Kaiser Permanente’s ICD-10 Readiness

On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014 (H.R. 4302) which included a provision delaying the implementation of ICD-10 by at least one year. Kaiser Permanente has evaluated the impact of the delay and has determined that we will continue to move forward with our current plans for ICD-10 compliance. For planning purposes, we have assumed an implementation date of October 1, 2015; however, this will be adjusted as necessary once CMS sets a definitive deadline.

In an effort to provide an open line of communication with our external providers and to ensure that you have the information you need from Kaiser Permanente regarding our plans and progress, we will continue to utilize the Provider website (https://providers.kp.org/ga) as the primary source of information on our ICD-10 preparations. ICD-10 Readiness FAQs will allow you to stay informed regarding Kaiser Permanente’s ICD-10 status, as well as our specific approach to some of the areas that may be of interest to you.

We recognize that the implementation of ICD-10 is a significant undertaking and we hope that by providing ongoing information, it will help inform your work and provide you the peace of mind that Kaiser Permanente is committed to ICD-10 compliance.

If you have any questions, please feel free to contact Provider Contracting at 404-364-4934. We will work with you to make sure your questions/concerns are addressed in a timely fashion.

See FAQs on page 5

Updates to Provider Manual

The Provider Manual will be updated to incorporate upcoming changes detailed in this newsletter. Look for the new version online coming November of 2014.

HIPPS Codes
Requirements for Home Health and Skilled Nursing Providers

The Centers for Medicare and Medicaid Services (CMS) delayed requirements for Medicare Advantage organizations to submit the Health Insurance Prospective Payment System (HIPPS) codes in the HIPAA 5010/837 institutional transaction format for all skilled nursing facility (SNF) and home health encounters to July 1, 2014. Beginning July 1, SNF and home health providers should provide HIPPS codes on claims for Kaiser Permanente members. Should you have any questions, please contact your contract manager at 404-364-4934.
Meaningful Use and Referral Information

There are changes in the referral information you receive from Kaiser Permanente. Kaiser Permanente is participating in the Meaningful Use Program (MU) created by the Centers for Medicare and Medicaid Services (CMS). This purpose of this program is to provide financial incentives to certain providers and hospitals who demonstrate “meaningful use” of certified Electronic Health Record (EHR) technology.

There are five Meaningful Use goals:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

The MU program includes a number of objectives to encourage the use of the electronic health record. One of those objectives is the “Summary of Care” objective which requires the provider who is referring a patient from one setting of care to another to send the most recent information that may be crucial to the provider to whom the patient is transferred or referred. This information is called the “Summary of Care Record”, which must include the following elements:

- Patient name
- Referring or transitioning provider's name and office contact information
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions. The care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient.
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral/discharge instructions
- Current problem list (providers may also include historical problems at their discretion)
- Current medication list
- Current medication allergy list

Beginning June 20, 2014, Kaiser Permanente began sending the Summary of Care Record as part of its routine referral process. While this may result in your organization receiving more information from Kaiser Permanente, we hope that the consistent format will make it easier to locate the information you need, and improve care coordination. We thank you for your support of our efforts to provide excellent patient care through enhanced communication with our partners.
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:

- Clear
- Concise
- Complete
- Contemporary
- Consecutive
- 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.

Kaiser Permanente Healthy Solutions Program

Kaiser Permanente Healthy Solutions is a program that offers support, access to educational materials, and health coaches to your patients with chronic and preference-sensitive conditions. The Healthy Solutions program is free, and members can contact health coaches by calling 1-888-251-6733 (toll free), Monday through Friday, 9 am to 4 pm.

Healthy Solutions uses two forms of targeted outreach: proactive outbound phone calls and targeted mailings.

Updated Targeted Review List

Kaiser Permanente released an updated Targeted Review List to be effective July 1, 2014. Please be sure to review it carefully.

Upcoming changes include the following additional medications:

- Xenazine
- Somavert
- Promacta
- Korlym
- Farxiga

The Targeted Review list will be updated on our Provider Website. As a reminder, failure to obtain authorization prior to providing the services listed will result in a denial of payment.
Kaiser Permanente Care Management Institute’s (CMI) Guideline Development Team (GDT) recently revised and approved the following National guidelines.

- ADHD Child/Adolescent has the most changes with 11 new recommendations in 6 categories and 8 updated recommendations in 6 categories.

- The Colon Cancer Clinical Pathway is comprised of four areas:
  - Evaluation of positive screening results and colon cancer symptoms, with expedited referral from PCP to GI specialist
  - The diagnostic process (colonoscopy/sigmoidoscopy and pathology)
  - Surveillance of non-malignant neoplasms or other medical findings
  - Staging and transition to initiation of treatment for malignancies

- Heart Failure review recommendations cover four areas:
  - Which Beta-Blocker to use
  - Lifestyle Factors: Sodium Restricted Diet
  - Target Blood Pressure
  - Reassessment of Systolic Performance

- For Diabetes Treatment the existing recommendations remain current except the target for blood pressure, which was updated to reflect the National Hypertension Guideline recommendations.

