Sentara Health and Kaiser Permanente Medicaid Program Participating Provider Manual

KAISER PERMANENTE®

June 2025

Contents

1.0 INTRODUCTION: SENTARA HEALTH AND KAISER PERMANENTE MEDICAID PROGRAM

Kaiser Permanente has engaged into an innovative collaboration with Sentara Health, formerly branded as Optima Health, to create a fully integrated health experience. Sentara Health is a Managed Care Organization with a long history of providing access to care throughout the Commonwealth. It shares Kaiser Permanente's values of quality, innovation, education, affordability, and service to our members and communities. Unless they choose otherwise, current Kaiser Permanente members will continue to receive Kaiser Permanente's integrated health care.

1.1 THE KAISER PERMANENTE MEDICAL CARE PROGRAM

Welcome to Kaiser Permanente. As a participating provider, you provide services to members of Kaiser Permanente. This includes the Medicaid and Family Access to Medical Insurance Security Plan ("FAMIS") population in the Commonwealth of Virginia.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Health Plan") is a managed care organization. We operate under the trade name "Kaiser Permanente", and are a subsidiary of the national organization, Kaiser Foundation Health Plan, Inc. Both Health Plan and its parent corporation are non-profit organizations. Health Plan provides or arranges for health care services through direct agreements with participating providers for ancillary services or indirectly through exclusive agreements with Kaiser Foundation Hospitals (KFH), a non-profit corporation, for hospitals and the Mid-Atlantic Permanente Medical Group, P.C. (MAPMG) for professional medical services to meet the health care needs for the underserved population in the Commonwealth of Virginia. 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.

1.2 Service Area

Kaiser Permanente's Virginia Medicaid Service Area includes the following counties and cities in Northern Virginia: Alexandria City, Arlington County, Fairfax County, Fairfax City, Falls Church City, Loudoun County, Manassas City, Manassas Park, and Prince William County.

1.3 Using this Manual

This Participating Provider Manual (Manual) is intended to complement your on-site or Web-based orientation as a reference manual for administrative policies and procedures and clinical issues. It also provides a quick and easy resource with contact phone numbers, detailed processes and site lists for various services.

These policies and procedures are specific to Kaiser Permanente participating providers in compliance with the rules and regulations in the contract between Health Plan and the Virginia Department of Medical Assistance Services (DMAS). Any change to the policies and procedures included in this Manual will have an effective date at least thirty (30) days after distribution of the written notice of such change to all participating providers.

The Kaiser Permanente Provider Experience Department is available to provide support to you and your office staff. This includes providing updates and revisions to this Manual when issued,

as well as supporting you and your staff with operational inquiries and education on new products or plans.

If, at any time, you have a question or concern about the information outlined in this Manual or about the Kaiser Permanente Medical Care Program, you can reach the Provider Experience Department by calling ☎ 877-806-7470.

1.4 Provider Experience Department

Kaiser Permanente is committed to supporting the role of its community-based 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 entities, the Provider Experience Department 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.
- Assisting participating providers in identifying appropriate Kaiser Permanente Medical Centers and/or the participating provider locations/ services available for patient care.
- The Provider Experience Department can be contacted at ☎ 877-806-7470.

1.5 Utilization Management Operations Center

The Kaiser Permanente Utilization Management Operations Center (UMOC) is a telephonic Utilization Management (UM) and Referral Management Service Center designed to assist MAPMG and participating providers in coordinating health care services for Kaiser Permanente members.

To contact the UMOC call ☎ 800-810-4766, fax ☎ 800-660-2019, or send a referral message by logging on to Kaiser Permanente Online Affiliate at www.kp.org/mas.

- Authorization services for planned inpatient and outpatient care are available Monday-Friday from 8:30 a.m. to 5 p.m.
- Urgent preservice referrals are managed seven days a week, including holidays from 8:30 a.m. to 5 p.m.
- On weekends and holidays, nurses can be reached from 8:30 a.m. to 5 p.m. at the UMOC Weekend and Holiday Line: ☎ 301-960-1436

Registered nurses at the UMOC work collaboratively with licensed, board-certified UM Physician managers and practitioners managing the patient's medical, surgical, or behavioral health care through telephonic utilization review of requested services and equipment, and by coordinating care across the continuum.

The following services are coordinated through the UMOC:

• Preservice medical, surgical, or behavioral health care admissions to acute care facilities • Preservice medical, post-surgical, or behavioral health care admissions to sub-acute care facilities • Retrospective review of inpatient acute care that was not pre-authorized • Retrospective review of outpatient care that was not pre-authorized	• Home care • Durable Medical Equipment • Follow-up primary care practitioner or behavioral health care practitioner visits • Specialty referrals (including radiology and laboratory) outside Kaiser Permanente Medical Centers

Pre-service review is required for selected procedures and services. This process is administered at the UMOC. UMOC registered nurses (RNs) (Specialty Outpatient, Durable Medical Equipment and Home Health) and UM ancillary staff manage the referrals following Kaiser Permanente UM policies and procedures. Referrals requiring medical necessity review are forwarded to UM Medical Directors who are licensed physicians in the Commonwealth of Virginia.

The UMOC can be reached at ☎ 800-810-4766 and follow the prompts to speak with a staff member. The UMOC staff can assist you with the following:

- Provide information regarding utilization management processes
- Check the status of a referral or an authorization
- Provide copies of criteria/guidelines utilized for decision making
- Answer questions regarding a benefit denial decision
- Connect callers to an UM physician on any adverse medical necessity denial decision ☎ 800-810-4766 and select the appropriate option when prompted

1.6 Online Provider Tools (Kaiser Permanente Online Affiliate)

Kaiser Permanente offers an online provider portal designed to streamline processes for both contracted and non-contracted provider groups. This portal 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.

1.7 Member Services Department

The Kaiser Permanente Member Services Department has representatives to assist both participating providers and members who call for:

- General verification of member eligibility/enrollment
- Clarification of member benefits and coverage
- Information about services available at Kaiser Permanent Medical Centers
- Maps, driving directions, and other Kaiser Permanente literature
- Information about or assistance with filing a complaint or appeal
- Assistance with solving a problem
- Information about participating providers available for member care and/or assistance with selecting a Primary Care Physician (PCP)
- Requests for replacement member identification card(s)
- Requests by a member to change the member's address or phone number

Member Services representatives can be reached Monday – Friday between 7:30 a.m. and 5:30 p.m.:

Toll free: ☎ 855-249-5019
TTY for the hearing impaired: ☎ 866-513-0008

2.0 KAISER PERMANENTE MEDICAL CENTERS AND RESOURCES

This Section includes the:

- Kaiser Permanente Medical Centers
- Participating Hospitals
- Kaiser Permanente Urgent Care – After Hours Medical Centers

This resource listing is accurate and complete, as of the date of distribution. The continued availability and location of physicians or services at any Kaiser Permanente Medical Center is subject to change. Addresses, telephone numbers, and hours of operation are subject to change in our provider directory and/or our provider website. Not all services are available at each medical center or site. Kaiser Permanente reserves the right to relocate services. Consult our online directory at https://healthy.kaiserpermanente.org/ for the most current listing of Kaiser Permanente Medical Centers, participating hospitals, and/or participating provider locations.

If, at any time, you have any questions or concerns about Kaiser Permanente and/or participating provider resources available to members please, contact Provider Experience at ☎ 877-806-7470.

2.1 Kaiser Permanente Medical Centers – Virginia

Alexandria Medical Center
3000 Potomac Ave
Alexandria, VA 22305
Main Number: ☎ 703-721-6300
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Imaging Services/Radiology, Internal Medicine/Family Practice, Laboratory, Ob/Gyn, Optometry, Pediatrics, Pharmacy, Physical Therapy, Vision Essentials Optical Center

Ashburn Medical Center
43480 Yukon Drive
Ashburn, VA 20147
Main Number: ☎ 571-252-6000
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Behavioral Health, Family Practice, Healthy Living Classes, Internal Medicine, Laboratory, Newborn Care Center, Nutrition Counseling, Ob/Gyn, Pediatrics, Pharmacy, Radiology, Urgent Care (Call for an Appointment), Vision Essentials

Burke Medical Center
5999 Burke Commons Road
Burke, VA 22015
Main Number: ☎ 703-249-7700
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Behavioral Health, Infectious Disease, Laboratory, Ob/Gyn, Oncology/Hematology/Infusions, Pharmacy, Primary Care, Radiology, Vision Essentials Optical Center

Caton Hill Medical Center
13285 Minnieville Rd.
Woodbridge, VA 22192
Main Number: ☎ 703-986-2400
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult and Family Medicine, Advanced Urgent Care, Allergy, Ambulatory Surgery, Audiology, Behavioral Health, Cardiology, Chemotherapy/Infusion, Complementary & Alternative Medicine, Dermatology, ENT, Endocrinology, Endoscopy & Advanced Endoscopy, Gastroenterology, General Surgery, Head & Neck Surgery, HIMS, Hematology/Oncology, Infectious Disease, Interventional Pain, Laboratory, Nephrology, Neurology, Nutrition, Ob/Gyn, Ophthalmology, Optometry, Orthopedics, Pediatrics, Pharmacy, Physical Medicine & Rehabilitation, Physical Therapy, Podiatry, Pulmonology, Radiology/Imaging, Rheumatology, Sleep Medicine, Urology, Vascular Testing, Vision Essentials

Colonial Forge Medical Center
125 Hospital Center Blvd., Ste 110
Stafford, VA 22554
Main Number: □ 540-602-6500
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Behavioral Health, Cardiology, ENT, Laboratory, Optometry, Pharmacy, Physical Therapy, Podiatry, Primary Care (adult and family medicine), Radiology, Vision Essentials Optical Center

Fair Oaks Medical Center
12255 Fair Lakes Parkway
Fairfax, VA 22033
Main Number: ☎ 703-934-5700
Main Hours: 8 A.M. – 6 P.M. M – F
Services: Allergy, Diabetes Education, Family Medicine, General Surgery, Internal Medicine, Laboratory, Newborn Care Center, Ob/Gyn, Orthopedics, Pediatrics, Pharmacy, Physical Therapy, Podiatry, Radiology/Mammography, Urology, Vision Essentials Optical Center

Falls Church Medical Center
201 North Washington Street
Falls Church, VA 22046
Main Number: ☎ 703-237-4000
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Allergy, Alternative Medicine, Audiology, Cosmetic Dermatology, Dermatology, ENT, Endocrinology, Endoscopy, Family Medicine, Gastroenterology, HIMS, Internal Medicine, Laboratory, Newborn Care Center, Nutrition, Ob/Gyn, Ophthalmology, Optometry, Pediatrics, Pharmacy, Radiology, Rheumatology, Sleep Medicine, Vision Essentials Optical Center

Fredericksburg Medical Center
1201 Hospital Drive
Fredericksburg, VA 22401
Main Number: ☎ 540-368-3700
Main Hours: 8 A.M. – 5 P.M. M – F

Services: After Hours Care (by appointment only), Family Practice, Gastroenterology, Internal Medicine, Laboratory, Newborn Care Center, Ob/Gyn, Oncology, Pediatrics, Pharmacy, Radiology, Urgent Care, Urology

Haymarket Crossroads Medical Center
15050 Heathcote Blvd.
Haymarket, VA 20169
Main Number: ☎ 571-445-7200
Main Hours: 8:50 A.M. – 5 P.M. M – F
Services: Adult and Family Medicine, Behavioral Health, Laboratory, Ob/Gyn, Pharmacy, Radiology/Imaging, Vision Essentials

Manassas Medical Center
10701 Rosemary Drive
Manassas, VA 20109
Main Number: ☎ 703-257-3000
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult Primary Care, Allergy, Alternative Medicine, Laboratory, Newborn Care Center, Nutrition Education, Ob/Gyn, Pediatrics, Pharmacy, Radiology

Reston Medical Center
1890 Metro Center Drive
Reston, VA 20190
Main Number: ☎ 703-709-1500
Main Hours: 8 A.M. – 5 P.M. M – F
Services: After-Hours, Allergy Injections, CT Scan, Dermatology, Internal Medicine, Laboratory, MRI, Newborn Care Center, Ob/Gyn, Pediatrics, Pharmacy, Radiology, Urgent Care (Call for an Appointment), Vision Essentials Optical Center

Springfield Medical Center
6551 Loisdale Court
Springfield, VA 22150
Main Number: ☎ 571-622-2000
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Allergy, Anticoagulation, Dermatology, Endocrinology, Family Practice, General Surgery, HIMS, Infectious Disease, Internal Medicine, Laboratory, Neurology, Newborn Care Center, Nutrition, Ob/Gyn, Ophthalmology, Optometry, Orthopedics, Pediatrics, Pharmacy, Physical Therapy, Podiatry, Pre-Operative Education Clinic, Primary Care, Radiology, Rheumatology, Vision Essentials Optical Center, Wound Care

Tysons Corner Medical Center
8008 Westpark Drive
McLean, VA 22102
Main Number: ☎ 703-287-6400
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult Medicine, Advanced Urgent Care, After-Hours, Allergy, Ambulatory Surgery Center, Audiology, Cardiology, Clinical Decision Unit, Comprehensive Spine Care Center, ENT, General Surgery, Genetics, Imaging Services/Radiology, Interventional Pain/Chronic Pain, Laboratory, Mohs Surgery, Nephrology/Peritoneal Dialysis, Neurology, Newborn Care Center, Observation Unit, Ob/Gyn, Occupational Therapy, Oncology/Hematology/Infusion

Center, Ophthalmology, Optometry, Orthopedic Surgery, Pediatrics, Perinatology, Pharmacy, Physical Therapy, Plastic Surgery, Podiatry, Pre-Operative Evaluation and Education, Pulmonary, Radiology, Rehabilitation Services, Urology, Vascular Surgery, Vision Essentials Optical Center

2.2 Kaiser Permanente Medical Centers – District of Columbia

Capitol Hill Medical Center
700 Second Street, NE
Washington, DC 20002
Main Number: ☎ 202-346-3000
Main Hours: 8 A.M. – 5:30 P.M. M – F
Services: Advanced Urgent Care, After- Hours, Allergy, Audiology, Cardiology, Dermatology, ENT, Endocrinology, Gastroenterology, General Surgery, Head and Neck Surgery, HIMS, Hematology, Infectious Disease, Infusion Center, Internal Medicine, Laboratory, Nephrology, Neurology, Newborn Care Center, Oncology, Ophthalmology, Optometry, Orthopedics/Spine, Pediatric Endocrinology, Pediatric Neurology, Pediatrics, Perinatology, Pharmacy, Physical Therapy, Podiatry, Pulmonary, Radiology, Rheumatology, Urology, Vision Essentials Optical Center

Northwest DC Medical Center
2301 M Street, NW
Washington, DC 20037
Main Number: ☎ 202-419-6200
Main Hours: 8 A.M. – 5:30 P.M. M – F
Services: Behavioral Health, Laboratory, Ob/Gyn, Pediatrics, Pharmacy, Primary Care, Radiology

2.3 Kaiser Permanente Medical Centers – Maryland

Bowie Fairwood Medical Center
5400 Hillmeade Road
Bowie, MD 20720
Main Number: ☎ 301-867-1300
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult Family Medicine, Allergy, Behavioral Health, Laboratory, Obstetrics and Gynecology, Pediatrics, Pharmacy, Radiology

Camp Springs Medical Center
6104 Old Branch Avenue
Temple Hills, MD 20748
Main Number: ☎ 301-702-6100
Main Hours: 8 A.M. – 6 P.M. M – F
Services: After-hours Services, Diabetic Education, General Surgery, HIMS, Internal Medicine, Laboratory, Mammography, Nurse Clinic, Nutrition Counseling, Optometry, Orthopedics, Pediatrics, Pharmacy, Podiatry, Radiology, Vision Essentials Optical Center

Gaithersburg Medical Center
655 Watkins Mill Road
Gaithersburg, MD 20879
Main Number: ☎ 240-632-4000
Main Hours: 8 A.M. – 5:30 P.M. M – F
Services: Adolescent Medicine, Adult Medicine, Advanced Urgent Care, After-Hours, Allergy, Alternative & Complimentary Medicine, Ambulatory Surgery, Audiology, Cardiology, Clinical Decision Unit (CDU), Dermatology, ENT, Endocrinology, General Surgery, HIMS, Hematology/Oncology, Infectious Diseases, Infusion Center, Internal Medicine, Laboratory, Nephrology, Neurology, Newborn Care Center, Observation Unit, Ob/Gyn, Occupational Therapy, Ophthalmology, Optometry, Orthopedics, Pain Management, Pediatrics, Pharmacy, Physical Medicine, Physical Therapy, Podiatry, Presurgical Testing, Pulmonary, Radiology, Rehabilitation Services, Rheumatology, Sleep Medicine, Speech Therapy, Sports Medicine, Urology, Vision Essentials Optical Center

Kaiser Permanente Frederick Medical Center
7190 Crestwood Boulevard
Frederick, MD 21703
Main Number: ☎ 240-529-1700
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Behavioral Health, Family Practice, Internal Medicine, Laboratory, Ob/Gyn, Orthopedics, Pediatrics, Pharmacy, Radiology

Kensington Medical Center
10810 Connecticut Avenue
Kensington, MD 20895
Main Number: ☎ 301-929-7100
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult Primary Care, Ambulatory Surgery, Audiology/ENT, General Surgery, HIMS, Laboratory, Newborn Care Center, Ob/Gyn, Ophthalmology, Optometry, Orthopedics, Pain Management, Pediatrics, Perinatology/Genetics, Pharmacy, Physical Therapy, Plastic Surgery, Podiatry, Radiology, Retina, Specialty Care, Urology, Vision Essentials Optical Center, Wound Care

Lanham Rehabilitation Center
4400 Forbes Boulevard, Suite C
Lanham, MD 20706
Main Number: ☎ 301-618-5695
Main Hours: 6:30 A.M. – 5:30 P.M. M – F
Services: Occupational Therapy, Physical Medicine and Rehabilitation, Physical Therapy, Speech Therapy

Largo Medical Center
1221 Mercantile Lane
Upper Marlboro, MD 20774
Main Number: ☎ 301-618-5500
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Advanced Urgent Care, After-Hours, Ambulatory Surgery Center, Audiology, Behavioral Health, Cardiology, Dermatology, Diabetes Education, Endocrinology, Endoscopy, ENT, Gastroenterology, General Surgery, HIMS, Infectious Disease, Internal Medicine,

Laboratory, Nephrology, Neurology, Newborn Care Center, Ob/Gyn, Oncology, Oncology Infusion Center, Ophthalmology, Orthopedics, Pain Management, Pediatrics, Peritoneal Dialysis, Pharmacy, Podiatry, Pre-surgical Testing, Pulmonary, Radiology, Sleep Medicine, Urology, Vascular Surgery, Vision Essentials Optical Center, Wound Care

Marlow Heights Medical Center
5100 Auth Way
Suitland, MD 20746
Main Number: ☎ 301-702-5000
Main Hours: 8 A.M. – 5 A.M. M – F
Services: Laboratory, Ob/Gyn, Ophthalmology, Optometry, Perinatology, Pharmacy, Primary Care/Family Practice, Radiology, Ultrasound, Vision Essentials Optical Center

Physician's Office Building-Holy Cross Hospital
1500 Forest Glen Road, Ste 330
Silver Spring, MD 20910
Main Number: ☎ 301-905-3500
Main Hours: 8:30 A.M. – 5:30 P.M. M – F
Services: Bariatric Surgery, GYN Oncology, Nuclear Medicine, Vascular Surgery

Shady Grove Medical Center
1396 Piccard Drive
Rockville, MD 20850
Main Number: ☎ 301-548-5700
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Behavioral Health, Endoscopy/Colonoscopy Procedures, Family Practice, Gastroenterology, Internal Medicine, Laboratory, Pediatric Specialties, Peritoneal Dialysis, Pharmacy, Radiology

Silver Spring Medical Center
12201 Plum Orchard Drive
Silver Spring, MD 20904
Main Number: ☎ 301-572-1000
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult Primary Care, Behavioral Health, Diabetes Management, HIMS, Laboratory, Mammography, Ob/Gyn, Pediatrics, Pharmacy, Radiology, Vision Essentials Optical Center

Well by Kaiser Permanente at Friendship Heights
5402-A Wisconsin Ave.
Chevy Chase, MD 20815
Main Number: ☎ 703-359-7878
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult Primary Care

West Hyattsville Medical Center
5620 Ager Rd.
Hyattsville, MD 20782
Main Number: ☎ 240-906-6500
Main Hours: 8 A.M. – 5:30 P.M. M – F
Services: Laboratory, Pharmacy, Radiology/Imaging

2.4 Kaiser Permanente Medical Centers – Maryland (Baltimore)

Abingdon Medical Center
3400 Box Hill Corporate Center Drive, Ste 100
Abingdon, MD 21009
Main Number: ☎ 410-515-5440
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult & Family Medicine, Cardiology, Gastroenterology, General Surgery, Laboratory, Orthopedics, Pharmacy, Podiatry, Radiology

Annapolis Medical Center
888 Bestgate Road, Ste 111
Annapolis, MD 21401
Main Number: ☎ 410-571-7300
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Behavioral Services, Cardiology, Dermatology, Family Practice, Internal Medicine, Laboratory, Ob/Gyn, Orthopedics, Pediatrics, Pharmacy, Podiatry, Radiology

Baltimore Harbor Medical Center
815 E. Pratt Street
Baltimore, MD 21202
Main Number: ☎ 410-637-5700
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Family Practice, Internal Medicine, Laboratory, Ob/Gyn, Pharmacy, Radiology

Columbia Gateway Medical Center
7070 Samuel Morse Drive
Columbia, MD 21046
Main Number: ☎ 410-309-4600
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Allergy Shots, Behavioral Health, Diabetes Education, Family Practice, Internal Medicine, Laboratory, Newborn Care Center, Nutrition and Diabetes Education, Ob/Gyn, Pediatrics, Pharmacy, Radiology

Lutherville-Timonium Medical Center
2391 Greenspring Dr.
Lutherville-Timonium, MD 21093
Main Number: ☎ 410-847-3000
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Adult Medicine, Advanced Urgent Care, Allergy, Ambulatory Surgery, Audiology, Behavioral Health, Cardiology, Chemotherapy/Infusion, Chronic Pain Management, Complimentary and Alternative Medicine, Dermatology, Endocrinology, Endoscopy, Gastroenterology, General Surgery, Head & Neck Surgery, HIMS, Hematology/Oncology, Infectious Disease, Interventional Pain, Laboratory, Nephrology, Neurology, Ob/Gyn, Ophthalmology, Optometry, Orthopedics, Outpatient Procedure Suites, Pain Psychology, Pediatrics, Perinatology, Pharmacy, Physical Medicine & Rehabilitation, Plastic Surgery, Podiatry, Pulmonology, Radiology, Rheumatology, Sleep Medicine, Urology, Vascular Surgery, Vision Essentials

