Kaiser Permanente HealthChoice Provider Manual

Updated December 2024

HealthChoice Provider Manual
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SECTION I.
INTRODUCTION

THE MARYLAND HEALTHCHOICE PROGRAM

MEDICAID and HEALTHCHOICE

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.7 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With few exceptions Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a Managed Care Organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO on-line at www.marylandhealthconnection.gov or by calling 1-855-642-8572 (TYY: 1-855-642-8572). Members are encouraged to select an MCO that their primary care physician (PCP) participates with. If they do not have a PCP they can choose one at the time of enrollment. MCO members who are initially auto- assigned can change MCOs within 90 days of enrollment. Members have the right to change MCOs once every 12 months. The HealthChoice Program's goal is to provide patient-focused, accessible, cost-effective, high quality health care**.** The State assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the State's quality initiatives and oversight of the HealthChoice Program go to: https://health.maryland.gov/mmcp/healthchoice/Pages/Home.aspx

Providers who wish to serve individuals enrolled in Medicaid MCOs are now required to register with Medicaid. Kaiser Permanente also encourages providers to actively participate in the Medicaid fee-for service (FFS) program. Beneficiaries will have periods of Medicaid eligibility when they are not active in an MCO. These periods occur after initial eligibility determinations and temporarily lapses in Medicaid coverage. While MCO providers are not required to accept FFS Medicaid, it is important for continuity of care. For more information go to: https://eprep.health.maryland.gov/sso/login.do?. All providers must verify Medicaid and MCO eligibility through the Eligibility Verification System (EVS) before rendering services.

We do not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is their patient.

Introduction to Kaiser Permanente Maryland HealthChoice Plan

Welcome to the Kaiser Permanente Network. As a valued participating provider, you provide services to members of the Kaiser Permanente Maryland HealthChoice Plan. You have access to many systems of care.

The legal name of our health maintenance organization (HMO) is Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KPMAS or Health Plan). We operate under the trade name "Kaiser Permanente". We are a subsidiary of the national organization, Kaiser Foundation Health Plan, Inc. The local HMO and its parent are both non-profit organizations.

Kaiser Permanente provides or arranges for health care services through an exclusive agreement between the Kaiser Foundation Hospitals, Inc., a non-profit corporation and the Permanente Medical Group. Each division of the national program has its own autonomous medical group. In the Mid-Atlantic States, the physician group is the Mid-Atlantic Permanente Medical Group, P.C. (MAPMG). All community-based participating providers who provide services to Kaiser Permanente members hold contracts with MAPMG. This Provider Manual and any revisions and

updates shall serve as an extension of your contractual agreement with MAPMG and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Two local markets comprise Kaiser Permanente's service area. The Metropolitan Washington local market includes the District of Columbia, counties in Suburban Maryland and counties in Northern Virginia. The Baltimore Metropolitan local market includes Baltimore City, Baltimore County and the surrounding suburbs of Anne Arundel, Harford, Howard, Carroll and Frederick counties.

KPMAS is committed to supporting the role of the Network Participating Providers – community providers who are contracted and credentialed. The Provider Experience Department staff provides comprehensive and personalized support for all participating providers and their staff. As the liaison between the participating providers and KPMAS, the Provider Experience staff is responsible for the following support functions:

- Ensuring that each participating provider's issues or concerns are addressed and resolved to satisfaction;
- Communicating pertinent information regarding medical management procedures, compensation models, referral processes and new products to all participating providers; and
- Assisting participating providers in identifying appropriate network medical facilities and services available for patient care.

The Provider Experience Department can be contacted at 1-877-806-7470 or at provider.relations@kp.org.

Member Rights and Responsibilities

Kaiser Permanente is committed to providing our members and their family with quality health care services. In a spirit of partnership with you, here are the rights and responsibilities we share in the delivery of health care services to our members:

1. Receive information that empowers you to be involved in health care decision making. This includes your right to:
    a. Actively participate in discussions and decisions regarding your health care options.
    b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are.
    c. Receive relevant information and education that helps promote your safety in the course of treatment.
    d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.
    e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
    f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time.

g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your authorized representative will be asked to provide written permission before your records are released, unless otherwise permitted by law.

2. Receive information about Kaiser Permanente and your plan. This includes your right to:
    a. Receive information in languages other than English, in large print or other alternative formats.
    b. Receive the information you need to choose or change your Primary Care Physician, including the name, professional level, and credentials of the doctors assisting or treating you.
    c. Receive information about Kaiser Permanente, our services, our practitioners and providers, and the rights and responsibilities you have as a member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies.
    d. Receive information about financial arrangements with physicians that could affect the use of services you might need.
    e. Receive emergency services or Part D drug when you, as a prudent layperson, acting reasonably, would have believed
    f. Receive covered urgently needed services when traveling outside Kaiser Permanente's service area.
    g. Receive information about what services are covered and what you will have to pay and to examine an explanation of any bills for services that are not covered.
    h. File a complaint, grievance or appeal about Kaiser Permanente, Part D drug or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.

3. Receive professional care and service.
   This includes your right to:
    a. See plan providers, get covered health care services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.
    b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.
    c. Be treated with respect and dignity.
    d. Request that a staff member be present as a chaperone during medical appointments or tests.
    e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status including any mental or physical disability you may have.

f. Request interpreter services in your primary language at no charge.
g. Receive health care in facilities that are environmentally safe and accessible to all.

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

1. Promote your own good health:
    a. Be active in your health care and engage in healthy habits.
    b. Select a Primary Care Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Physician.
    c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.
    d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals.
    e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.
    f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.
    g. Schedule the health care appointments your physician or health care professional recommends.
    h. Keep scheduled appointments or cancel appointments with as much notice as possible.
    i. Inform us if you no longer live or work within the plan service area.

2. Know and understand your plan and benefits:
    a. Read about your health care benefits and become familiar with them. Detailed information about your plan, benefits and covered services is available in your Evidence of Coverage. Call us when you have questions or concerns.
    b. Pay your plan premiums and bring payment with you when your visit requires a copayment, coinsurance or deductible.
    c. Let us know if you have any questions, concerns, problems or suggestions.
    d. Inform us if you have any other health insurance or prescription drug coverage.
    e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our plan.

3. Promote respect and safety for others:
    a. Extend the same courtesy and respect to others that you expect when seeking health care services.
    b. Assure a safe environment for other members, staff, and physicians by not threatening or harming others.

HIPAA and Member Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) requires MCOs and providers to report their privacy practices to their members. The Notice of Privacy Practices informs members of their rights to privacy as well as the access and disclosure of their protected health information (PHI). Examples of PHI include medical records, medical claims/billing, and health plan records. If a member feels that their privacy rights have been violated, they can file a complaint with their provider, MCO, or the U.S. Department of Health and Human Services.

- Members can file complaints as follows:

- Provider: call your provider's office
- MCO: call MCO Member Services
- U.S. Department of Health and Human Services
  - Online at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
  - Email: OCRComplaint@hhs.gov
  - In Writing at:

    Centralized Case Management Operations
    U.S. Department of Health and Human Services
    200 Independence Avenue, S.W.
    Room 509F HHH Bldg.
    Washington, D.C. 20201

Anti-Gag Provisions

Providers participating with Kaiser Permanente will not be restricted from discussing with or communicating to a member, enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

(1) Communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations;
(2) Communication that is necessary or appropriate to maintain the provider-patient relationship while the member is under the participating physician's care;
(3) Communications that relate to a member's or subscriber's right to appeal a coverage determination with which the participating physician, member, enrollee, or subscriber does not agree; and
(4) Opinions and the basis of an opinion about public policy issues.

Participating providers agree that a determination by Kaiser Permanente that a particular course of medical treatment is not a covered benefit shall not relieve participating providers from recommending such care as he/she deems to be appropriate nor shall such benefit determination be considered to be a medical determination. Participating providers further agree to inform beneficiaries of their right to appeal a coverage determination pursuant to the applicable grievance procedures and according to law. **Providers contracted with multiple MCOS are prohibited from steering recipients to any one specific MCO.**

Assignment and Reassignment of Members

Members can request to change their MCO one time during the first 90 days if they are new to the HealthChoice Program as long as they are not hospitalized at the time of the request. They can also make this request within 90 days if they are automatically assigned to an MCO. Members may change their MCO if they have been in the same MCO for 12 or more months. Members may change their MCO and join another MCO near where they live for any of the following reasons at any time:

- If they move to another county where Kaiser Permanente does not offer care;
- If they become homeless and find that there is another MCO closer to where they live or have shelter which would make getting to appointments easier;
- If they or any member of their family have a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO;
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being placed can switch to the foster family's MCO; or

- The member desires to continue to receive care from their primary care provider (PCP) and the MCO terminated the PCP's contract for one of the following reasons:
    - For reasons other than quality of care;
    - The provider and the MCO cannot agree on a contract for certain financial reasons; or
    - Their MCO has been purchased by another MCO.
- Newborns are enrolled in the MCO the birthing parent was enrolled in on the date of delivery and cannot change for 90 days.

Once an individual chooses or is auto-assigned to Kaiser Permanente and selects a Primary Care Provider, Kaiser Permanente enrolls the member into that practice and mails them a member ID card. Kaiser Permanente will choose a PCP close to the member's residence if a PCP is not selected.

Kaiser Permanente is required to provide PCPs with their rosters on a monthly basis**.** Monthly rosters should not be used to determine member eligibility and PCP assignment as members may change PCPs at any time. Providers must still verify eligibility and PCP assignment prior to rendering services Kaiser Permanente members may change PCPs at any time. Members can call Kaiser Permanente Member Services Monday-Friday 7:30A.M. – 5:30P.M at 1-855-249-5019 to change their PCP.

PCPs may see Kaiser Permanente members even if the PCP name is not listed on the membership card. As long as the member is eligible on the date of service, and the PCP is participating with Kaiser Permanente, the PCP may see the Kaiser Permanente member. However, Kaiser Permanente does not request that the PCP assist the member in changing PCPs, so the correct PCP is reflected on the membership card.

Credentialing and Contracting with Kaiser Permanente

The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners under contract with MAPMG are qualified, appropriately educated, trained, and competent. All participating practitioners must be able to deliver health care according to Kaiser Permanente standards of care and all appropriate state and federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA) and Kaiser Permanente.

Kaiser Permanente participating providers must meet MAPMG credentialing requirements. Kaiser Permanente credentialing policies and procedures are intended to protect our members and ensure quality. The Mid-Atlantic States Credentialing and Privileging Committee (MASCAP), chaired by MAPMG's Associate Medical Director of Quality and Health Plan's Vice President of Quality, Regulatory Risk Management, oversees all credentialing and re-credentialing activities.

Initial credentialing and re-credentialing are part of the practitioner/provider contract process. No participating provider may see Kaiser Permanente members prior to being approved through the credentialing process. All physicians who cover for network providers must be credentialed by MAPMG. Providers will be credentialed upon initial application to the Kaiser Permanente provider network; re-credentialing occurs every three years thereafter except for those with Kaiser Permanente ambulatory surgery and moderate sedation privileges for whom re-credentialing occurs every two years. All participating providers must satisfactorily complete the re-credentialing process to

maintain an active status. This process is described in detail below in Section VII. Practitioners will be notified within sixty (60) calendar days in writing of the actions taken to approve or disapprove the applicant for participation with Kaiser Permanente.

Provider Responsibilities Under Credentialing Process

Provider responsibilities in the credentialing process include:

- Submission of a completed application and all required documentation before a contract is signed;
- Producing accurate and timely information to ensure proper evaluation of the credentialing application;
- Provision of updates or changes to their application within 30 days;
- Provision of a current certificate of insurance when initiating a credentialing application. A certificate of insurance must also be submitted at annual renewal; and
- Cooperation with site visit and medical record-keeping review process

Provider Rights Under the Credentialing Process

Provider rights in the credentialing process include:

- Being provided a copy of the MASCAP Policies and Procedures upon written request.
- Reviewing the information contained in your credentials file, except for peer references, recommendations, and peer-review protected information.
- Correcting erroneous information contained in your credentialing file within 10 days upon notification of a discrepancy. These corrections should be sent in writing to PPQA-MAS@kp.org. The organization is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.
- Being informed of the status of your application, upon request. You will be informed of the stage of the process your application is in within two business days. The response will be provided in the way you made the request.
- Appealing decisions of the MASCAP Committee if you are denied credentialing, have had your participation status changed, been placed on a performance improvement plan, or have had any adverse action taken against you.

These rights may be exercised by contacting the Practitioner and Provider Quality Assurance Department (PPQA) at ☎ 301-816-5853 or by fax at ☎ 855-414-2630. Written correspondence may also be emailed to PPQA-MAS@kp.org or sent to:

Kaiser Permanente
Practitioner and Provider Quality Assurance
4000 Garden City Drive
Hyattsville, MD 20785

Credentialing Files

- Credentialing files remain confidential according to KPMAS policies and procedures.
- Credentialing files are acted upon according to KPMAS policies and procedures.

Credentialing Process
All applications will be processed and verified according to KPMAS credentialing policies and procedures. The elements of the initial credentialing process include, but are not limited to, the following:

- Application
- Current and unrestricted license in each jurisdiction where practitioner provides services
- License sanctions
- DEA Certificate in each jurisdiction where practitioner provides services
- CDS Certificate
- Board Certification and Maintenance of Board Certification
- Graduate Professional Training
- Current Post Graduate Education
- Professional School Graduation
- Hospital Privileges
- References
- Professional Liability Coverage
- Claims History
- NPDB Query
- Work History
- Medicare and Medicaid Status and Sanctions
- Office Visit Report
- Mid-Level Practitioner Practice Agreement

Site Visits
KPMAS participating PCPs, obstetrician/gynecologist (OB/GYN), and high-volume behavioral health offices will be subject to a site visit. This site visit includes a review of medical record-keeping practices. The Mid-Atlantic States Credentialing and Privileging Committee and Regional Quality Improvement Committee uses the review results in the selection and ongoing quality monitoring of network sites. Additional site visits may be conducted as needed based on member complaints or to meet an action plan for a previously identified deficiency. Feedback is provided to each practice with the completed site review tools and request for action plan if indicated.

Participating Hospital Privileges
It is the policy of KPMAS to contract with and credential only those practitioners who have privileges at a participating hospital. In the event that there is a change in participating hospitals, participating providers with privileges at a terminated hospital will be notified of the change in hospital status, and of the need to obtain privileges at an alternative participating hospital or terminate their participation with Kaiser Permanente.

Board Certification Policy
If not already board certified, all physicians are required to obtain the American Board of Medical Specialties (ABMS)-recognized board certification in their contracted specialty within five (5) years of completion of training. Physicians must maintain specialty board certification throughout the life of their employment or contract with MAPMG. Providers whose certification lapses during the course of their contract or employment will be given two (2) years following the expiration of their board

certification to obtain recertification (MAPMG hourly physicians are not given the two (2) year grace period). Physicians who were practicing in a specialty prior to the establishment of board certification of that specialty are exempt from this policy with respect to that specialty. The following boards are accepted by KPMAS:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA) Directory of Osteopathic Physicians.
- American Podiatric Medical Association (APMA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Oral & Maxillofacial Surgeons American Midwifery Certification Board (AMCB)
- American Academy of Nurse Practitioners (AANP)
- American Nurses Credentialing Center (ANCC)
- National Certification Corporation (NCC)
- American Association of Nurse Anesthetists (AANA)
- National Commission on Certification of Physician Assistants (NCCPA)
- Pediatric Nursing Certification Board (PNCB)

Board Certification Exception Policy
Exceptions to the requirement for board certification of participating providers in the specialty for which they deliver care to KPMAS members may be made in individual circumstances in accordance with the principles outlined in the MAPMG Board Certification Policy.

Provider Reimbursement

Payment to providers is in accordance with your provider contract with Kaiser Permanente or with their management groups that contract on your behalf with Kaiser Permanente . In accordance with the Maryland Annotated Code, Health-General Article 15-1005, we must mail or transmit payment to our providers eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, we shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. We shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

Reimbursement for Maryland hospitals and other applicable provider sites will be in accordance with Health Services Cost Review Commission (HSCRC) rates. Kaiser Permanente is not responsible for payment of any remaining days of a hospital admission that began prior to a Medicaid participant's enrollment in our MCO. However, we are responsible for reimbursement to providers for professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Self-Referral and Emergency Services

Members have the right to access certain services without prior referral or authorization by a PCP. We are responsible for reimbursing out-of-plan providers who have furnished these services to our members.

The State allows members to self-refer to out of network providers for the services listed below. Kaiser Permanente will **pay out of plan providers** the State's Medicaid rate for the following services:

- Emergency services provided in a hospital emergency facility and medically necessary

post-stabilization services;
- Family planning services excluding sterilizations;
- Maryland school-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP who will be responsible for filing the form in the child's medical record. See Attachment B for a sample School Based Health Center Report Form;
- Pregnancy-related services when a member has begun receiving services from an out-of-plan provider prior to enrolling in an MCO;
- Initial medical examination for children in state custody (Identified by Modifier 32 on the claim);
- Annual Diagnostic and Evaluation services for members with HIV/AIDS;
- Renal dialysis provided at a Medicare-certified facility;
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge; and
- Services performed at a birthing center; and
- Children with special healthcare needs may self-refer to providers outside of Kaiser Permanente network under certain conditions. See Section II for additional information.

If a provider contracts with Kaiser Permanente for any of the services listed above the provider must follow our billing and preauthorization procedures. Reimbursements will be paid at the contracted rate.

Maryland Continuity of Care Provisions

Under Maryland Insurance law HealthChoice members have certain continuity of care rights. These apply when the member:

- Is new to the HealthChoice Program.
- Switched from another company's health benefit plan; or
- Switched to Kaiser Permanente from another MCO.

The following services are excluded from Continuity of Care provisions for HealthChoice members:

- Dental Services
- Mental Health Services
- Substance Use Disorder Services
- Benefits or services provided through the Maryland Medicaid fee-for-service program

Preauthorization for health care services

If the previous MCO or company preauthorized services we will honor the approval if the member calls 1-855-249-5019 Under Maryland law, insurers must provide a copy of the preauthorization within 10 days of the member's request. There is a time limit for how long we must honor this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

Right to use non-participating providers

Members can contact us to request the right to continue to see a non-participating provider. This right applies only for one or more of the following types of conditions:

- Acute conditions;
- Serious chronic conditions;
- Pregnancy; or
- Any other condition upon which we and the out-of-network provider agree.

There is a time limit for how long we must allow the member to receive services from an out of network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care provider after the baby is born.

If the member has any questions, they should call Kaiser Permanente Member Services at 1-855-249-5019 or the State's HealthChoice Help Line at 1-800-284-4510.

Section II.

OUTREACH AND SUPPORT SERVICES, APPOINTMENT SCHEDULING, EPSDT AND SPECIAL POPULATIONS

MCO Member Outreach and Support Services

Kaiser Permanente conducts outreach activities designed to ensure Maryland HealthChoice members get the medical care needed. In addition, Kaiser Permanente provides a dedicated on-boarding process that ensures a quality experience for new Maryland HealthChoice members. Our support and outreach services include a centralized team within our Clinical Contact Center that manages onboarding outreach activities related to Maryland HealthChoice members, including but not limited to assisting with kp.org registration, first appointment scheduling, PCP assignments, clinical pharmacy, and reviewing case management screeners.

Participating providers are required to make the necessary outreach to members to ensure the members are seen within the required timeframes for initial health care assessment and evaluation for ongoing health needs (e.g., timeliness of health care visits, screenings, and appointment monitoring). In the event, a member after two (2) unsuccessful attempts are made and documented to bring the member in for care, please contact Provider Experience at 1-877-806-7470. The Provider Experience representative will report the care gap concern to the Kaiser Permanente Medicaid Office who will assist in bringing the member back into care.

Provider Access to Health Education Materials

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

Content can be viewed through the centralized, internal "Clinical Library" which is an electronic inventory of health education information that can be used for all visit types. Health education content and links to education videos, education webpages, and other resources are also embedded into Kaiser Permanente HealthConnect® for inclusion in the member's "After Visit Summary", sent via secure messaging, or mailed directly to patient's addresses. For health education programs, providers can:

- Direct members to www.kp.org/appointments to register for classes.
- Use HealthConnect®, "After Visit Summaries", or hard copy flyers to provide members with information on how to self-register for programs.

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

- Visiting www.kp.org/healthyliving/mas.
- Contacting the Health Education automated line 301-816-6565 or toll-free at 800-444-6696.

State Non-Emergency Medical Transportation (NEMT) Assistance

If a member needs transportation assistance, contact the local health department (LHD) to assist members in accessing non-emergency medical transportation services (NEMT). Kaiser Permanente will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. **See Attachment C for NEMT contact information.**

MCO Transportation Assistance

Under certain circumstances Kaiser Permanente may provide limited transportation assistance when members do not qualify for NEMT through the LHD. The Kaiser Permanente Mid-Atlantic States (MAS) Emergency Care Management (ECM) department supports the Patient Transportation Assistance Program (PTAP), a community benefit that provides transportation for approved members to medical appointments authorized by their providers (UM PD pg. 6-7).

State Support Services

The State provides grants to local health departments to operate Administrative Care Coordination/Ombudsman services (ACCUs) to assist with outreach to certain non-compliant members and special populations as outlined below. MCOs and providers are encouraged to develop collaborative relationships with the local ACCU. **See Attachment C for these local ACCU contact information**. If you have questions, call the Division of Community Liaison and Care Coordination at 410-767-6750, which oversees the ACCUs or the HealthChoice Provider Help Line at 1-800-766-8692.

Scheduling Initial Appointments

HealthChoice members must be scheduled for an initial appointment within 90 days of enrollment, unless one of the following exceptions apply:

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to two years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.
- For pregnant and postpartum members who have not started to receive care, the initial health visit must be scheduled and the members seen within 10 days of a request.
- As part of the MCO enrollment process the State asks the member to complete a Health Services Needs Information (HSNI) form. This information is then transmitted to the MCO. A member who has an identified need must be seen for their initial health visit within 15 days of Kaiser Permanente's receipt of the HSNI.
- During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age appropriate physical exam. In addition, at the initial health visit, initial prenatal visit, or when a member's physical status, behavior, or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at 1-800-888-1965.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Requirements

Kaiser Permanente will assign children and adolescents under age 21 to a PCP who is certified by the EPSDT/Healthy Kids Program. If a member's parent, guardian, or caretaker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified, the non-EPSDT provider is responsible for ensuring that the child receives well child care according to the EPSDT schedule. If you provide primary care services to individuals under age 21 and are not EPSDT certified call (410) 767-1836. For more information about the HealthyKids/EPSDT Program and Expanded EPSDT services for children under age 21 go to https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx.

Providers must follow the Maryland Healthy Kids/EPSDT Program Periodicity Schedule and all associated rules to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The Program requires you to:

- Notify members of their due dates for wellness services and immunizations**.**
- Schedule and provide preventive health services according to the State's EPSDT Periodicity Schedule and Screening Manual.
- Refer infants and children under age 5 and pregnant teens to the Supplemental Nutritional

Program for Women Infants and Children (WIC). Provide the WIC Program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.
- Participate in the Vaccines For Children (VFC) Program. Many of the routine childhood immunizations are furnished under the VFC Program. The VFC Program provides free vaccines for health care providers who participate in the VFC Program. We will pay for new vaccines that are not yet available through the VFC Program.
- Schedule appointments at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.

Members under age 21 are eligible for a wider range of services under EPSDT than adults. PCPs are responsible for understanding these expanded services. See Benefits - Section III. PCPs must make appropriate referrals for services that prevent, treat, or ameliorate physical, mental or developmental problems or conditions.

Providers shall refer children for specialty care as appropriate. Referrals must be made when a child:
- Is identified as being at risk of a developmental delay by the developmental screen required by EPSDT;
- Has a 25% or more delay in any developmental area as measured by appropriate diagnostic instruments and procedures;
- Manifests atypical development or behavior; or
- Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

A child thought to have been physically, mentally, or sexually abused must be referred to a specialist who is able to make that determination.

