KPGA Network News: E-Edition

Kaiser Permanente of Georgia Named Top Health Plan in Patient Satisfaction

Kaiser Permanente took home the top rankings in all of their eligible regions, with Kaiser Permanente of Georgia scoring the highest overall:

- **California: Kaiser Foundation Health Plan (773)**
- **Colorado: Kaiser Foundation Health Plan (734)**
- **Maryland: Kaiser Foundation Health Plan (791)**
- **Northwest: Kaiser Foundation Health Plan (736)**
- **South Atlantic: Kaiser Foundation Health Plan (795)**

Thank you for your continued partnership in caring for and serving our members.

For the 13th year in a row, KPGA has been named the South Atlantic Region's top health plan for customer satisfaction, according to the J.D. Power 2022 U.S. Commercial Member Health Plan Study[1]. Beyond measuring member satisfaction, experience and engagement, the study also examined factors such as: billing and payment; cost; coverage and benefits; customer service; information and communication; and provider choice.

Practitioner Rights

Your rights as a practitioner contracted with Kaiser Permanente are outlined in the Provider Manual on our provider website at http://kp.org/providers/ga. Please see the chapter entitled "Provider Rights and Responsibilities" 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 on our website at http://kp.org/providers/ga

Referrals and Authorizations

- For all services that require a referral or authorization you must have a valid referral/authorization **prior** to providing services.
- If a referral/authorization is not received prior to rendering services, your claim will be denied, and the member will be held harmless.
- **Kaiser Permanente will not provide retro referrals/authorizations. Please refer to the provider manual for additional information.**

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2022 HEDIS & NCQA Overview for all Behavioral Health Clinicians

NCQA (National Committee for Quality Assurance) is an unbiased entity that assesses the quality of Kaiser Permanente and other health plans.

HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used to measure performance on important dimensions of care and service.

HEDIS makes it possible to compare performance of health plans on an "apples-to-apples" basis.

Employers and consumers use NCQA quality ratings when determining which health plan to choose.

HEDIS is not something that comes around once a year. It is something that we must make part of our daily clinical workflows. Please adhere to the following initiatives that greatly impact our ratings:

HEDIS/NCQA Standard	How we can positively affect the rates
ADHD Initiation Phase	Schedule a follow-up appointment with an MD in BH or Pediatrics within 21 days (no more than 30 days) of prescribing ADHD medications
ADHD Continuation Phase	Ensure patients follow-up at least every 3 months and obtain refills. Transition patients back to Pediatrics if stable.
AMM (Antidepressant Medication Management)	Write 90-day RX's when clinically appropriate, with 1 refill. Avoid prescribing to ambivalent patients because patients aren't entered into the denominator until the medication is dispensed.
APM (Antipsychotic Metabolic Monitoring)	Ensure patients prescribed antipsychotics complete metabolic lab test annually.
APP (Antipsychotic Psychosocial Care)	Ensure there is documentation of psychosocial care as first-line treatment, prior to a new prescription for antipsychotic medications. This could include documentation of individual, family, or group therapy, as well as IOP or PHP notes.
DMS (Utilization of PHQ-9)	Complete a PHQ-9 every encounter on members with a dx of depression or dysthymia. Initiate secure messaging of PHQ-9 when appropriate.
DSF (Depression screening and follow up)	All members should be screened annually for depression with a PH-9 or PHQ-2. If the score is elevated, a 30 day follow up visit is needed.
FUA & FUM (Follow-up after ER Discharge)	Ensure patients discharged from the ER with a principal Alcohol or Mental Health diagnosis are seen within 7 days or 30 days. Be sure that the **primary dx** in the follow up encounter is Alcohol or Mental Health diagnosis that led to the ER visit.
FUH (7-day & 30-day Follow-up after Hospitalization)	Ensure patients discharged from the hospital with a Mental Health illness are seen within 7 days or 30 days.
ME-7 Element E & F (Complaints & Appeals	Attitude & Service Complaints are the # 1 category of complaints received in the BH Department, followed by Access complaints. Please be intentional in exercising patience, kindness, and empathy during every encounter.

Updates to the Provider Manual

The Provider Manual is currently undergoing annual revisions. Look for the new version online via Online Affiliate at http://kp.org/providers/ga in December 2022.