North Arundel Medical Center
7670 Quarterfield Road
Glen Burnie, MD 21061
Main Number: ☎ 410-508-7650
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Allergy Shots, Family Practice, Internal Medicine, Laboratory, Nutrition and Diabetes Education, Ob/Gyn, Ophthalmology, Optometry, Pediatrics, Pharmacy, Radiology, Vision Essentials Optical Center

South Baltimore County Medical Center
1701 Twin Springs Road
Halethorpe, MD 21227
Main Number: ☎ 410-737-5000
Main Hours: 7:30 A.M. – 5 P.M. M – F
Services: Adolescent Medicine, Adult Medicine, Advanced Urgent Care, After-Hours, Allergy, Ambulatory Surgery, Audiology, Bariatric Nutrition, Cardiology, Dermatology, ENT, Endocrinology, Endoscopy, Family Medicine, Fluoroscopy, Gastroenterology, General Surgery, Head and Neck Surgery, HIMS, Infectious Disease, Internal Medicine, Laboratory, MRI, Mammography, Nephrology, Neurology, Newborn Care Center, Nuclear Cardiology, Observation Unit, Ob/Gyn, Orthopedics, Outpatient Procedure Suite, Pain Management, Pediatrics, Perinatology, Pharmacy, Physical Medicine, Plastic Surgery, Podiatry, Pre-Operative Evaluation & Education Center, Pulmonology, Radiology, Rheumatology, Sleep Medicine, Sterile Processing, Urology, Vascular Surgery

White Marsh Medical Center
4920 Campbell Boulevard
Nottingham, MD 21236
Main Number: ☎ 410-933-7600
Main Hours: 8 A.M. – 5 P.M. M – F
Services: After-Hours, Behavioral Health, Health Information Management Services (HIMS), Internal Medicine, Laboratory, Mammography, Newborn Care Center, Nutrition and Diabetes Education, Ob/Gyn, Orthopedics, Pediatrics, Pharmacy, Physical Medicine, Physical Therapy, Pre-Op Testing, Radiology

Woodlawn Medical Center
7141 Security Boulevard
Baltimore, MD 21244
Main Number: ☎ 800-777-7904
Main Hours: 8 A.M. – 5 P.M. M – F
Services: Baltimore Imaging Center, Behavioral Health, Diabetes Education, Hand Therapy (Occupational Therapy), Infusion Center, Internal Medicine, Laboratory, Nutrition, Ob/Gyn, Oncology, Ophthalmology, Optometry, Pediatrics, Peritoneal Dialysis, Pharmacy, Physical Therapy, Radiology, Vision Essentials Optical Center

2.5 Kaiser Permanente Participating Hospitals – Virginia

Virginia Hospital Center* 1701 N. George Mason Drive Arlington, VA 22205 ☎ 703-558-5000	**Reston Hospital Center*** 1850 Town Center Parkway Reston, VA 20190 ☎ 703-689-9000
Mary Washington Hospital	**Stafford Hospital Center***

1001 Sam Perry Boulevard Fredericksburg, VA 22401 ☎ 540-741-1100	101 Hospital Center Boulevard Stafford, VA 22554 ☎ 540-741-9000
* MAPMG providers available at hospital/facility	

2.6 Kaiser Permanente Participating Hospitals – MD

Greater Baltimore Medical Center 6701 N. Charles Street Baltimore, MD 21204 ☎ 410-828-2015	**Saint Agnes Hospital** 900 Caton Avenue Baltimore, MD 21236 ☎ 410-368-6000
Suburban Hospital 8600 Old Georgetown Road Bethesda, MD 20814 ☎ 301-530-3100	

2.7 Kaiser Permanente Participating Hospitals – Washington, DC

Children's National Medical Center 111 Michigan Avenue, NW Washington, DC 20010 ☎ 202-884-5000	**Medstar Washington Hospital Center*** 110 Irving Street, NW Washington, DC 20010 ☎ 202-877-7000
Medstar Georgetown University Hospital 3800 Reservoir Road, NW Washington, DC 20007 ☎ 202-444-2000	
* MAPMG providers available at hospital/facility	

2.8 Kaiser Permanente Ambulatory Surgery Centers

Capitol Hill Medical Center 700 Second Street, NE Washington, DC 20002 ☎ 202-346-3000	**Largo Medical Center** 1221 Mercantile Lane Largo, MD 20774 ☎ 301-618-5500
Gaithersburg Medical Center 655 Watkins Mill Road Gaithersburg, MD 20879 ☎ 240-632-4000	**South Baltimore County Medical Center** 1701 Twin Springs Road Baltimore, MD 21227 ☎ 410-339-5000
Kensington Medical Center 10810 Connecticut Avenue Kensington, MD 20895 ☎ 301-929-7100	**Tysons Corner Medical Center** 8008 Westpark Drive McLean, VA 2210 ☎ 703-287-6400

2.9 Kaiser Permanente Urgent Care Centers

Baltimore Harbor Medical Center 815 East Pratt Street Baltimore, MD 21202 ☎ 410-637-5700	**Camp Springs Medical Center** 6104 Old Branch Avenue Temple Hills, MD 20748 ☎ 301-703-6100

Capitol Hill Medical Center 700 Second Street NE Washington, DC 20002 ☎ 202-346-3000	**Fredericksburg Medical Center** 1201 Hospital Drive Fredericksburg, VA 22401 ☎ 540-368-3700
Gaithersburg Medical Center 655 Watkins Mill Road Gaithersburg, MD 20879 ☎ 240-632-4000	**Kensington Medical Center** 10810 Connecticut Avenue Kensington, MD 20895 ☎ 301-929-7100
Largo Medical Center 1221 Mercantile Lane Largo, MD 20774 ☎ 301-618-5500	**Manassas Medical Center** 10701 Rosemary Drive Manassas, VA 20109 ☎ 703-257-3000
Reston Medical Center 11445 Sunset Hills Road Reston, VA 20190 ☎ 703-709-1500	**South Baltimore County Medical Center** 1701 Twin Springs Road Halethorpe, MD 21227 ☎ 410-737-5000
Tysons Corner Medical Center 8008 Westpark Drive McLean, VA 22102 ☎ 703-287-6400	**White Marsh Medical Center** 4920 Campbell Boulevard Nottingham, MD 21236 ☎ 410-933-7600
Woodbridge Medical Center 14139 Potomac Mills Road Woodbridge, VA 22192 ☎ 703-490-8400	

3.0 PROGRAMS, BENEFITS, AND MEMBER IDENTIFICATION CARDS

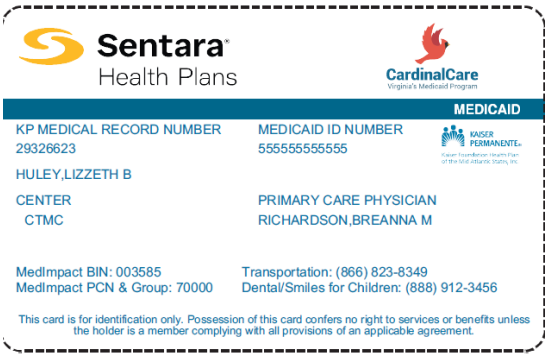
3.1 Virginia Medicaid and FAMIS Programs

Health Plan offers health care services to eligible populations in the Commonwealth of Virginia for Medicaid which includes Cardinal Care, FAMIS MOMS, and FAMIS. Family Access to Medical Insurance Security (FAMIS) is the Children's Health Insurance Program (CHIP). Information regarding these programs can be found at the website for the Virginia Department of Medical Assistance Services (DMAS) at www.dmas.virginia.gov/.

3.2 Membership Identification Cards

All Kaiser Permanente members receive a membership identification (ID) card. Each ID card identifies either the Primary Care Physician (PCP) or the Kaiser Permanente Medical Center location selected by the member, as well as the member's plan type (Medicaid or FAMIS). All ID cards display member name and the "medical record number." For billing and inquiries, please use the Kaiser Permanente medical record number. When members are seen in your office, please request the Kaiser Permanente ID card, the Medicaid ID card, and a photo ID to ensure member identification.

Medicaid Membership Identification Card


Sentara Health Plans

CardinalCare
Virginia's Medicaid Program

MEDICAID

KP MEDICAL RECORD NUMBER
29326623

MEDICAID ID NUMBER
555555555555

KAISER PERMANENTE

HULEY,LIZZETH B

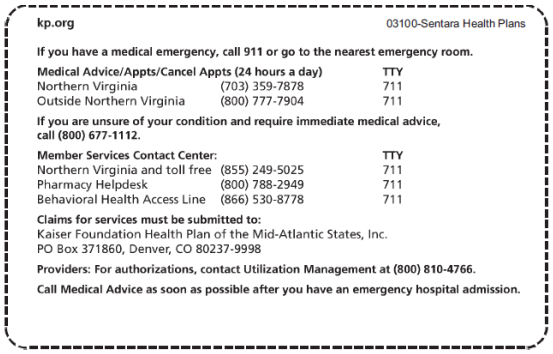
CENTER
CTMC

PRIMARY CARE PHYSICIAN
RICHARDSON,BREANNA M

MedImpact BIN: 003585
MedImpact PCN & Group: 70000

Transportation: (866) 823-8349
Dental/Smiles for Children: (888) 912-3456

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.


kp.org 03100-Sentara Health Plans

If you have a medical emergency, call 911 or go to the nearest emergency room.

Medical Advice/Appts/Cancel Appts (24 hours a day)		TTY
Northern Virginia	(703) 359-7878	711
Outside Northern Virginia	(800) 777-7904	711

If you are unsure of your condition and require immediate medical advice, call (800) 677-1112.

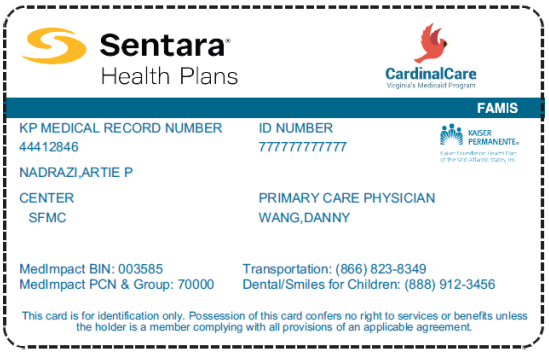
Member Services Contact Center:		TTY
Northern Virginia and toll free	(855) 249-5025	711
Pharmacy Helpdesk	(800) 788-2949	711
Behavioral Health Access Line	(866) 530-8778	711

Claims for services must be submitted to:
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
PO Box 371860, Denver, CO 80237-9998

Providers: For authorizations, contact Utilization Management at (800) 810-4766.

Call Medical Advice as soon as possible after you have an emergency hospital admission.

FAMIS Membership Identification Card


Sentara Health Plans

CardinalCare
Virginia's Medicaid Program

FAMIS

KP MEDICAL RECORD NUMBER
44412846

ID NUMBER
777777777777

KAISER PERMANENTE

NADRAZI,ARTIE P

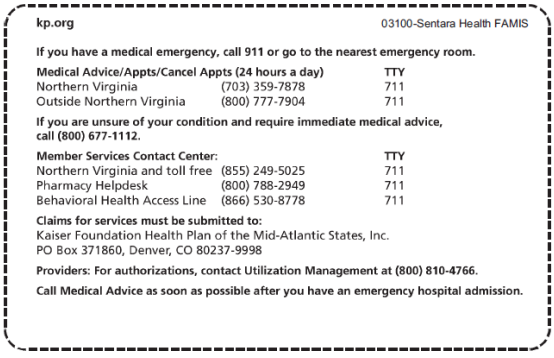
CENTER
SFMC

PRIMARY CARE PHYSICIAN
WANG,DANNY

MedImpact BIN: 003585
MedImpact PCN & Group: 70000

Transportation: (866) 823-8349
Dental/Smiles for Children: (888) 912-3456

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.


kp.org 03100-Sentara Health FAMIS

If you have a medical emergency, call 911 or go to the nearest emergency room.

Medical Advice/Appts/Cancel Appts (24 hours a day)		TTY
Northern Virginia	(703) 359-7878	711
Outside Northern Virginia	(800) 777-7904	711

If you are unsure of your condition and require immediate medical advice, call (800) 677-1112.

Member Services Contact Center:		TTY
Northern Virginia and toll free	(855) 249-5025	711
Pharmacy Helpdesk	(800) 788-2949	711
Behavioral Health Access Line	(866) 530-8778	711

Claims for services must be submitted to:
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
PO Box 371860, Denver, CO 80237-9998

Providers: For authorizations, contact Utilization Management at (800) 810-4766.

Call Medical Advice as soon as possible after you have an emergency hospital admission.

3.3 Benefit Limitations and Exclusions

Kaiser Permanente offers comprehensive health care coverage to all members. However, there are benefit limitations that may impact the scope of service available as covered benefits. Benefit limitations may apply.

Medicaid and FAMIS have certain services which are excluded from coverage altogether. Benefit exclusions also vary by plan design and will need to be determined on a member-by-member basis.

If you have questions about covered services or limitations, please call ☎ 855-249-5019 or log-on to HealthConnect® Online Affiliate at www.kp.org/providers/mas for member benefit information.

3.4 Drug Benefits Plans

Kaiser Permanente offers medication coverage through a variety of benefit plan designs. Members or their providers should call our Pharmacy Help Desk or the Member Services Department to verify specific information concerning their:

- Prescription drug exclusions,
- Prescription co-pay pricing structure,
- Prescription days' supply, and
- Locations of Kaiser Permanente Pharmacies and participating community pharmacies

Certain durable medical equipment (DME) is also available through our Kaiser Permanente pharmacies.

For drug benefit questions, call the pharmacy help desk at ☎ 703-466-4800, option 1, Monday-Friday 8 a.m. – 6 p.m.

Further information can be obtained from Member Services on a patient-specific basis at ☎ 855-249-5019.

In addition, the member may fill prescriptions at participating pharmacies such as Giant, Safeway, Rite Aid, and Wal-Mart. He/she can find a list of all participating pharmacies in the provider directory or by calling Member Services. Preauthorization may be required for high-cost prescriptions being filled at community-based participating pharmacies.

If the member is away from home and needs an emergency supply of medication, they can call our Pharmacy Benefits Manager, MedImpact at ☎ 800-788-2949. MedImpact can help find a participating pharmacy nearby. If the member is in another Kaiser Permanente region, he/she can go to another Kaiser Permanente pharmacy. If the member goes to a non-participating pharmacy, he/she can call Member Services for help submitting a claim.

4.0 ENROLLMENT AND ELIGIBILITY

4.1 Enrollment/Eligibility Verification

Kaiser Permanente has established an automated membership eligibility verification phone line (for providers only). Participating providers can call ☎ 800-810-4766 any time of day. Select option for co-pay and eligibility.

Participating providers enrolled with Kaiser Permanente Online Affiliate may also verify eligibility and benefit information online by logging on at www.kp.org/providers/mas. If you do not have access to Online Affiliate and would like to enroll, you may register by going to www.kp.org/providers/mas and select *Online Provider Tools*.

For assistance with Online Affiliate registration, you may submit a support case at https://kpnationalclaims.my.site.com/support/s/.

For other information or problem resolution, participating providers or members may call Member Services at ☎ 855-249-5019.

4.2 Medicaid Eligibility

The Department of Medical Assistance Services (DMAS) decides who can enroll in a Managed Care Organization (MCO) such as Kaiser Permanente. DMAS will verify eligibility and notify Health Plan of any changes while the member is actively enrolled.

4.3 Newborn Eligibility

Kaiser Permanente automatically covers newborns under the Medicaid Program from the date of birth and two additional months (up to a total of 90 days). Afterwards, the newborn will only be eligible if DMAS notifies Health Plan to continue coverage. The parent/guardian must contact their local department of social services after the newborns birth to apply for independent coverage.

4.4 Medicaid Enrollment

DMAS uses an enrollment broker to provide enrollment services for Medicaid members. DMAS contracts with MAXIMUS for Medicaid enrollees.

The enrollment broker provides basic information about MCOs to recipients who request it. They have information on hand about the provider and hospital networks for each MCO.

4.5 Effective and Termination Dates of Coverage

DMAS determines the members effective and termination dates of coverage. Coverage becomes effective one minute after midnight, on the first day of the month, after DMAS decides eligibility.

Note: If the member is hospitalized with Medicaid fee-for service upon the effective date of coverage with Kaiser Permanente, enrollment will start the first day of the month after discharge.

DMAS notifies Health Plan when coverage starts and ends. If a member chooses Health Plan and DMAS tells Health Plan that the member is eligible, his or her coverage will start one minute after midnight on the first day of the month after Health Plan receives confirmation from DMAS.

4.6 Dis-enrolling from Kaiser Permanente

Medicaid enrollees have the right to change from one MCO to another MCO for any reason during the first ninety (90) calendar days following their effective date of enrollment. Enrollees can call the DMAS Managed Care Help Line at ☎ 800-643-2273 to switch their MCO. Additionally, enrollees may dis-enroll from an MCO and move to another MCO at any time if they can demonstrate cause for the change. Requests to dis-enroll must be submitted to DMAS in writing. DMAS will then determine if good cause exists for disenrollment.

The member or parent/guardian of a member can also change the member's MCO when his/her Medicaid coverage renews. If a plan change occurs, it will be effective either on the first day of the next month or the first day of the month after that; it depends on when the change was initiated.

4.7 Renewal of Medicaid benefits

Losing and regaining Medicaid eligibility can occur periodically. The member may be dis-enrolled and lose coverage with Kaiser Permanente due to loss of eligibility for many reasons including:

- The member moves and the Department of Social Services (DSS) caseworker was not notified
- Fraud is committed by the member or parent/guardian

Medicaid must be renewed at least every twelve (12) months, even if nothing has changed. The DSS will send the member a letter telling him/her the date by which he/she must renew Medicaid benefits. If the member does not renew by the date in the letter, he/she will lose his/her benefits.

4.8 FAMIS Eligibility

The DMAS decides who can enroll in a MCO such as Kaiser Permanente. DMAS will verify eligibility and notify Health Plan of any changes while the member is actively enrolled.

4.9 Newborn Eligibility

Kaiser Permanente automatically covers newborns under the FAMIS Program from the date of birth and two additional months (up to a total of 90 days). Afterwards, the newborn will only be eligible if DMAS notifies Health Plan to continue coverage. The parent/guardian must contact the FAMIS Central Processing Unit (CPU) after the newborns birth to apply for independent coverage.

4.10 FAMIS Enrollment

DMAS uses the FAMIS Central Processing Unit (CPU) to provide enrollment services for FAMIS members. DMAS contracts with Affiliated Computer Services (ACS) to provide enrollment for FAMIS members.

4.11 Coverage Start and End

DMAS decides when coverage starts and ends. If a member chooses Health Plan and DMAS tells Health Plan that the member is eligible, his or her coverage will start one minute after midnight on the first day of the month after Health Plan receives confirmation from DMAS.

Eligible recipients interested in enrolling in FAMIS may call the FAMIS CPU at ☎ 866-873-2641 or visit the FAMIS website at www.famis.org to request an application. FAMIS applications are also available at local DSS offices.

4.12 Dis-enrolling from Kaiser Permanente

The member may change MCOs for any reason at any time during the first ninety (90) days of enrollment. After the first ninety (90) days, the member will not be allowed to dis-enroll from an MCO. The member can also change MCOs during the annual enrollment.

4.13 The Annual Enrollment Period

FAMIS has a period each year based on the member's annual eligibility re-determination date when he/she can choose to stay with Health Plan or pick a different participating MCO. This is called the annual enrollment period. During the annual enrollment period, the member may choose which MCO he/she wants for FAMIS coverage for that year and complete all the information needed for annual renewal.

FAMIS must be renewed at least every twelve (12) months, even if nothing has changed. The CPU will send the member a letter telling him/her the date by which he/she must renew FAMIS benefits. If the member does not renew by the date in the letter, he/she will lose his or her benefits.

5.0 MEMBER RIGHTS, COMPLAINTS/GRIEVANCES AND APPEALS

5.1 Referring Members for Assistance

The Member Services Department has representatives to assist with calls for:

- General verification of member eligibility and enrollment
- Clarification of member benefits and coverage
- Information about member benefits while traveling out of the area
- Information about services available at Kaiser Permanente Medical Centers
- Maps, driving directions and other Kaiser Permanente literature
- Status or payment information related to a claim submission
- Information about or assistance with making an inquiry, complaint, or filing a complaint or appeal
- Assistance with solving a problem
- Information about participating providers and assistance with selecting or changing a Primary Care Physician (PCP)
- Requests for replacement membership identification (ID) card(s)
- Requests by a member to change the member's address or phone number

Kaiser Permanente Member Services representatives can be reached Monday – Friday between 7:30 a.m. and 5:30 p.m.:

Toll free: ☎ 800-777-7902
TTY for the hearing impaired: ☎ 800-777-7902, 711 (TTY)

5.2 Selecting a Primary Care Physician

Our member enrollment forms request the designation of a PCP from Health Plan's provider directory for each enrollee. Each covered family member may designate a different PCP.

An ID card is mailed to the member upon enrollment. Kaiser Permanente participating providers should verify eligibility for any member who has not yet received an ID card using the process described in Section 3.2.

5.3 Changing a Primary Care Physician

Members may change their PCP by selecting a new provider from the provider directory and contacting a Member Services representative with the new designation (See Section 5.1 for Member Services phone numbers). Changes received by the 15th of the month will be effective the first of the following month. Otherwise, the new selection will not be effective until the subsequent month. For example, a change made on or before April 15th would become effective on May 1; but a change made after April 15th would not be effective until June 1.

When a PCP relocates or is no longer a participating provider, Kaiser Permanente sends a letter to all affected members explaining the change, when it will take place, and asking the member to select a new PCP. This written notification is provided at least (30) thirty days of the PCP change (effective date).

Participating providers with questions about this process may contact the Provider Experience Department at ☎ 877-806-7470.

5.4 Rights and Responsibilities: Our Commitment to Members

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.

MEMBER RIGHTS AND RESPONSIBILITIES

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

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 that an emergency medical condition existed.
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.

EQUITY, INCLUSION, DIVERSITY

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 or large print:** 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.
- **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 https://espanol.kaiserpermanente.org/esor https://healthy.kaiserpermanente.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.
- **Video Remote Interpretation** (VRI): 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.

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 see our Diversity & Inclusion Annual Report*.

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
  - United Language Group: www.unitedlanguagegroup.com/
  - Language Line Solutions: www.languageline.com/

- Sign Language
  - Sign Language U.S.A.: www.signlanguageusa.com/

- Document Translation

- UNO Translations and Communications: www.unotranslations.com/
- Akorbi: akorbi.com/
- Avantpage: avantpage.com/

5.5 Inquiries or Complaints

All members have the right to make an inquiry, and/or initiate a complaint with Kaiser Permanente. A member may contact us directly or have their authorized representative such as family member act on their behalf. As a participating provider, you have the right to make an inquiry and/or file a complaint on behalf of a member with their written permission/authorization.