EPSDT Outreach and Referral to LHD

For each scheduled Healthy Kids appointment, written notice of the appointment date and time must be sent by mail to the child's parent, guardian, or caretaker, and attempts must be made to notify the child's parent, guardian, or caretaker of the appointment date and time by telephone.
- For children from birth through 2 years of age who miss EPSDT appointments and for children under age 21 who are determined to have parents, caregivers or guardians who are difficult to reach, or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care.
- Document outreach efforts in the medical record. These efforts should include attempts to notify the member by mail, by telephone, and through face-to-face contact.

Schedule a second appointment within 30 days of the first missed appointment. Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian or caretaker by calling Kaiser Permanente at 1-855-249-5019**.** You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. **See Attachment D.** Continue to work collaboratively with **Kaiser Permanente** and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or receives appropriate follow-up care.

Support and outreach services are also available to members that have **impaired cognitive ability or psychosocial problems such as homelessness** or other conditions likely to cause them to have difficulty understanding the importance of care instructions or difficulty navigating

the health care system. You must notify Kaiser Permanente if these members miss three consecutive appointments or repeatedly does not follow their treatment plan. We will attempt to outreach the member and may make a referral to the ACCU to help locate the member and get them into care.

Special Populations

The State has identified certain groups as requiring special clinical and support services from their MCO. These special needs populations are:

- Pregnant and postpartum members
- Children with special health care needs
- Children in State-supervised care
- Individuals with HIV/AIDS
- Individuals with a physical disability
- Individuals with a developmental disability
- Individuals who are homeless

To provide care to a special needs population, it is important for the PCP and specialist to:

- Demonstrate their credentials and experience to us in treating special populations.
- Collaborate with our case management staff on issues pertaining to the care of a special needs member.
- Document the plan of care and care modalities and update the plan annually.

Individuals in one or more of these special needs populations must receive services in the following manner from us and/or our providers:

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care but will help keep track of the health care services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. **PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals. To contact the Special Needs Coordinator call the case management self-referral line at 301-321-5126 or 1-866-223-234 .
- Providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations promulgated under it).

Special Needs Population-Outreach and Referral to the LHD

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care must be referred to Kaiser Permanente. If a member continues to miss appointments, call Kaiser Permanente at 1-855-249-5919. We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the ACCU by completing the Local Health Services Request Form. **See Attachment D or**

https://mmcp.health.maryland.gov/pages/Local-Health-Services-Request-Form.aspx). The local ACCU staff will work collaboratively with Kaiser Permanente to contact the member and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

Services for Pregnant and Postpartum Members

Prenatal care providers are key to assuring that pregnant members have access to all available services. Many pregnant members will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these members during pregnancy and for one year after delivery after which they will automatically be enrolled in the Family Planning Waiver Program. (For more information visit: https://health.maryland.gov/mmcp/Documents/Factsheet3_Medicaid%20Family%20Planning%20Program.pdf)

Kaiser Permanente and our providers are responsible for providing pregnancy-related services, which include:

- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care);
- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form, MDH 4850. (For updated form visit: https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Documents/MPRA/Maryland%20Prenatal%20Risk%20Assesment%20Fillable%20-%20Revised%203.22.24.pdf)
- An individualized plan of care based upon the risk assessment and which is modified during the course of care as needed;
- Appropriate levels of inpatient care, including emergency transfer of pregnant members and newborns to tertiary care centers;
- Case management services;
- Prenatal and postpartum counseling and education including basic nutrition education;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant members;
- Doula support for prenatal visits, attendance at labor and delivery, and postpartum visits;
- Prenatal, postpartum, and infant home visits from pregnancy and childbirth up to two or three years of the child's age

The State provides these additional services for pregnant members:

- Special access to substance use disorder treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their parent;

Encourage all pregnant members to call the State's Helpline for Pregnant Woman at 1-800-456-8900. This is especially important for members who are newly eligible or not yet enrolled in Medicaid. If the member is already enrolled in HealthChoice call us and also instruct them to call our Member Services Department at 1-855-249-5019 Monday-Friday 7:30A.M. – 5:30P.M.

Pregnant member who are already under the care of an out of network practitioner qualified in obstetrics may continue with that practitioner if they agree to accept payment from Kaiser Permanente. If the practitioner is not contracted with us, a care manager and/or Member Services representative will coordinate services necessary for the practitioner to continue the member's care until postpartum care is completed.

The prenatal care providers must follow, at a minimum, the applicable American College of

Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to members of the prenatal appointment dates and times. The prenatal care provider, PCP and Kaiser Permanente are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcomes. Examples of an appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC). Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850 during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. Kaiser Permanente will pay for the initial prenatal risk assessment- use CPT code H1000.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- At each visit provide health education relevant to the member's stage of pregnancy. Kaiser Permanente will pay for this- use CPT code H1003 for an "Enriched Maternity Services"- You may only bill for one unit of "Enriched Maternity Services" per visit. Refer pregnant and postpartum members to the WIC Program.
- If under the age 21, refer the member to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days if a member misses a prenatal appointment. Call Kaiser Permanente if a prenatal appointment is not kept within 30 days of the first missed appointment.
- Refer pregnant members to the Maryland Healthy Smiles Dental Program. Members can contact Healthy Smiles at 1-855-934-9812; TDD: 855-934-9816; Web Portal: http://member.mdhealthysmiles.com/ if you have questions about dental benefits.
- Refer pregnant and postpartum members in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated they are required to arrange for substance abuse treatment within 24 hours.
- Educate pregnant members on doula services or refer eligible members for home visits if medically necessary and appropriate.
- Record the member's choice of pediatric provider in the medical record prior to their eighth month of pregnancy. We can assist in choosing a PCP for the newborn. Advise the member that she should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns", MDH 1184. (The hospital must complete this form so Medicaid can issue the newborns ID number.) The newborn will be enrolled in the postpartum member's MCO.

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:
A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care unless the 48 hour (uncomplicated vaginal delivery)/96 hour (uncomplicated cesarean section) length of stay guaranteed by State law is longer than that required under the Guidelines.

If a member must remain in the hospital after childbirth for medical reasons, and the member requests that their newborn remain in the hospital while they are hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.

If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by State law, a home visit must be provided. When a member opts for early discharge from the

hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

Postnatal home visits must be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a postpartum member and newborn, and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse symptoms of the newborn;
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the postpartum member;
- Blood collection from the newborn for screening, unless previously completed; and
- Appropriate referrals; and any other nursing services ordered by the referring provider.

If the member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

Unless we provide for the service prior to discharge, a newborn's initial evaluation by an out-of-network on-call hospital physician before the newborn's hospital discharge is covered as a self-referred service.

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit. Breast pumps are covered under certain situations for breastfeeding members. Call us at the Newborn Care Center:

DC/Suburban Maryland: 1-866-264-4766
Baltimore Area: 410-737-5464

Children with Special Health Care Needs

Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in Kaiser Permanente. Medical services directly related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

New Member: A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment into Kaiser Permanente and we approve the services as medically necessary.

Established Member: A child who is already enrolled in Kaiser Permanente when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We are obliged to grant the member's request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

If we deny, reduce, or terminate the services, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, we may

reimburse for services provided.

For children with special health care needs Kaiser Permanente will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers under certain circumstances. We log any complaints made to the State or to Kaiser Permanente about a child who is denied a service by us. We will inform the State about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the State's HealthChoice Help Line at (800) 284-4510
- Work closely with the schools that provide education and family services programs to children with special needs.

Children in State-Supervised Care

We will ensure coordination of care for children in State-supervised care. If a child in State-supervised care moves out of the area and must transfer to another MCO, the State and Kaiser Permanente will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

We are required to provide the following services for persons with HIV/AIDS:

- An HIV/AIDS specialist is provided for treatment and coordination of primary and specialty care.
- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance use treatment is provided within 24 hours of request.
- The right to ask us to send them to a site doing HIV/AIDS related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.
- Providers will maintain the confidentiality of client records and eligibility information, in accordance with all Federal, State and local laws and regulations, and use this information only to assist the participant in receiving needed health care services.

Kaiser Permanente will provide case management services for any member who is diagnosed with HIV. These services will be provided with the member's consent, and will facilitate timely and coordinated access to appropriate levels of care and support continuity of care across the continuum of qualified service providers. If a member initially refuses HIV case management services they may request services at a later time. The member's case manager will serve as the member's advocate to resolve differences between the member and providers pertaining to the course or content of therapeutic interventions.

Individuals with Physical or Developmental Disabilities

Providers who treat individuals with physical or developmental disabilities must be trained on the special communications requirements of individuals with physical disabilities. We are responsible for accommodating hearing impaired members who require and request a qualified interpreter. We can delegate the financial risk and responsibility to our providers, but we are ultimately responsible for ensuring that our members have access to these services.

Before placement of an individual with a physical disability into an intermediate or long-term care facility, we will cooperate with the facility in meeting their obligation to complete a Pre-admission Screening and Resident Review (PASRR) ID Screen.

Homeless Individuals

Homeless individuals may use the local health department's address to receive mail. If we know an individual is homeless we will offer to provide a case manager to coordinate health care services.

Rare and Expensive Case Management Program

The Rare and Expensive Case Management (REM) Program is an alternative to managed care for children and adults with certain diagnosis who would otherwise be required to enroll in HealthChoice. If the member is determined eligible for REM they can choose to stay in Kaiser Permanente or they may receive services through the traditional Medicaid fee-for-service program. They cannot be in both an MCO and REM. **See Attachment A** for the list of qualifying diagnosis and a full explanation of the referral process.

SECTION III.

HEALTHCHOICE BENEFITS AND SERVICES

MCO BENEFITS AND SERVICES OVERVIEW

Kaiser Permanente must provide comprehensive benefits equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service system. Only benefits and services that are medically necessary are covered.

Audiology Services

Audiology services will be covered by Kaiser Permanente for both adults and children. For individuals under age 21, bilateral hearing amplification devices are covered by the MCO. For adults 21 and older, unilateral hearing amplification devices are covered by the MCO. Bilateral hearing amplification devices are only covered for adults 21 and older when the individual has a documented history of using bilateral hearing aids before age 21.

Blood and Blood Products

We cover blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.

Case Management Services

We cover case management services for members who need such services including, but not limited to**,** members of State designated special needs populations as described in Section II. If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by the MCO or when requested by the State. A case manager may conduct home visits as necessary as part of Kaiser Permanente's case management program.

Making a Referral for Case Management Services

You or the member may request case management services via the Kaiser Permanente Case Management Provider Telephone Line, which offers help in obtaining additional resources or assistance coordinating your care. Providers can call 301-960-1435. Members and their caregivers can call the Self-Referral Telephone Line at 301-321-5126 or toll free at 866-223-2347. This confidential self-referral line is available 24 hours a day, seven days a week. The self-referral line will be answered between the hours of 8:00 A.M. and 5:00 P.M. Monday through Friday (excluding holidays). If calling outside of these hours, please leave a detailed message and contact information.

NCQA Complex Case Management

The NCQA Complex Case Management program supports the social and medical needs of our most vulnerable members with the goal of helping them make progress and stabilize their health status. The mission and focus of the NCQA Complex Case Management program is to assist members with an intense need for management and coordination of care or an extensive use of services. Core features of the program include consent from the member for participation, an extensive initial assessment and the development of a detailed care plan as well as a self-management plan.

Key to the success of NCQA Complex Case Management is the identification of appropriate members for enrollment in the program. The program makes use of two primary strategies to identify members, i.e., referrals (including self-referral) and data reports. NCQA Complex Case Management is available to all members who meet the program criteria.

Clinical Trial Items and Services

We cover certain routine costs that would otherwise be a cost to the member.

Dental Services
The Maryland Healthy Smiles Dental Program (MHSDP) provides comprehensive dental services which include diagnostic, preventative, restorative, endodontic, periodontic, and certain prosthodontic services; oral maxillofacial surgery; and sedation.

Diabetes Care Services
We cover all medically necessary diabetes care services. For members who have been diagnosed with diabetes we cover:

- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related durable medical equipment and disposable medical supplies, including:
- Blood glucose meters for home use;
- Finger sticking devices for blood sampling;
- Blood glucose monitoring supplies; and
- Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood.
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Diabetes Prevention Program
Members are eligible to participate in an evidence-based diabetes prevention program established by the Centers for Disease Control and Prevention if they:

- Are 18 to 64 years old
- Overweight or obese
- Have an elevated blood glucose level or a history of gestational diabetes mellitus
- Have never been diagnosed with diabetes; and
- Are not currently pregnant.

Diagnostic and Laboratory Services
Diagnostic services and laboratory services performed by providers who are CLIA certified or have a waiver of a certificate registration and a CLIA ID number are covered. However, viral load testing, Genotypic, phenotypic, or HIV/AIDS drug resistance testing used in treatment of HIV/AIDS are reimbursed by the State.

Dialysis Services
We cover dialysis services either through participating providers or members can self-refer to non-participating Medicare certified providers. HealthChoice members with End Stage Renal Disease (ESRD) are eligible for the REM Program.

Disease Management
We offer disease management for members with the following chronic conditions:

Kaiser Permanente Mid-Atlantic States population care management programs (PCM) help you to monitor and manage your patients with chronic conditions. Members with diabetes, asthma, coronary artery disease, chronic kidney disease, hypertension, attention deficit hyperactivity disorder (ADHD), and/or depression are enrolled into care management programs.

These programs are designed to engage your patients to help care for themselves, better understand their condition(s), update them on new information about their disease, and help manage their disease with assistance from your health care team and the population care management department. This

information and education are designed to reinforce your treatment plan for your patient.

Members in these programs receive mailings, secure messages, and/or phone calls periodically, including care gap reminders. Multi-media resources introduce the programs and provide education on topics such as the latest information on managing their condition, physical activity, tobacco cessation, medication adherence, planning for visits and knowing what to expect, and coping with multiple diseases. You receive member-level data to help you manage your panel, quality process and outcome information, and comparative quality reporting to help you improve your practice. In addition, you receive tools for you and your team, including online tools; shared-decision making tools, such as best practice alerts, smart sets, and health maintenance alerts within Kaiser Permanente HealthConnect; and direct patient management for our highest risk members by our Care Management Program.

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

Your patients do not have to enroll in the programs; they are automatically identified into a registry. Enrollment in these programs is voluntary and can be discontinued at any time. If you have patients who have not been identified for program inclusion, or who have been identified as having a condition but do not actually have the condition, you can "activate" or "inactivate" them from the program by calling 877-806-7470.

Durable Medical Services and Durable Medical Equipment (DMS/DME)

We cover medically necessary DMS/DME services. We must provide authorization for DME and/or DMS within a timely manner so as not to adversely affect the member's health and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. We must pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from **Kaiser Permanente**, as long as the member remains Medicaid eligible during the 90-day time period.

We cover disposable medical supplies, including incontinency pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection. We cover all DMS/DME used in the administration or monitoring of prescriptions. We pay for breast pumps under certain circumstances in accordance with Medicaid policy.

To refer a member for DME, please fax a complete uniform referral form (URF) with required documentation to the Utilization Management Operations Center (UMOC) to 1-800-660-2019.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

We must cover EPSDT services listed below for members under 21 years of age.

Well-child services provided in accordance with the EPSDT/Healthy Kids periodicity schedule by an EPSDT-certified provider, including:

- Periodic comprehensive physical examinations;
- Comprehensive health and developmental history, including an evaluation of both physical and mental health development;

- Immunizations;
- Laboratory tests including blood level assessments;
- Vision, hearing, and oral health screening; and
- Health education.

The State must also provide or assure the MCO provides expanded EPSDT services and partial or inter-periodic well-child services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions. Services must be sufficient in amount, duration, and scope to treat the identified condition, and all must be covered subject to limitations only based on medical necessity. These include such services as:

- Chiropractic services;
- Nutrition counseling;
- Private duty nursing services;
- Durable medical equipment including assistive devices; and
- Behavioral Health services.

Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program. Providers are responsible for making appropriate referrals for publicly funded programs not covered by Medicaid, including Head Start, the WIC program, Early Intervention services; School Health-Related Special Education Services, vocational rehabilitation, and evidenced based home visiting services provided by community-based organizations.

When a secondary review is needed, the primary care pediatrician or specialist will fax a URF to 800-660-2019 or call UMOC at 800-810-4766.

Family Planning Services

We will cover comprehensive family planning services such as:

- Office visits for family planning services;
- Laboratory tests including pap smears;
- All FDA approved contraceptive devices; methods and supplies;
- Immediate Postpartum Insertion of IUDs;
- Oral Contraceptives (must allow 12-month supply to be dispensed for refills);
- Emergency contraceptives and condoms without a prescription;
- Voluntary sterilization procedures (Sterilization procedures are not self-referred; members must be 21 years of age and must use in-network providers or have authorization for out of network care.)

Gender-Affirming Services

We cover medically necessary gender-affirming surgery and other somatic care for members with gender incongruence.

Habilitation Services

We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the ACA. These services include physical therapy, occupational therapy and speech therapy. If you have questions about which adults are eligible, call Kaiser Permanente Members Services at 1-855-249-5019.

Home Health Services

We cover home health services when the member's PCP or ordering provider certifies that the services are necessary on a part-time, intermittent basis by a member who requires home visits.

Covered home health services are delivered in the member's home and include:

- Skilled nursing services including supervisory visits;
- Home health aide services (including biweekly supervisory visits by a registered nurse in the member's home, with observation of aide's delivery of services to member at least every other visit);
- Physical therapy services;
- Occupational therapy services;
- Speech pathology services; and
- Medical supplies used in a home health visit.

To refer a member for Home Health Care, please fax a URF to UMOC at 855-414-1695.

Hospice Care Services

Hospice services can be provided in a hospice facility, in a long-term care facility, or at home. We do not require a hospice care member to change their out of network hospice provider to an in-network hospice provider. Hospice providers should make members aware of the option to change MCOs. MDH will allow new members who are in hospice care to voluntarily change their MCO if they have been auto-assigned to a MCO with whom the hospice provider does not contract. If the new member does not change their MCO, then the MCO, which the new member is currently enrolled with, must pay the out-of-network hospice provider.

Hospice providers should inform their Medicaid participants (or patients applying for Medicaid coverage) as soon as possible after they enter hospice care about the MCOs with whom they contract so that they can make an informed choice.

Inpatient Hospital Services

We cover inpatient hospital services. Kaiser Permanente is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in our MCO. We are, however, responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

For special rules for length of stay for childbirth, see page 28.

Mobile Integrated Community Health

We cover mobile integrated health services provided by approved EMS agencies for eligible adults.

Nursing Facility Services

For members that were enrolled in Kaiser Permanente prior to admission to a nursing facility, chronic hospital or chronic rehabilitation hospital and who meet the State's level of care (LOC) criteria, Kaiser Permanente is responsible for up to 90 days of the stay subject to specific rules.

Outpatient Hospital Services

We cover medically necessary outpatient hospital services. As required by the State we limit observation stays to 24 hours.

Outpatient Rehabilitative Services

We cover outpatient rehabilitative services including but not limited to medically necessary physical therapy for adult members. For members under 21 rehabilitative services are covered by Kaiser Permanente when the service is part of a home health visit or inpatient hospital stay.

To refer a member for physical therapy/occupational therapy/speech therapy (PT/OT/ST), please fax a URF to UMOC at 855-414-1698.

Requests for reauthorizations should be faxed to the following department fax numbers:
Home Care: 855-414-1695
PT, OT, ST: 855-414-1698
DME: 855-414-1695

Oxygen and Related Respiratory Equipment
We cover oxygen and related respiratory equipment.

Pharmacy Services and Copays
We are responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. We cover medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health drugs are on the State's formulary and are the responsibility of the State.

There are no copays for children under 21, pregnant member, individuals in a nursing facility, or hospice, American Indians, or for family planning drugs and devices.

- HealthChoice members co-payments for covered medications are as follows:
  - Up to a $3.00 co-payment for non-preferred brand-name drugs;
  - Up to a $1.00 co-payment for preferred drugs, all generic drugs, and HIV drugs
  - Any other charge up to the fee-for-service limit as approved by the Department.
- Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

Plastic and Restorative Surgery
We cover these services when the service will correct a deformity from disease, trauma, congenital or developmental anomalies or to restore body functions. C**osmetic surgery to solely improve appearance or mental health is not covered by the State or by the MCO.**

Podiatry Services
We cover medically necessary podiatry services. We also cover routine foot care for children under age 21 and for members with diabetes or vascular disease affecting the lower extremities.

Pregnancy-Related Care
Refer to Section Refer to Section II: Services for Pregnant and Post-Partum members.

Primary Behavioral Health Services
We cover primary behavioral health services, including assessment, clinical evaluation and referral for additional services. The PCP may elect to treat the member, if the treatment, including visits for Buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Referrals for behavioral health services can be made by calling the State's ASO at 1-800-888-1965, Monday - Friday: 8:00 AM to 6:00 PM.

Specialty Care Services
Specialty care services provided by a physician or an advanced practice nurse (APN) are covered

when services are medically necessary and are outside of the PCP's customary scope of practice. Specialty care services covered under this section also include:

- Services performed by non-physician, non-APN practitioners, within their scope of practice, employed by a physician to assist in the provision of specialty care services, and working under the physician's direct supervision;
- Services provided in a clinic by or under the direction of a physician or dentist; and
- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians.

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary. PCPs must follow our special referral protocol for children with special healthcare needs who suffer from a moderate to severe chronic health condition which:

- Has significant potential or actual impact on health and ability to function;
- Requires special health care services; and
- Is expected to last longer than 6 months.

A child functioning at 25% or more below chronological age in any developmental area, must be referred for specialty care services intended to improve or preserve the child's continuing health and quality of life, regardless of the services ability to effect a permanent cure.

Telemedicine and Remote Patient Monitoring

We must offer telemedicine and remote patient monitoring to the extent they are covered by the Medicaid FFS Program.

Kaiser Permanente offers telemedicine/video visits which enables a member to see a physician for certain conditions by video visit. Video visits are an extension of the care a member receives at Kaiser Permanente. The member, physicians, and other caregivers are connected through the member's Kaiser Permanente electronic medical record. Eligible members must have an active online Kaiser Permanente account and access to a computer, smartphone, or tablet with video capability and a good internet or data connection.

Video visits are available for certain specialties including:

- Primary care;
- Pediatrics;
- Behavioral health;
- Urgent care; and
- Nutrition and genetic counseling

Video visits are available for certain conditions such as:

- Follow-up visits
- Minor burns/sunburn
- Cuts and wounds
- Bug bites
- Medication questions
- Sinus problems

- Skin rash or infection
- Eye problems
- Shingles
- Sprains and injuries
- Flu
- Sore throat
- Nausea/vomiting/diarrhea
- Backaches
- Joint problems

To learn more about telemedicine and video visits, go to
https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/support/telehealth

Kaiser Permanente also offers remote patient monitoring to monitor members with uncontrolled hypertension outside of conventional settings in support of continuous patient care. Remote Data Monitoring (RDM) technology enables clinicians to receive data from personal health monitoring devices members use at home or outside the care center to check their patients' health status. Qualified members are invited to join the program by their primary care provider.

Qualifications include:

- Uncontrolled hypertension (blood pressure is > 139/89);
- BMI within range (Men: 18.39-46.61; Women: 18.45-49.18);
- Not currently pregnant or diagnosed with end-stage renal disease (ESRD);
- Not currently being managed by the Regional Heart Failure Program (i.e., on congestive heart failure (CHF) program registry);
- Member's age 18-75

Transplants

We cover medically necessary transplants to the extent that the service would be covered by the State's fee-for-service program.

Health Plan contracts with local and national centers of excellence for transplant services. Referring participating providers should work with our transplant coordinators when they identify a member who may be a candidate for transplantation or requesting a referral for transplant from the PCP.

Transplant candidates should be routed through the Transplant Coordinator. Please call the National Transplant Services (NTS) Department at 1-888-989-1144, then ask to be connected to the transplant on-call coordinator to refer a member for an evaluation for a transplant or to receive additional information about the NTS.

Vision Care Services

We cover medically necessary vision care services. We are required to cover one eye examination every two years for members age 21 or older; and for members under age 21, at least one eye examination every year in addition to EPSDT screening. For members under age 21 we are required to cover one pair of eyeglasses per year unless lost, stolen, broken, or no longer

vision appropriate; contact lenses must be covered if eyeglasses are not medically appropriate for the condition.