Reminder: Please use Online Affiliate for claims, appeals, disputes, inquiries, EOPs, responding to requests for information (RFI), and uploading claims supporting documents. Please do not use faxes for provider appeals/disputes.

Incorrect Demographics

New address? New billing address? New provider? If your information is incorrect, your claims may not pay correctly.

Help us reduce provider and member frustration by:

- Making sure your demographic information is up to date
- Responding to outreach by your network manager
- Letting us know of changes in advance.

Please let your network manager know, or contact us with any demographic changes as soon as possible: ga.provider-relations@kp.org.

Targeted Review List (QRM) Updates

All procedures on the Target Review List **must be authorized prior to rendering services**, or the procedure will not be covered. Please see http://kp.org/providers/ga for more information regarding the Target Review List.

Medications Requiring Prior Authorization

Kaiser Permanente periodically updates the QRM List of Medications following P&T meetings which occur on the even months (i.e. February, April, etc.) of the year. Please be sure to review the list carefully.

The criteria restricted medications identifies drugs that the Pharmacy and Therapeutics Committee has placed under specific designations. Criteria restricted medications on the Targeted Review List require review and approval before the prescription can be dispensed as a covered benefit. Please note affected members will be notified of changes. To access the criteria restricted medication (QRM) list and coverage criteria, you must log on to Clinical Library to review the Criteria Restricted Medications document. To request review of a criteria restricted medication, the provider should call Kaiser Permanente Quality Resource Management (QRM) at 404-364-7320 and select option 3 or fax 866-452-4585. The list of prescription drugs requiring review and authorization is subject to periodic review and modification by our Pharmacy and Therapeutics Committee.

New QRM medications effective 5.4.2022
- Cortrophin (repository corticotropin)
- Dual therapy with GLP-1 Receptor Agonists and SGLT2 Inhibitors
- Exkivity (mobocertinib)
- Livmarli (maralixibat)
- Rezurock (belumosudil)
- Tezspire (tezepelumab-ekko)
- Tivdak (tisotumab vedotin-tftv)
- Welireg (belzutifan)

New QRM medications effective 1.1.2023
- Egrifta SV (tesamorelin)
- Strensiq (asfotase alfa)

QRM criteria REMOVAL effective 5.4.2022
- Jardiance (empagliflozin)

QRM criteria updates effective 5.4.2022
- Acthar (corticotropin)
- Cinqair (reslizumab)
- DPP-4 Inhibitors
- Dupixent (dupilumab)
- Enbrel (etanercept)
- Fasenra (benralizumab)
- GLP-1 Receptor Agonists
- Humira (adalimumab)
- Ilaris (canakinumab)
- Nucala (mepolizumab)
- Oxbryta (voxelotor)
- Rinvoq (upadacitinib)
- SGLT2 Inhibitors
- Simponi (golimumab)
- Xolair (omalizumab)

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Targeted Review List (QRM) Updates
Medications Requiring Prior Authorization (Cont.)

Medicare Part D Benefit Coverage – Product Additions/Removals
During the year, Kaiser Permanente may make changes to our Medicare Part D Formulary (Drug List). For product removals, affected members who were prescribed these drugs prior to the removal effective date will receive a one-time 30-day Transition Benefit (TB) fill. For the members to continue receiving the medication for the remainder of the year, a medical necessity override will be required.

Product Removals
Effective 5.1.2022:

- Brand name: CARBAGLU 200 MG TABLETS
  - Alternative product available: generic CARGLUMIC ACID 200 MG TABLETS (added to Specialty Tier 5)
- Brand name: CUVPOSA 1 MG/5 ML SOLUTION
  - Alternative product available: generic GLYCOPYRROLATE 1 MG/5 ML SOLUTION (added to Generic Tier 2)
- Brand name: SELZENTRY 150 MG
  - Alternative product available: generic MARAVIROC 150 MG (added to Generic Tier 2)
- Brand name: SELZENTRY 300 MG
  - Alternative product available: generic MARAVIROC 300 MG (added to Generic Tier 2)

Effective 6.1.2022:

- Brand name: VIMPAT TABS 50 MG
  - Alternative product available: generic LACOSAMIDE TABS 50 MG (added to Non-preferred Tier 4)
- Brand name: VIMPAT TABS 100 MG
  - Alternative product available: generic LACOSAMIDE TABS 100 MG (added to Non-preferred Tier 4)
- Brand name: VIMPAT TABS 150 MG
  - Alternative product available: generic LACOSAMIDE TABS 150 MG (added to Non-preferred Tier 4)
- Brand name: VIMPAT TABS 200 MG
  - Alternative product available: generic LACOSAMIDE TABS 200 MG (added to Non-preferred Tier 4)

Effective 7.1.2022:

- Brand name: RESTASIS EMUL 0.05 %
  - Alternative product available: generic CYCLOSPORINE EMUL 0.05 % (added to Non-preferred Tier 4)
- Brand name: FERRIPROX TABS 1000 MG
  - Alternative product available: generic DEFERIPRONE TABS 1000 MG (added to Specialty Tier 5)
- Brand name: CHANTIX STARTING MONTH PAK TABS 0.5 MG X 11 & 1 MG X 42
  - Alternative product available: generic VARENICLINE TARTRATE MISC 0.5 MG X 11 & 1 MG X 42 (added to Generic Tier 2)

The 2022 Kaiser Permanente Corporate Run, Walk & Roll is set to take place on Thursday, September 1 at 7 p.m. at Piedmont Park, a new location. This year's KP Corporate Run, Walk & Roll is dedicated to bringing back teamwork and camaraderie, while improving fitness. Our annual 5K is a unique workplace fitness program that kicks off with an 8-week "Let's Move" training promotion powered by Phidippides and culminates in a 5K Run, Walk & Roll in Piedmont Park.

Since 2004, Kaiser Permanente of Georgia has sponsored the Corporate Run, Walk & Roll Fitness Program to motivate Metro Atlanta's workforce to lead healthier, more active lifestyles. A portion of the KP Corporate Run, Walk & Roll proceeds benefits the Atlanta Community Food Bank, Piedmont Park, Back on My Feet, the Kyle Pease Foundation, and the Elliott Galloway Scholarship Fund.

See the race website for more information or to register your teams: https://runsignup.com/Race/GA/Atlanta/KPRunwalk

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://kp.org/providers/ga under the Pharmacy tab/Formulary. 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

	Two Tier Closed HMO Formulary		**Three Tier Open HMO Formulary**	
	KP Owned and Operated Pharmacies	Network Pharmacies	KP Owned and Operated Pharmacies	Network Pharmacies
Preferred Generic	$5-$35	$11-$45	$5 to $35	$8 to $35
Preferred Brand	$10 to $70	$10 to $80	$20 to $60	$35 to $70
Non-Preferred	**N/A**	**N/A**	$25 to $115	$35 to $115

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 for the Two Tier Closed HMO Formulary.

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 and fax to 404467-2731 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. The non-formulary form is located on the affiliated community network provider website at: http://kp.org/providers/ga under Forms. 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 a call or based on the information submitted, the pharmacist will enter a benefit exception in the pharmacy benefit manager (PBM). A listing of non-formulary drugs and alternatives is located online at http://kp.org/providers/ga under the Pharmacy tab/ Formulary and is updated bi-monthly.

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INFORMATION ABOUT KAISER PERMANENTE'S HMO DRUG FORMULARY (Cont.)

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. Providers must call 404-364-7320 (Option 3) to initiate the QRM review for all QRM medications. The criteria restricted medication list is available online at http://kp.org/providers/ga under the Pharmacy tab/Formulary and is updated bimonthly.
- **Step Therapy (ST):** For the Three Tier Open HMO Formulary, drugs may be designated as step therapy required when they have criteria for approval which encourages use of safe and cost effective first line medications prior to second or third line medication options. A complete listing of drugs that require step therapy and alternatives is located online at http://kp.org/providers/ga under the Pharmacy tab/ Formulary and is updated bi-monthly.
  - When prescribing, if you wish to request benefit coverage for a medication requiring step therapy, the physician can complete the *Non-Formulary* form with the appropriate reason for its use and fax to 404-467-2731 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. The non-formulary form is located on the network provider website at http://kp.org/providers/ga under Forms.

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://kp.org/providers/ga under the Forms tab. 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 request via email to KPGA-DrugInformation@kp.org or via fax to 1-855-526-3294. Please contact Carole Gardner, MD, AGSF, Physician Program Director, Pharmacy and Therapeutics/Medication Safety, at (404) 364-7238 or at carole.gardner@kp.org if you have any questions about our formulary process.