Our Member Services Department is available to assist members or their authorized representative (including a provider acting on behalf of a member) with:

- Questions about health care services
- Providing Kaiser Permanente with feedback about a positive care experience
- Concerns about member treatment or how they have been treated
- Concerns with a decision made by Health Plan; or if you disagree with decision made about the member's care
- Questions or concerns regarding a claim or bill received by the member for health care services

A member or their authorized representative may initiate an inquiry, complaint telephonically by calling ☎ 800-777-7902; ☎ 800-777-7902, 711 (TTY), TTY/TDD.

A member or their authorized representative also has the option to initiate an inquiry, complaint, or appeal in person at a Kaiser Permanente Medical Center. Written inquiries, complaints, or appeals can also be sent to the following address:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Nine Piedmont Center, 3495 Piedmont Road, NE
Atlanta, GA 30305-1736
Fax#: ☎ 404-949-5001
☎ 800-777-7902, 711 (TTY)

All complaints are investigated and handled by our Member Service Representatives through coordination with the appropriate departments. Our Member Services Representatives will do their best to resolve issues or concerns at the time of initial contact. If the issue cannot be immediately resolved, it will be handled within (30) thirty calendar days.

5.6 Appeals

Members and/or their authorized representative (such as a participating provider acting on their behalf) have the right to file an appeal orally or in writing when they disagree with Health Plan's decision to deny or authorize a reduced amount for medical services or not to pay a claim for health care services. Any provider will not be penalized in any way by Kaiser Permanente for assisting a member with filing an appeal and/or acting on a member's behalf.

A member or their authorized representative may file an appeal by calling ☎ 800-777-7902; ☎ 800-777-7902, 711 TTY/TDD or

An appeal can also be sent in writing to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736

A written appeal letter should include:

- The member's name
- Kaiser Permanente Medical record number
- Description of the services (or claims) that were denied
- The reason that Health Plan should authorize the service or pay the claim
- A copy of the denial notice that was received, if applicable

For an appeal request related to a medical necessity determination and/or related to a health care service that has initially been determined by Health Plan to be experimental/investigational services, please see additional details under Utilization Management Section 9.25 – Denials and Appeals.

5.7 Appeal Timeframes

Expedited Appeal

An expedited appeal can be requested and is available for medically urgent situations if the member or their authorized representative feels that the regular period of time to review your request could endanger the life or health of the member.

To request an expedited appeal a member or provider should contact our Member Services Department at:
☎ 800-777-7902, toll-free
☎ 800-777-7902, 711 TTY/TDD

Once the expedited appeal is submitted with all the necessary information to review the case, a decision will be made no later than three (3) business days from initial receipt. This timeframe can be extended if the member or representative requests additional time and/or if additional information is needed up to fourteen (14) calendar days.

If for some reason the initial request does not qualify as an expedited appeal, the request will follow the timeframe for a standard appeal.

Standard Appeal

A standard appeal that does not require expedited handling is processed within thirty (30) calendar days of receipt of the initial request and after all information is received to make a decision. The standard appeal timeframe can be extended up to fourteen (14) calendar days if more time is needed to gather additional information.

5.8 State Fair Hearing

Kaiser Permanente is committed to ensuring that member concerns are fairly heard and properly resolved. If under certain circumstances, a member has concerns about health care

services that they believe have not been satisfactorily addressed by Health Plan, the members have the right to submit an appeal to the Department of Medical Assistance Services (DMAS).

Medicaid members may file a complaint at any time once an initial determination has been made by Health Plan. Medicaid members must exhaust Health Plan's complaint and appeal process prior to filing an appeal to DMAS.

Medicaid State Fair Hearing for FAMIS and Cardinal Care Members

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
Fax: ☎ 804-371-8491

A State Fair Hearing request must be submitted in writing and can be filed at any time after an appeal decision is made by Kaiser Permanente.

A decision to uphold or reverse a decision made by Kaiser Permanente will be handled in accordance with 12 VAC 30-20-500 et. seq.

For State fair hearing process questions, members may contact DMAS Appeals by phone at ☎ 804-371-8488.

Appeal must be submitted in writing and filed within (120) calendar days after final appeal decision by Kaiser Permanente.

A decision to uphold or reverse a decision made by Kaiser Permanente will be made in accordance with 12 VAC 30-141-40.

FAMIS and Cardinal Care members must exhaust Health Plan's internal appeal process first prior to filing an appeal to DMAS.

6.0 PARTICIPATING PROVIDER RESPONSIBILITIES AND REQUIREMENTS

6.1 Primary Care Physician Responsibilities

Physicians who have entered into Primary Care Physician Agreements with Mid-Atlantic Permanente Medical Group (MAPMG) to serve as Primary Care Physicians (PCPs) have responsibilities to the member as well as to Kaiser Permanente. These responsibilities are detailed in the contractual agreement.

Most PCPs have entered into a fee-for-service arrangement for payment of services to Kaiser Permanente members. All PCPs who have contracted with MAPMG have the same responsibilities regardless of the reimbursement structure involved:

- Make every effort to ensure Children with Special Health Care Needs, Foster and Adoption Assistance Individuals, and Aged and Disabled Members receive a visit to their assigned PCP within 60 calendar days of enrollment and every year thereafter.
- Responsible for providing, evaluating, triaging and arranging for a patient's care 24 hours a day, 7 days a week - this responsibility includes the evaluation of the need and consequent arrangement of appropriate specialty referral or consultation.
- Office visits during regular visit hours for the evaluation/management of common medical conditions - patient education functions may be delegated to appropriately trained staff under the participating PCPs supervision.
- Management of patient care in hospital, skilled nursing facility, home, hospice, or acute rehabilitation unit.
- Preventive care services, including well child, adolescent and adult preventive medicine, nutrition, health counseling and immunization. Immunizations will be in accordance with the Virginia Department of Health (VDH) Virginia Vaccines for Children Program requirements (provider process pending Health Plan receipt of final decision from VDH).
- Well-woman exams including breast exams and routine gynecological care with pap and pelvic exams when the PCP is chosen by the female member to render such services.
- On-call coverage, 24 hours a day, 7 days a week - members are entitled to access their PCP, or his/her designee who must be a MAPMG contracted, credentialed provider, by telephone after regular office hours.
- Therapeutic injections (including cost of medication).
- Allergy injections (includes administration, excludes cost of serum).
- Standard testing and/or rhythm strip echocardiograms (EKGs) in adults.
- Basic pulmonary function tests, including timed vital capacity and maximum capacity in adults, and peak flow studies in children.
- Local treatment of first degree and uncomplicated second-degree burns.
- Minor surgical procedures (e.g., simple skin repair, incision and drainage, removal of foreign body, benign skin lesion removal or destruction, aspiration).
- Simple splinting and treatment of fractures.
- Removal of foreign body or cerumen from external ear.
- Rectal exams and use of anoscopy and sigmoidoscopy.
- Standard screening vision and hearing exams.
- PPD skin tests.
- Laboratory worked performed in the PCPs network office that does not require Clinical Laboratory Improvement Amendments (CLIA) certification (e.g. urinalysis by dipstick, blood sugar by fingerstick, hemoglobin and/or hematocrit, stool occults blood, etc.).

For additional information concerning capitation or fee-for-services arrangements, call the Provider Experience Department at ☎ 877-806-7470.

6.2 Department of Medical Assistance Services Participation Requirements

As a participating provider under contract with a Kaiser Permanente entity for Medicaid programs the requirements of the contract between Health Plan and the Department of Medical Assistance Services (DMAS Contract) are incorporated by reference into your Participating Provider Agreement for Medicaid services. Further, guidelines established by the Centers for Medicare and Medicaid Services (CMS) and/or other applicable state or federal law also apply. Based on those requirements, among other things:

- You agree to provide medical services to all populations identified as eligible by DMAS and to comply with all applicable non-discrimination requirements.
- You cannot have been excluded from participation in Medicare or other federal or state health care programs.
- In the event there is a conflict between the terms of your Participating Provider Agreement and the terms of the DMAS Contract, the terms of the DMAS Contract will apply.
- You agree to participate in and contribute data to Kaiser Permanente quality improvement/assurance programs.
- You agree to abide by the terms of your Participating Provider Agreement for timely provision of emergency and/or urgent care services and/or as defined in this Manual. Where applicable, you agree to follow those procedures for handling urgent and emergent care to members.
- You agree to submit utilization/claims data in the format required by Kaiser Permanente, and so that this information can be provided to DMAS.
- You agree to abide by Kaiser Permanente referral and authorization guidelines as defined in Section 9.0 Utilization Management of this Manual. You also agree to clearly communicate these requirements to your participating providers and/or sub-contractors.
- You agree not to charge Medicaid or FAMIS members for missed appointments.
- You agree not to bill a Medicaid or FAMIS member for medically necessary services covered under the DMAS Contract.
- You shall promptly provide or arrange for the provision of all services required under your Participating Provider Agreement.
- If you are a participating PCP, you agree to provide comprehensive, periodic health assessments, or screenings which meet reasonable standards of practice as specified in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical periodicity schedule established by DMAS for Medicaid members.
- You agree to report members you suspect of fraud and abuse by calling Health Plan's Provider Experience Department at ☎ 877-806-7470 for reporting to Health Plan's Fraud Unit and/or DMAS.
- You agree to allow Kaiser Permanente and/or any authorized representative of DMAS access to your premises, contracts and/or medical records.
- You agree to preserve the full confidentiality of medical records.
- You agree to comply with all record retention and maintenance requirements as required by DMAS and/or outlined under Section 10.9 Medical Record Keeping Practices of this Manual.

- Upon request, you agree to make medical records available to members, their authorized representative, or Kaiser Permanente within ten (10) working days of the request.
- You agree to take a comprehensive health and development history, including assessment of both physical and mental development.
- You agree to make a comprehensive unclothed physical examination including vision and hearing screening, dental inspection, nutritional assessment, review and administration of immunization according to age and health history.
- You agree to seek appropriate laboratory tests according to the recommendations of DMAS and health assessment criteria for the member. Minimum tests include:
    - Hemoglobin/Hematocrit/EP
    - Hereditary/Metabolic screening
    - Urinalysis
    - Tuberculin test for high risk
    - Blood lead testing
    - Reporting of lead testing results to DMAS
- You agree to provide Health education.
- You agree to make referrals for treatment of any abnormalities or any diagnoses discovered.
- You agree to obtain and document the consent form as required under 42 C.F.R §441.259 prior to the performance of any sterilization, and to comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia, §54.1-2974.
- You agree to ensure confidentiality of family planning services, except to the extent required by law, including but not limited to the Virginia Freedom of Information Act.
- For participating PCPs and obstetrician/gynecologists (OB/GYNs), you agree to advise every pregnant member of the value of human immunodeficiency virus (HIV) testing and agree to request consent as set forth in §54.1-2403.01 of the Code of Virginia. A pregnant member may refuse HIV testing or recommended treatment. You agree to document refusal in the member's medical record.
- You acknowledge that therapeutic abortion is not covered for Medicaid or FAMIS members. All abortion claims should be coordinated and filed directly with DMAS.
- You agree to provide and coordinate the provision of health care services to Medicaid and FAMIS members in the same manner as you provide those services to any other Health Plan member.
- You agree to assist enrollees with their special needs which include heath maintenance practice and preventive care services as well as communication challenges. You can coordinate assistance by referring members to community resources such as Women Infants and Children (WIC), Head Start, and or other community-based intervention programs. Refer to Section 9.35 Pre-Natal and Infant Program Overview of this Manual for more information on prenatal and infant programs.
- You agree to cooperate with Kaiser Permanente and external review organizations contracted by DMAS to perform quality studies.
- You agree to refer members to Kaiser Permanente case management services as needed, including women experiencing a high-risk pregnancy and members with complex medical needs.

Provider Services Solution (PRSS) Requirements

In accordance with Federal requirements in the 21st Century Cures Act, all Virginia Medicaid managed care providers, groups, and facilities must enroll directly with DMAS through PRSS. Providers who fail to enroll in PRSS will be terminated as Virginia Medicaid MCO network providers and will no longer receive payments for Virginia Medicaid members enrolled in managed care.

Licensed Providers and Healthcare Professionals, groups, and facilities in the Commonwealth of Virginia can register with PRSS at the following link: https://virginia.hppcloud.com/. Registration requires valid National Provider Identifier (NPI), Tax ID, and Office Location information for successful enrollment.

Should you have any questions, please call the PRSS Provider Enrollment Helpline at ☎ 804-270-5105 or email vamedicaidproviderenrollment@gainwelltechnologies.com.

6.3 Access and Appointment Standards

As a participating provider, you agree to provide care in accordance with the following appointment standards:

Type of Appointment	**Kaiser Permanente Standard FAMIS**	**Kaiser Permanente Standard Medicaid**
Routine primary care (excludes health assessments and regularly scheduled visits to monitor chronic conditions)	Within 2 weeks of request	Within 30 calendar days of request
Health assessments, preventive care, initial health assessments for new members	Within 30 calendar days of request	Within 30 calendar days of request
Maternity – During the first trimester	Within 14 calendar days of request	Within 14 calendar days of request
Maternity – During the second trimester	Within 7 calendar days of request	Within 7 calendar days of request
Maternity – During the third trimester	Within 3 business days of request	Within 3 business days of request
Maternity – If determined as high-risk pregnancy	Within 3 business days or immediately if an emergency exists	Within 3 business days or immediately if an emergency exists
Urgent care	Within 24 hours of the request	Within 24 hours of the request
Emergency services	Available immediately upon request	Available immediately upon request

Additionally, you agree to participate in annual and/or periodic access and availability survey, as requested by Health Plan's Provider Experience Department.

6.4 Access to Services

Kaiser Permanente monitors its participating provider network to ensure adequate access to covered services is available to its members and maintained. Our members are surveyed on a regular basis to also help assess the accessibility of services and the adequacy of the participating provider network. The results of surveys help us evaluate the performance of participating providers in the community and the need for services.

6.5 Compliance with Policies and Programs

As a participating provider you agree to review, participate in and comply with Kaiser Permanente medical policies, quality assurance programs, and medical management programs. Additional information regarding these policies can be located in Section 9.0 Utilization Management and Section 10.0 Quality Management.

6.6 Discrimination Prohibited

Participating providers may not discriminate against a Kaiser Permanente member based on race, religion or any other factor prohibited by law. In addition, participating providers may not discriminate in the provision of medical services based on health status. Participating providers may not restrict their practice to individuals perceived to be healthy or refuse to accept members as a patient under the premise that the payment methodology would not compensate them for providing services to this population.

6.7 Continuation of Services after Termination

Participating providers acknowledge that services to Kaiser Permanente members will not be interrupted should Kaiser Permanente be unable to pay its debts or terminates its contract with DMAS or another provider. In cases where a member is hospitalized, the participating provider's obligation to provide services continues until the member's discharge from the hospital.

6.8 Cooperate with Independent Quality Review

Participating providers must participate in quality reviews and are obligated to participate in any quality review function Kaiser Permanente designates.

6.9 Cultural Competence

Participating providers must ensure that their services are provided in a culturally competent manner to members. Kaiser Permanente expects participating providers to provide health care that is sensitive to the needs and health status of different population groups. This includes members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities. Kaiser Permanente has developed material and resources that can be made available to participating providers on culturally competent care. To obtain/request more information about diversity and care competency, contact Provider Experience at ☎ 877-806-7470. Interpreter services are available at Kaiser Permanente facilities, or we can provide services to members at alternative facilities. If you need assistance call Member Services.

6.10 Disclosure of Quality and Performance Indicators

Kaiser Permanente conducts ongoing studies and surveys of member satisfaction and health outcomes. Participating providers must participate in these studies and surveys as requested by KPMAS.

6.11 Follow-up Care and Training Self-Care

Participating providers must provide members with the information they need to participate fully in their own care, including information on such subjects as: self-care, medication management, use of medical equipment, potential complications and when these should be reported to providers, and scheduling of follow-up services.

6.12 Professionally-Recognized Standards of Care

Services to members must be provided in a manner consistent with professionally recognized standards of care.

6.13 Requirements Binding on Participating Providers' Subcontractors

In the event that a participating provider has approval to subcontract for care provided to Kaiser Permanente members, those contracts must include provisions assuring that your subcontractor is subject to the same contractual requirements with regard to Kaiser Permanente members.

6.14 Non-Emergency Transportation Services for Medicaid

Lack of transportation to health care appointments can be a significant barrier that can impact access to preventive care visits and/or other medically necessary health care services. Emergency and non-emergent transportation is a covered benefit for Medicaid members. As a participating provider, you agree to assist members in coordinating for their health care needs. This includes arranging for transportation for Medicaid members by a participating transportation provider.

Health Plan has adopted DMAS guidelines to determine transportation needs of Medicaid members. Guidelines to determine transportation necessity:

- Transportation is covered only when no other means of transportation is available to the member.
- Transportation is covered to the nearest available source of care capable of providing for the member's medical needs.

Health Plan has an agreement with LogistiCare to meet non-emergent transportation needs of its Medicaid members.

<u>LogistiCare Reservation Requirements</u>

Kaiser Permanente Member ID#
Pickup Address
Destination Address
Date and time of appointment
Return Time (if known)

To make a reservation for transportation, providers or members should call:

☎ 866-823-8349, TTY/TDD ☎ 866-288-3133 or go online at https://member.logisticare.com.

For members who require ride assistance, LogistiCare “Where’s My Ride” can be contacted at ☎ 866-823-8350.

6.15 Health and Acute Care Program

Effective December 1, 2014, the Virginia Department of Medical Assistance Services (DMAS) launched the Health and Acute Care Program (HAP). The Health and Acute Care Program includes Medicaid individuals enrolled with Health Plan and one of the five home and community-based waivers.

DMAS transitioned individuals in the Elderly or Disabled with Consumer-Direction (ECDC) waiver, who are eligible for managed care, to the managed care health plans for acute care services only. Eligible home and community bases care services (HCBS) waiver individuals will receive their acute and primary medical care from Health Plan. The individual’s home and community-based care waiver services, including transportation to the waiver services, is paid through the Medicaid fee-for-services system as a “carved out” service.

Participating providers are responsible for the coordination of acute care services for HAP members. The participating providers are not responsible for the coordination of acute services with any necessary waiver services. In addition, no case management is required for waiver care services.

6.16 Foster Care Services

Health Plan covers members up to age 26 years old for medical necessary EPSDT service. participating providers will ensure children receive routine check-ups, screenings, evaluations and treatments. Participating providers may write a referral for a case manager, when needed, to work with the social worker and foster parent to make sure foster care children keep scheduled appointments

7.0 COMPLIANCE AND REGULATORY POLICY

7.1 Our Commitment to Compliance

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 ☎ 877-806-7470.

7.2 Medical Record-Keeping Practices

All participating providers are responsible for maintaining a complete medical record for at least ten (10) years for Health Plan members who elect to receive their health care through their offices. Additionally, medical records should be made available for members within ten (10) days of request. The Kaiser Permanente Medical Care Program has developed specific criteria for maintaining the medical record. These standards are a part of the periodic site review done within each network office. More detailed standards for medical record-keeping practices are described in Section 10.0 Quality Resource Management of this Manual.

7.3 Provider Responsibility for Patient Confidentiality

As participating providers of Kaiser Permanente, ensuring member confidentiality is the responsibility of all providers. Before a Kaiser Permanente member is seen in your office, please request the Kaiser Permanente identification (ID) card and a photo ID to ensure member identification.

All Health Plan members are assured that their personal and medical information remains confidential. Participating providers must follow the level of confidentiality as stated below in the Confidential Information section. Pursuant to applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), Kaiser Permanente protects members' rights to privacy and confidentiality.

The following information is shared with Kaiser Permanente members regarding their rights to privacy and confidentiality:

Confidential Information Distributed to Members

Everyone at Kaiser Permanente knows that protecting your right to privacy is important. You have entrusted us with your personal and medical information. Therefore, we believe that you have the right to know how we keep your information confidential and how we may use it. We also want you to know the many policies and procedures we have in place throughout the entire health care system to protect your right to privacy and confidentiality.

Here are just a few examples of how we manage appropriate and confidential treatment of your information:

1. Kaiser Permanente physicians and employees sign confidentiality statements affirming their commitment to protect your information. Your medical record may only be viewed by those who “need to know” to make decisions about your health treatment.
2. Contractors sign a non-disclosure statement ensuring that they will also protect your information.
3. Your right to confidentiality of your medical records is part of Kaiser Permanente’s Member Rights and Responsibilities.
4. You have the right to deny release of personal or medical information, except when required by law.
5. Your right to review your medical records is included in contracts with Kaiser Permanente participating providers.

We may use your protected information in the following day-to-day functions of Kaiser Permanente:

- Giving parents the status of their child’s claim (if the child is less than 18 years of age).
- Providing your name and address to Kaiser Permanente contracted mail houses so you can receive our health education materials as part of our disease management, self-care and prevention programs and other health care information.
- Sharing information with government agencies or other insurers for determining our liability and payment.
- Supporting medical research for clinical reasons.
- Using information for professional, tracking, or quality improvement activities.

Note: References to “You” also refer to your authorized representative.

In addition, it is the shared responsibility of all providers and their staff to maintain patient confidentiality as described in the following Sections.

7.4 Provider Responsibility to the Member

- All medical records are confidential, secure, current, authenticated, legible and complete.
- Medical records are the property of the provider and are maintained for the benefit of the patient, the medical staff and the provider.
- The provider is responsible for safeguarding both the record and its informational content against loss, defacement, tampering and from use by unauthorized agents.
- The patient’s written consent (or that of his/her legally qualified representative) is required prior to the release of medical information to persons/entities not otherwise authorized to receive the information.

Authorized uses of medical records include, but are not limited to:

- Automated data processing of designated information.
- Use in activities concerned with the monitoring and evaluation of the quality and appropriateness of patient care.
- Kaiser Permanente review of work performance.
- Official surveys for compliance with accreditation, regulatory, and licensing standards.
- State and federal regulatory audits.
- Educational purposes.

7.5 Discrimination Prohibited

Every Kaiser Permanente participating provider is responsible for providing services to members without discrimination on account of race, sex, color, religion, national origin, age, physical or mental disability or veteran's health status. As a governmental contractor, Kaiser Permanente is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which may be applicable to participating providers. Kaiser Permanente is required to give notice to participating providers subject to certain federal laws, executive orders and regulations by incorporating herein by reference the following clauses from the Federal Acquisition Regulation (FAR) at 48 CFR Part 52: (a) Equal Opportunity (Feb. 1999) at FAR 52.222-26; (b) Equal Opportunity for Veterans at FAR 52.222-35 and -37; (c) Affirmative Action for Workers with Disabilities at FAR 52.222-36, and (d) Utilization of Small Business Concerns at FAR 52.219-8, (e) Certification of Non-Segregated Facilities at FAR 52.222-21, (f) Use of Patented Inventions at FAR 52.227-1 and -2, and (g) Encouraging Contractor Policies to Ban Text Messaging While Driving at FAR 52.223-18.