Kaiser Permanente covers additional vision services for adults. We will cover members aged 21 and over with one (1) eye exam/year and one (1) pair of eyeglasses every two (2) years. Contact lenses are covered only when medically necessary. For a complete listing of Kaiser Permanente locations with vision centers, please visit our online facility directory on our Community Provider Website at www.providers.kp.org/mas or contact Provider Experience at 1-877-806-7470.

OPTIONAL SERVICES COVERED BY KAISER PERMANENTE

In addition to those services previously noted Kaiser Permanente currently provides the following optional services to our members. These services are not taken into account when setting our capitation rate. MCO optional services may change each Calendar Year. We may not discontinue or reduce these services without providing advance notification to the State.

MEDICAID BENEFITS COVERED BY THE STATE - not covered by KAISER PERMANENTE

- **The State covers dental** services for all members who receive full Medicaid benefits. The Maryland Healthy Smiles Dental Program is responsible for routine preventative services, restorative service and orthodontia. Orthodontia must meet certain criteria and requires preauthorization by SKYGEN USA, the State's ASO. SKYGEN USA assigns members to a dentist and issues a dental Healthy Smiles ID card. However, the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits, call 1-855-934-9812.
- Outpatient rehabilitative services for children under age 21;
- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System;
- Intermediate Care Facilities for Individuals with Intellectual Disabilities or Persons with developmental disabilities;
- Personal care services;
- Medical day care services, for adults and children;
- Abortions (covered under limited circumstances – no Federal funds are used -claims are paid through the Maryland Medical Care Program). If a member was determined eligible for Medicaid based on their pregnancy, they are not eligible for abortion services;
- Emergency transportation (billed by local EMS);
- Non-emergency transportation services provided through grants to local governments;
- Services provided to members participating in the State's Health Home Program; and Certain high-cost low-volume drugs.

BENEFIT LIMITATIONS

Kaiser Permanente does not cover these services except where noted and the State does not cover these services.

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO but may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid;
- Services that are not medically necessary;
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state);
- Services that are beyond the scope of practice of the health care practitioner performing the service;

- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial;
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities;
- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the State of Maryland unless the provider is part of Kaiser Permanente network. Services may be covered when provided by an MCO network provider who has obtained the proper referral or pre-authorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out-of-state provider is enrolled in Maryland Medicaid;
- Services provided outside the United States;
- Immunizations for travel outside the U.S.;
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis;
- Private hospital room is not covered unless medically necessary or no other room is available;
- Autopsies;
- Private duty nursing services for adults 21 years old and older;
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction;
- Ovulation stimulants, in vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar;
- Reversal of voluntary sterilization procedures;
- Medications for the treatment of sexual dysfunction;
- MCOs are not permitted to cover abortions. We are required to assist members in locating these services and we are responsible for related services (sonograms, lab work, but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service;
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is under 12 years old and non-legend drugs other than insulin and enteric-coated aspirin for arthritis;
- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
- Diet and exercise programs for weight loss except when medically necessary
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified);
- MCOs do not cover emergency transportation services and are not required to cover non-emergency transportation services (NEMT). Kaiser Permanente will assist members to access non-emergency transportation through the local health department. We will provide some transportation if necessary to fill any gaps that may temporarily occur in our network.

Section IV

PRIOR AUTHORIZATION
AND
MEMBER COMPLAINT, GRIEVANCE
AND APPEAL PROCEDURES

Utilization Management
Utilization management (UM) describes the different ways to make sure that you receive the right care at the right time in the right place. Kaiser Permanente's UM Program uses advice and cooperation from your primary care physician (PCP) and other caregivers. UM activities happen across all health care settings where Kaiser Permanente provides care. UM activities include facility-based medical management, behavioral care management, emergency care management, outpatient specialty referral management, home care, outpatient durable medical equipment, rehabilitative therapy referral management, complex case management, renal case management, and transplant case management, among others.

If you want to find out more about our UM program, contact a Member Services representative, who can give you:

- Information about the status of a referral or an approval;
- A copy of our criteria, guidelines, or protocols used for decision making; and
- Answers to your questions about a denial decision.

Member Services can also connect you with someone on the UM staff. Call Member Services representatives, Monday through Friday, 7:30 a.m. to 5:30 p.m., except holidays, at: 1-855-249-5019, TTY 711.

Affirmative Statement
Kaiser Permanente practitioners and health care professionals make decisions about which care, and services are provided based on the member's clinical needs, the appropriateness of care and service, and existence of health plan coverage.

Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. The Health Plan does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or benefits or care.

No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and services or result in underutilization. In order to maintain and improve the health of our members, all practitioners and health professionals should be especially diligent in identifying any potential underutilization of care or service.

Services Requiring Prior Authorization

Please note that this is periodically updated and may not be an all-inclusive list. Questions should be directed to the Utilization Management Operations Center (UMOC) at 1-800-810-4766, follow the prompts. Please see Section III for detailed information on Maryland HealthChoice Benefits and Services.

A. Inpatient Services

1. Acute Inpatient Hospital Admissions (elective and emergent)
2. Short Stay Admissions
3. Observation Services
4. Acute Rehabilitation Admissions
5. Sub-acute Rehabilitation Admissions
6. Skilled Nursing Facility (SNF) Admissions
7. Long-Term Acute Care (LTAC) Admissions

8. Inpatient Behavioral Health Admissions
9. Outpatient Behavioral Health Admissions*

*Partial Hospitalization

B. Elective Services

1. Abortions, Elective/Therapeutic
2. Acupuncture
3. Anesthesia for Oral Surgery
4. Any Services Outside Washington Baltimore Metro Areas
5. Behavioral Health Services
6. Biofeedback
7. Blepharoplasty
8. Breast Surgery for any reason
9. Chiropractic Care
10. Clinical Trials
11. Cosmetic and Reconstructive or Plastic Surgery
12. CT Scans (Computerized Tomography)
13. Durable Medical Equipment (DME)
    - 13.1. Assistive Technologies
14. Gastric Bypass Surgery, Gastroplasty
15. Home Health Care Services
16. Infertility Assessment and Treatment
17. Infusion Therapy and Injectables (Home IV, Excluding Allergy Injections)
18. Intensity Modulated Radiation Therapy (IMRT) – Modulated Therapy
19. Interventional Radiology
20. Investigational/Experimental Services
21. Magnetic Resonance Imaging (MRI)
22. Narrow Beam Radiation Therapy Modalities
    - 22.1. Cyberknife
    - 22.2. Gamma Knife
    - 22.3. Stereotactic Radiosurgery
23. Nasal Surgery (Rhinoplasty or Septoplasty)
24. Non-Participating Provider Requests
25. Nuclear Medicine
26. Obstructive Sleep Apnea Treatment including Sleep Studies
27. Oral Surgery
28. Orthognatic Surgery
29. Outpatient Surgery – All Hospital Settings/Ambulatory Surgery Centers
30. Pain Management Services
31. Penile Implants
32. Positron Emission Tomography (PET) Scan
33. Podiatry Services
34. Post Traumatic (Accidental)
35. Prosthetics/Braces/Orthotics/Appliances
36. Prostate Biopsies - Ambulatory Surgery Center or Outpatient Hospital Surgery Setting
37. Radiation Oncology
    - 37.1. Radiology Services (all radiology and imaging services, including diagnostic plain films)
    - 37.2. Imaging studies requiring fiducial markers
38. Rehabilitation Therapies
    - 38.1. Cardiac Rehabilitation

38.2. Occupational Therapy
38.3. Physical Therapy
38.4. Pulmonary Rehabilitation Therapy
38.5. Speech Therapy
38.6. Vestibular Rehabilitation
39. Scar Revision
40. Sclerotherapy and Vein Stripping Procedures
41. Screening Colonoscopy – Consultations
42. Uvulopalatopharyngoplasty (UPPP)
43. Social Work Services
44. Temporo Mandibular Joint Evaluation and Treatment
45. Transplant Services – Solid Organ and Bone Marrow

Services Not Requiring Preauthorization

Members can elect to receive certain covered services from out-of-plan providers. Kaiser Permanente will cover these pursuant to Code of Maryland Regulations (COMAR) 10.09.67.28. The services that a member has the right to access on a self-referral basis include:

- Family planning services including office visits, diaphragm fitting, intrauterine device (IUD) insertion and removal, special contraceptive supplies, Norplant removal, Depo-Provera-FP, latex condoms, and PAP smear.
- Certain school-based healthcare services including diagnosis and treatment of illness or injury that can be effectively managed in a primary care setting, well child-care and the family planning services listed above.
- Initial medical examination for a child in State-supervised care.
- Unless Kaiser Permanente provides for the service before a newborn is discharged from the hospital, the initial examination of a newborn before discharge, if performed by an out-of-network on-call hospital provider.
- Annual Diagnostic and Evaluation Service (DES) visit for a member diagnosed with HIV or AIDS.
- Continued obstetric care with her pre-established provider for a new pregnant member.
- Renal dialysis services.
- Pharmaceutical and laboratory services, when provided in connection with a legitimately self-referred service, provided on-site by the same out of plan provider at the same location as the self-referred service.
- A newly enrolled child with a special health care need may continue to receive medical services directly related to the child's medical condition under a plan of care that was active at the time of the child's initial enrollment, if the child's out-of-plan provider submits the plan of care to Kaiser Permanente for review and approval within thirty (30) days of enrollment (For additional information, see Children with Special Healthcare Needs Page 24).
- Emergency services as described in COMAR 10.09.66.08 B.
- Services performed at a birthing center located in Maryland or a contiguous state.
- Hospice-eligible admissions

Prior Authorization Procedures

How to request a referral for Specialist Care (No Authorization Required)

Step 1: VERIFY that the referral specialist is a Kaiser Permanente Maryland HealthChoice participating provider.
Step 2: VERIFY that the requested procedure DOES NOT REQUIRE AUTHORIZATION.

Step 3: FAX a copy of the Maryland Uniform Referral or the KPMAS Referral request to the UMOC via fax at 1-800-660-2019.

-OR-

MAIL a copy of the Maryland Uniform Referral or the KPMAS Referral request to:
Kaiser Permanente New Carrollton Administrative Office Building
Utilization Management Operations Center
4000 Garden City Drive
Hyattsville, MD 20785
Step 4: Give a copy of the referral form to the member to take to the appointment with the Kaiser Permanente Maryland HealthChoice Participating Specialist.

How to request referrals for Specialist Care (Authorization Required)
Step 1: Verify that the procedure/service requires authorization.
Step 2: Determine if the specialist is a Kaiser Permanente Maryland HealthChoice participating provider.
Step 3: Complete the referral form and fax to the UMOC via fax 1-800-660-2019.
Step 4: Ensure that any required clinical documentation accompanies the referral request.
Step 5: Complete the referral form and attach appropriate lab, x-ray results, or medical records. Incomplete referrals will be faxed back to the participating PCP or participating specialist office with request to include required information. Be sure to include fax numbers on the request.

Referring Members for Radiology Services
Kaiser Permanente provides members with access to radiology and imaging services at our Medical Office Buildings, Imaging Centers, and through community-based providers within our participating provider network.

Following patient consultation, participating providers should follow the procedures below when referring a member for radiology services:

1. Provide the member with a script for the necessary radiological/imaging service or order the necessary radiological/imaging services via Online Affiliate.
2. Instruct the member to contact Kaiser Permanente to secure a radiology/imaging appointment.

The member may contact the Radiology Department at his/her preferred Kaiser Permanente Office Building or Imaging Center directly or call the Medical Advice/Appointment Line at 1-800-777-7904 to secure an appointment with a representative.

Radiology and Imaging Referral Verification Process
When a Kaiser Permanente Maryland HealthChoice member presents to your office with a script for radiology or imaging services, you must confirm that an approved Kaiser Permanente External Referral Summary Report has been issued to your practice or facility prior to rendering the services.

- Kaiser Permanente External Referral Summary Reports are issued electronically to providers with access to Kaiser Permanente HealthConnect® Online Affiliate.
    - If you receive Kaiser Permanente referrals electronically, you may view and print your approved referral by logging-on to Kaiser Permanente HealthConnect® Online Affiliate at www.providers.kp.org/mas.
    - If you do not receive referrals electronically from Kaiser Permanente, the referral will be sent to your office via fax upon approval by our UMOC.

In the event a member presents to your office for radiology or imaging services without an approved Kaiser Permanente External Referral Summary Report, you must contact our UMOC at 1-800-810-4766 to confirm the status of the referral or direct the member to contact their referring Provider.

Please note that imaging studies requiring fiducial markers will require a separate authorization.

Referring Members for Laboratory Services
Members requiring laboratory services under care with your practice should be directed to a Kaiser Permanente Medical Center or participating laboratory. Laboratory procedures covered under a current Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a current CLIA Certificate of Provider-Performed Microscopy Procedures may be performed in your office.

Orders can be entered via Online Affiliate or members can be given a signed script to present to the Kaiser Permanente laboratory. The script or order must include the following:

- Provider name;
- Provider address;
- Practice phone and fax number;
- Member name;
- Member date of birth;
- Description of test(s) requested; and
- ICD-10 codes.

The laboratory results will be faxed to the number provided on your signed script or order. Participating providers with access to Kaiser Permanente HealthConnect® Online Affiliate may obtain laboratory results via the web at www.providers.kp.org/mas.

Inpatient Admissions and Concurrent Review

Emergency Care Notification

For contracted facilities where Kaiser Permanente (MAPMG) physicians are on site, if the member requires inpatient admission or observation after an ED visit, notify the Kaiser Permanente physician on duty.

For other contracted and non-contracted entities, please be sure to notify ECM of the admission to obtain an in-patient/observation authorization ahead of time. Notification can be made by calling ☎ 800-810-4766 (Option 1).

You may refer the member to call our 24-hour medical advice line. Additionally, you may also refer a member to a Kaiser Permanente or participating urgent care facility. For a full list of urgent care facilities in our network, please go to www.kaiserpermanente.org/facilities.

Hospital Admission Notification Requirements
The hospital is responsible to notify Kaiser Permanente at the time the member is admitted.

If the admitting physician is not the participating PCP, it is the admitting physician's responsibility to contact the participating PCP in order to authorize the admission and discuss plans for care.

Participating hospitals are responsible for notifying Kaiser Permanente of all inpatient emergency admissions within 24 hours of the admission. Notification must be made to the UM department via

phone: 1-800-810-4766 or fax: 855-414-1704. Specifically, in the event that a member requires emergency care and is then transitioned to "inpatient status", Kaiser Permanente must be notified of the admission to inpatient status within 24 hours of the admission. Upon notification, Kaiser Permanente reserves the sole discretion to provide authorization for continuation of care. Kaiser Permanente also maintains the right to transfer the member to another facility. Failure to notify Kaiser Permanente may result in a denial of payment of claims. The participating hospital may not hold the member financially responsible for lack of authorization or late notification.

Subsequently, Kaiser Permanente must be notified of all births within 8 hours of the birth, unless the baby is born after 6:00 p.m. If born after 6:00 p.m., notification must be received by 6:00 a.m. of the following day. Timely notification of births will allow for pre-enrollment and/or enrollment of the newborn to begin documentation in their new individual medical records. This will also allow for Kaiser Permanente to properly provide authorizations as necessary for the newborn.

Managing Our Members in Participating Hospitals/Facilities
Once a member has been admitted and Kaiser Permanente has been notified of the admission, the participating hospital must provide daily notification (seven days a week) of a member's continued stay. Daily notification will be accepted via a daily census and submission of the necessary and meaningful clinical medical records, including any peer-to-peer interactions, to determine the member's stability and continued need for additional hospitalization. Failure to provide daily clinical records may result in partial denial of the authorization.

Neonatal Care for Premature and Medically Complex Newborns
Kaiser Permanente partners with ProgenyHealth, a company which specializes in Neonatal Care Management Services. Progeny Health's Neonatologists, Pediatricians and Neonatal Nurse Care Managers work closely with Kaiser Permanente members, as well as attending physicians and nurses, to promote healthy outcomes for Kaiser Permanente premature and medically complex newborns.

For contracted facilities where a Kaiser Permanente MAPMG physician with medical staff hospital privileges is on site, please notify ProgenyHealth directly of admissions via secured fax at 1-877-485-4892. Include a cover sheet along with supporting clinical information. Their clinical staff will contact your designated staff to perform utilization management and discharge planning.

For other contracted and non-contracted entities, please follow current practices by notifying our Emergency Care Management (ECM) Department of the NICU admission by calling ☎ 844-552-0009 or ☎ 800-810-4766 (Option 1). ECM will direct facilities to send supporting clinicals with a cover sheet via secured fax at 1-877-485-4892. ProgenyHealth's clinical staff will contact your designated staff to perform utilization management and discharge planning.

Transition Care Management
Transition care management begins when the Member is admitted to the hospital or skilled nursing facility (SNF) and continues throughout the stay. Its purpose is to capitalize on inpatient admissions to kick off a new set of multidisciplinary activities that support care post discharge and ensures Members transition safely between care venues while preventing readmissions and medication errors.

The Patient Care Coordinators work with the attending physician and the health care team to ensure the Member's transition needs are anticipated and met. The keys to safe and proactive transition management are:

- early assessment and needs identification/anticipation;

- development of a realistic and sound plan of care based on clinical evidence;
- establishing open communication with the Member and/or authorized representative and the health care team;
- coordination with all disciplines involved;
- ensuring members have a timely follow-up appointment with their PCP;
- ensuring post-acute services are delivered as ordered; and
- ensuring our high-risk members who are discharged home have the opportunity for telephonic medication reconciliation with a Health Plan clinical pharmacist.

For continued inpatient stays, the patient care coordinator evaluates the patient's needs by partnering with the member and his/her family, the attending physician and the healthcare team throughout the member's hospitalization. Transition of care is initiated on admission and regularly revisited based on the clinical status and specific needs of the patient.

During the transition of care process, the following factors are taken into consideration to ensure member's clinical needs are assessed based on the characteristics of the local delivery system:

- Availability of rehabilitation services, long-term care facility/SNF services, home care, DME, palliative care or timely access to Kaiser Permanente's internal services to support the patient after hospital discharge where needed; and
- Local hospitals' ability to provide recommended services.

Kaiser Permanente partners with Post Acute Analytics (PAA) to automate the Skilled Nursing Facility (SNF) Prior Authorization and SNF Concurrent Review processes by using the Anna™ software platform. All contracted hospitals and skilled nursing facilities that admit Kaiser Permanente Medicare Advantage, Commercial, and Medicaid members are required to work with PAA and use Anna™.

Hospitals are required to:

- Request and receive SNF authorization via Anna™
- Identify the accepted SNF
- Communicate that authorization to the SNF

SNFs are required to:

- Notify Kaiser Permanente of a member's arrival into a SNF (admission verification notification) through Anna™
- Conduct SNF concurrent review processes, including providing clinical documentation to receive authorization of additional days beyond the initial approved days within Anna™

Delays in Service Provided to Members in an Inpatient Setting

All authorized services and procedures, including but not limited to testing and imaging, must be completed within 24 hours of the authorization. Denial of payment for an inpatient day may occur if the lack of timely completion of such services and/or procedures results in a medically unnecessary extension of the member's hospital stay.

Please note that imaging studies requiring fiducial markers will require a separate authorization.

The tables below outline specific examples of common delays in service/procedure by hospital, SNF or physician category. This table lists hospital and SNF services that hospitals and SNFs, respectively, are expected to be able to deliver seven days a week, provided that such services are within the scope of the provider/facility's services. Note: This is not an exclusive list.

Hospital Delays

Diagnostic Testing/Procedures

- Magnetic resonance imaging (MRI) and computed tomography (CT) scans (test performed/read/results available)
- Other radiology delays (test performed/read/results available)
- Laboratory tests (test performed/read/results available)
- Cardiac catheterization delays (including weekends and holidays)
- Peripherally inserted central catheter (PICC) Line placement
- Echocardiograms
- GI Diagnostic procedures (esophagogastroduodenoscopy (EGD), Colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), etc.)
- Stress tests
- Technical delays (i.e., machine broken or machine is not appropriate for patient, causing delay)
- Dialysis
- Transfusions
- Acid-fast bacilli (AFBs)
- Pathology

Operating Room (OR)

- Coronary artery bypass graft (CABG) delays
- No OR time
- Physician delay (i.e., lack of availability)

Ancillary Service

- Physical therapy/occupational therapy/speech therapy (PT/OT/ST) evaluation
- Social Work/Discharge Planning

Nursing

- Delay in carrying out or omission of physician orders
- Medications not administered
- Nil per os (NPO) order not acknowledged
- Kaiser Permanente UM not notified that the patient refuses to leave when discharged

SNF Delays

Diagnostic Testing/Procedures

- Laboratory tests (test performed/read/results available)
- PICC line placement
- Radiology delays (test performed/read/results available)

Ancillary Service

- Social Work/ Discharge Planning
- Delay in initiation of therapy services (PT/OT/ST)
- Lack of weekend therapy services
- Delay in initiation of respiratory services
- Delay in pharmacy services

Nursing

- Appointment delays due to transportation issues
- Delay in initiation of nursing services

SNF

- Physician delays in facilities that do not have Kaiser Permanente on-site reviewers

Attending or Consulting Physician Delays

Hospital

- Delays in Specialty consultations.
- Delay in discharge order for alternative placement
- Delays in scheduling procedures in the Operating Room and Catheterization laboratory; and
- Member not seen by attending physician or not seen in a timely manner.

Daily Hospital Censuses

Kaiser Permanente requires participating hospitals to submit daily census for the following:

- Daily newborn census;
- Daily emergency department visits w/diagnoses;
- Daily emergency department visits converted to observation; and
- Daily current inpatient census.

Period of Preauthorization

Prior authorization numbers are valid for the date of service authorized or for a period not to exceed 90 days after the date of service authorized. This period of authorization is a general timeframe and certain specialties and services may have different applicable periods. The member must be eligible for Medicaid and enrolled in Kaiser Permanente Maryland HealthChoice on each date of service. For information about how to verify member eligibility, Prior to any appointment for a HealthChoice member, you must call the eligibility verification system (EVS) at 1-866-710-1447 to verify their eligibility and MCO enrollment. This procedure will assist in ensuring payment for services.

Providers may enroll with Online Affiliate to verify eligibility and benefit information for Kaiser Permanente members. Online Affiliate allows providers to view key information for verifying eligibility and benefits. You can also view the member Evidence of Coverage document to get comprehensive benefits information. Sign on or register for Online Affiliate at kp.org/providers/mas and select Online Provider Tools from the Provider Resources menu.

If you need assistance with Online Affiliate registration, please contact Provider Experience at 1-877-806-7470.

Prior Authorization and Coordination of Benefits

Kaiser Permanente may not refuse to pre-authorize a service because the member has other insurance. Even if the service is covered by the primary payer, the provider must follow our prior authorization rules. Preauthorization is not a guarantee of payment. Except for prenatal care and Healthy Kids/EPSDT screening services, you are required to bill other insurers first. For these services, we will pay the provider and then seek payment from the other insurer.

Medical Necessity Criteria

A "medically necessary" service or benefit must be:

- Directly related to diagnostic, preventive, curative, palliative, habilitative or

ameliorative treatment of an illness, injury, disability, or health condition;
- Consistent with current accepted standards of good medical practice;
- The most cost-effective service that can be provided without sacrificing effectiveness or access to care; and
- Not primarily for the convenience of the member, the member's family or the provider.

Clinical Guidelines

Clinical practice guidelines are systematically designed tools to assist participating practitioners and patient decisions regarding specific medical conditions and preventive care. Guidelines are informational and are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by participating practitioners in any particular set of circumstances for each patient.

KPMAS has adopted and implemented evidence-based clinical practice guidelines developed by Permanente Medical Groups and by the Care Management Institute in conjunction with Permanente physician-experts from across the Kaiser Permanente program. These guidelines cover preventive, acute, and chronic care. Preventive care guidelines include, but not limited to, prenatal care, preventive care for all ages, breast cancer screening, cervical cancer screening, colorectal cancer screening, prostate cancer screening, tobacco screening guidelines, and abdominal aortic aneurysm screening. Clinical practice guidelines address the primary care management of common diagnoses, such as adult and pediatric asthma, diabetes mellitus, hypertension, attention deficit hyperactivity disorder, coronary artery disease, and adult depression.

