ICD-10, at http://providers.kp.org/ga.
Visit the CMS ICD-10 website at www.cms.gov/ICD10 for the latest information and links to resources for providers to prepare for the ICD-10 implementation.

Contact information:
Kaiser Permanente, CMI
Attn: Cristina Bozocea, RN
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
E-mail – cristina.e.bozocea@kp.org
Phone: 404-504-5628 Fax: 404-364-4798
The Kaiser Permanente HMO Drug Formulary is updated bimonthly in February, April, June, August, October, and December. A newsletter, Formulary Update, is distributed bimonthly to highlight recent formulary changes. The newsletter and updated Formulary are placed on the affiliated community network provider website at: http://providers.kp.org under the Pharmacy tab/Formulary and on our intranet under Healthcare Delivery/Guides and References/Formularies. The drugs in the formulary are grouped into categories related to the medical condition being treated; an index is provided. Generic drug names are listed in lower case letters and brand drug names are listed in capital letters.

The Kaiser Permanente HMO drug formulary is a formulary of preferred drugs and is aligned with the member’s pharmacy benefits. Some plans have a two tier closed formulary benefit and some plans have a three tier open formulary benefit. For the two tier closed formulary benefit, only drugs listed in the formulary are available to the member for their copay. These tiers are called preferred generic and preferred brand. Benefits vary by plan and members can contact Member Services for specifics regarding their drug benefit and copay information. The copays for the HMO formularies are listed below based on the tiers:

### Copay Range for KPGA HMO Formularies

<table>
<thead>
<tr>
<th></th>
<th>Two Tier Closed HMO Formulary</th>
<th>Three Tier Open HMO Formulary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Generic</td>
<td>$5 to $35</td>
<td>$5 to $35</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$15 to $60</td>
<td>$15 to $60</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>N/A</td>
<td>$25 to $80</td>
</tr>
</tbody>
</table>

**Note:** A coinsurance of up to 50% may be applied to specialty medications for some plans.

As drugs become available in generic form, the pharmacy can change from a brand to a generic if it is considered AB rated by the FDA. Generally, if a drug is available as a generic, the generic is on the formulary and the brand is not. Therapeutic interchange and step-therapy protocol are not employed.

There may be rare occasions when non-formulary drugs are medically necessary to provide the best care for our members. A non-formulary drug is considered for coverage under the two tier closed formulary drug benefit if the member meets one of three criteria:

1. Allergic to formulary alternatives,
2. Intolerant to formulary alternatives, or
3. Failed treatment on formulary alternatives.

### Yearly CMS Fee Schedule Release Effective March 1, 2015

The Centers for Medicare and Medicaid (CMS) released the updated fee schedules for professional services. Per Kaiser Permanente’s policy, we implement the new schedules within 45 business days of the release of all components to the base fee schedule. We implemented the 2015 fee schedules effective for claims with dates of services on or after March 1, 2015.
When prescribing, if you wish to request benefit coverage for a non-formulary (NF) medication, the physician can complete the Non-Formulary form, with the appropriate reason for its use documented or call the Pharmacy Consult Service at 404-365-4159 Monday through Friday from 8:30am to 5:30 pm to justify why over-the-counter or formulary drug(s) cannot be used. A pharmacist at the Pharmacy Consult Service will review the NF request and discuss why formulary alternatives cannot be used. If the benefit coverage is authorized during the call, the pharmacist will take a verbal order for the prescription, request the member's pharmacy preference, and enter authorization for coverage in the pharmacy system.

Some covered drugs may have requirements or limits on coverage. The requirements and limits may include:

- **Quantity Limits (QL):** For certain drugs, Kaiser Permanente limits the amount of the drug that will be covered.
- **Age Restriction (Age):** For certain drugs, Kaiser Permanente limits coverage based on a designated age.
- **Criteria Restricted Medication:** For certain drugs, Kaiser Permanente requires review and authorization prior to dispensing. Criteria restricted medications continue to require review by our Quality Resource Management (QRM) department. Because many of these drugs are limited to specialty procurement or require in-office administration, physicians must contact QRM directly by telephone or fax to request coverage of a criteria restricted medication. The criteria restricted medication list is available online at http://providers.kp.org under the Pharmacy tab/Formulary and on our intranet under Healthcare Delivery/Guides and References/Formularies and is updated bi-monthly.

To request a change in formulary status of a drug (e.g., addition, deletion, restriction), the physician must complete the Application Form for Addition of New Drug to the Formulary. This form is located on the network provider website at: http://providers.kp.org/ga under the Forms tab or on the intranet under Job Tools and Forms. Practitioners requesting change in formulary status of a drug will also be asked to complete a Conflict of Interest disclosure form before the Pharmacy and Therapeutics Committee will consider the request.

To request a hard copy of the formulary and/or the Non-Formulary Drug Prescription form, or to request a change in formulary status of a drug (e.g., addition, deletion), please send your written request to Pharmacy Administration, Kaiser Permanente Georgia Region, 3495 Piedmont Road, N.E., Atlanta, GA 30305. Please contact Daniel J. Lee, MD, the Physician Program Director of Pharmacy at (404) 504-5524 or at daniel.j.lee@kp.org if you have any questions about our formulary process.

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**Your Practitioner Rights**

Your rights as a practitioner contracted with Kaiser Permanente are outlined in the Provider Manual. Please see the chapter entitled “Provider Rights and Responsibilities”, available on the provider website, for additional details.

**Kaiser Permanente Member Rights & Responsibilities**

Kaiser Permanente members can expect to be treated in a respectful, considerate manner and are allowed to participate in the decision making process related to their care. A detailed listing of our Member Rights & Responsibilities can be found in the Kaiser Permanente Provider manual in the “Member Rights and Responsibilities” Section.
Changes at Dekalb Technology Film Retention Center

Since the implementation of PACS in 2009 Kaiser Permanente, Georgia has experienced substantial benefits of image digitization, becoming far less reliant on analog film and film jackets. Through the PACS evolution, the roles and responsibilities of the file room clerks has changed. The Imaging department has continually evaluated the long term needs for a fully functioning film library hub.

Starting May 8, 2015, operations at the DeKalb Technology Film Retention Center will be integrated into the Imaging department processes at the 4 major Imaging Hubs (Glenlake, Gwinnett, Southwood, and Townpark). This integration will provide a greatly improved quality and service experience for current and future KP customers and members.

The change in service directly affects the following:

1. Requests for hard copy images- Requests for KPGA images will be sent to 1 of the Imaging sites listed above for fulfillment.
2. Receipt of mailed external images – Mail will be re-directed to the TownPark and Glenlake Imaging hubs for processing
3. Telephone contact- The main telephone line will providing instructional contact information.
4. Centralized radiologists contact – Radiologist consultations are still available. The radiologist can be reached by contacting the Central Communication Line (CCL) at 404-364 7243.
5. On-site radiologists reading location – There will be no change in this area. Radiologist will continue to utilize this KPGA facility for image interpretations.

Imaging Department Facility Clerk Contact Numbers

• Glenlake: 770-677-5826
• Southwood: 770-603-3526
• TownPark: 770-514-5626
• Gwinnett: 770-931-6450