7.6 Notification to Members of Participating Provider Termination

A participating provider must give ninety (90) days prior notice or as otherwise specified in the participating agreement, of termination to the Mid-Atlantic Permanente Medical Group (MAPMG) or Health Plan's Provider Experience Department. Once notice is received, Health Plan is responsible for the written notification to all impacted members regarding their physician's upcoming termination. This written notification is provided to members thirty (30) days prior to the physician change (effective date). If the terminating provider is a Primary Care Physician (PCP), the written notification will include instructions to assist members with selecting a new PCP.

7.7 Advance Directives

Advance directives are defined by the Centers for Medicare and Medicaid Services (CMS) as a written instruction, such as a living will or durable power of attorney for health care, recognized under appropriate state law. This Section addresses advance directives in order to assure compliance with the Federal Patient Self-Determination Act of 1990, which mandates patients' rights to participate in determining the course of their medical care.

The law requires that all hospitals, hospice programs, and home health programs comply with the following:

- Assure compliance with the law
- Document whether a patient has an advance directive
- Provide written information regarding advance directives; and
- Provide staff and member education.

The law also requires that enrollees be provided information regarding the Patient Self-Determination Act and Advance Directives. Legal applicability to minors includes only those minors who are emancipated.

Informing Your Patient

A pamphlet regarding advance directives is available through the Member Services Department. Members with medical questions related to advance directives should be referred to their personal physician. Members with legal questions should be advised to consult their attorneys. For more information on Advance Directives, electronic copies of state specific forms and to

learn about Life Care Planning, Kaiser Permanente's branded Advance Care Planning services, visit www.kp.org/lifecareplan.

Filing of Advance Directives
A copy of the member's advance directive should be placed in the member's medical records. The member is advised to maintain a copy of his/her advance directive and to provide one to his/her surrogate decision-maker, in order to assure that a copy is available should the member be admitted to a hospital.

7.8 Physician Involvement with Member Decision-Making Process

Federal law strongly encourages physician involvement with the member in the decision-making process regarding advance directives.

The attending physician reviews the advance directive with the member or his/her surrogate decision-maker at the time of admission, and periodically thereafter at the member's request.

All discussions between the member/surrogate and his/her physician regarding advance directives must be documented in the medical record.

7.9 Release of Information Policy

Guidelines for Release of Health Information
Procedures have been developed to address the release of health information and medical records to the member or the authorized representative.

- All members have the right to access their medical records.
  This includes the right to inspect and obtain copies of their medical record, and to amend any incorrect information.
- Member access may be restricted if the health information would adversely affect the health and well-being of the member.
- The physician should make an entry in the member's medical record specifying what information is not to be released.
- A written authorization to release information must be received from the member before any information from the medical record is released (fax copy is acceptable).

Please contact Member Services to obtain an authorization form.
The authorization for release must contain:

1. Member's Name
2. Name of organization, institution or person being asked to make disclosure
3. To whom the information is being released
4. Reason for release
5. Description of specific information to be released
6. Member's or authorized representative's signature and the date of the request (proper legal documentation when applicable). A statement specifying the duration of the authorization.
7. A statement informing the member of his/her right to revoke the authorization prospectively, except for information that has already been released in reliance on the revocation. The authorization must contain information concerning how to revoke an authorization.

8. A statement specifying that by signing the authorization, the disclosed information is no longer protected from further re-disclosure; information disclosed pursuant to the authorization could be re-disclosed by the recipient; and such re-disclosure is, in some cases, not protected by applicable state law and may no longer be protected by federal confidentiality law.
9. A statement that the provider may not condition treatment, payment, enrollment or eligibility for benefits on the member providing or refusing to provide this authorization.
10. A statement that a copy of the authorization will be included in the patient's medical record.

If the authorization pertains to drug or alcohol treatment, the following disclosures:

For Insurance Contracts Issued in the Commonwealth of Virginia: I understand that this authorization shall be valid: (a) in the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits: (1) Thirty months from the date the authorization is signed if the application or request involves life, accident and sickness, or disability insurance; (b) in the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy: (1) the term of coverage of the policy if the claim is for an accident and sickness insurance benefit; or (2) the duration of the claim if the claim is not for an accident and sickness insurance benefit."

Legal guardians, natural and foster parents may sign for the release of information contained within a minor's medical record, unless the minor was seen on his own accord for such services as sexually transmitted disease, birth control, pregnancy, abortion, behavioral health, substance abuse or alcohol abuse treatment or HIV status.

Requests for the release of health record information to members must be coordinated through Health Plan Health Information Management Services Department (HIMS).

Guidelines for Release of Mental Health Information
A written authorization to release mental health information must be received from the patient before any information from the medical record is released (fax copy is acceptable). Please contact Member Services to obtain an authorization form.

The authorization for release of mental health information must contain:

- Member's Name
- Name of organization, institution or person being asked to make disclosure
- To whom the information is being released
- Reason for release
- Description of specific information to be released.
- Member's or authorized representative signature and the date of the request (proper legal documentation when applicable).
- A statement specifying the duration of the authorization.
- A statement informing the member of his or her right to revoke the authorization prospectively, except for information that has already been released in reliance on the revocation. The authorization form must contain information concerning how to revoke an authorization.
- A statement specifying that by signing the authorization, the disclosed information is no longer protected from further re-disclosure; Information disclosed pursuant to the

authorization could be re-disclosed by the recipient; and such re-disclosure is, in some cases, not protected by applicable state law and may no longer be protected by federal confidentiality law.

- A statement that the provider may not condition treatment, payment, enrollment or eligibility for benefits on the member providing or refusing to provide this authorization.
- A statement that a copy of the authorization will be included in the patient's medical record
- If the authorization pertains to drug or alcohol treatment, the following disclosures:

For Insurance Contracts Issued in the Commonwealth of Virginia: I understand that my Behavioral Health records are protected under the applicable state law governing health care information that relates to mental health services. They may also be protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CRF Part 2).

I understand that this authorization shall be valid: (a) in the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits: (1) Thirty months from the date the authorization is signed if the application or request involves life, accident and sickness, or disability insurance; (b) in the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy: (1) the term of coverage of the policy if the claim is for an accident and sickness insurance benefit; or (2) the duration of the claim if the claim is not for an accident and sickness insurance benefit.

"TO THE PERSON(S) RECEIVING RECORDS: <u>If this authorization pertains to alcohol or drug information,</u> please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient"

Legal guardians, natural and foster parents must sign for the release of mental health information contained within a minor's medical record, if the member is under 16 years of age, unless the minor was seen on his own accord for such services as sexually transmitted disease, birth control, pregnancy, behavioral health or substance abuse or alcohol abuse treatment, abortion or HIV status.

A physician may refuse access to the medical record by a patient only in cases of a psychiatric or psychological problem and access is contraindicated in the physician's medical judgment. In cases where access is denied the member, the physician may provide a summary of the contents of the record to the member upon request. The member may also request to have the record be reviewed by another provider for a second opinion.

The physician should make an entry in the member's record specifying why the information is not to be released.

Requests for the release of mental health record information to members must be coordinated through Health Plan's HIMS.

7.10 Health Information Facsimile Policy

Only certain materials may be transmitted via facsimile and specific procedures must be followed to safeguard the confidentiality of the information and preserve the integrity of the data. Only the information requested should be included in the transmission. Documentation of facsimile transmission should be incorporated into the permanent medical record of the member if faxed to a requestor other than Kaiser Permanente. A cover sheet with a confidentiality notice statement should be used for all facsimile transmissions.

Permitted Transmissions:

- Provider progress notes and consultation
- Diagnostic and laboratory studies
- Member authorization for release of information, including a statement indicating the faxed copy may be deemed as having the same force and effect as the original document

Prohibited Transmissions:

- Patient care documentation reflecting any of these conditions or diagnoses:
- Drug or alcohol abuse
- Mental health records
- HIV/AIDS related services
- Any document reflecting peer review, risk management or quality assurance activities
- Any other document marked “confidential”

8.0 CLAIMS

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 Medicaid and FAMIS 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.

Electronic First Remittance Advice Policy
Remittance Advice information will be provided electronically through your clearing house or via the secure Online Affiliate Provider Portal. To register for Electronic Remittance Advice (ERA) or Online Affiliate, please refer to Section 4.1. Providers are responsible for ensuring that they can access and retrieve electronic remittance information.

Payment Processing
Payments will be disbursed electronically though EFT or an approved digital payment method as outlined on the Community Provider Portal Website under the Claims section: Claims | Community Provider Portal | Kaiser Permanente. Providers must maintain an active electronic payment account on file. Paper checks will only be issued in rare instances where electronic payment is not feasible.

Failure to adhere to this electronic first policy may result in delays in claim processing or payment disbursement. Providers are encouraged to ensure their systems are compatible with the digital platforms to avoid any disruptions.

8.1 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 has been 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 / Submission
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 providers to submit electronic claim supporting documents and respond to requests for information (RFI) via Online Affiliate. If additional information is needed for claim processing, you will receive a request for information from Kaiser Permanente, which can be responded to via the Online Affiliate portal. Kaiser Permanente will request the supporting documentation by sending a request for information (RFI) letter via USPS.

You may also use Online Affiliate to view pending Kaiser Permanente Requests for Information (RFI). Online Affiliate now has an RFI tab that displays which claims we are requesting more information. You can submit the RFI documentation online with a few clicks of the mouse.

Navigate to the following link to access Online Affiliate and start using this feature today: www.kp.org/providers/mas.

To Initiate Electronic Claims Submissions
Providers 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 payer 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

To Initiate Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)
Kaiser Permanente collaborated with Citi Payment Exchange to provide a portal for enrolling in Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) through Citi Payment Exchange. Kaiser Permanente requests that all vendors pursuing EFT/ERA enrollment utilize the Payment Exchange portal for enrollment and changes to existing EFT/ERA. The portal is open 24 hours a day and 7 days a week for new enrollments or changes.

Signing up for EFT/ERA helps reduce turn-around-time for receipt of payments and remove overhead costs associated with handling paper correspondence.

Please note - each Kaiser Permanente region requires a separate enrollment.

Providers can create a new enrollment for EFT/ERA in the MAS region at the following link: Secure Portal (activation code R4GWM4 is required at login).

More information about ERA/EFT, including frequently asked questions, can be found on the Community Provider Portal Website under the Claims section: Claims | Community Provider Portal | Kaiser Permanente.

Paper Claim Forms
Original CMS-1500 version 02/12 must be used for all professional services and suppliers. Original CMS-1450 (UB04) must be used by all facilities (e.g., hospitals, UB-04 form). Original claim forms are those that are printed using Flint OCR Red J6983 (or exact match) ink per the national form standard approved by the NUCC.

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 claim features. The claims features 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)

Providers can register/sign up with Online Affiliate by visiting the Community Provider Portal at www.kp.org/providers/mas and selecting *Online Provider Tools* from *Provider Resources*.

PRSS Requirements for Claims Processing
The rendering, attending, prescribing, and billing provider NPIs reflected on all claims must be enrolled as participating providers with DMAS through PRSS. Kaiser Permanente will be unable to pay claims for covered services if these NPIs are not actively enrolled with PRSS on the date of service.

Providers can enroll in PRSS or update their information at https://virginia.hppcloud.com/. Any questions about enrollment can be directed to the PRSS Provider Enrollment Helpline at ☎ 804-270-5105 or emailed to vamedicaidproviderenrollment@gainwelltechnologies.com.

8.2 Timely Filing Requirements

Claims/bills for services provided to Health Plan members must be received within twelve months (365 calendar days) of the date of service to be considered for processing and payment.

8.3 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.
- 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 below).
- The original claim number for any corrected or voided claim submission (see Sections 8.9 Fully Funded: Claim Adjustments/Corrections (Retrospective or Otherwise), 5.21 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
CDT- 1 (The Code on Dental Procedures and Nomenclature)	Maintained and distributed by the American Dental Association
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 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 claims editing software product from Lyriq, ClaimsXten. ClaimsXten includes edit rules such as incidental, bundled and mutually exclusive 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.

Telehealth

Telehealth is the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions.Kaiser Permanente follows federal and state guidelines related to the specific services which may be eligible for telehealth.

Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions, and asynchronous store-and-forward transfers. Telehealth may be conducted using audio and video or audio only.

Reimbursements for telehealth continue to evolve, so it is important to reference resources on billing and reimbursement for Medicare, Medicaid, and private insurers. Kaiser Permanente will process claims for payment with the appropriate CPT-4 or HCPCS codes when coding for services delivered by telehealth, for both synchronous and asynchronous interactions. Providers must annotate the claim using the correct Place of Service, 02, and modifier, 95 and applicable billing modifiers.

8.4 Addiction and Recovery Treatment Services (ARTS) Billing

Covered ARTS services:

American Society of Addiction Medicine (ASAM) Level of Care	**ASAM Description**
4.0	Medically Managed Intensive Inpatient
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)

3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)
3.1	Clinically Managed Low-Intensity Residential Services
2.5	Partial Hospitalization Services
2.1	Intensive Outpatient Services
1.0	Outpatient Services
1.0	Opioid Treatment Program (OTP)
1.0	Office-Based Opioid Treatment (OBOT)
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)
n/a	Substance Use Case Management

Withdrawal Management services shall be covered when medically necessary as a component of the Medically Managed Inpatient Services (ASAM Level 4), Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7), Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5), Opioid Treatment Services (Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT), and Substance Use Outpatient Services (ASAM Level 1).

ARTS covered services, including procedure codes and reimbursement rates are posted online at:
http://www.dmas.virginia.gov/Content_atchs/bh/ARTS%20Reimbursement%20Structure%2012132016.pdf

There are specific billing methods for each ASAM Level of Care. Kaiser Permanente allows for the billing methods by ASAM Level of Care as defined by DMAS and detailed in the table below:

ASAM Level	**Billing Method**
0.5	CMS-1500
1.0	CMS-1500
2.1	CMS-1500 or UB
2.5	CMS-1500 or UB
3.1	CMS-1500
3.3	UB
3.5 Residential	UB
3.5 Inpatient	UB
3.7 Residential	UB
3.7 Inpatient	UB
4.0	UB
Opioid Treatment Program	CMS-1500
Office Based Opioid Treatment	CMS-1500
Substance Use Case Management	CMS-1500
Substance Use Care Coordination	CMS-1500

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. Duplicate claim lines are those claim lines that match previously submitted claim lines.

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.

8.5 Clinical Review

The National Clinical Review (NCR) team reviews facility and professional claims to ensure that providers comply with commonly accepted standards of coding and billing, that services rendered are appropriate and Medically Necessary, and that payment is made in accordance with any applicable provider contract and/or Provider Manual requirements. If we do not have enough information to adjudicate a claim, we will mail you a request for specific additional medical records. We may also request itemized statements.

Clinical Review Payment Determination Policy use sources of commonly accepted standards of coding and billing such as CMS guidelines and practice, National Uniform Billing Committee (NUBC), the National Correct Coding Initiative (NCCI), professional specialty organizations (e.g., American College of Surgeons, American Academy of Orthopaedic Surgeons), state and federal mandates, Kaiser Permanente medical policies, and other publicly available industry policies and standards, professional and academic journals and publications such as the American Medical Association Current Procedural Terminology (CPT).

If you would like more information about commonly accepted standards applied by Kaiser Permanente, please contact Kaiser Permanente Member Services at ☎ 800-777-7902.

Kaiser Permanente's claims payment policies are available on the Community Provider Portal website, at:
https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/provider-info#provider-manuals

Examples of these standards include, but are not limited to:

Edit	Description
Medical Necessity	A determination of medical necessity must adhere to the standard of care and always be made on a case-by-case basis that applies to the actual direct care and treatment of the patient.
Diagnosis Related Group (DRG)	Where payment is made on a DRG basis, we may conduct a review to confirm that the claim as billed is supported by the corresponding medical records
Trauma Activation	Trauma activation is only payable when all criteria based on CMS guidelines are met, including that the invoice contain a charge for critical care (CPT 99291/99292).

3-day Look Back	Payment of outpatient services provided on either the date of a beneficiary's admission or during the three calendar days immediately preceding the date of a beneficiary's inpatient admission, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services that are furnished to the beneficiary during the 3-day (or 1 day) payment window for cases which are reimbursed by a DRG.
Multiple Procedure Payment Reductions - Facility Cardiac and Ophthalmology	When services are performed at the same patient encounter, there is an overlap of the pre-procedure and post-procedure work. Kaiser Permanente will apply payment reductions as indicated by CMS.
Multiple Procedure Reimbursement	Multiple procedures and/or surgeries performed in the same operative session will be reimbursed at 100% of the rate indicated for the first procedure from the highest payment group. All other procedures will be paid at 50% or respective rates
Intra Operative Neuromonitoring (IONM)	IONM is utilized to minimize neurological morbidity from operative manipulations. Reimbursement for IONM will be based on Kaiser Permanente's Payment Determination Policy and IONM criteria.
30-day Re-admission	If a patient was discharged too early and was readmitted within 30 days with the same or related diagnosis in the same or related facility, the readmission will be reimbursed at 50% of the allowed amount.

8.6 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.

8.7 Preventable Emergency Room Visits and Hospital Readmissions

Virginia's Department of Medical Assistance Services (DMAS) issued a bulletin, *Reimbursement Reductions for Preventable Emergency Room Visits and Hospital Readmissions*, which communicates changes to the reimbursement structure of such claims. These changes were retroactively effective as of July 1, 2020.

The reimbursement changes:

- Reduce payment to 50% of the normal payment when patients are readmitted to the hospital for the same or similar diagnosis between six (6) and thirty (30) days of the discharge excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals or in any case where the patient was originally discharged against medical advice. Hospital readmission claims within dates of service six (6) to thirty (30) days from the date of discharge from the same facility and having the same or similar principal diagnosis code will be subject to a reimbursement reduction of 50% of the contracted rate. The initial discharge date for the first admission must have occurred on or after July 1, 2020. Principal diagnosis codes considered to be the same or similar contain the same first three digits. If a readmission claim is subject to a reimbursement reduction, the initial hospital admission claim will not be affected. Exclusions to this policy are planned readmissions, obstetrical readmissions, and readmissions where the patient discharged against medical advice.

The DMAS bulletin can be found on the Virginia Medicaid Web Portal at https://www.virginiamedicaid.dmas.virginia.gov.

8.8 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 echocardiogram (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:

- EKGs
- 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

8.9 Provider Payment Dispute Process

Participating providers, who disagree with a decision not to pay a claim in full or in part, may file a payment dispute request. Payment disputes must be filed within one hundred eighty (180) days of the date of the denial, partial payment and/or explanation of payment (EOP). The dispute process applies only to clean claims as outlined in Section 8.3 – Clean Claims. Claims disputes received outside of the allowable time frame will be considered untimely and denied. You may request a dispute online or by mail.

Online Requests

To submit requests electronically, please visit kp.org/providers/mas, and locate *Online Provider Tools* from the *Provider Resources* section. When you submit disputes online, you will receive an acknowledgement letter and resolution letter in your Online Affiliate in-basket.

For help with Online Affiliate enrollment or navigation, please submit a support case at https://kpnationalclaims.my.site.com/support/s/.

Mail Requests

Please provide the following information when requesting a dispute via the mail:

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

Rejection of Appeal

If the minimum required information is not received or is inaccurate/incorrect, KFHP will reject the dispute appeal without further review and notify the provider.

The provider notification of rejected appeal will be sent within 30 calendar days of receipt of the provider request.

The notification will inform the provider of the reason for rejection and specify the minimum required information that was missing or inaccurate/incorrect. The provider will be informed that they may file a new request that includes all minimum required information within the timeframe allowed to file a provider appeal.

Online
To submit electronically, please visit kp.org/providers/mas, and locate *Online Provider Tools* from the *Provider Resources* section.

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/.

Mail
A payment dispute request may also be submitted in writing and sent to:

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

Kaiser Permanente provides a decision on all provider disputes within thirty (30) days. In the event of an adverse appeal decision by Kaiser Permanente, you may submit the dispute/complaint to the Virginia Department of Medical Assistance Services (DMAS). You must first exhaust Kaiser Permanente's payment dispute process prior to submitting the dispute to DMAS. A written request to appeal the decision with DMAS should be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

A decision to uphold or reverse the decision made by Kaiser Permanente will be issued by DMAS.

Timely Filing Requirements and Appeal of Timely Filing
All claims must be received within the timeframes defined under Section 8.2 – Timely Filing Requirements.

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 frames outlined in Section 8.2. 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.
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 insurance 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.

8.10 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. Claims submitted without the original claim number will be rejected.

Paper: A corrected (CMS-1500) paper claim should include:

- Frequency Type Code 7 in box 22 (Resubmission Code)
- The original claim number in box 22 – Original Ref. No. field. Claims submitted without the original claim number will be rejected

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. Claims submitted without the original claim number will be rejected.

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Paper: A corrected UB-04 (CMS 1450) paper claim should include:

- Frequency Type Code "7" in the Type of Bill code in Field 4.
- The original claim number in box 64 Document Control Number field. Claims submitted without the original claim number will be rejected

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

8.11 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 applicable
- 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
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.

8.12 Coordination of Benefits

There are many instances in which a member's episode of care may be covered by more than one insurance carrier. Commercial plans will always be primary for those members enrolled in our Medicaid and FAMIS programs. Kaiser Permanente participating providers are responsible for determining the primary payor and for billing the appropriate party. In addition, providers are responsible for seeking authorization from another payor (if authorization is required) and/or responding to requests for information submitted by the other payor to make an authorization determination.

To determine the Primary Payor:

1. 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.
2. For a dependent child whose parents are married or are living together and 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.
3. 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:

Insurance carried by the:
- natural parent with custody pays first;
- step-parent with custody pays next;
- natural parent without custody pays next;
- step-parent without custody pays last.

If the parents have joint custody of the dependent child, then benefits are applied according to the birthday rule referenced above.

4. The commercial benefit plan is primary for Medicare beneficiaries who are covered by a Large Employer Group Health Plan (EGHP) as a result of their own or a family members' current employment status when the CMS Working Aged or Disabled Beneficiaries provisions apply.
5. Medicare is primary for Medicare beneficiaries who are covered by an Employer Group Health Plan (EGHP) whose subscriber is a retiree of the employer when the CMS Working Aged or Disabled Beneficiaries provisions apply.
6. Medicare is the primary payer for individuals eligible for or entitled to Medicare benefits based on ESRD after the duration of coordination period as stipulated under the Medicare Secondary Payer Provisions for End-Stage Renal Disease (ESRD) Beneficiaries.

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.

For people who have dual entitlement, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their state Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the state's payment limit.

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 Pary 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 TPL is 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.

9.0 UTILIZATION MANAGEMENT AND AUTHORIZATION

Overview
Kaiser Permanente utilization management (UM) activities include emergency care management, complex case management, skilled nursing facility case management, renal case management, facility-based utilization management, outpatient specialty referral management, home care including advanced urgent care at home, durable medical equipment, rehabilitative therapy referral management, and hospice care. Collectively, these areas implement the UM Program for medical, surgical, pediatric, maternal health, geriatric and behavioral health care.