Clinical practice guidelines are available to Kaiser Permanente Mid-Atlantic States participating providers through Community Providers Portal at www.kp.org/providers/mas under Provider Information and Clinical Library or by contacting the Utilization Management Operations Center (UMOC) at 1-800-810-4766. Network providers can also access Kaiser Permanente-MAS HealthConnect® and Clinical Library through their Online Affiliate access at https://cl.kp.org/natl/home.html.

UM Criteria, Medical Coverage Policies and Guidelines

Measurable, evidence-based, and objective decision-making criteria ensure that decisions are fair, impartial, and consistent. Kaiser Permanente utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, and regionally developed Medical Coverage Policies (MCP). Additionally, subject matter experts currently certified in the specific field of medical practice are actively engaged in the guideline development process.

All criteria sets are reviewed and revised annually, then approved by the Regional Utilization Management Committee (RUMC) as delegated by the Regional Quality Improvement Committee (RQIC). Our UM criteria is not designed to be the final determinate of the need for care but has been developed in alignment with local practice patterns and are applied based upon the needs and stability of the individual patient. In the absence of applicable criteria or MCPs, the UM staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service.

The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system.

UM Criteria for Maryland HealthChoice Members

Non-Behavioral Health

Referral Service Type *Approved criteria sets are used in order of hierarchy	UM Approved Criteria Sets
Acute Rehabilitation (Inpatient)	MCG
Ambulance Services	MCP
Durable Medical Equipment (DME) and Supplies	MCP MCG NCD-LCD
Orthotics and Prosthetics	MCP MCG NCD-LCD
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	EPSDT Guidelines
Home Health Services	MCG
Hospice (Inpatient/Outpatient)	MCG
Inpatient Services	MCG
Neonatal Care	MCG
Outpatient Services	MCP MCG
PT/OT/Speech	MCP MCG
Skilled Nursing Facility	MCG Transmittal # 213 or Transmittal #237
Transplant Services	National Transplant Network (NTN) Services Referral Guidelines InterQual® Criteria • Transplant and Hematology/Oncology

Behavioral Health

Referral Service Type *Approved criteria sets are used in order of hierarchy	UM Approved Criteria Sets
Applied Behavioral Analysis (ABA)	Not Applicable
Behavioral Health: Substance Use Disorder (SUD) specifically *All levels, i.e., IP, OP, RTC, PHP, IOP	Not Applicable
Behavioral Health: Inpatient	Not Applicable
Behavioral Health: Outpatient *Excludes SUD	Not Applicable
Behavioral Health: Partial Hospitalization *Excludes SUD	Not Applicable

Key to Abbreviations:

- MCP/MCG™: NICU and Neonatal Care Admission and Discharge (Revised MCG® Neonatal Intensive Care Unit Levels)
- MCG™: Formerly called Milliman Care Guidelines
- ASAM: American Society of Addiction Medicine
- IQ: InterQual® Criteria

- Mental Health Services (formerly CMHRS – Community Mental Health Rehabilitative Services) Criteria
- IP: Inpatient
- MCP: Medical Coverage Policies (locally developed)
- NCD-LCD: Medicare Coverage Policies – National and Local Coverage Determination
- NTS: KP National Transplant Network Services Patient Selection Criteria
- RTC: Residential Treatment Center
- PHP: Partial Hospitalization Program
- SUD: Substance Use Disorder
- OP: Outpatient

*Use Approved UM Criteria Sets in order of hierarchy. Example, criteria 1, must be applied first. In the absence of applicable criteria from number 1, then use criteria 2, then criteria 3.
[1] Federal EPSDT Medical Necessity Guidelines
https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Hard copies of UM criteria or guidelines used in UM review are available by calling the UMOC at 800-810-4766, and selecting the appropriate prompt. Updates to medical coverage policies, UM criteria and new technology reports are featured in "*Network News*", our quarterly participating provider newsletter. You can also access current and past editions of "*Network News*" on our provider website by visiting online at:
https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/provider-info#newsletters

Accessibility of Utilization Management
The Kaiser Permanente UM Department ensures that all members and providers have access to UM staff, physicians and managers 24 hours a day, 7 days a week. You can reach the Kaiser Permanente UM Department by calling the UMOC at 800-810-4766, Option 2 (Provider) and follow prompts to be directed to Call Center (available 24 hours, 7 days a week). Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. TDD/TTY services are available for members who need them. Language assistance is available for Providers through Language Select at 888-325-2646 (Provider Access Code and Department).

The table below provides the UM hours of operations and responsibilities:

UM Department Section	Hours of Operation	Core Responsibilities
Emergency Care Management (ECM) Department	24 hours/day, 7 days/week including holidays	• Process transfer and admission requests for Members who need to be moved to a different level of care including emergency rooms, inpatient facilities, and Kaiser Permanente Medical Office Buildings • Assist with repatriation from hospital to hospital • Support all cardiac transfers for level of care needed
UM: Outpatient, Specialty Referrals, and Clinical	Monday through Friday, except clinical trials:	• Conduct pre-service review of specialty referrals (outpatient

UM Department Section	Hours of Operation	Core Responsibilities
Research Trials	8:30 A.M. to 5:00 P.M. Clinical Trials: 8:00 A.M. to 4:30 P.M. Weekends and holidays, except clinical trials: 8:30 A.M. to 5:00 P.M. for Urgent and emergent referrals and care coordination referrals	and inpatient) to include external clinical trial requests • Weekends and holidays pre-service review of urgent/emergent referrals except clinical research trials
UM: • Durable Medical Equipment (DME) • Home Care • Rehabilitative Therapies • Physical, Occupational and Speech Therapies	Monday through Friday: 8:30 A.M. to 5:00 P.M. Weekends and holidays: 8:30 A.M. to 5 P.M. (for urgent and routine discharge care coordination referrals)	• Conduct pre-service and concurrent review of Home Care, Durable Medical Equipment, Physical Therapy, Occupational Therapy, and Speech Therapy • Post-service review provided to Kaiser members outside a Kaiser medical facility
UM Hospital Services-Non-Behavioral Health (located at affiliated hospitals)	Seven days a week, including holidays: 7:00 A.M. to 5:30 P.M. Limited Evening hours (3:00 P.M. to 11:30 P.M.) at the following Premier Hospitals only: Holy Cross Silver Spring Washington Hospital Center Virginia Hospital Center	Conduct concurrent review and transition care management
Skilled Nursing Facility (SNF) and, Rehabilitation Services	Monday through Friday: 8:00 A.M. to 4:30 P.M. Including weekends and holidays	Conduct concurrent review and transition care management for members in SNF
Long Term Acute Care Hospitals (LTACH)	Monday through Friday: 8:00 A.M. to 4:30 P.M. Including weekends and holidays	Conduct concurrent review and transition care management for members in Acute Rehab
UM Hospital Services – Behavioral Health	Seven days a week: 7:30 A.M. to 5:00 P.M. Including weekends and holidays	Conduct concurrent review and transition care management services of behavioral health service
UM Outpatient Services – Behavioral Health	Monday to Friday: 7:30 A.M. to 5:00 P.M. Excluding weekends and holidays	Conduct Pre-service and concurrent review of behavioral outpatient services
Outpatient Continuing Care: Complex Case Management	Monday through Friday 8:30 A.M. to 4:30 P.M. Excluding weekends and holidays	Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members
Renal Case Management	Monday through Friday 8:30 A.M. to 5:00 P.M.	Coordinates care to slow progression of kidney disease, facilitates early

UM Department Section	Hours of Operation	Core Responsibilities
	Excluding weekends and holidays	intervention, educates members regarding kidney failure, and dialysis modalities. Collaborates with external dialysis centers, supports members receiving dialysis and monitors program goals.
Advanced Care at Home	24 hours/day, 7 days/week including holidays	• Offers Virtual Physician and nurse follow up for members who have been recently discharged from the hospital. • Bridges gap between hospital discharge and follow up with PCP • Admission avoidance by providing acute care in the home

*For the purposes of the above, the term "holidays" refers to the following: Christmas Day, New Year's Day, Martin Luther King Day, Memorial Day, Labor Day, Fourth of July, President's Day, and Veteran's Day

Communication After Business Hours

Communications received after normal business hours, as laid out in the chart above, are addressed the next business day. After business hours, our member's first line of contact is through the Kaiser Permanente Member Services Department at ☎ 800-777-7902. Members are instructed to follow prompts to be directed to the call center. The phone number is also listed on the member's ID card.

After business hours, practitioners and providers may contact the Utilization Management Operations Center (UMOC) toll-free at ☎ 800-810-4766 and follow prompts to be directed to the call center, available 24 hours, 7 days a week.

UM staff can receive inbound communications regarding UM issues after normal business hours by:

- UMOC toll-free number ☎ 800-810-4766, Option 1 (Member) or Option 2 (Provider);
- Kaiser Permanente HealthConnect® Online Affiliate;
- Kaiser Permanente HealthConnect® (KPHC) messaging system-available to providers linked to the KPHC system; and
- Direct email to a UM staff person.

Communication Services to Members with Special Needs

Communication with deaf, hard of hearing, or speech impaired members is handled through Telecommunications Device for the Deaf (TDD) or teletypewriter (TTY) services. TDD/TTY is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. The UMOC staff have a speed dial button on their phones to facilitate sending and receiving messages with the deaf, hearing, or speech impaired. Additionally, a separate TDD/TTY line for deaf, hard of hearing, or speech impaired members is available through Member Services. Members are informed of the access to TDD/TTY through the Member's ID card, the Member's Evidence of Coverage Manual, and/or the Annual Subscriber's Notice.

Non-English-speaking members may discuss UM related issues, requests, and concerns

through the KPMAS language assistance program offered by an interpreter, bilingual staff, or the language assistance line. The UMOC staff have the Language Line programmed into their phones to enhance timely communication with non-English-speaking members. Language assistance services are provided to members free of charge.

Timeliness of Decisions and Notifications to Providers and Members

Kaiser Permanente makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Maryland Department of Health. Kaiser Permanente adheres to the following decision/notification time standards:

- Standard authorizations - within 2 business days of receipt of necessary clinical information, but not later than 14 calendar days of the date of the initial request;
- Expedited authorizations - no later than 72 hours after receipt of the request if it is determined the standard timeframe could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function; and
- Covered outpatient drug authorizations - within 24 hours by telephone to either authorize the drug or request additional clinical information.
- Post-service authorizations within 14 calendar days of the request

Kaiser Permanente will send notice to deny authorizations to providers and members:

- Standard authorizations - within 72 hours from the date of determination
- Expedited authorizations - within 24 hours from the date of determination
- Post-service authorization decisions within 30 calendar days of the request

For Medicaid urgent concurrent and urgent preservice, KPMAS must make a decision and must notify the member and the member's authorized representative, as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. Notification may be orally or in writing. If the decision is a denial, KPMAS must mail written notification of its decision within 3 calendar days after providing oral notification.

For ongoing concurrent reviews, the notification period begins on the day of the review. KPMAS documents the date of the ongoing review, the decision and the notification in the UM denial file in the electronic medical record.

Tables A – D below summarize the timeliness requirements for Maryland HealthChoice members.

Table A: Timeliness Guidelines for Urgent Concurrent Review and Notification

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within 72 hours of receipt of request	Within 72 hours of receipt of request	Within 72 hours of receipt of request

Table B: Timeliness Guidelines for Urgent Pre-service Review and Notification

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within 72 hours of receipt of request	Within 72 hours of receipt of request	Within 72 hours of receipt of request

Urgent care means health care services for a medical condition that manifests itself by symptoms of sufficient severity that the absence of medical attention within 48 hours could reasonably be expected, by a prudent layperson who possesses an average knowledge of health and medicine, to result in an emergency medical condition.

Table C: Timeliness Guidelines for Non-Urgent (Standard/Routine) Pre-Service Review and Notification

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within two (2) business days of receipt of clinical information, but no later than 14 calendar days from the receipt of initial request	Within 72 hours of receipt of request	Within 72 hours from receipt of request

Table D: Timeliness Guidelines for Post-Service Review and Notification

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within 14 calendar days of receipt of request	Not Applicable	Within 14 business days of receipt of request

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Kaiser Permanente will assign a prior authorization number, which refers to and documents the approval. Kaiser Permanente sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request. Refer to Section I for a list of self-referred services which are services we must allow members to access out-of- network. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out- of-network provider. Kaiser Permanente makes such decisions on a case-by-case basis.

Overview of Member Complaint, Grievance and Appeal Processes

Our MCO member services line, 1-855-249-5019, operates Monday through Friday, 7:30 a.m. to 5:30 p.m. Member services resolves or properly refers members' inquiries or complaints to the State or other agencies. Kaiser Permanente informs members and providers of the grievance system processes for complaints, grievances, appeals, and Maryland State Fair Hearings. This information is contained in the Member Handbook and is available on the Kaiser Permanente website at https://thrive.kaiserpermanente.org/wp-content/uploads/2014/07/888d2ee38bf78090176b.pdf.

Members or their authorized representatives can file an appeal or a grievance with Kaiser

Permanente orally or in writing. An authorized representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney. Representatives must be designated in writing. Providers will not be penalized for advising or advocating on behalf of an enrollee.

Members and their representatives may also request any of the following information from Kaiser Permanente free of charge, to help with their appeal by calling 1-855-249-5019.

- Medical records;
- Any benefit provision, guideline, protocol, or criterion Kaiser Permanente used to make its decision;
- Oral interpretation and written translation assistance; and
- Assistance with filling out Kaiser Permanente's appeal forms.

Kaiser Permanente will take no punitive action for:

- Members requesting appeals or grievances;
- Providers requesting expedited resolution of appeals or grievances;
- Providers supporting a member's appeal or grievance; or
- Members or providers making complaints against Kaiser Permanente or the Department.

Kaiser Permanente will also verify that no provider or facility takes punitive action against a member or provider for using the appeals and grievance system. Providers may not discriminate or initiate disenrollment of a member for filing a complaint, grievance, or appeal with Kaiser Permanente.

Our internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member's native language if the member is a member of a substantial minority. Kaiser Permanente delivers a copy of its complaint policy and procedures to each new member at the time of initial enrollment, and at any time upon a member's request.

MCO Member Grievance Procedures

A grievance is a complaint about a matter that cannot be appealed. Grievance subjects may include but are not limited to dissatisfaction with access to coverage, any internal process or policy, actions or behaviors of our employees or vendors or provider office teams, care or treatment received from a provider, and drug utilization review programs applying drug utilization review standards.

Examples of reasons to file an administrative grievance include:

- The member's provider's office was dirty, understaffed, or difficult to access.
- The provider was rude or unprofessional.
- The member cannot find a conveniently located provider for their health care needs.
- The member is dissatisfied with the help he/she received from the provider's staff or Kaiser Permanente.

Examples of reasons to file a medical grievance include:

- The member is having issues with filling their prescriptions or contacting the provider.
- The member does not feel they are receiving the right care for their condition.
- Kaiser Permanente is taking too long to resolve the member's appeal or grievance about a medical issue.
- Kaiser Permanente denies the member's request to expedite their appeal about a medical issue.

Grievances may be filed at any time with Kaiser Permanente orally or in writing by the member or their authorized representative, including providers. Kaiser Permanente responds to grievances within the following timeframes:

- 30 calendar days of receipt for an administrative (standard) grievance;
- 5 calendar days of receipt for an urgent (medically related) grievance; and
- 24 hours of receipt for an emergent or an expedited grievance.

If we are unable to resolve an urgent or administrative grievance within the specified timeframe, we may extend the timeframe of the grievance by up to fourteen (14) calendar days if the member requests the extension or if we demonstrate to the satisfaction of the Maryland Department of Health (MDH), upon its request, that there is need for additional information and how the delay is in the member's interest. In these cases, we will attempt to reach you and the member by phone to provide information describing the reason for the delay and will follow with a letter within two (2) calendar days detailing the reasons for our decision to extend.

For expedited grievances, Kaiser Permanente will make reasonable efforts to provide oral notice of the grievance decision and will follow the oral notice with written notification. Members are advised in writing of the outcome of the investigation of all grievances within the specified processing timeframe. The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells members how to ask the State to review our decision and to obtain information on filing a request for a State Fair Hearing, if applicable.

MCO Member Appeal Procedures

An appeal is a review by the MCO or the Department when a member is dissatisfied with a decision that impacts their care. Reasons a member may file an appeal include:

- Kaiser Permanente denies covering a service ordered or prescribed by the member's provider. The reasons a service might be denied include:
    - The treatment is not needed for the member's condition, or would not help you in diagnosing the member's condition.
    - Another more effective service could be provided instead.
    - The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
- Kaiser Permanente limits, reduces, suspends, or stops a service that a member is already receiving. For example:
    - The member has been getting physical therapy for a hip injury and he/she has reached the frequency of physical therapy visits allowed.
    - The member has been prescribed a medication, it runs out, and he/she does not receive any more refills for the medication.
- Kaiser Permanente denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean."
- Kaiser Permanente fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service a member or their provider requested).
- Kaiser Permanente denies a member's request to speed up (or expedite) the resolution about a medical issue.

The member will receive a Notice of Adverse Benefit Determination (also known as a denial letter) from us. The Notice of Adverse Benefit Determination informs the member of the following:

- Kaiser Permanente's decision and the reasons for the decision, including the

policies or procedures which provide the basis for the decision
- A clear explanation of further appeal rights and the timeframe for filing an appeal
- The availability of assistance in filing an appeal
- The procedures for members to exercise their rights to an appeal and request a State Fair Hearing if they remain dissatisfied with Kaiser Permanente's decision
- That members may represent themselves or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them, in writing
- The right to request an expedited resolution and the process for doing so
- The right to request a continuation of benefits and the process for doing so

If the member wants to file an appeal with Kaiser Permanente, they have to file it within 60 days from the date of the denial letter. Our denial letters must include information about the HealthChoice Help Line. If the member has questions or needs assistance, direct them to call 1-800-284-4510. Providers may call the State's HealthChoice Provider Help Line at 1-800-766-8692. If you would like to appeal a decision on a member's behalf, you must obtain the member's consent to appeal in writing and submit it to us.

When the member files an appeal, or at any time during our review, the member and/or provider should provide us with any new information that will help us make our decision. The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help Kaiser Permanente make a decision, they may call Kaiser Permanente at 1-800-777-7902 and ask for an extension.

Kaiser Permanente may also request up to 14 additional days to resolve the appeal if we need to get additional information from other sources. If the MCO requests an extension, the MCO will send the member a letter and call the member and their provider.

When reviewing the member's appeal we will:
- Use doctors with appropriate clinical expertise in treating the member's condition or disease;
- Not use the same MCO staff to review the appeal who denied the original request for service; and
- Make a decision within 30 days, if the member's ability to attain, maintain, or regain maximum function is not at risk.

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. Kaiser Permanente resolves expedited appeals effectively and efficiently as the member's health requires. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf for an expedited appeal. If the appeal needs to be reviewed quickly due to the seriousness of the member's condition, and Kaiser Permanente agrees, the member will receive a decision about their appeal as expeditiously as the member health condition requires or no later than 72 hours from the request. If an appeal does not meet expedited criteria, it will automatically be transferred to a standard timeframe. Kaiser Permanente will make a reasonable effort to provide verbal notification and will send written notification within two (2) calendar days.

Once we complete our review, we will send the member a letter letting them know our decision. Kaiser Permanente will send written notification for a standard appeal timeframe, including an

explanation for the decision, **within 2 business days of the decision.**

For an expedited appeal timeframe, Kaiser Permanente will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 24 hours of the decision.

If we decide that they should not receive the denied service, that letter will tell them how to ask for a State Fair Hearing.

Request to Continue Benefits During the Appeal

If the member's appeal is about ending, stopping, or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member should contact us within 10 days of receiving the denial notice at 1-800-777-7902 if they would like to continue receiving services while their appeal is reviewed. The service or benefit will continue until either the member withdraws the appeal, or the appeal or fair hearing decision is adverse to the member. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

Members or their designated representative may request to continue to receive benefits while the State Fair Hearing is pending. Benefits will continue if the request meets the criteria described above when the member receives the MCO's appeal determination notice and decides to file for a State Fair Hearing. If Kaiser Permanente or the Maryland Fair Hearing officer does not agree with the member's appeal, the denial is upheld, **and the member continues to receive services,** the member may be responsible for the cost of services received during the review. If either rendering party overturns Kaiser Permanente denial, we will authorize and cover the costs of the service within 72 hours of notification.

State Fair Hearing Rights

A HealthChoice member may exercise their State Fair Hearing rights, but the member must first file an appeal with Kaiser Permanente. If Kaiser Permanente upholds the denial the member may appeal to the Office of Administrative Hearings (OAH) by contacting the HealthChoice Help Line at 1- 800-284-4510. If the member decides to request a State Fair Hearing, we will continue to work with the member and the provider to attempt to resolve the issue prior to the hearing date.

If a hearing is held and the Office of Administrative Hearings decides in the member's favor, Kaiser Permanente will authorize or provide the service no later than 72 hours of being notified of the decision. If the decision is adverse to the member, the member may be liable for services continued during our appeal and State Fair Hearing process. The final decision of the Office of Administrative Hearings is appealable to the Circuit Court and is governed by the procedures specified in State Government Article, §10-201 et seq., Annotated Code of Maryland.

State HealthChoice Help Lines

If a member has questions about the HealthChoice Program or the actions of Kaiser Permanente direct them to call the State's HealthChoice Help Line at 1-800-284-4510. Providers can contact the HealthChoice Provider Line at 1-800-766-8692.

Section V.

PHARMACY MANAGEMENT

Pharmacy Benefit Management

Kaiser Permanente is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. prescription medications and certain over-the-counter medicines. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, a new brand name drug rated as P (priority) by the FDA will be added to the formulary.

Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided within 24 hours of request. When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests. The State expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

Pharmaceutical services and counseling ordered by an in-plan provider, by a provider to whom the member has legitimately self-referred (if provided on-site), or by an emergency medical provider are covered, including:

- Legend (prescription) drugs;
- Insulin;
- All FDA approved contraceptives (we may limit which brand drugs we cover);
- Latex condoms and emergency contraceptives (to be provided without any requirement for a provider's order);
- Non-legend ergocalciferol liquid (Vitamin D);
- Hypodermic needles and syringes;
- Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, jejunostomy, or gastrostomy tube;
- Enteric coated aspirin prescribed for treatment of arthritic conditions;
- Non-legend ferrous sulfate oral preparations;
- Non-legend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for members under age 12;
- Formulas for genetic abnormalities; and
- Medical supplies for compounding prescriptions for home intravenous therapy.

Carved Out Drugs:

The following carved out drugs are covered by Maryland Department of Health (MDH). These drugs can't be included in the Kaiser Permanente's Maryland Medicaid Formulary.

- Drugs when used for management of substance use disorder
- Drugs when used for management of Behavioral (Mental) Health

Excluded Drugs:

The following are not covered by the State or the MCO:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight;
- Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition.

- Medications for erectile dysfunction; and
- Ovulation stimulants.
- Drug Efficacy Study Implementation (DESI) drugs based on FDA drug control act requiring all drugs to be safe and efficacious; and
- Medications used for cosmetic purposes or hair growth

Kaiser Permanente contracts with MedImpact to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

Mail Order Prescriptions

We cannot require a member to use mail-order but we do offer mail-order pharmacy services for certain drugs.

Kaiser Permanente offers members an option to voluntarily have new and refill prescriptions sent to them by mail-order, however, members may pick up their medications at a local Kaiser Permanente pharmacy if they choose.

The mail order program is self-administered at a separately licensed Kaiser Permanente pharmacy located in Sterling, VA. Members may request their prescriptions by mail, telephone, mobile app, or by placing an online order using Kaiser Permanente's secure site and the member's personal identification. Members may also use our telephone, mobile app, or online systems to check the status of their refill requests and delivery.

If a member has no refills remaining on their prescription, the prescriber is contacted to authorize additional refills. The mail-order pharmacy mails non-controlled and Schedule III-V (CIII-CV) prescriptions to Kaiser Permanente members, but does not mail Schedule II (CII) prescriptions, certain refrigerated medications, compounded medications, certain specialty medications, and certain over-the-counter medications; members may pick up these drugs at a medical center pharmacy.