INFORMATION ABOUT KAISER PERMANENTE'S QUALIFIED HEALTH PLAN FORMULARY

The Kaiser Permanente Qualified Health Plan (QHP) formulary applies only to small group and individuals enrolled in ACA compliant plans. The Kaiser Permanente QHP 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://kp.org/providers/ga under the Pharmacy tab/Formulary. 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 Metal Plans (Bronze, Silver, and Gold) offered by Kaiser Permanente of Georgia are tiered offerings with different levels of copays, coinsurance, and deductibles for essential health benefits.

The Kaiser Permanente 2022 QHP formulary is an open formulary that works in conjunction with the member's six tier pharmacy benefit. These tiers are called preventative generics, preferred generics, preferred brands, non-preferred drugs, specialty, and ACA mandated preventive medications. Benefits vary by plan and members can contact Member Services for specifics regarding their drug benefit and cost share information. The cost share for the QHP formulary is listed below based on the tiers:

Copay Range for KPGA QHP Formulary

Tiers	QHP Formulary Cost Shares at KP pharmacies
Preventative Generics	$0-$35
Preferred Generics	$15-$45
Preferred Brands	$20-$80
Non-preferred Drugs	$20-$130
Specialty	25-50%
ACA mandated preventive medications	$0

**Note: Copays and coinsurance may be applied after deductible is met.

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. Open formulary benefits have a generic cost sharing requirement. This means that if a patient fills a prescription for a brand name drug when a generic is available, that in addition to the standard copayment or coinsurance, they will also pay the difference in cost between the brand name and generic drug.

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INFORMATION ABOUT KAISER PERMANENTE'S QUALIFIED HEALTH PLAN FORMULARY (Cont.)

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

- **Quantity Limits (QL):** For certain drugs, the P&T Committee may make recommendations to limit the quantity of medication dispensed per co-pay. Examples include drugs with significant potential for diversion or drugs with significant potential for waste due to special storage requirements, frequent changes in therapy, dose, or regimen, high potential for discontinuation or high cost of unused medication. Patients have the option to pay retail price for quantities that exceed the quantity limit. In the event of a drug shortage, a quantity limit may be imposed temporarily until the shortage resolves without awaiting P&T approval.
- **Age Restriction (Age):** For certain drugs, Kaiser Permanente limits coverage based on a designated age.
- **Criteria Restricted Medication (PA):** For certain drugs, Kaiser Permanente requires review and authorization prior to dispensing. Criteria restricted medications require review by our Quality Resource Management (QRM) department. Providers must call 404-364-7320 (Option 3) to initiate the QRM review for all QRM medications. The criteria restricted medication list is available online at http://kp.org/providers/ga under the Pharmacy tab/Formulary and is updated bimonthly.
- **Step Therapy (ST):** Drugs may be designated as step therapy required when they have criteria for approval which encourages use of safe and cost effective first line medications prior to second or third line medication options. A complete listing of drugs that require step therapy and alternatives is located online at http://kp.org/providers/ga under the Pharmacy tab/ Formulary and is updated bi-monthly.
    - When prescribing, if you wish to request benefit coverage for a medication requiring step therapy, the physician can complete the *Non-Formulary* form with the appropriate reason for its use and fax to 404-467-2731 or call the Pharmacy Consult Service at 404-3654159 Monday through Friday from 8:30 am to 5:30 pm to justify why over-the-counter or formulary drug(s) cannot be used. The non-formulary form is located online at: http://kp.org/providers/ga under Forms.

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 affiliated community network provider website at: http://kp.org/providers/ga under the Pharmacy tab. 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 email your written request to KPGA-DrugInformation@kp.org or fax to 1-855-526-3294. Please contact Carole Gardner, MD, AGSF, the Physician Program Director of Pharmacy & Therapeutics/ Medication Safety at (404) 364-7238 or at carole.gardner@kp.org if you have any questions about our formulary process.

Kaiser Permanente Plus™ (KP Plus) Plans:

Information for Providers

KP Plus members: This information is designed to help you get more seamless care from out-of-network providers.