- The HTN Treatment Guideline update contains the recommendations from the new JNC 8 HTN Guidelines from Dec 2013. The ACEI is no longer a compelling drug choice in DM and Beta Blockers are not included in first line agents. Monitor the member’s BP and track over time, instituting medication changes every 2-4 weeks, until at goal. See blood pressure goals below:
  - BP goal for age < 60 or >60 with CKD/DM is <140/90
  - BP goal for age >60 without CKD/DM is <150/90

<table>
<thead>
<tr>
<th>Member</th>
<th>Medication selection Initial rx characteristics</th>
<th>Evidence Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-black</td>
<td>Thiazide CCB ACEI ARB</td>
<td>B</td>
</tr>
<tr>
<td>Black</td>
<td>Thiazide CCB</td>
<td>B – pts with diabetes</td>
</tr>
<tr>
<td>CKD</td>
<td>ACEI ARB</td>
<td>B</td>
</tr>
</tbody>
</table>

- Prostate Cancer Screening review concludes that is no longer a recommended routine screening; however, it is a shared decision-making process between the physician and patient. Be aware of the particular populations who are at higher risk.

- ACC/AHA Lipid Guideline recommends emphasis on lifestyle modification, treating obesity as a disease and statin therapy for many members, and those who fall in the high risk category for ASCVD, irrespective of their cholesterol level.

Please refer to the KP Clinical Library available on the provider website (https://providers.kp.org/ga) further information.
Kaiser Permanente ICD-10 Readiness FAQs

Please be advised that this information is valid as of the date it was written and may not necessarily reflect subsequent progress. We look forward to working with you over the coming months to comply with this federal mandate.

### A. ICD-10 COMPLIANCE PLAN

1. **How is Kaiser Permanente responding to the recently announced delay in the ICD-10 implementation date?**

   Kaiser Permanente has evaluated the impact of the delay and has determined that we will continue to move forward with our current plans and timelines for ICD-10 compliance. For planning purposes, we have assumed an implementation date of October 1, 2015; however, this will be adjusted as necessary once CMS sets a definitive deadline.

2. **Are you planning to accept ICD-10 codes before the compliance date?**

   No. Any claims submitted with ICD-10 codes prior to the compliance deadline will be rejected.

3. **During the transition period, can both ICD-9 and ICD-10 codes appear on the same claim?**

   No. Claims which include both ICD-9 and ICD-10 codes will be rejected, as CMS guidelines do not allow for both codes on a single claim.

4. **Must claims that span the ICD-10 compliance date be split into two separate claims (one billed with ICD-9 codes for dates of service before the compliance date, and the other billed with ICD-10 codes for dates of service on or after the compliance date)?**

   Yes, with a few exceptions which are detailed in Tables A-D in the CMS article "MLN Matters® Number: MM7492" located on the CMS website.

### B. CLAIMS PROCESSING

5. **What format does your organization plan to use to transmit and pay claims post-ICD-10?**

   KP will continue to use the HIPAA standard v5010 transaction sets for electronic claims (i.e. X12 EDI formats: 837 I/P), as well as the standard paper format for health care claims (i.e. UB04, HCFA 1500).

6. **If you utilize external partners to process claims for your members, will they be prepared, and what steps are you taking to ensure their readiness?**

   We are working closely with external partners to ensure that they will be ready to comply with the ICD-10 mandate. We require regular status reports which provide us visibility into their progress.

### C. EXTERNAL PROVIDER SUPPORT

7. **To whom may external providers direct their questions around ICD-10 and their current KP contracts?**

   Please refer to the provider website (https://providers.kp.org/ga).

8. **Will there be a special help line for ICD-10 related issues post implementation? If not, will the provider service line assume these types of specialized calls?**

   We are currently looking at various options for providing post ICD-10 implementation support to our external partners and will provide an update as soon as more information is available.
Information about Kaiser Permanente’s HMO Drug Formulary

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.**

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 8:30 am 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](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](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.

**News Briefs**

**Notice: Information regarding codes valued at $0**

For fee schedules based on RBRVS, Kaiser Permanente follows Medicare guidelines for codes which are valued at $0. Your explanation of payment will not display a denial code, but will reflect a payment of $0 on these codes.

**NOTICE: CMS 2nd Quarter Drugs & Biologicals Release**

The Centers for Medicare and Medicaid (CMS) recently released the updated 2nd Quarter Drugs & Biologicals component to fee schedules for professional services. Kaiser Permanente will not be implementing 2nd Quarter Drugs & Biologicals at this time. Additional notice will be send with regard to 3rd quarter Drugs & Biologicals and our intent to implement.

If you have questions about these changes, contact Provider Contracting & Network Management at 404-364-4934.
The new Kaiser Permanente Southwood Comprehensive Medical Center (CMC) is now offering 24-hour care for urgent medical needs. The CMC also offers primary care, a wide range of medical and surgical specialty services, high-end diagnostic and imaging services, and outpatient procedures.

“The Southwood CMC, which is open 24/7/365, supports our goals of providing members with high-quality health care that is coordinated, convenient, and affordable,” said Jonna Kirkwood, vice president of operations. “When members need care right away, but don’t need to go to the ER, they’ll have a better option. At Southwood CMC, members can receive personalized care quickly, in a relaxed environment by doctors who have access to their electronic health record.”

The CMC will add several new specialties, including ophthalmology, optometry and orthopedics. Ophthalmology and optometry opened March 27 and orthopedics will open later in the fall. Specialties include: adult medicine, advanced care, audiology, behavioral health, cardiology, dermatology, endocrinology, gastroenterology, general surgery, geriatrics, health education, infectious disease, lab, nephrology, neurology, nutrition, ob/gyn, oncology and infusion, ophthalmology, optometry, orthopedics, otolaryngology/ENT, pain management, pediatrics/adolescent medicine, pharmacy, podiatry, pulmonology, rheumatology, urology, urogynecology, vascular surgery, and X-ray.