The mail order pharmacy uses a combination of robotic dispensing by the Optifill® System and manual filling, which rely on bar code scanning. Pharmacy personnel follow stringent quality assurance guidelines for accuracy and review patient profiles for potential drug interactions, allergies, cost effective prescribing patterns and clinical appropriateness. Patient education material for each drug is included with the order, which describes common usage guidelines, cautions, and possible side effects. Completed prescription orders are packaged on site and sent via first class U.S. mail or Priority mail depending on weight in tamper-resistant packages. We can dispatch "special handling prescriptions" through FedEx, which may require a signature for receipt. Kaiser Permanente uses audit tools to monitor prescription refill timeliness adherence to policies and procedures, regulatory compliance and quality assurance and patient safety standards.

Specialty Pharmacy Services

For specialty pharmacy services Kaiser Permanente contracts with a Kaiser Permanente Specialty Pharmacy, and if the product has limited distribution, Kaiser Permanente will arrange for pharmacy services as instructed by the manufacturer for those products with limited distribution/pharmacy services.

Kaiser Permanente is responsible for formulary development, drug utilization review, and prior authorization. Kaiser Permanente's drug utilization review program is subject to review and approval by MDH and is coordinated with the drug utilization review program of the Behavioral Health Service delivery system.

Prescription and Drug Formulary

Check the current Kaiser Permanente formulary, via the online Community Provider Portal for affiliated practitioners available at https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/pharmacy before writing a prescription for either prescription or over-the-counter drugs Kaiser Permanente members must have their prescriptions filled at a network pharmacy.

Most Behavioral Health medications are paid by Medicaid not the MCO. The State's Medicaid formulary can be found at: https://client.formularynavigator.com/Search.aspx?siteCode=9381489506

Prescription Copays

There are no copays for children under 21, pregnant members, individuals in a nursing facility, or hospice, American Indians, or for family planning drugs and devices.

- HealthChoice members co-payments for covered medications are as follows:
  - Up to a $3.00 co-payment for non-preferred brand-name drugs.
  - Up to a $1.00 co-payment for preferred drugs, all generic drugs, and HIV drugs
  - Any other charge up to the fee-for-service limit as approved by the Department.
- Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program

The pharmacy cannot withhold services even if the member cannot pay the co-payment. The member's inability to pay the co-payment does not excuse the debt and they can be billed for the co-payment at a later time.

Over-the-Counter Products

Over the counter (OTC) products covered under the prescription drug benefit are listed in the MDH preferred drug list. Like other drugs, OTC drugs require a prescription in order to be covered under the drug benefit. The MDH preferred drug list can be accessed at https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/maryland-health-choice-preferred-drug-list-formulary-mas-en.pdf.

Injectables and Non-Formulary Medications Requiring Prior-Authorization

Drugs listed on the MDH Formulary are covered by the drug benefit. When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests according to state's expectation that a non-formulary drug is approved if documentation is provided indicating that the formulary alternative is not medically appropriate. The exception process was developed to provide prescribers and members access to medically necessary drugs under the drug benefit, even when that drug is not on the formulary. The recognized exceptions for a non-formulary drug to be covered are:

a. Allergy or adverse drug reaction to Formulary agent;
b. Treatment failure to Formulary agent;
c. Meets specific criteria for use of Non-Formulary agent

Prior Authorization Process

Medications with established prior authorization criteria are marked with an abbreviation "PA" in

the MDH preferred drug list which can be accessed at https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/maryland-health-choice-preferred-drug-list-formulary-mas-en.pdf.

The PA criteria are reviewed at least annually by Kaiser Permanente Mid-Atlantic States (KPMAS) Pharmacy and Therapeutics Committee. Visit the Community Provider Portal for the Maryland HealthChoice preferred drug list and prior authorization criteria available at https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/pharmacy#formulary.

Kaiser Permanente will accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for prior authorization requests.

Kaiser Permanente will follow authorization procedures within prescribed time frame and promptly notify both the physician, enrollee and the pharmacy provider when applicable of its decision consistent with COMAR 10.67.09.04 requirements.

Kaiser Permanente will provide notice by telephone or other telecommunication device within 24 hours of a preauthorization request with approval, denial or request additional information.

Notice of a decision to deny a prior authorization requests will be provided to the enrollee and the requesting provider within 24 hours of the decision.

If the drug is prescribed for an "emergency medical condition", Kaiser Permanente will pay for at least a 72-hour supply of the drug to allow Kaiser Permanente time to make a decision.

We follow the State's medical criteria for coverage of Hepatitis C drugs.

Step Therapy and Quantity Limits

KPMAS shall notify the Division of Clinical Pharmacy Services at least 30 days prior to implementation of any step therapy criteria or protocols. All step therapy criteria or protocols will be reviewed and approved by the KPMAS Pharmacy and Therapeutics Committee.

The MDH list of preferred drugs can be accessed via the Community Provider Portal. The list includes whether quantity limits are in place for a particular drug. The list can be access at https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/maryland-health-choice-preferred-drug-list-formulary-mas-en.pdf.

Maryland Prescription Drug Monitoring Program

Kaiser Permanente complies with the Maryland Prescription Drug Monitoring Program. The Maryland Prescription Drug Monitoring Program (PDMP) is an important component of the Maryland Department of Health initiative to halt the abuse and diversion of prescription drugs.

The Maryland Department of Health is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The Maryland Department of Health does not collect data on any other drugs.

Pharmacies must submit data to the Maryland Department of Health at least once every 15 days. This requirement applies to pharmacies that dispense CDS or HGH in outpatient settings in Maryland, and by out-of-state pharmacies dispensing CDS or HGH into Maryland. Patient information in the Maryland Department of Health is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations, confirm patients' drug histories, and document compliance with therapeutic regimens.

New registration access to the Maryland Department of Health database at https://crisphealth.org/services/prescription-drug-monitoring-program-pdmp/pdmp-registration/ is granted to prescribers and pharmacists who are licensed by the State of Maryland and in good standing with their respective licensing boards. Prescribers and pharmacists authorized to access the Maryland Department of Health, must certify before each search that they are seeking data solely for the purpose of providing healthcare to current patients. Authorized users agree that they will not provide access to the Maryland Department of Health to any other individuals, including members of their staff.

Corrective Managed Care Program
We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the State's criteria for Corrective Managed Care. The Corrective Managed Care (CMC) Program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call 1-855-249-5019 if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. Kaiser Permanente will work with the State in these efforts and adhere to the State's Opioid preauthorization criteria.

Maryland Opioid Prescribing Guidance and Policies

The following policies apply to both Medicaid Fee-for-Service and all 9 Managed Care Organizations (MCO):

Policy
Prior authorization is required for long-acting opioids, fentanyl products, methadone for pain, and any opioid prescription that results in a patient exceeding 90 morphine milliequivalents (MME) per day.[1] A standard 30 day quantity limit for all opioids is set at or below 90 MME per day. The CDC advises, "clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 MME/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day." In order to prescribe a long acting opioid, fentanyl products, methadone for pain and opioids above 90 MME daily, a prior authorization must be obtained every 6 months.

The prior authorization requires the following items: an attestation that the provider has reviewed Controlled Dangerous Substance (CDS) prescriptions in the Prescription Drug Monitoring Program (PDMP); an attestation of a Patient-Provider agreement; attestation of screening patient with random urine drug screen(s) before and during treatment; and attestation that a naloxone prescription was given/offered to the patient/patient's household member. Patients with Cancer, Sickle Cell Anemia or in Hospice are excluded from the prior authorization process but they should also be kept on the lowest effective dose of opioids for the shortest required duration to

[1] Instructions on calculating MME is available at: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

minimize risk of harm. *HealthChoice MCOs may choose to implement additional requirements or limitations beyond the State's policy.*

Naloxone should be prescribed to patients that meet certain risk factors. Both the CDC and Centers for Medicaid and Medicare Services have emphasized that clinicians should incorporate strategies to mitigate the risk of overdose when prescribing opioids.[2] We encourage providers to prescribe naloxone - an opioid antagonist used to reverse opioid overdose - if any of the following risk factors are present: history of substance use disorder; high dose or cumulative prescriptions that result in over 50 MME; prescriptions for both opioids and benzodiazepine or non-benzodiazepine sedative hypnotics; or other factors, such as drug using friends/family.

Guidance:

Non-opioids are considered first line treatment for chronic pain. The CDC recommends expanding first line treatment options to non-opioid therapies for pain. In order to address this recommendation, the following evidence-based alternatives are available within the Medicaid program: NSAIDs, duloxetine for chronic pain; diclofenac topical; and certain first line non-pharmacological treatment options (e.g., physical therapy). Some MCOs have optional expanded coverage that is outlined in the attached document.

Providers should screen for Substance Use Disorder. Before writing for an opiate or any controlled substance, providers should use a standardized tool(s) to screen for substance use. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an example of a screening tool.[3] Caution should be used in prescribing opioids for any patients who are identified as having any type of or history of substance use disorder. Providers should refer any patient whom is identified as having a substance use disorder to a substance use treatment program.

Screening, Brief Intervention and Referral to Treatment (SBIRT), is an evidenced-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs. The practice has proved successful in hospitals, specialty medical practices, emergency departments and workplace wellness programs. SBIRT can be easily used in primary care settings and enables providers to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues.

The provision of SBIRT is a billable service under Medicaid. Information on billing may be accessed here: https://health.maryland.gov/mmcp/MCOupdates/Documents/pt_43_16_edicaid_program_updates_for_spring_2016.pdf.

Patients Identified with Substance Use Disorder Should be Referred to Substance Use Treatment. Maryland Medicaid administers specialty behavioral health services through a single Administrative Services Organization Optum Maryland. If you need assistance in locating a substance use treatment provider, Optum may be reached at 800-888-1965. If you are considering a referral to behavioral health treatment for one of your patients, additional resources may be accessed at maryland.optum.com

Providers should use the PMDP every time they write a prescription for CDS. Administered

[2] CDC guidance: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm; and CMS guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf)

by MDH, the PDMP gives healthcare providers online access to their patients' complete CDS prescription profile. Practitioners can access prescription information collected by the PDMP *at no cost* through the Chesapeake Regional Information System for our Patients (CRISP) health information exchange, an electronic health information network connecting all acute care hospitals in Maryland and other healthcare facilities. Providers that register with CRISP get access to a powerful "virtual health record" that includes patient hospital admission, discharge and transfer records, laboratory and radiology reports and clinical documents, as well as PDMP data.

For more information about the PDMP, visit the MDH website: https://health.maryland.gov/pdmp/pages/home.aspx. If you are not already a registered CRISP user you can register for **free** at https://crisphealth.force.com/crisp2_login. PDMP usage is highly encouraged for all CDS prescribers and is mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law).

If a MCO is implementing any additional policy changes related to opioid prescribing, the MCO will notify providers and beneficiaries**.**

Section VI.

CLAIMS SUBMISSION, PROVIDER APPEALS, QUALITY INITIATIVES, PROVIDER PERFORMANCE DATA AND PAY FOR PERFORMANCE

Facts to Know Before You Bill

You must verify through the Eligibility Verification System (EVS) that participants are assigned to Kaiser Permanente Maryland HealthChoice before rendering services.

- You are prohibited from balance billing anyone that has Medicaid including managed care organization (MCO) members.
- You may not bill Medicaid or MCO members for missed appointments.
- Medicaid regulations require that a provider accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services.
- Any Medicaid provider that practices balance billing is in violation of their contract.
- For covered services MCO providers may only bill us or the Medicaid program if the service is covered by the State but is not covered by the MCO.
- Providers are prohibited from billing any other person, including the Medicaid participant or the participant's family members, for covered services.
- HealthChoice participants may not pay for covered services provided by a Medicaid provider that is outside of their MCO provider network.
- If a service is not a covered service and the member knowingly agrees to receive a non-covered service, the provider MUST: Notify the member in advance that the charges will not be covered under the program. Require that the member sign a statement agreeing to pay for the services and place the document in the member's medical record. We recommend you call us to verify that the service is not covered before rendering the service.

Submitting Claims to Kaiser Permanente

As a participating provider, you have agreed to a fee-for-service arrangement as defined in your Participating Agreement with Kaiser Permanente. The rate established in your Participating Agreement with Kaiser Permanente Maryland HealthChoice members constitutes payment in full for covered services provided. Members may not be balanced billed for the difference between the actual billed amount for covered services and your contracted reimbursement rate.

Methods of Claim Filing

Electronic Data Interchange (EDI)

Electronic Claim Submissions: Kaiser Permanente encourages electronic submission of claims.

EDI is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI transactions replace the submission of paper claims. Required data elements (for example, claims data elements) are entered into the computer only ONCE - typically at the Provider's office, or at another location where services were rendered.

Benefits of EDI Submission

- Reduced Overhead Expenses: Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated.
- Improved Data Accuracy: Because the claims data submitted by the Provider is sent electronically to Kaiser Permanente via the Clearinghouse, data accuracy is improved, as there is no need for re-keying or re-entry of data.
- Low Error Rate: Additionally, "up-front" edits applied to the claims data while information is being entered at the Provider's office, and additional payer-specific edits applied to the data by the Clearinghouse before the data is transmitted to the appropriate payer for

processing, increase the percentage of clean claim submissions.
- Bypass U.S. Mail Delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system.
- Standardized Transaction Formats: Industry-accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple payers.

Electronic Claims Forms / Submission
Kaiser Permanente accepts all claims submitted by mail or electronically.
Professional and facility claims can be submitted electronically via the current version of:
- 837P must be used for all professional services and suppliers
- 837I must be used by all facilities (e.g., hospitals)

Standardized Transaction Formats
Industry-accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple payers.

Supporting Documentation for EDI Claims
Kaiser Permanente allows you to submit claim supporting documentation via Online Affiliate. You can easily view pending Kaiser Permanente Requests for Information in the Request for Information Activity tab.

You can quickly determine which claims require additional documentation for processing by navigating to the Online Affiliate Request for Information Activity tab. You will be presented with the Kaiser Permanente claim number, date of request, and reason we are requesting additional information.

Otherwise, Kaiser Permanente will request supporting documentation by sending a request for information (RFI) letter via USPS, which can be responded to via Online Affiliate.
To submit electronically or enroll for access to Online Affiliate, navigate to kp.org/providers/mas and select **Online Provider Tools** from the Provider Resources menu.

To Initiate Electronic Claims Submissions
Trading partners or trading parties interested in implementing EDI transactions with Kaiser Permanente should contact EDI Support for information by opening a support case at https://kpnationalclaims.my.site.com/EDI/S/.

Providers with existing electronic connectivity, please use the Payor ID list below:
The Kaiser Permanente Mid-Atlantic States payor IDs are as follows:
- Office Ally: 52095
- Availity: 54294
- SSI: 52095
- Relay Health Alternate IDs: RH010 & NG008

Paper Claim Forms
Professional charges must be submitted on a preprinted OCR red lined CMS-1500 v 0212 form (or successor form) with current ICD-10 diagnostic and CPT-4 procedure coding (or successor coding accepted commonly in the industry). Entries must be completed in accordance with National Uniform Claim Committee (NUCC) directions and contain all mandatory entries, and as required by applicable statutes and regulations. Reference material can be found at WWW.NUCC.ORG.

Institutional charges must be submitted using a preprinted OCR red lined UB-04 claim form (or successor form) with appropriate coding. Entries must be completed in accordance with National Uniform Billing Committee (NUBC) directions and contain all mandatory entries, and as required by applicable statutes and regulations. Reference material can be found at WWW.NUBC.ORG

Kaiser Permanente does not accept claims that are handwritten, faxed or photocopied.

All claims/bills should be mailed to:

Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

Payment is generally made within thirty (30) days of receiving the claim/bill.

Providers may check the status of a claim/bill submitted for payment electronically using Online Affiliate. Any questions related to a previously submitted claim, billing, or utilization will need to be directed to Online Affiliate using the claims feature. The claims feature allows users to do the following:

- View detailed claim information
- Perform the following "Take Action" on a claim:
    - Submit a claim inquiry related to 'denied' or 'in progress' claims
    - Submit an inquiry related to a check payment, receive a copy of a check or report a change of address for a specific claim.
    - Submit appeals or disputes – request a reconsideration of a payment
    - Respond to Kaiser Permanente request for information (RFI)

To access the Kaiser Permanente Online Affiliate portal, please visit https://kp.org/providers, choose your Region, and navigate to the "Online Provider Tools" section.

Other complex claim questions can be addressed by contacting Member Services Call Center at 1-855-249-5019 and selecting the Claims prompt to speak to a Member Services representative. If no resolution is received after thirty (30) days, please feel free to contact Provider Experience Department at 1-877-806-7470.

Timely Filing Requirements
Claims/bills for services provided to Health Plan members must be received within twelve (12) months, (365 calendar days) of the date of service to be considered for processing and payment. However, we encourage you to submit claims within six (6) months for more expedited claims processing and reimbursement for covered services.

Clean Claim
Kaiser Permanente considers a claim "clean" when the following requirements are met:

- Correct Form: Kaiser Permanente requires all professional claims to be submitted using the 837P EDI Format or Original Red Industry Standard CMS Form 1500 ver 02/12, and all facility claims (or appropriate ancillary services) to be submitted using the 837I EDI Format or CMS Form 1450 (UB04) based on CMS guidelines.
- Standard Coding: All fields should be completed using industry standard coding.

- Applicable Attachments: Attachments should be included in your submission when circumstances require additional information.
- Completed Field Elements for 837P/CMS Form 1500 (02/12 based on CMS guidelines) Or 837I/CMS 1450 (UB-04 based on CMS guidelines): All applicable data elements of CMS forms should be completed.

A claim is not considered to be "clean" or payable if one or more of the following are missing or are in dispute:

- The format used in the completion or submission of the claim is missing required fields or codes are not active.
- The eligibility of a member cannot be verified.
- The service from and to dates are missing.
- The rendering physician is missing or incorrect (all claims submitted to Kaiser Permanente must include the name and NPI number of the physician, practitioner, or clinician that actually rendered the services reported on the claim form).
- The vendor is missing.
- The diagnosis is missing or invalid.
- The place of service is missing or invalid.
- The procedures/services are missing or invalid.
- The amount billed is missing or invalid.
- The number of units/quantity is missing or invalid.
- The type of bill, when applicable, is missing or invalid.
- The responsibility of another payor for all or part of the claim is not included or sent with the claim.
- Other coverage has not been verified.
- Additional information is required for processing such as COB information, operative report or medical notes (these will be requested upon denial or pending of claim).
- The claim was submitted fraudulently.
- The claim does not comply with coding standards (detailed in Sections 5.39-5.40 of this Provider Manual).
- The original claim number for any corrected or voided claim submission (see Sections 5.30 Fully Funded: Claim Adjustments/Corrections (Retrospective or Otherwise), 5.31 Self-Funded: Claim Adjustments/Corrections (Retrospective or Otherwise), and the section for Correcting a Previously Submitted Claim).

Clean claims for covered benefits will be processed according to jurisdictional regulations and paid, unless covered under a capitation agreement. Inaccurate coding may result in claim processing and payment delays. As many factors are considered in the processing of a claim, we note that a pre-authorized referral does not guarantee payment, except under very limited conditions.

Coding Standards

Coding – All fields should be completed using industry standard coding as outlined below.

Code Set	Standard

CPT- 4 (Current Procedure Terminology)	Maintained and distributed by the American Medical Association, including its codes and modifiers, and codes for anesthesia services
ICD-10 CM (International Classification of Diseases, Clinical Modification)	Maintained and distributed by the National Center for Health Statistics-Centers for Disease Control and Prevention
HCPCS and **Modifiers** CMS Healthcare Common Procedure Coding System)	Maintained and distributed by the U.S. Department of Health and Human Services
NDC (National Drug Codes)	Prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services
ASA (American Society of Anesthesiologists)	Anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists
DSM-IV (American Psychiatric Services)	For psychiatric services, codes distributed by the American Psychiatric Association
Revenue Code	For facilities, use the national or state uniform billing data elements specifications

Supporting documentation is required only when requested upon the denial or pending of a claim. The need for this information will be indicated by the remark codes returned on the 835 electronic transaction or paper remittance advice. Your claim will not be reprocessed until the information is received. Any claim supporting documentation can be submitted via Online Affiliate (refer to page 6 for details).

When billing with an unlisted CPT code, to expedite claims processing and adjudication, providers should submit supporting written documentation.

Claims Editing Software Program
Services must be reported in accordance with the reporting guidelines and instructions contained in the American Medical Association (AMA) CPT Manual, "CPT® Assistant," HCPCS publications", CMS guidelines and other industry coding guidelines. Providers are responsible for accurately reporting the medical, surgical, diagnostic, and therapeutic services rendered to a member with the correct CPT and/or HCPCS codes, and for appending the applicable modifiers, when appropriate. Provider documentation must support services billed.

Claims are processed utilizing the claims editing software product ClaimsXten Portfolio. ClaimsXten includes edit rules such as incidental, bundled and mutually as well as other edits that are recognized by industry guidelines. ClaimsXten is updated at a minimum quarterly. The software is reviewed on a regulatory basis to ensure that the clinical content used in ClaimsXten is clinically appropriate and withstands the scrutiny of both payers and providers.
The code edit software may change and edit your claim, perhaps substantially, as a result of industry coding guidelines. When a change is made to your submitted code(s), Kaiser Permanente will provide an explanation of the reason for the change.

Possible outcomes include:

- Accepting the code(s) as submitted.
- Adding a new code to a claim to comply with generally accepted coding practices that are consistent with Physicians CPT, the HCPCS Code Book
- Denying services for outdated or invalid codes.
- Denying line items for coding guidelines such as medically unlikely or CMS' National Correct Coding Initiative (NCCI).
- Deny services for bundling or unbundling codes as appropriate.
- Denying code(s) as incidental or inherent part of the more global code billed.
- Seeking additional information from the physician's office due to inconsistent information in the claim.

Fraudulent coding will be investigated by Kaiser Permanente. In addition, individual physician evaluation and management coding statistics are routinely trended and compared with national statistics. Aberrant coding statistics may result in contract termination and investigation by federal regulators.

Claim Code Edits and Descriptions

Supplies on the same day as surgery – CMS has established that certain supplies should be denied when billed on the same day as surgical procedures for which the concept of the global surgical package applies.

Bundled Service – Identifies procedures indicated by CMS as always bundled when billed with any other procedure. According to CMS, certain codes are always bundled when billed with other services on the same date of service.

Deleted Procedure Codes – Identifies deleted service and procedure codes that were in past editions of the CPT and HCPCS books. CMS does not permit reimbursement of AMA deleted codes when they are submitted after the deletion date and beyond the permitted submission period.

Inappropriate Procedure for Gender – Identifies procedures that are inconsistent with the member's gender.

Duplicate Line Items – Identifies duplicate line items.

Global Surgical Package – Procedure codes have a time frame associated with them which includes services and supplies associated with the procedure. The time frames are set by both CMS and broadly accepted industry sources.

Modifier Validation – According to CMS or industry accepted standards, the professional component modifier should have been reported for services rendered in this place of service.

New Patient Code – The AMA has established that a provider practice can only bill a patient code as new once every three years.

According to AMA, add-on procedures are to be listed in addition to the primary (base code) procedure. Primary (base code) procedures are typically billed with a quantity of one. When a provider is billing a primary (base code) procedure with quantity of one, those additional services beyond the primary (base code) procedure should be billed as add-on codes.

Inappropriate CPT to Modifier Combination – Certain procedure codes and modifier combinations are not appropriate.

Component Billing – Identifies a component procedure (technical or professional) billed when the comprehensive procedure has been previously billed.

Professional Component Not Allowed – Identifies pathology/laboratory procedures billed with a professional component when no such component applies per CMS guidelines.
Medical Imaging: 3D rendering and interpretation of CT, MRI, US and rereads of imaging studies – Kaiser Permanente considers 3D rendering of imaging studies to be included in the reimbursement for most imaging studies performed and 3D rendering of CT, MRI or US imaging will not be separately reimbursed. When reimbursed, the 3D rendering must be ordered by the provider ordering the study and the 3D imaging is referred to in the resulting report and interpretation. This policy does not apply to breast tomosynthesis (3D Mammography). Additionally, reimbursement for the same service more than once represents duplicate reimbursement. This includes multiple interpretations of the same diagnostic study (e.g., imaging or laboratory service). Kaiser Permanente will not reimburse subsequent interpretation or reviews of medical imaging exams performed in the same place of service or elsewhere.