Providers:

KP Plus plans provide members with broad coverage within Kaiser Permanente's care system, **plus the opportunity to access care from any licensed out-of-network provider, regardless of whether the provider is contracted with Kaiser Permanente** (with certain exclusions). Members do not need a referral to use their limited out-of-network benefits.

OUT-OF-NETWORK COVERAGE

Medical services

This plan covers up to 10 out-of-network provider visits or outpatient medical services (including radiology and certain labs) per year—without a referral or prior authorization from Kaiser Permanente.

Medical claims

Mail all medical claims to:

Kaiser Permanente National
Claims Administration - Georgia
P.O. Box 370010
Denver, CO 80237-9998
EDI Payer ID: 21313

For questions or assistance, call Claims Services at **1-855-364-3185** (TTY **711**), Monday through Friday from 8 a.m. to 6 p.m.

Prescriptions

For KP Plus members, prescribed medications can be filled through either of two options:

- **For a lower cost to the member:** Prescriptions can be filled through a Kaiser Permanente pharmacy or a contracted network pharmacy. If written by a Kaiser Permanente provider, prescriptions can also be filled through our Mail Order Pharmacy.
- **For a higher cost to the member:** Prescriptions can be filled at an out-of-network pharmacy of the member's choice. The number of prescriptions covered out of network is limited to 5 fills within any licensed out-of-network pharmacy each contract year, up to a 30-day supply per fill.

Members may refill prescriptions online at **kp.org** or by calling **1-800-700-1479** (TTY **711**).

For questions about out-of-network pharmacy benefits and claims, call **1-855-364-3185** (TTY **711**), Monday through Friday from 8 a.m. to 6 p.m.

To determine if a medication is on the Kaiser Permanente formulary, you can also visit **kp.org/formulary** and select the Five-Tier Formulary.

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Fulfilling laboratory and imaging orders

For KP Plus members, orders for laboratory and imaging can be fulfilled through these options:

- **For a lower cost:** Orders can be filled at a Kaiser Permanente facility. These orders will not count towards the member's 10 out-of-network medical services limit. Instructions for bringing orders from an out-of-network provider to a Kaiser Permanente facility are below.
- **For a higher cost:** Orders for blood or urine specimen collection and for simple radiology can be filled at any licensed out-of-network provider. These orders will count towards the member's 10 out-of-network medical services limit and the member may have a higher cost share.

Laboratory

To order **blood tests** at a Kaiser Permanente facility, please fill out a lab test requisition with the information below along with your signature and provide this to the member.

- Provider's name, address, phone, and fax
- Member name and date of birth
- ICD-10 diagnosis code
- Test name

Members may go to any Kaiser Permanente facility for blood or urine specimen collection.

Other clinically collected specimens such as rapid strep, wound culture, throat culture, or Pap test will need to be ordered by a Kaiser Permanente provider in order to be processed at a Kaiser Permanente facility. Please have the member call **1-888-865-5813** (TTY **711**), 24 hours a day, 7 days a week, to get the appropriate labs done.

When all testing is complete, the results will be faxed to your office.

Radiology

To order a radiology exam, please fax a script to Kaiser Permanente Radiology department at **1-877-206-2482.** The following information should be included with the order:

- Provider's name, address, phone and fax
- National Provider Identifier (NPI)
- Member name and date of birth
- Written clinical diagnosis
- Test name
- Electronic signature

For **routine/plain film exams**, members can walk in, without an appointment, to any Kaiser Permanente radiology facility and provide their script.

Orders for **advanced studies**—including MRIs, CTs, ultrasound, mammography, fluoroscopy, nuclear medicine procedures, and PET scans—require an appointment at a Kaiser Permanente facility. Please have the member call the Kaiser Permanente Radiology department to schedule an appointment at **770-677-5821,** Monday through Friday 8 a.m. to 8 p.m. or Saturday and Sunday 9 a.m. - 6 p.m., 24 hours after the script has been faxed. Note that advanced studies will not be covered unless performed at a Kaiser Permanente facility.

You can obtain a report or a CD with images directly from any Kaiser Permanente facility that has X-ray services. To choose the Kaiser Permanente facility where you'd like to pick up your report or CD with images, visit **kp.org/facilities**. If you need help contacting a specific facility, please call **1-888-865-5813** (TTY **711**), 24 hours a day, 7 days a week. Members can also obtain their report results through **kp.org**.

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