Kaiser Permanente UM is supported in partnership with board certified UM physician reviewers who hold a current license to practice without restriction. These licensed physicians oversee UM decisions to ensure consistent and appropriate medical necessity determinations. Registered nurses (RN) perform concurrent review of members' admission to both participating and non-participating hospitals and facilities, including skilled nursing and acute rehabilitation facilities. RNs also review or process outpatient referrals, requests for durable medical equipment, home

care services, and coordinate emergency care and out-of-area admissions. Rehabilitative Therapy Utilization Coordinators (RTUC) are licensed physical therapists responsible for reviewing clinical appropriateness for members with functional and mobility needs who may require durable medical equipment, physical and occupational therapies.

9.1 Attestation Regarding Decision-Making and Compensation

Utilization Management 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.

UM Decision Making
Evidence-based, measurable 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, the opinions of subject matter experts certified in the specific field of medical practice are sought 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 nationally recognized or internally developed criteria, 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.

9.2 Utilization Management Criteria

Guide for Selecting UM Criteria - Virginia Medicaid and FAMIS

- MCG – formerly called Milliman Care Guideline

- ❖ InterQual-Acute Level of Care for Adult and Pediatric Transplants
- ❖ MCP: Medical Coverage Policies (Locally developed by Kaiser Permanente Mid-Atlantic States)
- ❖ Medicare NCD-LCD: Coverage Policies (National Coverage Determination & Local Coverage Determinations)
- ❖ ASAM-American Society of Addiction Medicine criteria
- ❖ Department of Medical Assistance Services (DMAS)
- ❖ * Use Approved 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

BEHAVIORAL HEALTH
2024 Utilization Management Criteria

Referral Service Type Approved criteria sets are used in order of hierarchy.	**Medicaid (VA Medicaid and FAMIS)**
Behavioral Health: Substance Use Disorder (SUD) specifically *All Levels (i.e., IP, OP, RTC, PHP, IOP)	ASAM
Behavioral Health: Inpatient	MCG
Behavioral Health: Outpatient *Excludes SUD	MCG
Behavioral Health: MHS Covered Services[4]	DMAS

Virginia Medicaid Behavioral Health and Substance Abuse Disorders
Addiction and Recovery Treatment Services (ARTS)

Traditional Behavioral Health (BH) Services	**UM Criteria**
Outpatient Therapy – Individual, Family, and Group - BH	MCG
Inpatient Hospital - BH	MCG

Mental Health Services (MHS)	**UM Criteria**
MH Case Management	Registration Only
MH Peer Support - Individual	DMAS SA after Initial Registration
MH Peer Support - Group	DMAS SA after Initial Registration
Mobile Crisis Response	DMAS Registration
23 Hour Crisis Stabilization	DMAS Registration
Community Stabilization	DMAS SA after Initial Registration
Residential Crisis Stabilization	DMAS after Initial Registration

Assertive Community Treatment	DMAS after Initial Registration
Intensive In-Home	DMAS Service Auth
Therapeutic Day Treatment for Children School Day	DMAS Service Auth
Therapeutic Day Treatment for Children After School	DMAS Service Auth
Therapeutic Day Treatment for Children Summer	DMAS Service Auth
Partial Hospital Program	DMAS Service Auth
Mental Health Skill Building Services	DMAS Service Auth
Psychosocial Rehab	DMAS Service Auth
Applied Behavior Analysis	DMAS Service Auth
Intensive Outpatient Program	DMAS Service Auth
Functional Family Therapy	DMAS Service Auth
Multisystemic Therapy	DMAS Service Auth

Addiction and Recovery Treatment Services (ARTS)	**UM Criteria**
ARTS 0.5 Early Intervention/SBIRT	No referral needed
ARTS 1.0 CD Outpatient Services	No referral needed
ARTS 2.1 CD Intensive Outpatient (IOP)	ASAM SA for BH IOP
ARTS 2.5 CD Partial Hospital Program (PHP)	ASAM SA for BH PHP
ARTS 3.1 Clinically Managed Low Intensity Residential	ASAM SA for BH RTC
ARTS 3.3 Clinically Managed Population Specific High Intensity Residential	ASAM SA for BH RTC
ARTS 3.5 Clinically Managed High Intensity Residential	ASAM SA for BH RTC
ARTS 3.7 Medically Monitored Intensive Inpatient	ASAM for Inpatient Service
ARTS 4.0 Medically Managed Intensive Inpatient	ASAM for Inpatient Service
CD OP Med Management - Addiction Medicine	No referral needed
OTP/OBAT Opioid Treatment Program/Preferred Office Based Addiction Treatment	No referral needed
MAT/MOUD - Medication Assisted Treatment/Medication for Opioid Use Disorder	No referral needed
CD Group Therapy	No referral needed
CD Case Management	Registration
ARTS Peer Support	ASAM Service Auth
ARTS Family Support	ASAM Service Auth
Care Coordination	No referral needed

Sources:

1. DMAS mandating use of ASAM criteria as of April 1, 2017 in concert with the implementation of ARTS benefits that were previously carved out

2. Federal EPSDT Medical Necessity Guidelines https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html
3. * Source: VA Medicaid Contract Cardinal Care and FAMIS
4. Department of Medical Assistance Services (DMAS) criteria for Mental Health Services (MHS), formerly called Community Mental Health Rehabilitative Services (CMHRS)

NON-BEHAVIORAL HEALTH
2024 Utilization Management Criteria

Referral Service Type Approved criteria sets are used in order of hierarchy	**Medicaid (VA Medicaid and FAMIS)**
Acute Rehabilitation (Inpatient)	MCG
Ambulance Services	KP-MAS MCP
Behavioral Health: Substance Use Disorder (SUD) specifically *All Levels (i.e., IP, OP, RTC, PHP, IOP)	ASAM 4/1/2017
Behavioral Health: Inpatient	MCG
Behavioral Health: Outpatient (Excludes SUD)	MCG
Behavioral Health: Partial Hospitalization (Excludes SUD)	MCG
Behavioral Health: Mental Health Services (MHS) Covered Services – Refer to UM Policy 11.1 VA Medicaid Referral Process (Page 5 – Table 2 for full list of services)	DMAS Criteria
Durable Medical Equipment (DME) and Supplies	KP-MAS MCP MCG NCD-LCD
Orthotics and Prosthetics	KP-MAS MCP MCG NCD-LCD
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	EPSDT
Home Health Services	MCG
Hospice (Inpatient and Outpatient)	MCG
Inpatient Services	MCG
Neonatal Care	MCG
Outpatient Services	KP-MAS MCP MCG
PT/OT/Speech	KP-MAS MCP MCG
Skilled Nursing Facility	MCG *For VA FAMIS only
Transplant Services	NTS IQ

Sources:
1. VA Medicaid Contract Cardinal Care and FAMIS

2. Federal EPSDT Medical Necessity Guidelines https://www.medicaid.gov/Medicaid-CHIP-Program-%20%20Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html

As a participating provider you can access our medical coverage policies online at https://cl.kp.org/mas/home.html.

Hard copies of UM criteria or guidelines used in UM review are also available by calling the Utilization Management Operations Center (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 https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/provider-info#newsletters.

9.3 Adopting New and Emerging Technology for UM Referral

Medical research identifies new drugs, procedures, and devices that can prevent, diagnose, treat and cure diseases. The Kaiser Permanente Technology Review and Implementation Committee (TRIC) collaborates with Kaiser Permanente's Interregional New Technologies Committee (INTC) to assist physicians and patients in determining whether a new or emerging procedure, treatment or device is medically necessary and appropriate. TRIC provides recommendation to the Health Plan of the potential adoption or exclusion of a new or emerging technology as a covered benefit based on indications for use, safety, effectiveness, and relevance of the technology for the health care delivery system.

If compelling scientific evidence is found indicating a new/emerging technology exceeds or is comparable to the safety and effectiveness of currently available drugs, procedures, or devices, the committee will recommend the new technology be implemented internally by Kaiser Permanente and/or authorize for coverage from external sources of care for its indication for use. This technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

9.4 Accessibility of Utilization Management

Accessibility is important to our members and providers. To ensure that members and practitioners can access the Kaiser Permanente UM Department to discuss UM issues, UM staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls to ☎ 800-810-4766. Staff are identified by name, title, and organization name when they initiate or return calls regarding UM issues.

Communication After Business Hours

Communications received after normal business hours are responded to the next business day. UM can receive inbound communications regarding UM issues after normal business hours through the following methods:

- Utilization Management Operations Center (UMOC) telephonic toll-free number - ☎ 800-810-4766 (Option 1 – Member; Option 2 – Provider)

- Fax sent to UMOC
- Kaiser Permanente Health Connect Online Affiliate
- Kaiser Permanente Health Connect (KPHC) messaging system – available to those providers linked to the KPHC system
- Direct email to a UM staff member

After business hours, members' first line of contact is through the Kaiser Permanente Member Services Department. Members are instructed to follow prompts to be directed to the Call Center. The phone number is listed on the member's ID card. Practitioners and providers may contact the UMOC toll-free number at ☎ 800-810-4766 (Option 2) and follow prompts to be directed to the Call Center (available 24 hours, 7 days a week).

The following table provides the specific UM hours of operations and main responsibilities:

2024 UTILIZATION MANAGEMENT HOURS OF OPERATION:

UM Department Section	Hours of Operation	Core Responsibilities
Emergency Care Management (ECM) – Clinical Call Center 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 Research Trials	Monday through Friday, except clinical 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	• Conduct pre-service review of specialty referrals (outpatient 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 VHCP: 8:00 A.M. to 12:30 A.M. Seven days per week, including 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. Excluding weekends and holidays	Coordinates care to slow progression of kidney disease, facilitates early 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/ 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 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.

9.5 Behavioral Health Services

For information on referrals and case management for behavioral health services, please see Section 12.0 – Behavioral Health Services

9.6 Early and Periodic Screening, Diagnosis, and Treatment Program for Medicaid Members

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a comprehensive and preventive child health program for Medicaid members under the age of 21. EPSDT includes medically necessary periodic screenings; and vision, dental, and hearing services. EPSDT includes services needed to correct or ameliorate a medical condition. Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. Refer to Section 6.2 regarding provider responsibilities for providing EPSDT services.

Dental Screenings
An oral inspection must be performed as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

Participating PCPs or other screening provider must make an initial direct referral to a dentist when the child received his or her six (6) month screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three (3)

or older unless it is known and documented that the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, referral must be made for needed dental services.

Immunizations/Vaccinations
Immunizations will be in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the conduct of the EPSDT screening and that members are not inappropriately referred to other providers for immunizations. PCPs who administer childhood immunizations should enroll in the Virginia Vaccines for Children Program (VVFC), administered by the Virginia Department of Health (VDH). Providers may enroll at http://www.vdh.virginia.gov/immunization/vvfc/vfcenroll/.

Kaiser Permanente and its participating providers shall participate in the statewide immunization registry database. Kaiser Permanente is required to submit its immunization data to the Virginia Immunization Registry on a monthly basis.

Participating primary care pediatricians or specialists will arrange for and/or refer patients for any medically necessary services to correct, maintain or ameliorate the child's medical condition. Services will include all those covered under EPSDT per the Virginia Medicaid Program.

Participating primary care pediatricians or specialists are required to adhere to standards established by the American Academy of Pediatrics (AAP) such as the EPSDT Periodicity Chart for well child visits for members under the age of 21. For the periodicity schedule, please go to http://brightfutures.aap.org

All care will be documented in members' medical records. Participating providers must submit claims for services for EPSDT with the appropriate modifiers.

Secondary Review
Members and/or parents/guardians of a Medicaid child will have the right to receive a secondary review under the Centers for Medicare and Medicaid (CMS) federally mandated EPSDT criteria/guidelines

- Referrals for EPSDT services will be reviewed by a secondary physician reviewer using the federally mandated EPSDT criteria/guidelines.
- When a secondary review is needed, the primary care pediatrician or specialist will fax ☎ 800-660-2019 the Uniform Referral form or call ☎ 800-810-4766 UMOC.
- No service can be denied to a child under EPSDT as non-covered unless specifically noted as a carved-out service under the Medicaid contract and/or referenced in the federally mandated EPSDT criteria/guidelines.

Kaiser Permanente will report EPSDT data for Health Plan members to DMAS as per contract requirements to ensure compliance with the Virginia DMAS and the CMS.

Referral Requests

Please reference **Attachment A** at the end of the Utilization Management Section of this manual for the Uniform Referral Consultation Form.

Referral Request for Non-Participating providers

A referral to a non-participating provider may be appropriate if the member is diagnosed with a condition or disease that requires specialized medical care and when:

- Kaiser Permanente does not have in its network a specialist with the professional training and expertise to treat the condition or disease; or
- Kaiser Permanente cannot provide timely access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

9.7 Participating Specialist Responsibilities

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. Failure to secure referral approval may result in a claims payment denial and/or reduction in reimbursement for otherwise covered services. Under such circumstances, the member may not be balanced billed.

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.

9.8 Initial and Ongoing Visits

During the initial office visit, a participating specialist may perform the specific services indicated on the referral. The participating provider should ensure that services are:

Rendered in accordance with the member's Virginia Medicaid and FAMIS handbook performed as listed on the referral.

Each approved referral is valid only until the identified expiration date as noted on the Kaiser Permanente Referral Summary Report. Only one (1) visit is approved per referral, unless otherwise indicated on the authorized Referral Summary Report. We encourage our referring participating PCPs and specialists to use their clinical judgment and discretion in anticipating a reasonable number of visits required for a particular consultation with a participating specialist.

9.9 Requesting for additional visits, care, or consultations

Should a member require additional visits or care with the treating specialist or other provider, the specialist must submit a new referral request by submitting a Uniform Consultation Referral Form (URF) to the UMOC by fax at ☎ 800-660-2019 before the next visit and/or additional care is provided. The request should include any required and/or supporting clinical documentation.

> In the event a member presents to your office for care without an approved referral, please, call the UMOC at ☎ 800-810-4766. Participating providers with access to Online Affiliate may check the status and/or retrieve a copy of

an approved referral in the Online Affiliate. Alternatively, the status of a referral may be checked by going to www.kp.org/providers/mas.

9.10 Second Opinion

Members have the right to seek a second medical opinion for covered services at no cost. Access to a second opinion is available to members to diagnose an illness and/or to confirm a treatment plan of care. If a second opinion is indicated, the member's PCP should initiate a new referral request by completing a URF and fax it to the UMOC at ☎ 800-660-2019.

9.11 Family Planning

Members have the right to seek family planning service without pre-authorization or a referral. For individuals of childbearing age this includes, but is not limited to, family planning supplies, drugs and devices that delay or prevent pregnancy (including the Food and Drug Administration (FDA)-approved contraceptives) or family planning health education.

9.12 Home Health Care

Cardinal Care members have coverage for home health following preauthorization for nursing services, rehabilitation therapies, and home health aide services when it is medically necessary, appropriate, and preauthorized. (See Sections 10.21-10.22)

To send a referral for Home Health Care, please fax a URF to the UMOC at fax ☎ 800-660-2019.

9.13 Durable Medical Equipment (DME)

Kaiser Permanente covers medically necessary DME, supplies, and appliances for rental and purchase. DME services must be preauthorized by Kaiser Permanente.

Medically necessary DME and supplies must be:

- Ordered by the practitioner
- Reasonable and medically necessary part of the member's treatment plan
- Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational)
- Furnished at a safe, effective, and cost-effective level
- Suitable for use in the member's home environment

In addition, DME and supplies must not be furnished solely for the convenience of the family, attending practitioner, or other practitioner or supplier.

To request a referral for DME, please fax a complete URF with required documentation to the UMOC at ☎ 800-660-2019.

9.14 Inpatient, Outpatient, and Rehabilitative Therapy: Physical, Occupational, and Speech

Authorization for physical, occupational, speech therapies (PT/OT/ST) and rehabilitative services are based upon medical necessity for both acute and non-acute conditions.

To request a referral for PT/OT/ST, please fax a URF to the UMOC at ☎ 855-414-1698.

9.15 Emergency, Urgent, and Post Stabilization Care

Emergency, Urgent, and Post Stabilization Care

Emergency Medicine physicians are responsible for providing evaluation, triage, and telephone services 24 hours a day, 7 days a week. If the member must be directed to a hospital Emergency Department (ED), the Kaiser Permanente advice nurse instructs the member to go to the ED of the nearest hospital. The advice nurse coordinates the care with the Emergency Care Providers and sends a note to the member's PCP to inform that the patient has been referred for emergency care.

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. The ECM Department can be reached by phone at ☎ 844-552-0009 or toll-free at ☎ 800-810-4766.

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.

Post Stabilization Care

The ultimate goal of the Kaiser Permanente UM Program is to determine what resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner. To that goal, efforts will be made to transfer members to a participating hospital where services can be delivered by Mid-Atlantic Permanente Medical Group (MAPMG) doctors and/or participating providers. After it has been determined that a member is medically stable, Kaiser Permanente will make arrangements for safe transport to a Kaiser Permanente participating facility where a MAPMG doctor and/or participating provider will receive the member and resume care.

Post stabilization covers all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred. Post-stabilization coverage includes services, subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized.

Notification of Emergency Department Visits
Kaiser Permanente members may be directed and/or self-direct to a participating hospital or facility for emergency care. While prior authorization or referral approval is not required for reimbursement of covered emergency care services provided to a member, we request notification within 24 hours when a member presents to the ED for urgent and/or emergent care services. This notification will ensure that our members are being given the best coordination and follow-up care possible.

There are two (2) quick and convenient options for providing notification to Kaiser Permanente:

Option 1: Fax Option: Complete the ED Visit Notification Form and fax to the UMOC at ☎ 855-414-2634.
A copy of the ED Visit Notification Form can be located at the end of this Section.

Option 2: Contact Emergency Care Management (ECM) at ☎ 800-810-4766. Follow the prompts to report the ED visit.

All emergency room notifications should include the following information:

- Member name
- Member medical record number (MRN) – social security number (SSN) if MRN is not available
- Name of hospital or facility
- Complaint/Diagnosis
- Date of service

9.16 Self-Referred Services

Virginia Medicaid and FAMIS members are entitled to direct access to the following services through participating providers without securing a referral from their PCP:

- Routine and preventive OB/GYN services
- Initial consultation for outpatient behavioral health services (treatment of mental illness, emotional disorders, and substance abuse) when provided by a Plan Provider
- Vision care services (Excludes services from an ophthalmologist)
- Family planning services (From any licensed provider)

9.17 Direct Access for Members with Special Health Care Needs

Direct Access, using standing referrals, to a specialist for members with special health care needs
Members with special health care needs are allowed direct access through a standing referral to specialists if they have a chronic, complex, or serious medical condition. The PCP must consult with the specialist and develop a treatment plan for a certain number of visits, allowing the member to be seen without additional referrals. The PCP must obtain authorization for the specialist referral beforehand using guidelines when creating a treatment plan for the member.

9.18 Referral Management Procedures

Some services may not require pre-authorization but will require a copy of the referral submitted to Health Plan to ensure proper claims payment.

How to submit a copy of your referral when pre-authorization/authorization is not required

Step 1: Verify that the specialist named in the referral is a participating provider
Step 2: Verify that the requested procedure/service does not require authorization
Step 3: Fax
Fax a copy of the Uniform Referral or the referral request to the UMOC via Fax ☎ 800-660-2019

-OR-

MAIL
Mail a copy of the URF 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 his/her appointment with the participating specialist

To submit a referral approval for specialist care when pre-authorization/ authorization is required follow Step 1-3 above, and then perform the following:

All required clinical documentation should accompany the referral request. This includes lab, x-ray results, or pertinent medical records, and office fax numbers. *Please note: incomplete referrals will be faxed back to the participating or PCP/specialist office with request to include required information.

9.19 Referring Members for Radiology Services

Kaiser Permanente provides members with access to radiology and imaging services at our Medical Centers, 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 ☎ 800-777-7904 to secure an appointment with a representative.

9.20 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 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
- ICD-10 codes

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

9.21 List of Services Which Require Prior Authorization (Service Authorization)

The following services require prior authorization (service authorization) from Kaiser Permanente. Prior authorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. Please note that this is periodically updated and may not be an all-inclusive list. Questions should be directed to the UMOC at 1-800-810-4766, follow the prompts.

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 Hospice Admissions
9. Inpatient Behavioral Health Admissions
10. Outpatient Behavioral Health Admissions*
    *Partial Hospitalization

ELECTIVE SERVICES

1. Abortions, Elective/Therapeutic
2. Acupuncture
3. Anesthesia for Oral Surgery/Dental
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. Dental Services Covered Under Medical Benefit
14. Durable Medical Equipment (DME)
    14.1. Assistive Technologies
15. Gastric Bypass Surgery, Gastroplasty
16. Home Health Care Services (Including Hospice)
17. Infertility Assessment and Treatment
18. Infusion Therapy and Injectables (Home IV, Excluding Allergy Injections)
19. Intensity Modulated Radiation Therapy (IMRT) – Modulated Therapy
20. Interventional Radiology
21. Investigational/Experimental Services
22. Magnetic Resonance Imaging (MRI)
23. Narrow Beam Radiation Therapy Modalities
24. Cyberknife
25. Gamma Knife
26. Stereotactic Radiosurgery
27. Nasal Surgery (Rhinoplasty or Septoplasty)
28. Non-participating provider Requests
29. Nuclear Medicine
30. Obstructive Sleep Apnea Treatment including Sleep Studies
31. Oral Surgery
32. Orthognatic Surgery
33. Outpatient Surgery – All Hospital Settings/Ambulatory Surgery Centers
34. Continued Outpatient Treatment for Behavioral Health condition and Substance-Use Disorder
35. Pain Management Services
36. Penile Implants
37. Positron Emission Tomography (PET) Scan
38. Podiatry Services
39. Post Traumatic (Accidental) Dental Services
40. Prosthetics/Braces/Orthotics/Appliances
41. Prostate Biopsies - Ambulatory Surgery Center or Outpatient Hospital Surgery Setting
42. Radiation Oncology
43. Radiology Services (all radiology and imaging services, including diagnostic plain films)
    43.1. Imaging studies requiring fiducial markers
44. Rehabilitation Therapies
    44.1. Cardiac Rehabilitation
    44.2. Occupational Therapy
    44.3. Physical Therapy
    44.4. Pulmonary Rehabilitation Therapy
    44.5. Speech Therapy
    44.6. Vestibular Rehabilitation
45. Scar Revision
46. Sclerotherapy and Vein Stripping Procedures
47. Screening Colonoscopy – Consultations
48. Uvulopalatopharyngoplasty (UPPP)
49. Social Work Services
50. Temporo Mandibular Joint Evaluation and Treatment
51. Transplant Services – Solid Organ and Bone Marrow

*Refer to Section 12.2

9.22 Services Covered by DMAS

The following checked services are provided by DMAS, not Kaiser Permanente. We will work with you to help coordinate these services. In some cases, for DMAS covered services members may still be entitled to Health Plan transportation coverage.