Reimbursement Policy for Comprehensive and Component Codes
When two or more related procedures are performed on a patient during a single session or visit, there are instances when a claim is submitted with multiple codes instead of one comprehensive code that fully describes the entire service. Kaiser Permanente will allow the comprehensive procedure code.

The specific procedure code relationships in this Reimbursement Policy are modeled after the Correct Coding Initiative (CCI) administered through CMS, AMA CPT and other general industry-accepted guidelines.

Same Service/Same Code Billed by Multiple Providers - In accordance with CMS Medicare guidelines for payment of claims, Kaiser Permanente will only pay for an "interpretation and report" of an x-ray or an electrocardiogram (EKG) procedure and not a "review" of the same procedures. As defined in the Medicare claims manual, an interpretation and report should address the findings, relevant clinical issues, and comparative data (when available). A professional component billing based on a "review" of the findings of the procedure without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for a separate payment.

Exceptions to this policy will only be made under unusual circumstances for which documentation is provided justifying a second interpretation. The studies subject to this policy are:

- EKG, echocardiograms
- Neurological testing such as electroencephalogram (EEG)
- X-rays, plain films, ultrasound, magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and fluoroscopy studies

Timely Filing Requirements and Appeal of Timely Filing
All claims must be received within the timeframes defined under the Timely Filing Requirements section of this manual.

Resubmitted claims along with proof of initial timely filing received within six (6) months of the

original date of denial or explanation of payment will be allowed for reconsideration of claim processing and payment. Any claim resubmissions received for timely filing reconsideration beyond six (6) months of the original date of denial or explanation of payment will be denied as untimely submitted.

Proof of Timely Filing
Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time-frame. Acceptable proof of timely filing may include the following documentation and/or situations:

Proof or Documentation	Examples
System generated claim copies, account print-outs, or reports that indicate the original date that claim was submitted, and to which insurance carrier. *Hand-written or typed documentation is not acceptable proof of timely filing.	• Account ledger posting that includes multiple patient submissions • Individual patient ledger • CMS UB-04 or 1500 with a system generated date or submission
Electronic Data Interchange (EDI) Transmission report	• Reports from a provider clearinghouse (i.e., Emdeon)
Lack of member insurance information. Proof of follow-up with member for lack of insurance or incorrect insurance information. *Members are responsible for providing current and appropriate coverage information each time services are rendered by a provider.	• Copies of dated letters requesting information or requesting correct information from the member. • Original hospital admission sheet or face sheet with incomplete, absent, or incorrect insurance information. • Any type of demographic sheet collected by the provider from the member with incomplete, absent, or incorrect insurance information.

Claim Adjustments/Corrections

Professional Claims

EDI:

- Corrected claims should be submitted using Frequency Type Code "7" Loop 2300 CLM05-3. Please include the original claim number on the corrected claim.

Paper:

- Identification of the corrected claim is based on codes entered in specific fields on the form. No additional notifications are required. For example, do not write "Corrected Claim" on the form or include a cover page indicating that a corrected claim is being submitted.
- The CMS 1500 0212 box (resubmission code) should contain a "7" and under the Original Ref. No., the Kaiser Permanente (Tapestry) claim number should be provided. Claims submitted without the valid original claim number will be rejected. The DCN/Original claim number can be obtained from the 835 Electronic Remittance Advice (ERA) or the provider's EOP.
- If the Tapestry claim number is not provided, the claim will be rejected for missing the original claim number.

Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address.

Institutional Claims

EDI:

- Corrected claims should be submitted using Frequency Type Code "7". Loop 2300 CLM05-3. Please include the original claim number on the corrected claim.

Paper:

- Identification of the corrected claim is based on codes entered in specific fields on the form. No additional notifications are required. For example, do not write "Corrected Claim" on the form or include a cover page indicating that a corrected claim is being submitted.
- On the UB04 claim, a correct claim is indicated by the last digit of the type of bill field (Block 4) being a "7" (ex. 117, 137, etc.). The original claim number is placed in Block 64 (Document Control Number), and it needs to be in the same row as the payor in Block 50. For example, if this is a corrected claim, and Kaiser Permanente has been identified in Row A in Block 50, the Tapestry claim number needs to be in Block 64 Row A when submitting a paper claim.
- If the Tapestry claim number is not provided, the claim will be rejected for missing the original claim number.

Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address.

Claim Overpayment

In the case of an overpayment of a claim, Kaiser Permanente will provide the participating provider with a written notice of explanation. The participating provider should send the appropriate refund to Kaiser Permanente within thirty (30) days of receiving the overpayment notice or when the participating provider confirms that he/she is not entitled to the payment, whichever is earlier.

Please include the following information when returning uncontested overpayments:

- Name of each Health Plan member who received care for which an overpayment was received
- Copy of each applicable remittance advice from other carriers
- Primary carrier information, if applied
- Each applicable member's Kaiser Permanente medical record number (MRN)
- Authorization number(s) for all applicable non-emergency services
- Claim number(s)
- Date(s) of service

Mail refunds to:

Kaiser Foundation Health Plan – Mid-Atlantic States
Attention: Regional Claims Recovery
P.O. Box 740814
Los Angeles, CA 90074-0814

If for some reason the participating provider's refund is not received within thirty (30) days of receiving the overpayment notice, Kaiser Permanente may deduct the refund amount from future payments.

Coordination of Benefits

There are many instances in which a member's episode of care may be covered by more than one insurance carrier. Maryland HealthChoice will always be the payor of last resort. Kaiser Permanente participating providers are responsible for determining the primary payor and for billing the appropriate party.

Coordination of Benefits (COB) is a method for determining the order in which benefits are paid and the amounts which are payable when a member is covered under more than one plan. It is intended to prevent duplication of benefits when an individual is covered by multiple plans providing benefits or services for medical or other care and treatment.

Kaiser Permanente contracted providers are responsible for determining the primary payor and for billing the appropriate party.

Providers are required to cooperate with the administration of COB, which may include, without limitation, seeking authorization from another payor (if authorization is required) and/or responding to requests for medical records.

How to Determine the Primary Payor
Primary coverage is determined using the guidelines established under applicable law and the member's benefit plan. Examples are as follows but not limited to:

Dependent vs. Non-Dependent Adults:
The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. If the person is a Medicare beneficiary, then Centers for Medicare & Medicaid Services (CMS) Guidelines must apply.

Children:
For a dependent child whose parents are married or are living together and who is covered by both parents, the "birthday rule" applies – the payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor. If the parents have joint custody of the dependent child, then benefits are applied according to the birthday rule referenced above.

When determining the primary payor for a child of separated or divorced parents, inquire about the court agreement or decree. In the absence of a divorce decree/court order stipulating parental healthcare responsibilities for a dependent child, insurance benefits for that child are applied according to the following order:

- The insurance carried by the natural parent with custody pays first
- The step-parent with custody pays next
- The natural parent without custody pays next
- The step-parent without custody pays last

Medicare Members
The commercial benefit plan is primary for Medicare beneficiaries who are covered by a Large Employer Group Health Plan (EGHP) as a result of current employment status of their own or a family members' current employment status when the CMS Working Aged or Disabled Beneficiaries provisions apply.

Medicare is primary for Medicare beneficiaries who are covered by an Employer Group Health Plan (EGHP) whose subscriber is a retiree of the EGHP when the CMS Working Aged or

Disabled Beneficiaries provisions apply.

Medicare is the primary payer to GHPs for individuals eligible for or entitled to Medicare benefits based on End-Stage Renal Disease (ESRD) after the duration of coordination period as stipulated under the Medicare Secondary Payer Provisions for ESRD Beneficiaries.

COB Payment Methodologies
Coordination of Benefits allows benefits from multiple health benefit plans or carriers to be considered cumulatively, so the Member receives the maximum benefit from their primary and secondary health benefit plans together.

When Kaiser Permanente is secondary to another payor, Kaiser Permanente will coordinate benefits and determine the amount payable to the Provider, where the standard payment determination methodology is to pay the difference between what the primary paid and their allowable, in an amount not to exceed the Kaiser Permanente benefit allowable.

Third Party Liability (TPL)
Kaiser Permanente may seek reimbursement from a member's settlement or judgement due to injuries or illnesses caused by a third party. In order to prevent duplicate payments for healthcare costs that are also paid by another responsible party, providers are required to assist Kaiser Permanente in identifying all potential TPL situations and to provide Kaiser Permanente with information that supports Kaiser Permanente's TPL inquiries

First and Third-Party Liability Definitions
First Party Liability refers to situations in which the member's own automobile or other policy covers healthcare costs related to injuries or illnesses due to an accident, regardless of fault. In the event that you receive a partial payment from an automobile or other carrier that falls under the category of First Party Liability (such as Med Pay, Personal Injury Protection, etc.), please submit your claim and indicate the automobile carrier name and amount paid along with the Explanation of Benefits (EOB).

Third Party Liability refers to situations in which a third party's automobile or other policy covers healthcare costs related to injuries or illness caused by or alleged to be caused by a third party.

Both definitions of alternate liability here shall be considered Third Party Liability (TPL) for the purposes of this section.

First and Third-Party Liability Guidelines:
Providers are required to assist and cooperate with Kaiser Permanente's efforts to identify these situations by entering the following information on the billing form, if applicable:

- Automobile carrier information in appropriate fields, along with payment information
- ICD-10 diagnosis data in appropriate fields
- Accident-related claim codes (e.g., occurrence codes, condition codes, etc.)

Kaiser Permanente retains the right to investigate TPL recoveries through retrospective review of ICD-10 and CPT-4 codes from the billing forms where a possible TPLis indicated.

Workers' Compensation
If a member indicates that his or her illness or injury occurred while the Member was "on the job", you should do the following:

- Document that the Member indicates the illness or injury occurred "on the job" on the claim
- Complete applicable fields on the billing form indicating a work-related injury
- Submit the claim to the patient's Workers' Compensation carrier/plan

If the Member's Workers' Compensation carrier/plan ultimately denies the Workers' Compensation claim, you may submit the claim for covered services to Kaiser Permanente in the same manner as you submit other claims for services. You must also include a copy of the denial letter or Explanation of Payment from the Workers Compensation carrier.

If you have received an authorization to provide such care to the Member, you should submit your claim to Kaiser Permanente in the same manner as you submit other claims for services. Your Agreement may specify a different payment rate for these services.

Third Party Liability (TPL) for Medical Support Enforcement Beneficiaries
In accordance with TPL requirements regarding medical support enforcement beneficiaries outlined by CMS in 42 CFR 433.139(b)(3), Maryland Medicaid must pay and chase claims rendered to a medical support enforcement beneficiary if the provider has (1) first billed the noncustodial parent's insurance and (2) not received payment after 100 days from the date of service.

The Maryland Department of Health (MDH) notified Medicaid MCOs that we are similarly required to align claims processes with the new medical support enforcement requirements.

TPL medical support enforcement beneficiaries claims for Kaiser Permanente Maryland HealthChoice members must be submitted as follows:

Electronic Submission (Recommended):
- Complete the 837 through your electronic clearinghouse.
- Within 24-48 hours of the initial submission, locate the Kaiser Permanente assigned claim number via Online Affiliate.
- Submit a completed Attestation Form and proof of claim submission to the primary insurer with that claim number via the Request for Information (RFI) process on Online Affiliate. This must be completed no later than 21 calendar days after Kaiser Permanente's receipt of the claim.
    - Institutional Claims – Use "MD Medicaid UB-04 Medical Support Enforcement Third Party Claim Billing Provider Attestation Form"
    - Professional Claims – Use "MD Medicaid CMS-1500 Box 11 – Rejection Reason S Provider Attestation Form"

Paper Submission:
- Complete the CMS-1500 or UB-04 billing form as usual.
- Attach a completed Attestation Form and proof of claim submission to the primary payer with that claim number.
    - Institutional Claims – Use "MD Medicaid UB-04 Medical Support Enforcement Third Party Claim Billing Provider Attestation Form"
    - Professional Claims – Use "MD Medicaid CMS-1500 Box 11 – Rejection Reason S Provider Attestation Form"
- Mail using the following address:

ATTENTION: COB

Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

This process is applicable for claims received on or after November 1, 2023. Claims must be submitted at least 100 days after and within 12 months from the date of service. Fully completed Attestation Forms must be submitted no later than 21 calendar days after Kaiser Permanente's receipt of the claim. Claims and Attestation Forms submitted outside of those windows or those submitted with incorrect or incomplete documentation will be denied.

Three Month Grace Period for Members Electing APTC Subsidy

Members enrolled in a Kaiser Permanente Individuals and Families (KPIF) plan often elect to receive the federal premium subsidy to help them pay their monthly premium. When they make this election and they do not pay their monthly premium payment on time, they are entitled to a three-month grace period pursuant to federal law. During the first month of the grace period, the member's claims must be processed by Kaiser Permanente. If the member fails to make payment during the second and/or third months (so that all the premiums owed for the three months are paid on or before the last day of the grace period), the member's claims are held and not processed, until the end of the grace period.

If premiums are not paid in full by the end of the grace period, the Member's coverage terminates on the last day of the first month of the grace period. Any claims incurred in the second and third months will be denied due to the retroactive termination of coverage based on the Member's failure to be enrolled on the date(s) of service due to their non-payment of premiums.

Kaiser Permanente notifies providers in writing of their patient's claim status when the patient enters the second month of the grace period. Providers may seek reimbursement directly from the member at the end of the three-month grace period, if the claim is denied for the member not being enrolled (and, therefore, ineligible), due to termination of coverage based on the non-payment of premiums.

Kaiser Permanente encourages providers to continue to see members as they may become current in their premiums. However, if they do not pay all premiums that are due on or before the last day of their grace period, then the member's coverage will be terminated as of the last day of the first month of the grace period. The former (terminated) member will be responsible for payment to the provider if they are terminated at the end of their grace period for services provided during the second and third months of their grace period.

Provider Appeal of Kaiser Permanente Claim Denial

Denial of claims is considered a contractual issue between the MCO and the provider. Providers must contact the MCO directly. The Maryland Insurance Administration refers MCO billing disputes to the Maryland Department of Health (MDH). MDH may assist providers in contacting the appropriate representative at Kaiser Permanente, but MDH cannot compel Kaiser Permanente to pay claims that Kaiser Permanente administratively denied.

Kaiser Permanente is committed to ensuring that any concerns submitted by a participating provider and/or other provider are fairly heard and properly resolved. A provider may not be penalized in any way by the Health Plan for acting on a member's behalf or filing an appeal on

their own behalf.

A provider who disagrees with a decision made by the Health Plan not to pay a claim in full or in part, has the right to file an appeal or payment dispute. Payment disputes must be filed in writing within ninety (90) working days of the date of denial and/or EOP. Claims appeals received outside of the allowable time frame will be considered untimely and denied.

Online submission of payment disputes
Kaiser Permanente allows providers to submit payment disputes using Online Affiliate. When filing a dispute or appeal online, you will be prompted to complete a form with key information such as:

- Dispute amount
- Dispute reason (drop-down selection)
- Additional details regarding submission
- PDF attachments to support your dispute

By submitting online, you will receive an online auto-acknowledgment letter and resolution letter.

To submit electronically or enroll for access to Online Affiliate, navigate to kp.org/providers/mas and select **Online Provider Tools** from the Provider Resources menu.

For help with Online Affiliate or to contact our support team, please access the Online Affiliate Support Site at https://kpnationalclaims.my.site.com/support/s/.

Written submission of appeal or payment dispute
Upon receipt of a provider appeal or payment dispute, a formal acknowledgement letter must be sent to the provider with five (5) working days. The provider appeal/dispute process applies only to clean claims as outlined under the Submitting Claims section of this manual.

- A summary of the dispute;
- Kaiser Permanente Claim number(s) at issue;
- Specific payment and/or adjustment information;
- Necessary supporting documentation to review the request; and
- (i.e., medical records, proof of timely filing, other insurance carrier explanation of payment, and/or Medicare Summary Notice (MSN)).

A payment appeal/dispute should be submitted in writing and sent to:

Mid-Atlantic Claims Administration
Kaiser Permanente
PO Box 371860
Denver, CO 80237-9998

Kaiser Permanente resolves initial appeals within thirty (30) working days of receipt. Kaiser Permanente must provide a decision on all provider appeal and payment disputes, regardless of the number of appeal levels, within ninety (90) working days from the initial appeal/dispute date.

A provider may initiate a second level appeal should they disagree with a first level appeal decision made by Kaiser Permanente. Second level appeals should also be submitted in writing and labeled “Second Level Appeal Request” within fifteen (15) working days of the first level

decision.

Once a second level appeal is received by the Health Plan, the appeal is directed to a physician not previously involved with the case or the first level appeal.

A provider may initiate a third and final level appeal following the second adverse determination within fifteen (15) working days of the second level decision. Once a third/final appeal level is initiated, the case is directed to the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. President, or their designee for final determination.

Any additional claims payments required as a result of an overturned decision are made within thirty (30) calendar days.

State's Independent Review Organization (IRO)

The Department contracts with an IRO for the purpose of offering providers another level of appeal for providers who wish to appeal **medical necessity denials** only. Providers must first exhaust all levels of the MCO appeal process. By using the IRO, you agree to give up all appeal rights (e.g., administrative hearings, court cases). The IRO only charges **after** making the case determination. If the decision upholds the MCO's denial, you must pay the fee. If the IRO reverses the MCO's denial, the MCO must pay the fee. The web portal will walk you through submitting payments. The review fee is $425. More detailed information on the IRO process can be found at https://mmcp.health.maryland.gov/SitePages/IRO%20Information.aspx.The IRO does not accept cases for review which involve disputes between the Behavioral Health ASO and Kaiser Permanente.

Claim Overpayment Identified by a Participating Provider

In the case of an overpayment identified by a participating provider, they are required to report to Kaiser Permanente within 60 days of identification by sending the refund and corresponding detail back to Kaiser Permanente at the address listed below. If you would like to discuss the overpayment, you may call Regional Claims Recovery at (844) 412-0917.

If a participating provider has identified an overpayment, and wants to send a refund back to Kaiser Permanente, they are advised to send it to:
Kaiser Foundation Health Plan Mid Atlantic
PO Box 740814
Los Angeles, CA 90074-0814

When sending in a refund, the following claim/member information must be included to ensure proper application of the refund:

- Provider name;
- Provider tax identification number;
- Member name;
- Kaiser Permanente medical record number;
- Dates of service;
- Kaiser Permanente claim number;
- Claim paid amount;
- Claim paid date;
- Refund amount; and
- Refund reason.

MCO Quality Initiatives

The Kaiser Permanente Quality of Care and Service Program (the "Program") seeks to promote and support continuous, objective-based improvement in the delivery of care and service. The Program, which includes yearly Quality Improvement (QI) activities, addresses all clinical, behavioral health, and service activities across the continuum of care. The KPMAS quality program processes, goals, and outcomes related to member care and service are available on the provider website and communicated in member publications.

All Kaiser Permanente participating providers and staff are involved in quality initiatives and ongoing quality improvement. Key staff serve on Quality of Care and Service Program Committees, including but not limited to the Regional Quality Improvement Committee (RQIC) which has oversight and direct accountability for quality assessment and improvement, risk management, service, patient safety, infection control, and behavioral health (BH) care quality.

The quality program conducts routine system-wide reviews of care quality as part of oversight of the quality and safety of care, treatment and services provided to members. Summarized analysis of those reviews is distributed as appropriate to leadership as part of quality monitoring and ongoing quality improvement. Publicly reported quality information is available to providers and members from entities including but not limited to:

- Joint Commission Core Measures, Leapfrog, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and other Kaiser Permanente inpatient quality data from contracted providers;
- National Committee on Quality Assurance (NCQA) Health Plan Accreditation, Health Plan Rating, Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores; and
- Ambulatory surgery center annual reports.

The quality program includes annual evaluation of overall effectiveness of the program. The effectiveness assessment monitors the Quality Programs' progress in achieving goals, including quality and safety of clinical practice. The summary of effectiveness addresses: adequacy of quality program resources; quality committee structure; practitioner participation and leadership involvement in the quality program.

The activities monitored and reviewed by the Quality of Care and Service Program includes, but is not limited to, the following:

- Monitoring access and member satisfaction;
- Development and measurement of compliance with clinical practice guidelines and standards of care;
- Focused studies of preventive and chronic care;
- Identification of individual adverse outcomes and risk events;
- Peer Review; and
- Incorporation of recommendations from external review bodies including the NCQA, an external quality review organization (EQRO) and Kaiser Permanente's Health Plan Quality Oversight (HPQO).

In addition, the Quality of Care and Service Program establishes effective monitoring and evaluation of care and services to ensure the care and service that KPMAS offers its customers meets or exceeds accepted national standards. The Program accomplishes this by:

1. Developing mechanisms to identify, monitor, evaluate and improve important aspects of care and service, including high-volume, high-risk services, by:

- Ensuring that information from monitoring and evaluation activities is disseminated and used to improve quality of care and service in inpatient, ambulatory, and affiliated settings;
- Supporting the development and use of evidence-based clinical practice guidelines and formulating implementation plans and outcomes monitoring;
- Ensuring full qualifications and competence of health care professionals through adherence to KPMAS's credentialing and recredentialing standards;
- Assuring compliance with accreditation and regulatory standards;
- Monitoring access standards and evaluating KPMAS's compliance with these standards; and
- Providing appropriate oversight of delegated functions and monitoring delegate's performance against pre-established standards.

2. Providing consistent and timely identification and analysis of opportunities for improvement and intervene to improve care, where appropriate, by:
    - Evaluating the continuity and coordination of care provided to KPMAS members;
    - Promoting member satisfaction and improvements in the health status of members;
    - Viewing complaints about care or service as opportunities for improvement; and
    - Providing periodic feedback to members and practitioners regarding measurement and outcomes of quality improvement activities.

3. Improving the health status of KPMAS members whenever possible by:
    - Continually integrating evidence-based clinical standards into quality programs and including these in the development of benchmarks;
    - Surveying members periodically about their perceived health status;
    - Promoting effective health management and case management for members identified with chronic diseases;
    - Encouraging all members to utilize appropriate preventive health services in order to promote member wellness; and
    - Identifying and reducing access barriers for any segment of the member population.

4. Continuing to be a recognized leader in local, state and national efforts to promote quality healthcare for all populations, within and outside KPMAS, by:
    - Collaborating with public and private health agencies in quality improvement activities;
    - Demonstrating value to purchasers through outcome-oriented quality assurance and clinical quality improvement activities; and
    - Aligning the Program with well-recognized evidence-based clinical goals.

5. Continuing to develop and implement the people strategy by increasing KPMAS employee engagement and satisfaction, attracting diverse and highly talented physicians and staff, fostering a learning environment, and ensuring continuity of organizational knowledge and culture that supports the mission, vision and values of KPMAS by:
    - Creating meaningful practices that reward the organization, physicians, staff and our members; and
    - Demonstrating that we respect and value our work force by:
    - Developing their competencies and rewarding their accomplishments;
    - Collaborating with each individual and team in order to develop clear, targeted, and measurable expectations; and
    - Ensuring that highly achieving, talented, committed physicians and staff remain with the organization.

Members and participating providers may request information about the Program including a report of our progress toward quality improvement goals by calling or writing the Member Services Department at:

Kaiser Permanente
Member Services
4000 Garden City Drive
Hyattsville, MD 20785
Inside the Local Calling Area: 301-468-6000
Toll free Outside the Local Calling Area: 1-800-777-7902
TDD for the Hearing Impaired: 301-816-6344

Patient Centered Medical Home (PCMH)

KPMAS is recognized by NCQA as a PCMH designed to help improve the quality, appropriateness, timeliness, and efficiency of care coordination including clinical decisions and care plans.

An overall performance goal is to improve the quality and efficiency of health care for members across the continuum from wellness to prevention to managing members with complex and chronic conditions. To achieve this goal, it is the expectation of the PCMH Health Care Team (HCT), led by the Primary Care Physician (PCP), to manage the health of these members. The health plan is responsible for identifying patients who qualify for its wellness, prevention, disease management and complex case management programs, notifying the PCMH HCT about the identification, and maintaining a tracking mechanism that includes these members.

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

- Determine and update care coordination needs;
- Create and update a proactive plan of care;
- Communication across transitions of care and collaborative with other practitioners; and
- Align resources with population needs based upon assessment to address gaps and disparities in services and care.

Population Care Management

Population Care Management is one of the foundations of the KPMAS clinical care strategy that provides evidence-based, systematic support to the health care teams and physicians who care for Maryland HealthChoice members. The PCM strategy is used to support care delivery to populations of members with preventive care and chronic diseases and conditions. It is explicitly designed to augment and support the foundational relationship between PCP and the patient used in the PCMH model.

The PCM strategy is based on evidence-based care supported via clinical practice guidelines (reviewed/revised and approved at least every two years).

Member registries, based on claims, encounter, laboratory, pharmacy, health appraisal data, and more, that support monitoring:

- Customized information technology to support the program with tracking and feedback;
- Patient-centered medical home-based care that supports the physician-patient relationship;
- Involvement of the patient in his/her own care;

- Interventions and care designed and tailored to address specific and special needs of patients, including social determinants of health, age -specific opportunities, different abilities, and serious and persistent mental illness; and
- Monthly and annual performance assessments and annual population analysis regarding program resources and activities.

The tools and interventions that arise from these key concepts are targeted across the region at areas of need and potential impact. For each program, the interventions are determined by the health and/or risk of the individual and population.

Provider Performance Data

Participating providers are required through their Kaiser Permanente contract to comply with the Kaiser Permanente Quality Improvement Program. MAPMG and participating providers agree to provide Kaiser Permanente with access to medical records, participate in QI program activities and allow the use of performance data. Participating providers are given regular updates on the status of health plan activities through the Permanente Journal, the Permanente Post, Network News, and other practitioner mailings.
Kaiser Permanente encourages participating providers to participate in the QI program through membership and participation in Quality Improvement Committees. Participating providers are also encouraged to provide feedback to QM staff through response to newsletter topics and through practitioner satisfaction surveys.

Kaiser Permanente provides ongoing educational services to participating providers through new provider orientation materials, Provider Manual updates, provider meetings and provider training by provider education staff.

Patient Safety Events

This statement affirms the commitment Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) has to improving care through continuous learning. Patient Safety event reporting is an important part of error prevention. KFHP-MAS learns from patient safety events to promote system education, initiate process improvement and prevent and mitigate health care error. The purpose of this provision is to outline the tenets of the KFHP-MAS patient safety event reporting criteria that will result in the best patient outcomes.

Patient Safety Event: An event, incident or condition that could have resulted or did result in harm to a patient. Patient Safety Events are not determined based upon perceived negligence or wrongdoing on the part of a staff member or department. Not all patient safety events are preventable. Event analysis is warranted in order to identify a defective process design, a system breakdown, equipment failure or human error.

Adverse Event: A patient safety event that resulted in harm to a patient.

Sentinel Event: A subcategory of Adverse Events is a Sentinel Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

a. Death;
b. Permanent Harm; and/or
c. Severe Temporary Harm.

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the organization's emergency department (ED);
- Discharge of an infant to the wrong family;
- Abduction of any patient receiving care, treatment or services;
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose;
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Fire, flame or unanticipated smoke, heat or flashes occurring during an episode of patient care;
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure;
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery;
- Unanticipated death of a full-term infant;
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter);
- Any intrapartum (related to the birth process) maternal death;
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm;
- Any elopement (unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED) leading to the death, permanent harm or severe temporary harm of the patient;
- Rape, assault (leading to death, permanent harm or severe temporary harm), or homicide of any patient receiving care, treatment or services while on site at the organization;
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization.

Procedure to Report:

- Timely and comprehensive event reporting is key to driving a just patient culture. Organizations are expected to report all events within 48 hours of knowledge.
- All adverse events, patient safety events and sentinel events shall be phoned to the KFHP-MAS Patient Safety and Risk Management Department. Please call 703-359-7460 and ask for the Risk Manager on call.

Response to Events:

- Equipment involved in a Patient Safety Event shall be tagged and sequestered. Tubing or disposable products shall be kept with the equipment. Until a joint decision is made to release the equipment, the involved equipment shall not be used, cleaned or disturbed.
- Any event that involve criminal behavior, police or security investigation should be immediately phoned to Patient Safety and Risk Management.

Sentinel Event/Significant Event Root Cause Analysis Framework:

- Site leadership will provide a risk management contact.
- A cause analysis team shall initially review the event within three working days of notification of the event. A thorough and credible root cause analysis and action plan should be completed within 45 calendar days of the event or of becoming aware of the event.

Section VII.

PROVIDER SERVICES AND RESPONSIBILITIES

Overview of Kaiser Permanente Provider Services

Kaiser Permanente is committed to supporting the role of the Network Participating Providers – community providers who are contracted and credentialed. The Provider Experience Department staff provides comprehensive and personalized support for all participating providers and their staff. As the liaison between the participating providers and Kaiser Permanente, the Provider Experience staff is responsible for the following support functions:

- Ensuring that each participating provider's issues or concerns are addressed and resolved to satisfaction;
- Communicating pertinent information regarding medical management procedures, compensation models, referral processes and new products to all participating providers; and
- Assisting participating providers in identifying appropriate network medical facilities and services available for patient care.

The Provider Experience Department can be contacted at 1-877-806-7470 or provider.relations@kp.org.

Provider Web Portal

Our Community Provider Portal has online resources to provide quick and easy access to the information you need to work effectively with Kaiser Permanente and to provide the best possible service to our members. You can access our Community Provider Portal at kp.org/providers/mas.

On our portal you can find:

- Provider manuals;
- Online provider directories;
- Clinical guidelines;
- Newsletters;
- Downloadable forms;
- Trainings; and
- News and announcements.

On the portal, providers can also access Kaiser Permanente Online Affiliate, a secure web-based application which includes several time-saving features, such as:

- Accessing patient eligibility, benefits, and demographics
- Viewing referrals and authorizations (for contracted providers)
- Viewing and downloading Explanation of Payments (EOP)
- Checking the status of submitted claims and viewing claim details including service date, billed amount, allowed amount, and claim codes
- Confirming payment information such as check number, payment date, and total amount

Additionally, providers can manage their submitted claims through the portal using the Claims "Take Action" functionality. This feature allows provider to do the following:

- Respond to Kaiser Permanente Requests for Information
- Submit a claim inquiry related to "denied" or "in progress" claims
- Submit appeals or disputes to request a reconsideration of a payment
- Submit an inquiry related to a check payment, request a copy of a check, or report a change of address for a specific claim

To access the Kaiser Permanente Online Affiliate portal, please visit https://kp.org/providers, choose your

region, and navigate to the “Online Provider Tools” section.

Provider Inquiries

The Provider Relations Department and Member Services are available to assist providers with:

Member Services 1-855-249-5019	Provider Experience 1-877-806-7470
• Clarification of member eligibility and benefits • Appeal status • Members presenting with no Kaiser Permanente identification card	• Provider demographic updates • Contracted rate payment questions • Monthly reimbursement questions • Billing inquiries • Form requests

Re-Credentialing

After initial credentialing, Kaiser Permanente Mid-Atlantic States (KPMAS) participating providers will be re-credentialed every three (3) years except for those with Kaiser Permanente ambulatory surgery and moderate sedation privileges who shall be re-credentialed every two (2) years by following the applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA) and Kaiser Permanente. The elements of the re-credentialing process include, but are not limited to, the following:

- Application
- Current and unrestricted license in each jurisdiction where the practitioner provides services
- License sanctions
- DEA Certificate in each jurisdiction where the practitioner provides services
- CDS Certificate
- Board Certification and Maintenance of Board Certification
- Hospital privileges
- Professional liability coverage
- Claims history
- National Practitioner Data Bank (NPDB) query
- Work history
- Medicare and Medicaid status and sanctions
- Mid-Level practitioner practice agreement
- Practitioner quality profile
- Member complaints

Notification of Updates/Changes to Application or Credentials

It is incumbent upon participating providers to notify the Provider and Practitioner Quality Assurance (PPQA) Department by calling ☎ 301-816-5853 or emailing PPQA-MAS@kp.org regarding any updates or changes to their application or credentials within thirty (30) days of the occurrence. These updates and/or changes will be reviewed according to the credentialing procedures outlined by KPMAS and will be included in the participating provider credentials file. These may include, but are not limited to, the following:

- Voluntary or involuntary medical license suspension, revocation, restriction, or report filed;
- Voluntary or involuntary hospital privileges reduced, suspended, revoked, or denied;
- Any disciplinary action taken by a hospital, health maintenance organization (HMO), group practice, or any other health provider organization;

- Medicare or Medicaid sanctions, or any investigation for a federal healthcare program; and
- Medical malpractice action.

Overview of Provider Responsibilities

Kaiser Permanente is committed to meeting the many compliance and regulatory guidelines which are implemented in the best interest of patient quality service and overall care. These compliance and regulatory policies are enforced on the federal, state and/or local government, and health plan levels.

Compliance and regulatory policies represent guidelines, which are both monitored and reported to many outside agencies.

For questions regarding any compliance policy or to obtain a copy of "Principles of Responsibility", a compliance guide available to participating providers of Kaiser Permanente, please contact the Provider Experience Department at 1-877-806-7470.

Primary Care Providers (PCPs)

The PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member. Members can choose a Physician, Nurse Practitioner or Physician's Assistant as their PCP. The PCP will act as a coordinator of care and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits.

The PCP is required to:

- Address the member's general health needs;
- Treat illnesses;
- Coordinate the member's health care;
- Promote disease prevention and maintenance of health;
- Maintain the member's health records; and
- Refer for specialty care when necessary.

If a woman's PCP is not a women's health specialist, Kaiser Permanente will allow her to see a women's health specialist within **the MCO network** without a referral, for covered services necessary to provide women's routine and preventive health care services. Prior authorization is required for certain treatment services.

PCP Contract Terminations

If you are a PCP and we terminate your contract for any of the following reasons, the member assigned to you may elect to change to another MCO in which you participate by calling the Enrollment Broker within 90 days of the contract termination:

- For reasons other than the quality of care or your failure to comply with contractual requirements related to quality assurance activities; or
- Kaiser Permanente reduces your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to Kaiser Permanente by the Department, and Kaiser Permanente and you are unable to negotiate a mutually acceptable rate.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted

community standards of care and practices. MDH requires Kaiser Permanente to maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty provider, call Kaiser Permanente Member Services at 1-855-249-5019 for assistance.

Participating specialists receive referrals to provide care to members from PCPs and/or other specialists. A member receiving care from a specialist must have an approved referral for each visit. A referral summary indicating approval will be faxed to participating specialist prior to the member's scheduled appointment. The member also receives an approval letter. Each Kaiser Permanente referral has a unique referral number. This referral number should be reflected on the claim/bill for appropriate processing and payment.

To assist us with timely and accurate referral processing, participating specialists should ensure that Kaiser Permanente has the most up-to-date demographic and contact phone/fax numbers for their practice.

Out of Network Providers and Single Case Agreements

Authorizations for out of network providers will be reviewed on an individual Member basis. If approved, the provider will receive the necessary supporting documentation to deliver the authorized service and submit a claim.

Second Opinions

If a member requests a second opinion, Kaiser Permanente will provide for a second opinion from a qualified health care professional within our network. If necessary, we will arrange for the member to obtain one outside of our network.

If a second opinion is indicated, the member's PCP should initiate a new referral request by completing a uniform referral form (URF) and fax it to the Utilization Management Operations Center (UMOC) at 1-800-660-2019.

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask a member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

- The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:
  Kaiser Permanente
  Provider Experience
  4000 Garden City Drive
  Hyattsville, MD 20785
- The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.
- Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

Medical Records Requirements

Participating providers are responsible for maintaining the full medical records of members who elect to receive health services at their offices. Kaiser Permanente has developed specific criteria for maintaining medical records for members. These standards are evaluated and are part of the periodic review conducted within our participating provider offices. The standards for medical record-keeping practices and the documentation requirements for medical charts are as follows:

Standards for Medical Record-Keeping Practices

- Medical records are maintained in a confidential manner, maintained in a secure location and out of public view.
- The medical record shall be safeguarded against unauthorized use, damage, loss, tampering, and alteration.
- Each patient has an individual medical record. Individual medical records can be easily retrieved from files.
- Each page is identified with name of patient and birth date, or medical record number
- The medical record of a patient is confidential communication between the health care provider and the patient and shall not be released without appropriate authorization.
- Federal and state statutes require that when correcting the inaccuracy of a medical record entry, information shall not be eradicated or removed.

Documentation Standards for Medical Records for Medical Charts:

- Clearly identifiable member information on each page:
    - Medical record number
    - Patient name
    - Current address
    - Home telephone number
    - Work telephone number, when applicable
    - Date of birth or age
    - Gender
    - Name and telephone number of person to notify in case of an emergency
    - PCP name
    - Information regarding the patient's advance directives, when applicable
- All progress notes will:
    - Be dated (including the year);
    - Clearly identify the provider; and
    - Include appropriate signatures and credentials.
- Patient biographical/personal data are present.
- Notes are legible.
- Patient's chief complaint or purpose for visit is clearly documented by the physician.
- Working diagnoses are consistent with findings.
- There is clear documentation of the medical treatment received by the patient.
- Plans of action and treatment are consistent with diagnosis.
- Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate.
- Unresolved problems from previous visit are addressed.
- There is evidence of continuity and coordination of care between primary and specialty physicians.
- Consultant summaries, laboratory, and imaging study results reflect ordering physician review as evidenced by:

- Initials of the referring PCP following review;
- Recorded date of review; and
- Comments recorded in progress note regarding interpretation and findings;
- Indication of treatment notice to patient.

- Allergies and adverse reactions to medications are prominently displayed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- There is documentation of past medical history as it regards diagnoses of permanent or serious significance, and past surgeries or significant procedures. Pediatric patients will have similar documentation and/or prenatal and birth information.
- If a consultation is requested, there is a note from the consultant in the record.
- Significant illnesses and medical conditions are indicated on the problem list.
- There is a notation concerning use/non-use of cigarettes, alcohol, and substance abuse for patients 12 years of age and over.
- The history and physical document examination results with appropriate subjective and objective information for presenting complaints.
- There is evidence that preventive screening and services are offered in accordance with Kaiser Permanente's practice guidelines.
- The care appears to be medically appropriate.
- There is a completed immunization record for patients 18 years of age and under.
- An updated problem list is maintained.
- An updated medication list is maintained

Confidentiality and Accuracy of Member Records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a Kaiser Permanente member. Original medical records must be released only in accordance with federal or Maryland laws, court orders, or subpoenas. Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (http://www.hhs.gov/ocr/privacy/).

Reporting Communicable Disease

Providers must ensure that all cases of reportable communicable disease that are detected or suspected in a member by either a clinician or a laboratory are reported to the local health department (LHD) as required by Health - General Article, §§18-201 to 18-216, Annotated Code of Maryland and Code of Maryland Regulations (COMAR)10.06.01 Communicable Diseases. Any health care provider with reason to suspect that a member has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the provider cares for the member.

- The provider report must identify the disease or suspected disease and demographics on the member including the name age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH1140) as directed by COMAR 10.06.01.
- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours.
  - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by MDH.

Advance Directives

Providers are required to comply with federal and state law regarding advance directives for adult members. Maryland advance directives include Living Will, Health Care Power of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated. The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under Maryland law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections);
- Documenting in the member's medical record, whether or not the adult member has been provided the information and whether an advance directive has been executed;
- Not discriminating against a member because of their decision to execute or not execute, an advance directive and not making it a condition for the provision of care;
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities; and
- Educate patients on Advance Directives (durable power of attorney and living wills).
- Encourage patients to utilize electronic advance care planning documents.
- MCOs are required to make the Advance Directives Information Sheet available during enrollment and in member publications, on their website, and at the member's request.

Advance directive forms and frequently asked questions can be found at: https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx.

Communications toolkit for the Advanced Directive Information Sheet can be found at: https://mhcc.maryland.gov/mhcc/Pages/hit/hit_advancedirectives/hit_advancedirectives_communications_toolkit.aspx.

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) have established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit http://www.hhs.gov/ocr/hipaa/. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within the hearing range of other patients.

Cultural Competency

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid. Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin,

religion, gender, age, mental, or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Kaiser Permanente expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid.

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

Kaiser Permanente is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays, denials of services, receive care, services based on inaccurate or incomplete information. Providers must deliver services in a culturally effective manner to all members, including those with limited English proficiency (LEP) or reading skills.

Members have the right to free language services for health care needs. We provide free language services including:

24-hour access to an interpreter – When members call to make an appointment or talk to their personal physician, if needed, we will connect them to a telephonic interpreter.

Translation services – Some member materials are available in the member's preferred language.

Bilingual physicians and staff – In some medical centers and facilities, we have bilingual physicians and staff to assist members with their health care needs. They can call Member Services or search online in the medical staff directory at **kaiserpermanente.org.**

Braille, large print, or audio – Blind or vision impaired members can request for documents in Braille or large print or in audio format.

Telecommunications Relay Service (TRS) –If members are deaf, hard of hearing, or speech impaired, we have the Telecommunications Relay Service (TRS) access numbers that they can use to make an appointment or talk with an advice nurse or member services representative or with you.

Sign language interpreter services – These services are available for appointments. In general, advance notice of two or three business days is required to arrange for a sign language interpreter; availability cannot be guaranteed without sufficient notice.

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

Educational materials – Health education materials can be made available in languages other than English by request. To access Spanish language information and many educational resources go to **kp.org/espanol** or **kp.org** to access La Guía en Español (the Guide in Spanish). Members can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in La Guía en Español.

Prescription labels – Upon request, the KPMAS pharmacist can provide prescription labels in Spanish for most medications filled at the Kaiser Permanente Pharmacy

After Visit Summary (AVS) – AVS can be printed on paper or accessed electronically via kp.org for Kaiser Permanente members after their appointment. If the member's preferred written communication is documented in Kaiser Permanente HealthConnect® for a non-English language, the AVS automatically prints out in that selected language. This includes languages such as Spanish, Arabic, Korean, and several others.

At Kaiser Permanente, we are committed to providing quality health care to our members regardless of their race, ethnic background or language preference. Efforts are being made to collect race, ethnicity and language data through our electronic medical record system, HealthConnect®. We believe that by understanding our members' cultural and language preferences, we can more easily customize our care delivery and Health Plan services to meet our members' specific needs.

Currently, when visiting a medical center, members should be asked for their demographic information. It is entirely the member's choice whether to provide us with demographic information. The information is confidential and will be used only to improve the quality of care. The information will also enable us to respond to required reporting regulations that ensure nondiscrimination in the delivery of health care.

We are seeking support from our practitioners and providers to assist us with the member demographic data collection initiative. We would appreciate your support with the data collection by asking that you and your staff check the member's medical record to ensure the member demographic data is being captured. If the data is not captured, please take the time to collect this data from the member. The amount of time needed to collect this data is minimal and only needs to be collected once. Recommendation for best practices for collecting data is during the rooming procedure. In conclusion, research has shown that medical treatment is more effective when the patient's race, ethnicity and primary language are considered.

To access organization wide population data on language and race, please access the reports via our Community Provider Portal at www.kp.org/providers/mas under News and announcements.

To obtain your practice level data on language and race, please email the Provider Experience Department at provider.relations@kp.org.

For additional language resources, providers may request services from the following:

- Virginia
    - Virginia Department for the Deaf and Hard of Hearing: www.vddhh.org/interpreters.htm
    - The Blue Ridge Area Health Education Center: www.brahec.jmu.edu/services.html
    - Commonwealth Catholic Charities: www.cccofva.org/interpreter-services

- Washington, D.C.
    - U.S. Department of Health & Human Services: www.hhs.gov/civil-rights/for-individuals/special-topics/hospitals-effective-communication/limited-english-proficiency/index.html

- Phone Interpretation
    - Language Line Solutions: www.languageline.com/

    - United Language Group: www.unitedlanguagegroup.com/

- Sign Language
    - Sign Language U.S.A.: https://www.slusa.com/kp

- Document Translation
    - Akorbi: akorbi.com
    - Avantpage: avantpage.com
    - Access Ingenuity: accessingenuity.com

Access for Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity; or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways.

Section VIII.

QUALITY ASSURANCE MONITORING PLAN
AND
REPORTING FRAUD, WASTE, AND ABUSE

Quality Assurance Monitoring Plan

The quality assurance monitoring plan for the HealthChoice program is based upon the philosophy that the delivery of health care services, both clinical and administrative, is a process that can be continuously improved. The State of Maryland's quality assurance plan structure and function support efforts to deal efficiently and effectively with any identified quality issue. Daily and through a systematic audit of managed care organization (MCO) operations and health care delivery, the Department identifies both positive and negative trends in service delivery. Quality monitoring and evaluation and education through member and provider feedback are an integral part of the managed care process and help to ensure that cost containment activities do not adversely affect the quality of care provided to members.

The Department's quality assurance monitoring plan is a multifaceted strategy for assuring that the care provided to HealthChoice members is high quality, complies with regulatory requirements, and is rendered in an environment that stresses continuous quality improvement. Components of the Department's quality improvement strategy include: establishing quality assurance standards for MCOs; developing quality assurance monitoring methodologies; and developing, implementing and evaluating quality indicators, outcome measures, and data reporting activities, including:

- Health Service Needs Information form completed by the participant at the time they select an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs;
- A complaint process administered by the Maryland Department of Health (MDH) staff;
- A complaint process administered by Kaiser Permanente;
- A systems performance review of each MCO's quality improvement processes and clinical care performed by an External Quality Review Organization (EQRO) selected by the Department. The audit assesses the structure, process, and outcome of each MCO's internal quality assurance program;
- Annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS), a set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) and audited by an independent entity;
- Other performance measures developed and audited by MDH and validated by the EQRO;
- An annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS), developed by NCQA for the Agency for Healthcare Research and Quality;
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data;
- Development and implementation of an outreach plan;
- A review of services to children to determine compliance with federally required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards of care;
- Production of a Consumer Report Card; and
- An Annual Technical Report that summarizes all Quality Activities.

To report these measures to MDH, Kaiser Permanente must perform chart audits throughout the year to collect clinical information on our members. Kaiser Permanente truly appreciates the provider offices' cooperation when medical records are requested.

In addition to information reported to MDH, Kaiser Permanente collects additional quality information. Providers may need to provide records for standard medical record audits that ensure appropriate record documentation. Our Quality Improvement staff may also request records or written responses if quality issues are raised in association with a member complaint, chart review, or referral from another source.

Fraud, Waste, and Abuse Activities

Kaiser Permanente has a comprehensive compliance program in place to prevent, monitor, and detect fraud, waste, and abuse. Incidents of fraud, waste, and abuse could be committed by a provider, member, or an employee of Kaiser Permanente. As a Kaiser Permanente provider, it is your responsibility to report fraud, waste, and abuse if suspected.

Kaiser Permanente will investigate allegations of Provider fraud, waste or abuse, related to services provided to Members, and where appropriate, will take corrective action, including but not limited to civil or criminal action. The Federal False Claims Act and similar state laws are designed to reduce fraud, waste and abuse by allowing citizens to bring suit on behalf of the government to recover fraudulently obtained funds (i.e., "whistleblower" or "qui tam" actions). Kaiser Permanente employees may not be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Kaiser Permanente all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

To report fraud, waste, and abuse, contact Provider Experience at 1-877-806-7470 or email provider.relations@kp.org.

You can also report provider fraud to the MDH Office of the Inspector General at **410-767-5784 or 1-866-770-7175**), the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General, at **410-576-6521** (**1-888-743-0023**) or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477).**

The Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all Maryland agencies responsible for services funded by Medicaid.

Relevant Laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

- Knowingly presenting a false or fraudulent claim for payment or approval;
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government; or

- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The Self-Referral Prohibition Statute (Stark Law) prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

The Red Flag Rule (Identity Theft Protection) requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

The Health Insurance Portability and Accountability Act (HIPAA) requires:
- Transaction standards;
- Minimum security requirements;
- Minimum privacy protections for protected health information; and
- National Provider Identification (NPIs) numbers.