Service	VA Medicaid	VA FAMIS	Contact
Abortion services - when determined by DMAS to comply with federal and state laws and rules (only if a doctor certifies in writing that there is a substantial danger to the mother's life)	✓	✓	Provider Helpline ☎ 800-552-8627
Routine dental services	✓	✓	Smiles for Children ☎ 888-912-3456
School health services, which is any service given on school property including, but not limited to, physical therapy, occupational therapy, speech language therapy, psychological and psychiatric services, private duty nursing services, medical assessments, audiology services, personal care services, and services that are part of an individualized education program. Children may also receive covered EPSDT services while they are at school (see "Section 5, Your Benefits").	✓	✓	Provider Helpline ☎ 800-552-8627
Early intervention services through the Infant and Toddler Connection of Virginia (children under the age of three years old). PCP must sign an Individualized Family Service Plan to get these services.	✓	✓	Infant and Toddler Connection ☎ 804-786-3710
Certain behavioral health services including, but not limited to, the following: Mental health day treatment/Partial hospitalization services for adults Community behavioral health rehabilitative services Intensive-in home services for children and adolescents Substance abuse crisis intervention Residential Treatment Facility Services (RTF) Level C Therapeutic day treatment Therapeutic Foster Care (TFC) case management Psychosocial rehabilitation Mental health case management	✓	Some services have limited DMAS coverage or are not a covered benefit for FAMIS members	Provider Helpline ☎ 800-552-8627
Assisted living services	✓	Not a Covered Benefit	

Service	VA Medicaid	VA FAMIS	Contact
Case management services for members with auxiliary grants, for the elderly, mentally ill adults and emotionally disturbed children, youth at risk of serious emotional disturbance individuals with mental retardation and related conditions participating in home and community-based care waivers; the elderly; and recipients of auxiliary grants Case management services and private duty nursing services through Home and Community-based Care Services waivers (AIDS, Individual and Family Developmental Disabilities Support, Mental Retardation, Elderly or Disabled Consumer Direction, Day Support or Alzheimer's) and related transportation	✓	Not a Covered Benefit	Provider Helpline ☎ 800-552-8627
Residential day and substance abuse treatment for pregnant women	✓	Not a Covered Benefit	Provider Helpline ☎ 800-552-8627
Personal care services for EPSDT members if under the age of 21 years - PCP must complete an assessment to qualify for personal care services. DMAS will notify PCP if request for personal care services is approved.	✓	Not a Covered Benefit	Provider Helpline ☎ 800-552-8627
Specialized infant formula for children and medical foods for individuals under 21 years old	✓	✓	Provider Helpline ☎ 800-552-8627
Lead contamination investigations at home *Health plan will cover blood lead testing as part of well-baby/well-child care*	✓	✓	Contact Local Health Department
Testing of fluoridation levels in water	✓	✓	Contact Local Health Department
Hospice	✓	Coordinate with Health Plan	Coordinate with Health Plan
Skilled Nursing	✓	Coordinate with Health Plan	Coordinate with Health Plan

9.23 Services not Covered by Kaiser Permanente or DMAS

Certain services and supplies may not be covered and/or are specifically excluded from Health Plan's contract with DMAS. Both the Virginia Medicaid and FAMIS programs have specific exclusions. Participating providers should verify eligibility and benefits prior to rendering services to members. Contact the DMAS Provider Helpline ☎ 800-552-8627 for questions regarding services covered by DMAS.

9.24 Referral Process: Timeframes for Decision-Making and Notification

Kaiser Permanente Mid-Atlantic States adheres to the following timeline requirements in decision making and notification (verbal and/or written):

Referrals are processed based on the urgency of the referral request and according to designated time frames as described in the tables below.

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 C.F.R. 438.210. (d)(1)(ii)

Determination Timeframe	Written Notification
Within 72 hours of receipt of request	Within 72 hours of receipt of request

Urgent Decisions - For cases in which a provider indicates, or Kaiser Permanente determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Kaiser Permanente must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

Kaiser Permanente may extend the 72 hour turnaround time frame by up to fourteen (14) calendar days if the member requests an extension or Kaiser Permanente justifies to DMAS that the extension is in the member's interest.

Table C: Timeliness Guidelines for Non-Urgent (Standard/Routine) Pre-Service Review and Notification C.F.R. 438.210. (d)(1)(ii)

Determination Timeframe	Written Notification
Within fourteen (14) calendar days of receipt of request	Within fourteen (14) calendar days of receipt of request

Standard Authorization Decisions - Kaiser Permanente shall provide the decision notice as expeditiously as the member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

- the member or the provider requests extension; or
- Kaiser Permanente justifies to DMAS upon request that the need for additional information is in the member's interest.

Standard authorization decisions that extend the review timeframe in excess of the standard fourteen (14) calendar days, Kaiser Permanente must:

- mail the written notice no later than the 14th day to the member, describing the reason for the decision to extend the timeframe and informing the member of the right to file a grievance if he or she disagrees with that decision

- issue and carry out the review for the final determination as expeditiously as the member's health condition requires and shall not exceed the date on which the extension expires
- For standard authorization extension decisions not reached within the required timeframes (which constitutes a denial and is thus an adverse action), the notice must be issued on the date that the established timeframes for review expires.

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

Determination Timeframe	Written Notification
Within 30 calendar days of receipt of request	Within 30 working days of receipt of request

Sources:

- *National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans, UM Standards 4, 5, 6, and 7*
- *Commonwealth of Virginia Department of Medical Assistance Services - Cardinal Care Contract*
- *UM Policy 18.1 Virginia Medicaid and FAMIS Determination of Adverse Decisions and Reconsiderations*

9.25 Denials and Appeals Process

In the event, a referral and/or authorization request is denied, you have the right to speak with a UM Physician to discuss the decision or by calling ☎ 888-989-1144 or ☎ 703-359-7460. You may request to speak with the UM physician on-call within twenty-four (24) hours of the verbal notification of an adverse decision.

As a participating provider, you have the right to file an appeal on behalf of a member and/or act as the member's authorized representative should you or the member disagree with Health Plan's decision not to authorize medical services or pay a claim for health care services. You will not be penalized in any way by Kaiser Permanente for assisting a member with filing an appeal and/or acting on a member's behalf.
An appeal should include the following information:

- Name and identification number of the member involved
- Name of member's PCP
- Service that was denied authorization
- Name of initial Kaiser Permanente reviewing physician, if known

An expedited appeal can be requested and is available for medically urgent situations where a longer period of time could endanger the life or health of the member.

To request an expedited appeal a member or provider should contact our member Services Department at:

☎ 855-249-5019, toll-free
☎ 866-513-0008, TTY
Or by fax ☎ 301-816-6192

Our Member Services will notify the member or participating provider as expeditiously as the medical condition requires, but no more than seventy-two (72) hours after receipt of the request. Written confirmation of the disposition of the expedited appeal is sent within three (3) calendar

days after the decision has been verbally communicated. Timeframes may be extended by up to 14 calendar days upon your request.

Kaiser Permanente will notify DMAS of expedited appeal determination within forty-eight (48) hours of the decision.

Virginia Medicaid members may file an appeal at any time once an initial determination has been made by Kaiser Permanente. It is not necessary for Virginia Medicaid members to exhaust Kaiser Permanente's appeals process prior to filing an appeal to DMAS.

Virginia Medicaid
Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Appeals can be filed at any time after decision is made by Kaiser Permanente.

A decision to uphold or reverse a decision made by Kaiser Permanente will be issued by DMAS in accordance with 12 VAC 30-20-500 et. seq.

FAMIS members must exhaust Kaiser Permanente's internal appeal process first prior to submitting a written request to DMAS for an external review.

FAMIS
FAMIS External Review
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
Fax ☎ 804-786-5799

Appeal must be filed within 30 calendar days after appeal decision is first made by Kaiser Permanente.

A decision to uphold or reverse a decision made by Kaiser Permanente will be made in accordance with 12 VAC 30-141-40.

9.26 Hospital & Facility Admissions

Participating hospitals are responsible for notifying Kaiser Permanente of all inpatient, observation, and emergency admissions **within 24 hours of the admission**. Notification must be made to the UM department via phone: ☎ 800-810-4766, 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 or observation 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.

Non-Emergency & Elective Admissions
All non-emergent and elective admissions require preauthorization. The participating PCP should initiate the referral form for authorization or contact the UMOC at ☎ 800-810-4766. An authorization number will be generated for all approved admissions. The participating hospital or facility is responsible for notifying Kaiser Permanente for all non-urgent and elective admissions within 24 hours of the admission or on the next business day.

Concurrent Review Process
The Kaiser Permanente UM Department performs concurrent review of all hospital and/or facility admissions. The participating hospital and/or facility's Utilization Review department is responsible for providing clinical information to Kaiser Permanente UM nurses by fax, or electronic medical record (EMR) access. BALT hospitals should fax concurrent clinical to ☎ 855-717-1702, DCSM ☎ 855-414-1704, and NOVA ☎ 855-414-1705. **Failure to provide the clinical information within the required timeframe may result in medical necessity denial, as medical necessity cannot be determined without clinical information.** The participating Hospital cannot hold the member financially responsible for the denial. The UM nurse may contact the attending physician if further clarification of the member's clinical status and treatment plan is necessary. The UM nurse uses Kaiser Permanente approved criteria to determine medical necessity for acute hospital care. If the clinical information meets Kaiser Permanente's medical necessity criteria, the days/service will be approved. If the clinical information does not meet medical necessity criteria, the case will be referred to the UM Physician. Once the UM Physician reviews the case, the UM nurse will notify the attending physician and the facility of the outcome of the review. The attending physician may request an appeal of any adverse decision. The participating hospital cannot hold the member financially responsible for day(s) that are not deemed medically necessary.

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.

9.27 Transition Care Management

Transition care management begins when the eligible Medicaid member is admitted to the hospital, acute rehabilitation or 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 the Members safe transition between care venues while preventing readmissions and medication errors. Our transitions care management covers: transitions from hospital to home and transitions from skilled nursing facility to home.

The Patient Care Coordinators or hospital case managers in designated KP-MAS facilities 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: (1) early assessment and needs identification/anticipation; (2) development of a realistic and sound plan of care based on clinical evidence; (3) establishing open communication with the Member and/or authorized representative and the health care team; and (4) coordination with all disciplines involved (5) ensuring members have a timely follow-up appointment with their primary care physician (6) ensuring post-acute services are delivered as ordered and (7) 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 member'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 member.

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

- Availability of skilled nursing facilities, sub-acute care facilities, home care, DME, palliative care or timely access to Kaiser Permanente's internal services to support the patient after hospital discharge where needed.
- Coverage of benefits for SNF, sub-acute care facilities, home care, DME, or services available within the Kaiser Permanente Medical Centers.
- Local hospitals' ability to provide recommended services.

9.28 Skilled Nursing Facility (SNF)

Virginia FAMIS (only) members needing SNF placement may originate from acute care facilities, emergency departments, Kaiser Permanente medical centers, other health care facilities or his/her home.

We cover medically necessary skilled nursing services based on MCG® criteria for Virginia FAMIS members.

Non-FAMIS members who need SNF services receive their benefit coverage from Sentara and not Kaiser Permanente.

9.29 Hospice Care

We cover medically necessary services provided to terminally ill individuals in the home, outpatient, and inpatient settings by agencies certified by Medicare as hospice agencies to FAMIS members.

Hospice services are provided if the following criteria are met:

- Must be prescribed by a provider licensed, furnished and billed by a licensed hospice, and medically necessary.
- Member has a life expectancy of six (6) months or less, if the disease runs its normal course.

Non-FAMIS members who need SNF services receive their benefit coverage from Sentara and not Kaiser Permanente.

9.30 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

- MRI, 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 bacillus (AFBs)
- Pathology

Operating Room (OR)

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

Ancillary Service

- PT/OT/Speech 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

Ancillary Service

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

- Radiology delays (test performed/read/results available)

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

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

Physician Delays

Hospital
- Delays in specialty consultations
- Delay in discharge order for alternative placement
- Delays in scheduling procedures in the Operating Room or Catheterization Lab
- Member not seen by attending physician or not seen in a timely manner

9.31 Daily Hospital Censuses

Kaiser Permanente requires participating hospitals to submit daily censuses for the following:
- Daily newborn census
- Daily emergency department visits converted to observation
- Daily current inpatient census

9.32 Skilled Nursing Facility Transitions

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™

9.33 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 program criteria.

9.34 Transplant Services

KPMAS 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 Coordination. Please call the National Transplant Services (NTS) Department at ☎ 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.

9.35 Pre-Natal and Infant Program Overview

At Kaiser Permanente, we provide a comprehensive prenatal and postnatal program to support positive outcomes for members and babies. Our program is designed to support maximum health of members to help reduce infant mortality and morbidity. To support members throughout pregnancy and after the birth of their babies we focus on all their needs including medical and non-medical that impact their well-being and that of their babies.

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 and non-contracted facilities, please send transfer requests that require prior authorization directly to ProgenyHealth by secure fax 877-485-4872 or by phone 1-888-832-2006 prior to the transfer occurring. For adverse benefit determinations, a Peer-to-Peer may be requested with ProgenyHealth by calling 1-888-832-2006 and following the prompts for the Physician Advisor Line. ProgenyHealth will send notification of determinations via secure fax and provide verbal notification as applicable.

Special Needs
For members who have special needs during pregnancy Kaiser Permanente has the Comprehensive Perinatal Program. This program is designed to provide case management support to members experiencing high risk pregnancies due to medical and/or psychosocial issues. The program also aims to improve a member's chance of having a healthy, full-term infant and to decrease neonatal intensive care unit (NICU) admissions. Based on the initial and on-going assessments, providers can refer a member to the program at any time during pregnancy. Nurse case managers will work with the member to develop a care plan to maximize their chances of having a healthy baby. Nurse case managers coordinate needed medical and non-medical assistance and provide on-going follow-up to members in the program.

The Comprehensive Perinatal Program consists of:

Early Start: Provides support for pregnant and postpartum members experiencing issues of substance abuse (including alcohol and tobacco)

Perinatal Service Center: Telephonically manages pregnant members who are experiencing specific medical issues (i.e. gestational diabetes, gestational hypertension and preterm labor)

High-Risk Perinatal Case Management: High-risk perinatal case management provides support throughout the member's pregnancy with the end goal of a healthy baby and parent. This team consists of nurse and social work case managers that assist pregnant patients at a high risk of pregnancy-related complications and prenatal hospitalizations due to co-morbidities or social issues. These case managers work closely with OB/GYN providers, Perinatal Services Center nurses, care managers for gestational diabetes, hypertension, and preterm labor, Local Health Departments (LHDs), other outside resources, families, and caregivers to provide guidance in assessment, intervention and documentation of key actions needed or taken to close care gaps. The case managers follow the parent and baby up to the first 8 weeks postpartum. This team also coordinates with pediatric case managers to transition care of the newborn to other programs or services as needed.

High–Risk Case Management
Pediatric case management (birth to age 18, with the exception as noted above) is comprised of a team of specialized pediatric nurse and social work case managers who provide a comprehensive approach to care coordination throughout the care continuum inclusive of identifying social determinants of health needs, navigating the Kaiser Permanente delivery system, coordinating care for members with Autism (ABA), creating individualized care plans, addressing care gaps, and monitoring progress towards goals. The pediatric case managers assist primary and specialty care teams in providing the best care coordination to ensure optimal health goals are achieved. Members and their families are supported in addressing needs related to transportation, home care services, financial concerns, the acquisition of durable medical equipment, medication review and clinical education. The case manager may assist with facilitating access to the state "Early Intervention Benefit"/ "Habilitative Benefit" and the state "Early and Periodic Screening, Diagnosis, and Treatment Services" (EPSDT Federal Medicaid requirements).

Attachment A

Uniform Consultation Referral Form

Date of Referral:		**Carrier Information:**
Patient Information		Name: Kaiser Permanente
Name: (Last First, MI)		Address:
Date of Birth: (MM/DD/YY)	Phone:	Phone Number: 1-800-810-4766
Kaiser Member #:		
Site #:		Facsimile/Data #: 1-800-660-2019

Primary or Requesting Provider

Name: (Last, First, MI)	Specialty:	
Institution/Group:	Provider ID#: 1	Provider ID#: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number:	Facsimile/ Data Number:	

Consultant/Facility Provider

Name: (Last, First, MI)	Specialty:	
Institution/Group:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone #: 703-698-7100	Facsimile/ Data #: 703-207-9457	

Referral Information

Reason for Referral:		
Brief History, Diagnosis, Test Results:		
Services Desired: Provide Care as Indicated: ☐ Initial Consultation Only: ☐ Diagnostic Test: (specify) _____ ☐ Consultation with Specific Procedures: (specify) _____ ☐ Specific Treatment: ☐ Global OB Care & Delivery ☐ Other: (Explain)		Place of Service: ☐ Office ☐ Outpatient Medical/Surgical Center * ☐ Radiology ☐ Laboratory ☐ Inpatient Hospital * ☐ Extended Care Facility * ☐ Other: (Explain) * (Specific facility must be named.)
Number of Visits: (If blank, 1 visit is assumed)	Authorization #: (If required)	Referral is Valid Until: (Date) _____ (See Carrier Instruction)
Signature: (Individual completing form)	**Authorizing Signature:** (If required)	

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

Attachment B

*Utilization Management Operations Center Contracted Facility*_____
Emergency Department Visit Notification Form
Fax Number: 1-855-414-2634
Name/Department: _____
Telephone Number: 301-879-6143 or 1-800-810-4766
Date: _____Fax Number: _____
Telephone Number: _____

Patient's Name	**KP Medical Record #**	**Date of Birth**	**Date of Service**	**Complaint/Diagnosis**	**To Be Completed by KPMAS ECM Staff**	
					Visit entered? (Y or N)	Message sent to health care team? (Y or N)

To Be Completed by Kaiser Permanente Date Received _____ ECM Rep_____	If visit or message was not completed above, please explain below:

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10.0 QUALITY RESOURCE MANAGEMENT

10.1 Quality Resource Management Program

The Kaiser Permanente Quality of Care and Service Program (Program) applies to the patient care delivery system of Kaiser Permanente. The Program addresses all medical, behavioral health and service activities provided to internal and external customers, Participating providers and enrollees. Kaiser Permanente doctors can get a copy of our quality report. It is a summary of our quality goals, objectives, and activities. It explains how we improve care and service to our members, providers, and the community. For a free copy of this year's report, please call Member Service at ☎ 855-249-5019, ☎ 866-513-0008 TTY. You can also see the report online. Just visit our website at www.kaiserpermanente.org.

Kaiser Permanente
Member Services Unit
4000 Garden City Drive
Hyattsville, MD 20785

Toll free: ☎ 855-249-5019
TDD/TYY: ☎ 866-513-0008

10.2 Clinical Practice Guidelines

Clinical practice guidelines are systematically designed tools to assist participating providers 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 a participating provider in any particular set of circumstances for each patient.

Kaiser Permanente 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 participating providers at www.kp.org/providers/mas under Provider Information and Clinical Library.

10.3 Contracted Provider Participation

Participating providers are required through their Kaiser Permanente contract to comply with the Kaiser Permanente Mid-Atlantic States (KPMAS) Quality Improvement (QI) Program. Mid-Atlantic Permanente Medical Group (MAPMG) and participating providers agree to provide KPMAS 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 QI Committees. Participating providers are also encouraged to provide feedback to Quality 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.

10.4 Access and Availability Standards

Kaiser Permanente has established standards for availability of participating providers. These performance standards are reviewed no less than annually. Kaiser Permanente has established mechanisms to incorporate ongoing review of both availability and performance measures. This process for measurement of participating provider availability identifies opportunities for improvement and implementation of appropriate interventions to ensure participating provider availability to the Kaiser Permanente membership.

10.5 Credentialing & Re-credentialing Process

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. The credentialing process includes an initial and ongoing verification process through National Compliance Office (NCO) databases. Verification is conducted through an electronic query of reports such as Medicare Opt-Out report and the Medicare List of Excluded Individuals/Entities (LEIE). All physicians who cover for participating providers must be credentialed by MASCAP. 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 procedural 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 10.7. Practitioners will be notified within (60) sixty calendar days in writing of

the actions taken to approve or disapprove the applicant for participation with Kaiser Permanente.

Participating provider Responsibilities
Participating 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 calendar days.
- Cooperation with site visit and medical record-keeping review processes.

Participating Provider Rights
Participating 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 Kaiser Permanente policies and procedures.
- Credentialing files are acted upon according to Kaiser Permanente policies and procedures.

Credentialing Process
All applications will be processed and verified according to Kaiser Permanente 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 (1 million, 3 million coverage)
- Claims History
- National Practitioner Data Bank (NPDB) Query
- Work History
- Medicare and Medicaid Status and Sanctions
- LEIE
- Office Visit Report
- Mid-Level Practitioner Practice Agreement
- Site Visits

Kaiser Permanente participating Primary Care Physicians (PCP), obstetrician/gynecologist (OB/GYN), and high-volume behavioral health offices will be subject to a site visit. This site visit includes a review to access environment, availability, safety, appearance, and medical record-keeping practices. The MASCAP and Regional Quality Improvement Committee (RQIC) 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 and request for action plan if indicated.

Participating Hospital Privileges
It is the policy of Kaiser Permanente 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
All physicians are required to obtain and maintain American Board of Medical Specialties (ABMS)-recognized board certification in their contracted specialty. Physicians will be given 5 years from completion of training. Physicians who have certification lapses during the course of their contract will be given two (2) years following the expiration of their board certification to obtain recertification. (The two (2) year grace period does not apply to hourly MAPMG physicians). 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 Kaiser Permanente:

- 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)

10.6 Re-credentialing Process

After initial credentialing, Kaiser Permanente participating providers will be re-credentialed every three (3) years except for those with Kaiser Permanente ambulatory surgery and procedural 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 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
- Drug Enforcement Administration (DEA) Certificate in each jurisdiction where the practitioner provides services
- Controlled dangerous substances (CDS) Certificate
- Board certification and maintenance of board certification
- Hospital privileges
- Professional liability coverage ($1 million, $3 million coverage)
- Claims History
- NPDB Query
- Medicare and Medicaid Status and Sanctions
- Mid-Level Practitioner Practice Agreement
- Practitioner quality profile
- Member complaints

Notification

It is incumbent upon participating providers to notify the 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 policies and procedures outlined by MASCAP 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, HMO, group practice, or any other health provider organization
- Medicare or Medicaid sanctions, or any investigation for a federal healthcare program
- Medical malpractice action

10.7 Exclusion from Federal Related Health Care Programs

Kaiser Permanente shall require its providers to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 CFR § 455 Subpart B.

Kaiser Permanente shall utilize the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov/. In addition, participating providers should immediately report to Kaiser Permanente any exclusion information discovered.

Kaiser Permanente shall, at a minimum, check the OIG List of Excluded Individuals Entities and other Federal databases; (1) at least monthly for its non-Medicaid enrolled providers, (2) before contracting with providers, and (3) at the time of a provider's credentialing and re-credentialing.

10.8 Provider Profiling

As part of our mission and commitment to our member, Kaiser Permanente monitors care and service delivery by measuring several quality indicators to assess effectiveness. Deviations from the standard of care, adverse events, and member concerns and complaints will be reviewed on an ongoing basis and prior to credentialing or re-credentialing. Kaiser Permanente has established thresholds for performance measures in these areas.

Satisfaction measures consist of three components:

1. Overall satisfaction with the office visit,
2. Satisfaction with wait times for telephone answering, scheduling an appointment, and the waiting room,
3. Rate of members transferring out of the primary care office and into another practice (excluding members leaving the plan).

Clinical quality measures are indicators of quality and appropriateness of care. Kaiser Permanente approved guidelines, Health Plan report cards, and national statistics may be included in a comparative data analysis.

Member Complaints & Grievances - All quality-related complaints and grievances receive a quality review through KPMAS Quality Management and may become part of participating providers' profiles, offering the opportunity to track and trend data.

Referral measures measure the rate of visits for both specialty care and emergency room visits per thousand members. This rate, for example, could be compared to a range of PCP office practices.

Utilization statistics that reflect rates and patterns of care will be presented along with appropriate benchmarks, where possible.

Healthcare Effectiveness Data and Information Set (HEDIS)/NCQA. Quality indicators are used as measures of provider and health plan performance in the delivery of care. Selected services are evaluated and reported in accordance with the Department of Medical Assistance Services (DMAS) contract.

10.9 Medical Record-Keeping Practices

Kaiser Permanente participating providers are responsible for maintaining the full medical record of members who elect to receive their health care through their office. Kaiser Permanente encourages participating providers to maintain electronic medical records. The Kaiser Permanente has developed specific criteria for maintaining the medical record. These standards are a part of the periodic site review done within each participating provider office. 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.
- All medical records are maintained for at least six (6) years from the member's last office visit and/or date of service.
- The medical record shall be safeguarded against unauthorized use, damage, loss, tampering and alteration.
- Each member has an individual medical record. Individual medical records can be easily retrieved from files. (e.g., filed alphabetically or numerically).
- Each page is identified with name of member and birth date, or medical record number.
- The medical record of a member is confidential communication between the health care provider and the member 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:

- Name
- Date of birth/age
- Sex
- Medical record number
- Physician name
- Physician identification number
- All progress notes will:
- Be dated (including the year)
- Clearly identify the provider
- 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
    - 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 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

10.10 Health Engagement

Virtual group education classes are offered on a variety of topics and range in length between one-time meeting and multi-sessions. All classes are designed to support care recommendations and healthy lifestyle goals set forth by health care teams and practicing providers. Members can access the most current class schedule from http://www.kaiserpermanente.org/classes/mas. The following class topics are currently available:

- ***Prevention***
- ***Disease Management***
- ***Mental Health***
- ***Prenatal classes***
- ***Older adult classes***

Members learn about the availability of health education classes, online programs, and audio-visual resources through mailings, posted information on www.kaiserpermanente.org, and through printed materials available in Kaiser Permanente medical centers. Internal and external providers can provide members with approved, low-literacy health education materials by accessing the Clinical Library at https://cl.kp.org/mas/home.html.

For information about health education classes, programs, and resources, members can access www.kaiserpermanente.org/healthyliving or call the 24/7 automated information line at ☎ 301-816-6565 or ☎ 800-444-6696.

Members can receive lifestyle support over the phone through the Wellness Coaching program. The coaching service focuses on wellness and healthful behaviors and uses motivational interviewing techniques to address tobacco use cessation, physical activity, healthy eating,

weight management, and stress management. To make an appointment, members can log onto www.kaiserpermanente.org/appointments to find dates and times under Health Education Classes and Programs or call the centralized wellness coaching phone number at ☎ 866-862-4295, 24 hours a day. Coaching is offered in both English and Spanish and in other languages using Language Line.

Kaiser Permanente promotes completion of a Health Risk Assessment (HRA) to augment health assessment visits. The HRA is used to collect data related to each member's medical status, prevention needs, and health promotion behaviors, and it generates individual reports for the member. Member reports provide specific information and resources to encourage appropriate, healthy lifestyles and preventive practices. The HRA is available on the members-only Web site, www.kaiserpermanente.org.

10.11 Managing Chronic Diseases Program (Disease Management)

Kaiser Permanente's care management programs help participating practitioners monitor and manage members with chronic conditions. Members with diabetes, asthma, coronary artery disease, chronic kidney disease, hypertension, and/ or depression are enrolled into care management programs through a registry. Members are not required to enroll in these programs and may opt out.

Members enrolled in these programs receive mailings, secure email messages, text messages, and/or phone calls periodically, including care gap reminders. These communications 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.

Participating providers may receive member-level information to help manage their panel, and quality process and outcome information to help improve practices.

To refer your patient or to obtain information and tools to care for your members with chronic diseases contact the Health Education Information Line at ☎ 301-816-6565 (press 2 to leave a message).

10.12 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 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 ☎ 888-989-1144 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.

11.0 PHARMACY SERVICES

11.1 Kaiser Permanente Medical Center Pharmacy

All Health Plan members may access Kaiser Permanente Medical Center pharmacy locations.

For a complete listing of Kaiser Permanente Medical Centers with pharmacy locations please visit our online Provider Directory on our website at www.providers.kaiserpermanente.org/mas or contact Provider Experience at ☎ 877-806-7470.

11.2 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, the Kaiser Permanente 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, Kaiser Permanente 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 controlled 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 standard.

11.3 Specialty Pharmacy Services

For specialty pharmacy services, members may use a Kaiser Permanente Specialty Pharmacy or the specialty pharmacy of their choice. If the product has limited distribution, Kaiser Permanente will arrange for pharmacy services as instructed by manufacturer for those products with limited distribution/pharmacy services.

11.4 Kaiser Permanente Medical Center Pharmacy Prescription Guidelines

Complete patient information on the prescription is required. This includes member's name, Kaiser Permanente Medical Record Number (MRN), provider number (or printed last name), and special instructions. The most frequent errors incurred on prescriptions are omission errors or incorrect MRN. To reduce medication errors, it is recommended that all participating providers write out specific instructions on all prescriptions and that, "Take as directed" is not written unless the instructions are written on the package or a patient specific instruction sheet.

Prescription Quantity & Refills:

- Prescriptions for acute medications are typically eligible for a 34 day supply each time the prescription is dispensed.
- Members may receive up to a 90-day supply for refills of medications for chronic conditions identified in the "DMAS's 90-day Medication Maintenance list" after two (2) thirty-four (34) day or shorter duration fills. A complete list is found at https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/mas/2022/commonwealth-of-virginia-medicaid-90-days-maintenance-drug-list.pdf.
- Processing time for prescriptions that have no refills remaining is 24 hours after the refill request is approved by the physician.
- Processing time for prescriptions that have refills is 24 hours.
- Generic medications are used whenever possible consistent with Virginia's Medicaid Program Preferred Drug List, Common Core Formulary.
    - Unless otherwise specified in the formulary or by the Regional Pharmacy & Therapeutics Committee (P&T), products are approved for use and coverage on a generic basis and any brand may be used according to the principles of high quality pharmaceutical care, except where state laws and/or regulations prohibit.
    - Selection of generic medications is based on clinical effectiveness and safety compared to the branded (trade name) drug.
    - Members who request non-preferred brand name medications rather than the formulary generic alternative may pay full price for the drug if there is no determination of medical necessity.

11.5 Formulary System

Formulary

The Virginia Medicaid Formulary is a list of drugs approved by the Kaiser Permanente Mid-Atlantic States P&T committee. The formulary contains at a minimum all preferred drugs listed in the Departments of Medical Assistance Services (DMAS) Preferred Drug List (PDL), Common Core Formulary. The P&T Committee, with expert guidance from various specialties, evaluates, appraises and selects from available drugs those considered the most appropriate for patient care and general use.

The VA Medicaid Formulary will include drugs from the 6 Protected Classes as defined by the Center for Medicare and Medicaid Services (CMS) immunosuppressant (for prophylaxis of organ transplant rejection),antidepressant, antipsychotic, anticonvulsant, antiretroviral, and anti-neoplastic classes). Based on State Regulations, the VA Medicaid formulary will also include OTC drugs within specific therapeutic category and class. The specific therapeutic categories included:

- Analgesics

- Antacids
- Anti-Diarrheas
- Anti-Emetics, Anti-Vertigo
- Anti-Inflammatory Agents
- Anti-Itch, topical
- Antibiotics, topical
- Antiflatulents
- Antifungals, topical
- Antihistamines (loratadine and various others)
- Cold and Cough Preparations
- Contraceptives
- Cough Suppressants
- Decongestants
- Dermatological Agents – various
- Expectorants
- Eye and Ear Preparations
- Hemorrhoid Preparations
- Histamine-2 Receptor Antagonist (ranitidine and various others)
- Iron Supplements
- Laxatives, Cathartics, Bulk Producers, Stool Softeners
- Mineral Supplements (Calcium and various others)
- Nicotine Cessation
- Pediatric Electrolyte Solution
- Pediculicides
- Proton Pump Inhibitors (Prilosec® OTC)
- Scabicides
- Vitamins and Minerals (various)

Drugs reviewed for formulary consideration are classified as one of the following:

- **Formulary drug (F)** - A drug, including specific strengths and dosage forms, reviewed and approved based on sound clinical evidence that supports the safe, appropriate, and cost-effective use of the drug. May be prescribed by all credentialed prescribers, except where state laws and/or regulations prohibit.
- **Formulary drug with Criteria or Guidelines (FC)** - A formulary drug that includes specific criteria for prescribing and/or dispensing. Prescribers may prescribe these drugs as long as criteria are met, and the specific criteria are documented in the medical record. Criteria must be measurable and operationally practical.
- **Formulary drug with Restrictions (FR)** - A formulary drug with prescribing restricted to specific prescribers, e.g., specialty departments.
- **Non-formulary drug (NF)** - A drug not officially accepted for inclusion into the drug formulary. This includes*:* Drugs that have been reviewed but not accepted to the drug formulary; new drugs not yet reviewed for addition to the drug formulary; a brand, strength, or dosage form of a drug not approved for addition to the formulary.
- **Non-formulary drug with Criteria or Guidelines (NFC)** - A drug that has not been accepted to the formulary, though drug rider coverage for this drug meets specific criteria for use. The specific criteria are documented on the prescription.
- **Non-formulary drug with Restrictions (NFR) -** A drug that has been reviewed, but not accepted into the formulary. Drug rider coverage for this drug meets specific restrictions for use when prescriptions are written by or are written in consultation with the specific

prescribers, e.g., specialty, departments.

- Kaiser Permanente Regional Pharmacy and Therapeutics (P&T) Committee will follow DMAS' PDL/Common core formulary content and requirement related to utilization managements such as prior authorization, step therapy, quantity limits etc. Additionally, the formulary will include all closed classes identified by DMAS. KPMAS P&T committee will not add or remove drugs from the formulary designated as closed classes, including alternative dosage forms unless notified by the contractor.
- The Medicaid Formulary and formulary management procedures (i.e., inclusion or exclusion of therapeutic classes) are reviewed and updated at least quarterly.
- The inclusion of a drug to the Medicaid Formulary is based on scientific evidence and standards of practice, assessment of peer reviewed medical literature, pharmacoeconomic studies and outcomes research data or when mandated by CMS.
- All drugs are assessed for safety, efficacy and relative costs of medication, including, a medication safety assessment process using a systematic Medication Safety Evaluation process.
- The Regional P&T Committee reviews all policies related to dispensing limitations, including limiting refills, limiting quantity, or limiting the number of prescriptions, if not already limited by benefit design or regulatory requirements.
- The Regional P&T Committee reviews all policies that guide utilization management.

Exclusion from Coverage:

The following are excluded from coverage:

- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth. Agents used in the treatment of covered Gender Dysphoria services are not cosmetic.
- Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered
- Drugs which have been recalled.
- Experimental drugs or non-FDA-approved drugs, except for children and youth covered under EPSDT.
- Any drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.
- Drugs used for anorexia or weight gain.

Prior Authorization (PA) and Quantity Limits: The PA criteria are reviewed at least annually by KPMAS P&T Committee or whenever changes occur. Medications with established Prior Authorization criteria, step therapy, or quantity limits are designated in the drug formulary with the abbreviation "PA," "ST," and "QL", respectively. The most recent information on Commonwealth of Virginia Medicaid and FAMIS Preferred Drugs can be accessed via the online Community Provider Portal at http://www.providers.kaiserpermanente.org/html/cpp_mas/formulary.html?#Commonwealth of Virginia Medicaid and FAMIS Preferred Drug List.

Medication Evaluation: To request a drug or biological review by the P&T Committee, a "Drug Formulary Addition and Deletion" Form must be completed. A copy of this form is available on www.providers.kaiserpermanente.org/mas website, under "Pharmacy".

Obtaining a copy of the Drug Formulary:
The formularies are updated monthly with additions and/or deletions approved by the P&T Committee. The most recent information on drug formulary updates or changes can be accessed via the online Community Provider Portal available at http://providers.kaiserpermanente.org/html/cpp_mas/formulary.html.
A printed copy of each drug formulary is available upon request from the Provider Experience department, which can be contacted via email at Provider.Relations@kp.org.

11.6 Non-Formulary (NF) Drug Documentation Process

A participating provider will be requested to document a reason that a preferred formulary product is not appropriate for use for a specific member. The reasons for the use of a non-preferred product will be documented in the pharmacy information system.

The reasons for the use of a non-preferred drug are categorized:

- Allergy or adverse drug reaction
- Treatment failure to formulary drug
- Meets criteria/restriction for use
- Non-Kaiser prescription benefit/patient pays full cash
- OTC product
- Patient request NF product/patient pays full cash

The Clinical Pharmacy Service and Regional P&T Committee periodically evaluates the frequency of use of non-preferred drugs and considers those with significant use for addition to the formulary of preferred products. Information regarding the use of non-preferred medications will not be used in decisions regarding approval to participate with Health Plan.

KPMAS Member Prescription Benefit Information
The cost of members' prescriptions may vary depending upon the type of product and particular pharmacy benefit; however, providers can find general information on members' prescription copayment (pharmacy copays are not applicable to VA Medicaid members, consistent with DMAS requirements) and coinsurance information by member benefit plan type on the Online Affiliate, accessible via the Community Provider Portal (http://www.providers.kaiserpermanente.org/html/cpp_mas/providertools.html).

You will be asked to sign in with your User ID and password to access the copayment and coinsurance information, or to begin registration if you have not made an account. If you do not have access to Online Affiliate and would like to gain access, please contact Provider Experience at ☎ 877-806-7470 Monday through Friday, 8:30 a.m. to 5:30 p.m. EST. 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/.

11.7 Medical Equipment Available at Kaiser Permanente Pharmacies

Below are examples of medical equipment stocked at Kaiser Permanente Outpatient Pharmacies:

Aerochamber: This is the spacer holding device for use with metered-dose inhalers (MDIs). It is available in pediatric and adult sizes, with or without a mask.

Blood Glucose Monitors: The monitor is dispensed free of charge or at a nominal fee depending upon the member benefit. The strips used with the monitor are covered under the prescription benefits with a prescription from the provider.

Peak Flow meter: This device is used for measuring and monitoring peak expiratory flow meters.

11.8 Home Infusion Services

KPMAS offers Home Infusion Services for our members for:

- Continuation of infusion therapies at home after hospital discharge or new starts in clinic;
- IV therapies necessary for conditions too severe to be effectively treated with oral medications; and
- Chronic/long-term intravenous medication therapies.

The Home Infusion Service provides IV medication and catheter supplies for Maryland, Washington D.C. and Virginia.

Home Infusion Pharmacy:
Burke Admixture Pharmacy
Burke Medical Center
5999 Burke Commons Road, 4th Floor
Burke, VA 22015
Telephone: ☎ 703-249-7922
Fax: ☎ 703-249-7923
Page Operator: ☎ 888-989-1144
Hours of Operation: M-F: 8 a.m. – 6 p.m.

The program offers our members the following options:

- Patient may come to the medical center with infusion clinical services to have medication administered by a registered nurse.

- Home care nurse (from a contracted agency) will go to a patient's home to teach the patient/caregiver how to administer the medication. Kaiser Permanente Home Infusion pharmacy provides the medication and supplies. The first dose must be given in a controlled setting such as clinic or hospital, *unless it has been determined by a Virtual Home Care Program (VHCP) physician that the first dose can be safely administered in the patient's home by a home care nurse*. If nursing care is needed, a referral must be entered by the provider prior to calling the order into Home Infusion pharmacy. The Provider Service Center will set up the nursing care.

- Patients may be instructed to self-medicate, thereby administering the medication to themselves. THIS IS THE PREFERRED OPTION, since it provides the member

maximum flexibility. The first dose must be given in a controlled setting such as a clinic or hospital, *unless it has been determined by a Virtual Home Care Program (VHCP) physician that the first dose can be safely administered in the patient's home by a home care nurse*.

If nursing care is needed, a referral must be entered into Health Connect.

The first delivery will be sent to the hospital or home of the patient. Subsequent deliveries are made weekly to the patient's closest Kaiser Permanente Medical Office Building for the member or family to pick up from the outpatient pharmacy. This service is provided for the patient at no charge.

Treatment Types

- Antibiotics/Antivirals – Pediatric and Adult
- Total Parenteral Nutrition (TPN)
- Oncology – limited
- Pain control including patient-controlled analgesia (PCA)
- Hydration
- Other therapies may be done if safety for home infusion administration has been determined

Medication Delivery System

There are several methods of medication delivery available, based upon the medication and patient requirements. These include ambulatory infusion pumps, disposable elastomeric pumps and traditional IV bags. To determine the recommended delivery system for your specific situation, please contact the Home Infusion Pharmacist.

How to Order Home Infusion Services

If a patient is in the hospital, the physician should work with the Patient Care Coordinators at the facility to make the arrangements for care. The physician will need to provide a written order for the medication and labs to the Home Infusion Pharmacy.

For patients seen in clinic and needing home infusion services, the provider will enter the referral for home nursing into HealthConnect® as well as lab orders. The provider or agent will need to contact the Home Infusion pharmacy department to discuss plan of care.

Hospital, skilled nursing facility (SNF) and Nursing Home discharges should be arranged as early as possible, preferably 24 hours in advance. Discharge during the weekend may require additional time to set-up and deliver supplies. Please notify the contact person as soon as possible, so that they have adequate time to coordinate the medication, supplies, and nursing personnel.

11.9 Prior Authorization SCRIPT Standards

Effective July 1, 2016, Kaiser Permanente will follow prior authorization procedures pursuant to the Code of Virginia Section 38.2-3407.15:2. 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 and the pharmacy providers of its decision. Pharmacy services which are denied for children must be afforded a secondary review in accordance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements.

Kaiser Permanente's response to prior authorization requests will include whether the request is approved, denied, or requires supplementation or additional information limited to items specifically needed on the prior authorization request, necessary to approve or deny the prior authorization request. If additional information is requested from the prescriber in order to render a decision, the provider has seventy-two (72) hours to furnish the information. If no response is received within seventy-two hours, the request is considered denied. If coverage is denied, Kaiser Permanente will inform the member of his or her rights and the procedures for filing an appeal via the timeframes below, as applicable, including the reasons for denial. 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. Kaiser Permanente will respond to prior authorization requests as follows:

- If the prior authorization request is submitted to Kaiser Permanente, Kaiser Permanente will respond to the prescriber or designee within 24 hours of a prior authorization request electronically, telephonically or by facsimile with a decision of approval, denial or request for additional information.
- Notice of a decision to deny a prior authorization request will be provided to the enrollee and the requesting provider within 24 hours of the decision.

Kaiser Permanente will honor approved prior authorizations from other contractors or health plans for at least the initial thirty (30) days of a member's prescription drug benefit coverage, subject to the provision of Kaiser Permanente's evidence of coverage, upon Kaiser Permanente's receipt from the prescriber or designee (or other means as determined by the Department), a record demonstrating the previous health plan prior authorization approval. Kaiser Permanente will have a tracking system in place for all prior authorization requests, and that information must be provided to the prescriber or designee upon Kaiser Permanente's response to a prior authorization request.

Kaiser Permanente will also publicize all drug formularies, drug benefits subject to prior authorization by Kaiser Permanente, Kaiser Permanente's prior authorization procedures, and acceptable prior authorization request forms within 7 days of the approved changes

Pharmacy Utilization Management and Safety (PUMS) Pharmacy Lock-In Program

Kaiser Permanente's Pharmacy Assignment Program, also known as the Pharmacy Utilization Management and Safety (PUMS) Pharmacy lock-in Program identifies and evaluates members at-risk of abuse and/or over-use of controlled substance medications to ensure safe and effective care management and outcomes based on criteria listed in the Commonwealth of Virginia Cardinal Care and Managed Care Technical Manual (MCTM). Kaiser Permanente's Pharmacy Assignment Program will enroll participating Virginia Medicaid and FAMIS members into utilizing a single pharmacy location and prescribing physician to receive covered prescription controlled substance medications based on the monthly review and recommendations provided by Kaiser Permanente's Chronic Pain Management Board once one of the following criteria is met:

1) Opioid Use Disorder (OUD) Case Management: KPMAS may review any members receiving OUD. Furthermore, members with OUD may be referred for evaluation by case management in the presence of:

a) History of opioid overdose(s), emergency visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past 3 years
b) Pregnant women with OUD
c) Current or recent involvement (in the past 3 years) with the criminal justice system

Clinical expertise and judgment will be used to identify and manage any members determined to benefit from placement or remaining in lock-in to prescriber or practice group (cluster)

2) High average daily dose: ≥ 90 cumulative morphine milligram equivalents per day over the past 90 days

3) Opioids and Benzodiazepines concurrent use-at least 1 opioid claim and 14-day supply of Benzo (in any order)

4) Doctor and or pharmacy shopping: ≥ 3 prescribers OR ≥ 3 pharmacies writing/filling claims for any controlled substance in the past 60 days

5) Use of a controlled substance with a history of dependence, abuse or poisoning overdose: any use of a controlled substance in the past 60 days with at least 2 occurrences of a medical claim for controlled substance abuse or dependence in the past 365 days

6) History of substance use, abuse or dependence or poisoning /overdose: any member with a diagnosis of substance use, substance abuse, or substance dependence on any claim in any setting (e.g., ED, pharmacy. Inpatient, outpatient, etc.) within the past 60 days

The member will be enrolled into the Pharmacy Assignment Program for a period of 12 months. The enrollment in the PUMS program may be extended by an additional 12 months from the initial lock in end date if member is found to have continued inappropriate prescription utilization while in the lock-in program. The members identified for the PUMS program will receive notification letter 30 days before the effective day of the pharmacy and or provider assignment. The notice will provide the program start and end date, member appeal rights, the assigned physical pharmacy name and address, and assigned physician the member must utilize while the member is enrolled in the PUMS program.