The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Kaiser Permanente services through Maryland HealthChoice.

Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Kaiser Permanente providers will follow federal and Maryland laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Kaiser Permanente services through Maryland HealthChoice.

Under the Maryland False Claims Act, Md. Code Ann., Health General §2-601 et. seq.

Administrative sanctions can be imposed, as follows:
- Denial or revocation of Medicare or Medicaid provider number application (if applicable);
- Suspension of provider payments;
- Being added to the OIG List of Excluded Individuals/Entities database; or

- License suspension or revocation.

Remediation may include any or all of the following:
- Education;
- Administrative sanctions;
- Civil litigation and settlements;
- Criminal prosecution;
- Automatic disbarment; or
- Prison time.

Exclusion Lists & Death Master Report
Kaiser Permanente is required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), the Social Security Death Master Report, and any other such databases as the Maryland MMA Providers and other Entities Sanctioned List may prescribe.

Kaiser Permanente does not participate with or enter into any provider agreement with any individual, or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded providers or who have been terminated from the Medicaid, or any programs by Maryland Department of Health for fraud, waste, or abuse. The provider must agree to assist Kaiser Permanente as necessary in meeting our obligations under the contract with the Maryland Department of Health to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Additional Resources:
To access the current list of Maryland sanctioned providers follow this link:
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

ATTACHMENT A - RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

The Maryland Department of Health (MDH) administers a Rare and Expensive Case Management (REM) program as an alternative to the MCO for certain HealthChoice eligible individuals diagnosed with rare and expensive medical conditions.

Medicaid Benefits and REM Case Management

To qualify for the REM program, the HealthChoice enrollee must have one or more of the diagnoses specified in the Rare and Expensive Disease List below. The enrollee may elect to enroll in the REM Program, or to remain in **Kaiser Permanente** if the Department agrees that it is medically appropriate. REM participants are eligible for all fee-for-service benefits currently offered to Medicaid-eligible beneficiaries who are not eligible to enroll in MCOs. In addition REM participants may receive additional services which are described in COMAR 10.09.69.

The participant's REM case manager will:

- Gather all relevant information needed to complete a comprehensive needs assessment;
- Assist the participant select an appropriate PCP, if needed;
- Consult with a multi-disciplinary team that includes providers, participants, and family/caregivers, and develop the participant's plan of care;
- Implement the plan of care, monitor service delivery, modify the plan as warranted by changes in the participant's condition;
- Document findings and maintain clear and concise records;
- Assist in the participant's transfer out of the REM program, when and if appropriate.

Referral and Enrollment Process

Candidates for REM are generally referred by their PCP, specialty providers, MCOs, but may also self-identify. The referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information: in order to determine the member's eligibility for REM. If the intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the member and referral source. If the member does not meet the REM criteria, they will remain enrolled in the MCO.

If the intake nurse determines that the enrollee has a REM-qualifying diagnosis, the nurse approves the member for enrollment in REM. Before the enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services through the Medicaid fee-for service program. If the PCP is unwilling to continue to care for the member the case is referred to a case manager to select a PCP in consultation with the member. If the PCP will continue providing services, the Intake Unit will explain the program and give the member an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. The MCO is responsible for providing the member's care until the REM enrollment process is complete.

For questions and referral forms call 800-565-8190; forms may be faxed to 410-333-5426 or mailed to:

REM Intake Unit
Maryland Department of Health
201 W. Preston Street, Room 210
Baltimore, MD 21201-2399

Table of Rare and Expensive Diagnosis

ICD10	ICD 10 Description	AGE LIMIT
B20	Human immunodeficiency virus (HIV) disease	0-20
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	0-64
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	0-64
C96.6	Unifocal Langerhans-cell histiocytosis	0-64
D61.01	Constitutional (pure) red blood cell aplasia	0-20
D61.09	Other constitutional aplastic anemia	0-20
D66	Hereditary factor VIII deficiency	0-64
D67	Hereditary factor IX deficiency	0-64
D68.0	Von Willebrand's disease	0-64
D68.1	Hereditary factor XI deficiency	0-64
D68.2	Hereditary deficiency of other clotting factors	0-64
E70.0	Classical phenylketonuria	0-20
E70.1	Other hyperphenylalaninemias	0-20
E70.20	Disorder of tyrosine metabolism, unspecified	0-20
E70.21	Tyrosinemia	0-20
E70.29	Other disorders of tyrosine metabolism	0-20
E70.30	Albinism, unspecified	0-20
E70.40	Disorders of histidine metabolism, unspecified	0-20
E70.41	Histidinemia	0-20
E70.49	Other disorders of histidine metabolism	0-20
E70.5	Disorders of tryptophan metabolism	0-20
E70.8	Other disorders of aromatic amino-acid metabolism	0-20
E71.0	Maple-syrup-urine disease	0-20
E71.110	Isovaleric acidemia	0-20
E71.111	3-methylglutaconic aciduria	0-20
E71.118	Other branched-chain organic acidurias	0-20
E71.120	Methylmalonic acidemia	0-20
E71.121	Propionic acidemia	0-20
E71.128	Other disorders of propionate metabolism	0-20
E71.19	Other disorders of branched-chain amino-acid metabolism	0-20
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	0-20
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency	0-64
E71.311	Medium chain acyl CoA dehydrogenase deficiency	0-64
E71.312	Short chain acyl CoA dehydrogenase deficiency	0-64
E71.313	Glutaric aciduria type II	0-64
E71.314	Muscle carnitine palmitoyltransferase deficiency	0-64
E71.318	Other disorders of fatty-acid oxidation	0-64
E71.32	Disorders of ketone metabolism	0-64
E71.39	Other disorders of fatty-acid metabolism	0-64
E71.41	Primary carnitine deficiency	0-64
E71.42	Carnitine deficiency due to inborn errors of metabolism	0-64
E71.50	Peroxisomal disorder, unspecified	0-64
E71.510	Zellweger syndrome	0-64

E71.511	Neonatal adrenoleukodystrophy	0-64
E71.518	Other disorders of peroxisome biogenesis	0-64
E71.520	Childhood cerebral X-linked adrenoleukodystrophy	0-64
E71.521	Adolescent X-linked adrenoleukodystrophy	0-64
E71.522	Adrenomyeloneuropathy	0-64
E71.528	Other X-linked adrenoleukodystrophy	0-64
E71.529	X-linked adrenoleukodystrophy, unspecified type	0-64
E71.53	Other group 2 peroxisomal disorders	0-64
E71.540	Rhizomelic chondrodysplasia punctata	0-64
E71.541	Zellweger-like syndrome	0-64
E71.542	Other group 3 peroxisomal disorders	0-64
E71.548	Other peroxisomal disorders	0-64
E72.01	Cystinuria	0-20
E72.02	Hartnup's disease	0-20
E72.03	Lowe's syndrome	0-20
E72.04	Cystinosis	0-20
E72.09	Other disorders of amino-acid transport	0-20
E72.11	Homocystinuria	0-20
E72.12	Methylenetetrahydrofolate reductase deficiency	0-20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0-20
E72.20	Disorder of urea cycle metabolism, unspecified	0-20
E72.21	Argininemia	0-20
E72.22	Arginosuccinic aciduria	0-20
E72.23	Citrullinemia	0-20
E72.29	Other disorders of urea cycle metabolism	0-20
E72.3	Disorders of lysine and hydroxylysine metabolism	0-20
E72.4	Disorders of ornithine metabolism	0-20
E72.51	Non-ketotic hyperglycinemia	0-20
E72.52	Trimethylaminuria	0-20
E72.53	Primary Hyperoxaluria	0-20
E72.59	Other disorders of glycine metabolism	0-20
E72.81	Disorders of gamma aminobutyric acid metabolism	0-20
E72.89	Other specified disorders of amino-acid metabolism	0-20
E74.00	Glycogen storage disease, unspecified	0-20
E74.01	von Gierke disease	0-20
E74.02	Pompe disease	0-20
E74.03	Cori disease	0-20
E74.04	McArdle disease	0-20
E74.09	Other glycogen storage disease	0-20
E74.12	Hereditary fructose intolerance	0-20
E74.19	Other disorders of fructose metabolism	0-20
E74.21	Galactosemia	0-20
E74.29	Other disorders of galactose metabolism	0-20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0-20
E75.00	GM2 gangliosidosis, unspecified	0-20
E75.01	Sandhoff disease	0-20
E75.02	Tay-Sachs disease	0-20

E75.09	Other GM2 gangliosidosis	0-20
E75.10	Unspecified gangliosidosis	0-20
E75.11	Mucolipidosis IV	0-20
E75.19	Other gangliosidosis	0-20
E75.21	Fabry (-Anderson) disease	0-20
E75.22	Gaucher disease	0-20
E75.23	Krabbe disease	0-20
E75.240	Niemann-Pick disease type A	0-20
E75.241	Niemann-Pick disease type B	0-20
E75.242	Niemann-Pick disease type C	0-20
E75.243	Niemann-Pick disease type D	0-20
E75.248	Other Niemann-Pick disease	0-20
E75.25	Metachromatic leukodystrophy	0-20
E75.26	Sulfatase deficiency	0-20
E75.29	Other sphingolipidosis	0-20
E75.3	Sphingolipidosis, unspecified	0-20
E75.4	Neuronal ceroid lipofuscinosis	0-20
E75.5	Other lipid storage disorders	0-20
E76.01	Hurler's syndrome	0-64
E76.02	Hurler-Scheie syndrome	0-64
E76.03	Scheie's syndrome	0-64
E76.1	Mucopolysaccharidosis, type II	0-64
E76.210	Morquio A mucopolysaccharidoses	0-64
E76.211	Morquio B mucopolysaccharidoses	0-64
E76.219	Morquio mucopolysaccharidoses, unspecified	0-64
E76.22	Sanfilippo mucopolysaccharidoses	0-64
E76.29	Other mucopolysaccharidoses	0-64
E76.3	Mucopolysaccharidosis, unspecified	0-64
E76.8	Other disorders of glucosaminoglycan metabolism	0-64
E77.0	Defects in post-translational mod of lysosomal enzymes	0-20
E77.1	Defects in glycoprotein degradation	0-20
E77.8	Other disorders of glycoprotein metabolism	0-20
E79.1	Lesch-Nyhan syndrome	0-64
E79.2	Myoadenylate deaminase deficiency	0-64
E79.8	Other disorders of purine and pyrimidine metabolism	0-64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0-64
E80.3	Defects of catalase and peroxidase	0-64
E84.0	Cystic fibrosis with pulmonary manifestations	0-64
E84.11	Meconium ileus in cystic fibrosis	0-64
E84.19	Cystic fibrosis with other intestinal manifestations	0-64
E84.8	Cystic fibrosis with other manifestations	0-64
E84.9	Cystic fibrosis, unspecified	0-64
E88.40	Mitochondrial metabolism disorder, unspecified	0-64
E88.41	MELAS syndrome	0-64
E88.42	MERRF syndrome	0-64
E88.49	Other mitochondrial metabolism disorders	0-64
E88.89	Other specified metabolic disorders	0-64

F84.2	Rett's syndrome	0-20
G11.0	Congenital nonprogressive ataxia	0-20
G11.1	Early-onset cerebellar ataxia	0-20
G11.2	Late-onset cerebellar ataxia	0-20
G11.3	Cerebellar ataxia with defective DNA repair	0-20
G11.4	Hereditary spastic paraplegia	0-20
G11.8	Other hereditary ataxias	0-20
G11.9	Hereditary ataxia, unspecified	0-20
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)	0-20
G12.1	Other inherited spinal muscular atrophy	0-20
G12.21	Amyotrophic lateral sclerosis	0-20
G12.22	Progressive bulbar palsy	0-20
G12.29	Other motor neuron disease	0-20
G12.8	Other spinal muscular atrophies and related syndromes	0-20
G12.9	Spinal muscular atrophy, unspecified	0-20
G24.1	Genetic torsion dystonia	0-64
G24.8	Other dystonia	0-64
G25.3	Myoclonus	0-5
G25.9	Extrapyramidal and movement disorder, unspecified	0-20
G31.81	Alpers disease	0-20
G31.82	Leigh's disease	0-20
G31.9	Degenerative disease of nervous system, unspecified	0-20
G32.81	Cerebellar ataxia in diseases classified elsewhere	0-20
G37.0	Diffuse sclerosis of central nervous system	0-64
G37.5	Concentric sclerosis (Balo) of central nervous system	0-64
G71.00	Muscular dystrophy, unspecified	0-64
G71.01	Duchenne or Becker muscular dystrophy	0-64
G71.02	Facioscapulohumeral muscular dystrophy	0-64
G71.09	Other specified muscular dystrophies	0-64
G71.11	Myotonic muscular dystrophy	0-64
G71.2	Congenital myopathies	0-64
G80.0	Spastic quadriplegic cerebral palsy	0-64
G80.1	Spastic diplegic cerebral palsy	0-20
G80.3	Athetoid cerebral palsy	0-64
G82.50	Quadriplegia, unspecified	0-64
G82.51	Quadriplegia, C1-C4 complete	0-64
G82.52	Quadriplegia, C1-C4 incomplete	0-64
G82.53	Quadriplegia, C5-C7 complete	0-64
G82.54	Quadriplegia, C5-C7 incomplete	0-64
G91.0	Communicating hydrocephalus	0-20
G91.1	Obstructive hydrocephalus	0-20
I67.5	Moyamoya disease	0-64
K91.2	Postsurgical malabsorption, not elsewhere classified	0-20
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0-20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0-20
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0-20

N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0-20
N03.8	Chronic nephritic syndrome with other morphologic changes	0-20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0-20
N08	Glomerular disorders in diseases classified elsewhere	0-20
N18.1	Chronic kidney disease, stage 1	0-20
N18.2	Chronic kidney disease, stage 2 (mild)	0-20
N18.3	Chronic kidney disease, stage 3 (moderate)	0-20
N18.4	Chronic kidney disease, stage 4 (severe)	0-20
N18.5	Chronic kidney disease, stage 5	0-20
N18.6	End stage renal disease	0-20
N18.9	Chronic kidney disease, unspecified	0-20
Q01.9	Encephalocele, unspecified	0-20
Q02	Microcephaly	0-20
Q03.0	Malformations of aqueduct of Sylvius	0-20
Q03.1	Atresia of foramina of Magendie and Luschka	0-20
Q03.8	Other congenital hydrocephalus	0-20
Q03.9	Congenital hydrocephalus, unspecified	0-20
Q04.3	Other reduction deformities of brain	0-20
Q04.5	Megalencephaly	0-20
Q04.6	Congenital cerebral cysts	0-20
Q04.8	Other specified congenital malformations of brain	0-20
Q05.0	Cervical spina bifida with hydrocephalus	0-64
Q05.1	Thoracic spina bifida with hydrocephalus	0-64
Q05.2	Lumbar spina bifida with hydrocephalus	0-64
Q05.3	Sacral spina bifida with hydrocephalus	0-64
Q05.4	Unspecified spina bifida with hydrocephalus	0-64
Q05.5	Cervical spina bifida without hydrocephalus	0-64
Q05.6	Thoracic spina bifida without hydrocephalus	0-64
Q05.7	Lumbar spina bifida without hydrocephalus	0-64
Q05.8	Sacral spina bifida without hydrocephalus	0-64
Q05.9	Spina bifida, unspecified	0-64
Q06.0	Amyelia	0-64
Q06.1	Hypoplasia and dysplasia of spinal cord	0-64
Q06.2	Diastematomyelia	0-64
Q06.3	Other congenital cauda equina malformations	0-64
Q06.4	Hydromyelia	0-64
Q06.8	Other specified congenital malformations of spinal cord	0-64
Q07.01	Arnold-Chiari syndrome with spina bifida	0-64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0-64
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	0-64
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	0-5
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	0-5
Q31.0	Web of larynx	0-20
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	0-20
Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	0-20

Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	0-20
Q33.0	Congenital cystic lung	0-20
Q33.2	Sequestration of lung	0-20
Q33.3	Agenesis of lung	0-20
Q33.6	Congenital hypoplasia and dysplasia of lung	0-20
Q35.1	Cleft hard palate	0-20
Q35.3	Cleft soft palate	0-20
Q35.5	Cleft hard palate with cleft soft palate	0-20
Q35.9	Cleft palate, unspecified	0-20
Q37.0	Cleft hard palate with bilateral cleft lip	0-20
Q37.1	Cleft hard palate with unilateral cleft lip	0-20
Q37.2	Cleft soft palate with bilateral cleft lip	0-20
Q37.3	Cleft soft palate with unilateral cleft lip	0-20
Q37.4	Cleft hard and soft palate with bilateral cleft lip	0-20
Q37.5	Cleft hard and soft palate with unilateral cleft lip	0-20
Q37.8	Unspecified cleft palate with bilateral cleft lip	0-20
Q37.9	Unspecified cleft palate with unilateral cleft lip	0-20
Q39.0	Atresia of esophagus without fistula	0-3
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	0-3
Q39.2	Congenital tracheo-esophageal fistula without atresia	0-3
Q39.3	Congenital stenosis and stricture of esophagus	0-3
Q39.4	Esophageal web	0-3
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	0-5
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	0-5
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	0-5
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	0-5
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine	0-5
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified	0-5
Q43.1	Hirschsprung's disease	0-15
Q44.2	Atresia of bile ducts	0-20
Q44.3	Congenital stenosis and stricture of bile ducts	0-20
Q44.6	Cystic disease of liver	0-20
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	0-5
Q45.1	Annular pancreas	0-5
Q45.3	Other congenital malformations of pancreas and pancreatic duct	0-5
Q45.8	Other specified congenital malformations of digestive system	0-10
Q60.1	Renal agenesis, bilateral	0-20
Q60.4	Renal hypoplasia, bilateral	0-20
Q60.6	Potter's syndrome, with bilateral renal agenesis only	0-20
Q61.02	Congenital multiple renal cysts, bilateral only	0-20
Q61.19	Other polycystic kidney, infantile type, bilateral only	0-20
Q61.2	Polycystic kidney, adult type, bilateral only	0-20
Q61.3	Polycystic kidney, unspecified, bilateral only	0-20
Q61.4	Renal dysplasia, bilateral only	0-20
Q61.5	Medullary cystic kidney, bilateral only	0-20
Q61.9	Cystic kidney disease, unspecified, bilateral only	0-20
Q64.10	Exstrophy of urinary bladder, unspecified	0-20

Q64.12	Cloacal extrophy of urinary bladder	0-20
Q64.19	Other exstrophy of urinary bladder	0-20
Q75.0	Craniosynostosis	0-20
Q75.1	Craniofacial dysostosis	0-20
Q75.2	Hypertelorism	0-20
Q75.4	Mandibulofacial dysostosis	0-20
Q75.5	Oculomandibular dysostosis	0-20
Q75.8	Other congenital malformations of skull and face bones	0-20
Q77.4	Achondroplasia	0-1
Q77.6	Chondroectodermal dysplasia	0-1
Q77.8	Other osteochondrodysplasia with defects of growth of tubular bones and spine	0-1
Q78.0	Osteogenesis imperfecta	0-20
Q78.1	Polyostotic fibrous dysplasia	0-1
Q78.2	Osteopetrosis	0-1
Q78.3	Progressive diaphyseal dysplasia	0-1
Q78.4	Enchondromatosis	0-1
Q78.6	Multiple congenital exostoses	0-1
Q78.8	Other specified osteochondrodysplasias	0-1
Q78.9	Osteochondrodysplasia, unspecified	0-1
Q79.0	Congenital diaphragmatic hernia	0-1
Q79.1	Other congenital malformations of diaphragm	0-1
Q79.2	Exomphalos	0-1
Q79.3	Gastroschisis	0-1
Q79.4	Prune belly syndrome	0-1
Q79.59	Other congenital malformations of abdominal wall	0-1
Q89.7	Multiple congenital malformations, not elsewhere classified	0-10
R75	Inconclusive laboratory evidence of HIV	0-12 months
Z21	Asymptomatic human immunodeficiency virus infection status	0-20
Z99.11	Dependence on respirator (ventilator) status	1-64
Z99.2	Dependence on renal dialysis	21-64

ATTACHMENT B

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

☐ **Well child exam only (see attached physical exam form)**

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**

Student Name: **DOB:** **MA Number:** **SS Number:**	**Date of Visit:** **Type of Visit:** ☐ **Acute/Urgent** ☐ **Follow Up** ☐ **Health Maintenance**	**ICD-10 Codes**
Provider Name/Title:		**CPT Codes**
T: Hgt: Rapid Strep Test: - P: Wgt: Hgb: RR: BMI: BGL: BP: U/A: PF: PaO2:	**Drug Allergy:** ☐ **NKDA**	
	Current Medications:	**Immunization review:** ☐ **UTD** **Given today:** **Needs:**

Age: **Chief Complaint:**
HPI:

Past Medical History: ☐ **Unremarkable** ☐ **See health history** ☐ **Pertinent:**

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

Ears: ☐ TMs: pearly, + landmarks , + light reflex
☐ Cerumen removed curette/lavage
☐ Pertinent:

Eyes: ☐ PERRLA, sclerae clear, no discharge/crusting
☐ Pertinent:

Nose: ☐ Turbinates: pink, without swelling
☐ Pertinent:

Mouth: ☐ Pharynx without erythema, swelling, or exudate
☐ Normal dentition without caries
☐ Pertinent:

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

Cardiac: ☐ RRR, normal S1 S2, no murmur
☐ Pertinent:

Lungs: ☐ CTA bilaterally, no retractions, wheezes, rales, ronchi
☐ Pertinent:

Abdomen: ☐ Soft, non-tender, no HSM, no masses,
☐ Bowel sounds present
☐ Pertinent:

Genitalia: ☐ Normal female/normal male Tanner Stage
☐ Pertinent:

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

Provider Signature: _____

PCP F/U Required:
☐ **Yes** ☐ **No**

DHMH 2015 **For MCO formulary info, find MCO website at:** https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/Home.aspx

ATTACHMENT C

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	http://www.alleganyhealthdept.com/
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org/
Baltimore City	410-396-4398	410-396-7633	410-640-5000	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-8741	http://www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	http://www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8189	https://health.maryland.gov/carolinecounty/Pages/NewHome.aspx
Carroll	410-876-2152	410-876-4813	410-876-4941	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5130	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-901-8167	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-3124	301-600-3124	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-7727	301-334-7771	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	https://www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635	http://www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1758	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5600	https://health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-32229	https://health.maryland.gov/washhealth/Pages/home.aspx
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	http://www.worcesterhealth.org/

ATTACHMENT D

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

Date: / /
To:
Attention:
Address:
City/State/Zip:
Phone:

Client Information	
Client Name: Address: City/State/Zip: Phone: County: DOB: / / SS#: - - Sex: ☐M ☐F Hispanic: ☐Y ☐N MA#: Private Ins.: ☐ No ☐Yes Martial Status: ☐Single ☐Married ☐Unknown If Interpreter is needed specific language:	Race: ☐African-American/Black ☐Alaskan Native ☐American Native ☐Asian ☐Native Hawaiian ☐Pacific Islander ☐White ☐More than one race ☐Unknown Caregiver/Emergency Contact: Relationship: Phone:
FOLLOW-UP FOR: (Check all that apply) ☐Child under 2 years of age ☐Child 2 – 21 years of age ☐Child with special health care needs ☐ Pregnant EDD: ____ / ____ /____ ☐Adults with disability(mental, physical, or developmental) ☐Substance use care needed ☐Homeless (at-risk)	RELATED TO: (Check all that apply) ☐Missed appointments: ___ #missed ☐Adherence to plan of care ☐Immunization delay ☐Preventable hospitalization ☐Transportation ☐Other:
Diagnosis:	
Comments:	
MCO:	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) # Face to Face	☐Unable to Locate ☐Contact Date: / / ☐Advised ☐Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:
Local Health Department (County)	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) # Face to Face	☐No Action (returned) Reason for return:
Contact Person: Contact Phone:	Disposition: ☐Contact Complete: Date: / / ☐Unable to Locate: Date: / / ☐Referred to: Date: / /
Comments:	