12.0 BEHAVIORAL HEALTH SERVICES

Kaiser Permanente's Behavioral Health Services operates within the multi-specialty Mid-Atlantic Permanente Medical Group, PC (MAPMG). It is a regional service committed to providing high-quality, appropriate, and evidence-based treatment of mental health and chemical dependency disorders. The Kaiser Permanente Behavioral Health Delivery System includes psychiatrists, psychologists, social workers, nurses, addictionologists, and chemical dependency counselors at Kaiser Permanente Medical Centers, as well as a network of community-based participating behavioral health providers.

When a patient is seen by a behavioral health clinician within the Kaiser Permanente Delivery System, the following critical elements characterize our model of care:

- Establishing clearly defined and mutually agreed upon treatment goals
- Targeting interventions to address the member's present difficulties and destructive thinking patterns.
- Consistent monitoring of the patient's goal with written documentation.
- Use of adjunct approaches to obtain progress, (e.g., homework, community programs, suggested reading, etc.)
- Treatment planning that addresses specific goals and strategies, supports medical appropriateness, and considers duration and frequency of treatment.

12.1 Access to Behavioral Health Services

Kaiser Permanente members have direct access to mental health and chemical dependency services. Members do not need a referral for psychotherapy services in-house or from external contracted providers. Members can arrange services independently by calling the Behavioral Health Access Unit where licensed clinicians and intake schedulers assist members in arranging appropriate services.

Members seeking internal psychiatry services or care from an external non-contracted psychotherapist or psychiatrist should obtain an approved referral from their primary care physician (PCP).

Members call ☎ 866-530-8778

- Monday – Friday from 7:00am – 7:00pm: Select Option 1 – "Behavioral Health"
- Outside of the above hours: Say "Representative" or stay on the line.

12.2 Referrals and Authorizations for Behavioral Health Services

When members call the Behavioral Access Unit, they are given an appointment with the appropriate behavioral health clinicians in a Kaiser Permanente medical center. If a member with network benefits declines to be seen within a Kaiser Permanente medical center Behavioral Health department and chooses to see a network provider, a referral for psychotherapy and/or medication management is not needed.

For higher levels of care (IOP – Intensive Outpatient, PHP – Partial Hospital Program, RTC – Residential Treatment, or inpatient), prior authorization is required. All treating providers must ensure that they receive an approved referral prior to rendering those services. If a referral has not been received for the patient, please contact Behavioral Heath Utilization Management for assistance at ☎ 301-552-1212.

Continuing Consultations and Treatment

Prior to the last approved visit for care other than psychotherapy or medication management and before the expiration date on the referral, the treating provider must submit a treatment plan for the member.

The correct DMAS Service Authorization Form (either the Initial Service Authorization Form or Ongoing Care Authorization Form) must be faxed to the attention of the Behavioral Health Utilization Review Nurse at ☎ 855-414-1703. Upon receipt of the treatment plan, you will receive by fax or mail a letter indicating the review determination.

12.3 Addiction and Recovery Treatment Services (ARTS) Program

Effective April 1, 2017, Kaiser Permanente will offer ARTS to Kaiser Permanente Virginia Medicaid members. The ARTS program is a new Substance Abuse Disorder (SUD) benefit that expands access to a comprehensive continuum of addiction treatment services for Virginia Medicaid members.

The following changes will apply to all enrolled members effective April 1, 2017:

- **Expansion of the administration of community-based addiction and recovery treatment services through the Medicaid and FAMIS managed care organizations (MCOs).** This will allow Kaiser Permanente to provide the full continuum of ARTS, based on the intensity and urgency level of the individual's need. Kaiser Permanente also will integrate these treatment services with physical health and traditional mental health services for comprehensive care coordination. Providers will bill the Kaiser Permanente for all physical health, traditional mental health, and community-based addiction and recovery treatment services for Medicaid and FAMIS members who are enrolled with Kaiser Permanente.

Community-based addiction and recovery treatment services include:

- Residential treatment,
- Day treatment/partial hospitalization,
- Intensive outpatient treatment,
- Medication assisted treatment (includes individual, group counseling and family therapy and medication administration), and
- Case management.

- **Allowing for coverage of inpatient detoxification and inpatient substance use disorder treatment** for all full-benefit Medicaid and FAMIS enrolled members. The Virginia Department of Medical Assistance Services (DMAS) is expanding coverage of residential detoxification and residential substance use disorder treatment for all full-benefit Medicaid enrolled members.

DMAS worked in conjunction with the Department of Health Professions (DHP), Department of Behavioral Health and Developmental Services (DBHDS), Virginia Department of Health (VDH), MCOs, and stakeholders, to design a transformed model for addiction and recovery treatment which is based on the American Society of Addiction Medicine (ASAM) standards. These changes will help to ensure the integration of high-quality addiction treatment, physical health, and mental health services for Virginia's Medicaid and FAMIS enrolled members.

Services listed below are covered under the ARTS benefit and are reimbursable by the MCOs for managed care enrolled members, and through the behavioral health services administrator (BHSA) for fee-for-service enrolled members. The chart describes the ARTS service coverage by ASAM Level of Care.

ASAM Level of Care	ASAM Description
4.0	Medically Managed Intensive Inpatient
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)
3.1	Clinically Managed Low-Intensity Residential Services
2.5	Partial Hospitalization Services
2.1	Intensive Outpatient Services
1.0	Outpatient Services
1.0	Opioid Treatment Program (OTP)
1.0	Office-Based Opioid Treatment (OBOT)
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)
n/a	Substance Use Case Management

- The ARTS specific procedure codes and reimbursement structure is posted online at: http://www.dmas.virginia.gov/Content_atchs/bh/ARTS%20Reimbursement%20Structure%2012132016.pdf

12.4 Mental Health Services (MHS)

Kaiser Permanente offers MHS to Kaiser Permanente Virginia Medicaid members. Authorization for MHS is obtained by submission of a service authorization or for services requiring registration, a submission of the registration form via fax to the Behavioral Health Utilization Management at ☎ 855-414-1703.

In 2021, DMAS enhanced its behavioral health program with additional services that are designed to rebalance the Virginia Medicaid mental health system and were implemented in two phases.

Effective July 1, 2021:

- Mental Health Partial Hospitalization
- Mental Health Intensive Outpatient
- Assertive Community Treatment

For more detailed information on these services, go to the DMAS' provider portal at www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home to see the Medicaid Bulletin dated for March 2, 2021.

Effective December 1, 2021:

- Functional Family Therapy (FFT)

- Multisystemic Therapy (MST)
- Comprehensive Crisis Services
    - 23-Hour Crisis Stabilization
    - Community Stabilization
    - Mobile Crisis Response
    - Residential Crisis Stabilization Unit (RCSU)
- Applied Behavior Analysis Therapy (ABA)

For more detailed information on these services, go to the DMAS' provider portal at www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home to see the Medicaid Bulletin dated for October 15, 2021.

To learn more about all of the behavioral health enhancements, go to:

1. The DMAS Behavioral Health Enhancement website: https://www.dmas.virginia.gov/for-providers/behavioral-health/enhancements/
2. Virginia's DBHDS website: https://dbhds.virginia.gov/

12.5 Emergency and Acute Care Services

Participating providers are expected to be available for their patients with appropriate after-hours or on-call coverage for their practice.

Emergency Services can be authorized 24 hours a day, 7 days a week.

To arrange for Psychiatric Hospitalizations:
Call the **Kaiser Permanente Emergency Hotline** at ☎ 800-810-4766.

12.6 Behavioral Health Claims

As a participating provider billing for behavioral health services, please follow the procedures and adhere to the requirements outlined in Section 8.0 – Claims of this Manual.

12.7 Coordination of Care with Primary Care Physicians (PCPs)

Kaiser Permanente has been a leader in promoting the integration of behavioral and medical health care. Many mental health problems present as medical conditions and many medical conditions present with psychological symptoms. Communication between all providers caring for a member is essential to assure the best care. The member benefits greatly when their PCP is fully informed regarding all aspects of their health care. Communication between the behavioral health provider and the PCP is particularly important when a member has:

- Initiated behavioral healthcare treatment
- Been prescribed psychotropic medication
- Had a recent inpatient stay related to their mental health or substance abuse.
- A substance abuse problem that affects their physical health and which may require the member to seek additional medication from their PCP or other providers.

Behavioral Health providers are asked to obtain the member's consent, and communicate the following to the member's PCP within seven (7) days of the visit and/or treatment:

- Date of Service
- Patient's Diagnosis and brief assessment of their findings.

- Treatment Plan or recommendations, such as medication prescribed or continued therapy required.

You may send written communications, findings, and/or treatment plans to the PCP directly, or to the following address:

Kaiser Permanente-Burke Medical Center
HIMS
5999 Burke Commons Rd
Burke, VA 22015

You may also fax this information to ☎ 703-249-7723

Should the member decline to have information released to his/her PCP, please indicate this on the Treatment Plan Form.

12.8 Additional Kaiser Permanente Center-Based Services

In addition to general outpatient mental health and chemical dependency treatment services, Kaiser Permanente offers a range of behavioral health clinical services. These services are offered at Kaiser Permanente Medical Centers across the Mid-Atlantic States Region.

Mental Health – Intensive Outpatient Program (IOP)
Intensive outpatient treatment programs are located at many Kaiser Permanente Behavioral Health clinics throughout Maryland, DC, and Northern Virginia. Intensive outpatient treatment is a time-limited, multi-disciplinary program.

The program provides treatment assessment, crisis intervention, and stabilization. It is designed to help avert hospitalization and to provide a step-down for patients leaving the hospital. The treatment team consists of a psychiatrist, psychiatric nurse, clinical social worker and case manager.

Acute Care Services
Physicians and staff in our Behavioral Health Department maintain availability to see our members on an urgent basis.

24 Hour Medical Advice
Registered nurses are available 24 hours a day to assist, handle, or direct urgent as well as routine medical questions over the telephone.

Behavioral Health Urgent Care Services
As the treating participating provider, it is your responsibility to coordinate and meet the acute and urgent needs of the members referred to you for treatment. However, if a member requires an urgent/emergent appointment after-hours, during a weekend, or holiday members may call the Medical Advice Line at ☎ 800-777-7904 to arrange for services.

Behavioral Health Education
Kaiser Permanente's Behavioral Health Education Program offers a variety of classes at designated Kaiser Permanente Medical Centers across the Mid-Atlantic States Region. Clinical social workers, psychologists, counselors, or clinical nurse specialists conduct these classes. The classes focus on skill building and include topics such as "Managing Stress and Anxiety", "Overcoming Depression and Low Self-Esteem", and "Problem Solving for Couples".

13. APPLIED BEHAVIOR ANALYSIS (ABA)

At KPMAS, we are dedicated to providing our members with timely access to high-quality, affordable ABA services. We continue to work to streamline the authorization process while also adding comprehensive mechanisms for quality assurance. The result is a sustainable, innovative program that is both patient-centered and provider friendly. The purpose of this manual is to provide information necessary to efficiently navigate Kaiser Permanente's ABA processes, what type of documentation is needed, the scope of ABA medically necessary services, and allow our network providers to focus on care delivery. Please read through this manual and feel free to contact us with any questions you may have.

13.1. Criteria for ABA Services

KPMAS Member

a) As required under the member's plan, Commercial members must have a documented comprehensive evaluation with a diagnosis that meets the DSM-5 criteria by:
   - A qualified KPMAS provider or multi-disciplinary team appropriately licensed and trained in the diagnosis and treatment of the diagnosis; OR
   - A qualified non-KPMAS provider whose evaluation and diagnosis has been reviewed and confirmed by a qualified KPMAS provider or multi-disciplinary team appropriately licensed and trained in the diagnosis and treatment of ASD; AND

b) There is documentation of a severe challenging behavior and/or communication and social interaction issues, clearly related to characteristics of ASD that:
   - Presents a health or safety risk to self or others (such as self-injury, aggression toward others, destruction of property, elopement, severe disruptive behavior); or
   - Presents a significant functional interference within the home, school, and/or community; AND

c) There is a reasonable expectation on the part of a qualified treating practitioner or multi-disciplinary team that the individual's behavior will improve significantly with ABA therapy.

d) Member's health risk and safety considerations are also assessed, and potential interventions identified that promote health, independence, and safety with the informed involvement of the member, parent and or legal guardian.

e) Virginia Medicaid Members
   - For VA Medicaid, KPMAS will follow Project BRAVO criteria for ABA

ABA Provider

a) The lead behavior analyst (BCBA-D, BCBA, and/or BCaBA) providing treatment and/or clinical supervision must meet the criterion below:
   - Appropriately licensed in Maryland, Virginia, or the District of Columbia as a Behavior Analyst
   - Practicing within the scope of their licensure and certification
   - Approved by KPMAS

b) RBT shall have obtained formal certification within the profession of behavior analysts coordinated by the Behavior Analyst Certification Board (BACB)
   - Practicing within the scope of their licensure and certification
   - Must be certified by the BACB prior to providing services to KPMAS members

c) Behavioral interventions are implemented according to approved ABA Treatment Plan

d) Clinical Oversight of RBTs by BCaBA, BCBA or BCBA-D includes:
   - All aspects of clinical direction, supervision, and case management, including activities of the support staff and RBTs
   - Knowledge of each beneficiary and the treatment team's ability to effectively carry out clinical activities before assigning them
   - Familiarity with the beneficiary's assessment, needs, and ABA Treatment Plan
   - Regular observation of the direct service provider (RBT) implementing the plan
e) Family members may not be paid providers

13.2. Prior Authorization

a) For commercial members, the ABA provider will submit the request for assessment to KPMAS for prior authorization (PA) before assessment begins.
b) For VA Medicaid, KPMAS will follow Project BRAVO
c) For all members, the ABA provider will submit the ABA Treatment Plan to KPMAS for prior authorization (PA) before treatment begins.
d) The ABA Treatment Plan will be reviewed by KPMAS who will approve (or deny) the planned interventions.
e) A treatment plan should be submitted to KPMAS for any patient with KP as a primary or secondary insurer.
f) Requests for authorization should be faxed to BHUM at 855-414-1703.

CODE	Daily Unit Limit	NOTES
97151	8	• Initial Assessment up to 8 hours; 6-month re-authorization up to 6 hours • Includes completion of direct and indirect assessments with members and stakeholders, data analysis, treatment planning, BIP development, etc. (see 1.4 below) • Service provided in-person/ face-to-face and indirect; no telehealth
97152	16	• Information for medical necessity of this code is needed for all 97152 requests • Approved for no more than 8 hour per authorization period, on a case-by-case basis • Service provided in-person/ face-to-face; no telehealth
The following codes noted with * are prescribed and requested on a weekly basis and should be rendered as prescribed. Any missed time can be made up within the week it was missed as clinically appropriate		
97153*	32	• Request needs to indicate service provider level • Requests for services made on a per day/ per week allocation • Make-up sessions provided within the same week only • Cannot be billed concurrently with other services (e.g., speech, OT, PT)

		• When combined with services 97154 and 97158, hours do not exceed 8 hours (32 units) per day of therapy across services • Service provided in-person/ face-to-face only; no telehealth
97154*	18	• Request needs to indicate service provider level • Requests for services made on a per day/ per week allocation • Make-up sessions provided within the same week only • Cannot be billed concurrently with other services (e.g., speech, OT, PT) • When combined with services 97153 and 97158, hours do not exceed 8 hours (32 units) per day of therapy (32 units) across services • Service provided in-person/ face-to-face only; no telehealth
97155*	24	• May be requested for up to 15% of total RBT hours • Can concurrently bill with 97153/ 97154 if BCaBA/ BCBA/ BCBA-D is not providing direct therapy • Service provision should be in direct relation to direct therapy hours rendered by RBT (codes 97153 and 97154) ○ Case supervision is not provided in the absence of ongoing ABA services • Request needs to indicate service provider level • Team meetings are not billable services • For Members receiving less than 20 hours per week of therapy, supervision may be provided every other week up to 3 hours total • Up to 50% of total units rendered may be provided virtually • For these services, the authorized weekly units will be tracked on a calendar month basis • For example, if the percent of approved units per week equals 30 minutes per week, the services can be combined to then provider 60 minutes every other week or 2 hours per calendar month. The total units per the calendar week cannot exceed the sum of the weekly allowed units for the calendar month
97156	16	• Includes ongoing measurement of progress toward parent/ caregiver skill acquisition goals • Team meetings are not billable services • Service provided face-to-face or through telehealth • Up to 100% of total units rendered may be provided virtually
97157	16	• Treatment plan should clearly indicate goals to be targeted via group

		• Includes ongoing measurement of progress toward individualized parent/ caregiver skill acquisition goals, consistent with ABA • Service provided face-to-face or through telehealth • Up to 100% of total units rendered may be provided virtually
97158*	16	• Request needs to indicate service provider level • Requests for services made on a per day/ per week allocation • Make-up sessions provided within the same week only • Cannot be billed concurrently with other services (e.g., speech, OT, PT) • When combined with services 97153 and 97154, hours do not exceed 8 hours (32 units) per day of therapy (32 units) across services • Service provided in-person/ face-to-face only; no telehealth
H0032*	N/A	• Request needs to indicate service provider level • Service provision should be in direct relation to direct therapy hours rendered by RBT (codes 97153 and 97154) and not to exceed 5% of those hours • Treatment planning is not provided in the absence of ongoing ABA services • Treatment planning to be used for programming updates, protocol modification, behavior plan revisions • Creating stimuli is a non-billable service • For these services, the authorized weekly units will be tracked on a calendar month basis • For example, if the percent of approved units per week equals 30 minutes per week, the services can be combined to then provider 60 minutes every other week or 2 hours per calendar month. The total units per the calendar week cannot exceed the sum of the weekly allowed units for the calendar month

13.3. ABA Treatment Plan

The ABA Treatment Plan must have information gathered from multiple informants and data sources, with direct assessment and observation in different settings and situations, a file (record) review, interviews, rating scales, and assessment from other professionals. Kaiser Permanente report templates are to be used for initial and continued care reports. Failure to use these templates may result in submission of incomplete information which can delay the authorization process.

ABA Treatment Plans will include:

a) Agency responsible for implementation, location of service delivery, and number of referred service hours necessary to effectively address the challenging behaviors and skill acquisition goals

- If re-authorization is being requested, include utilization of hours for most recent authorization

b) Background information (i.e., identifying information, primary reason for services, and current levels of functioning) and case history (i.e., medical, family, social, and educational information)
c) Assessments completed for evaluation, treatment plan implementation, maintenance and generalization plan, and discharge plan
d) FBA, Functional Analysis (when available), operational definitions, baselines, assessments used, and specific Treatment Goals that include frequency, intensity, and duration data, and mastery criteria
e) Behavior intervention plan for each behavior targeted for decrease, including antecedent and consequence interventions, description of how barriers are being addressed
f) Skill Acquisition Goals and Objectives that are in the social, communication, cognitive, adaptive, and vocational domains. Goals and Objectives should be measurable and include implementation of evidence-based interventions, tailored to the individual, include baseline measurement levels, present levels of performance, address barriers and include changes to plan if limited or no progress has been made across multiple skills or regression has occurred, and an anticipated timeline and criteria for mastery.
g) Parent/Caregiver Training Goals including baseline measurement levels, present levels of performance, address barriers and include changes to plan if limited or no progress has been made, and an anticipated timeline and criteria for mastery.
h) A selection of programs and targets based on the functioning level of the individual, degree of behavior management required, and the time available to run programs
i) Coordination of care with other service providers
j) Crisis management plan for medical and behavioral emergencies
k) Plan for transition including how services will be faded and next level of care
l) Plan for discharge including quantitative criteria for discharge and reasons for discharge
m) Medical and behavioral crisis management plan

ABA services shall:

a) Be provided in those settings that maximize treatment outcomes for the individual (i.e., home, community, and/or center)
b) Be designed to provide a systematic approach to helping the member acquire functional skills while reducing undesirable behaviors
c) Include systematic safeguards and supervision to protect the member from critical incidents and other life-endangering situations
d) Have consent form signed by the member/guardian prior to starting ABA services. Assent should be provided when appropriate.
e) Maintain a confidential case file for each member
f) Not be duplicative of services offered by or required of the school/ educational system and/or Early Intervention Program or any other governmental programs
g) Be supervised only by those certified by the BACB and licensed to perform these services
h) Include a minimum supervision amount of 10% of direct therapy hours provided (i.e., codes 97153 and 97154) each month, with in-person supervision accounting for 50% or more of all supervised hours
i) ABA shall not include/ overlap with other services or therapies
j) Include the presence and active participation of a parent/legal guardian at treatment sessions.

i. Parent/caregiver training is critical to the success of this therapy modality and is a requirement of treatment. To ensure adequate intensity, the family/caregivers are required to participate in weekly parent/caregiver training for 5% of the member's 1:1 ABA treatment hours, but no less than 1 hour per week. For example, if a member is receiving 40 hours per week or 1:1 ABA, the requirement for parent/caregiver participation would be 2 hours per week. This ensures that the need of the member correlates with the need of the family caregivers. This also allows adequate time for the family/caregivers to be trained on the skills that are needed to maintain gains outside of direct treatment.

k) Include data (i.e., graphs and a narrative summary) submitted to KPMAS
l) Treatment planning and case supervision shall be provided in proportion to the amount of direct therapy services
m) Notify KPMAS' ABA Program Coordinator if there are changes of behavior that require a new functional analysis or impact services (e.g., bodily injuries, violent acts, natural disasters, disruption of services)

ABA treatment is not to include the following:

a) Care that is custodial in nature
b) A beneficiary that is not medically stable
c) Therapy when measurable functional improvement is not expected, or progress has plateaued
d) Services and supplies that are not clinically appropriate
e) Treatments considered experimental or lacking scientifically proven benefit
f) Services provided outside of the state
g) Services are provided by family or household members as a paid provider (e.g., RBT)
h) Services that are primarily educational in nature
i) Long-term services and support (LTSS) or respite service
j) Remote supervision (i.e., telehealth) provided for more than 50% of supervision hours
k) Supervision of ABA therapy services by staff that do not hold a minimum of BCaBA certification and licensing
l) Treatment planning and/ or case supervision in the absence of ongoing direct therapy services.
m) Weekly service hours exceeding the clinically recommended amount

Payment for ABA services shall only be made to credentialed and authorized ABA providers:

- The code and modifier billed should reflect the face-to-face time exclusively spent with the beneficiary
- If multiple individuals (i.e., licensed practitioner: BCBA-D, BCBA, BCaBA) are providing services to a beneficiary at the same time, only one ABA provider may bill for the services. No reimbursement for concurrent billing of these providers is allowed. Concurrent billing is reimbursable for RBT and the supervising clinician (BCaBA, BCBA, BCBA-D).
- Unless authorized, only one RBT may bill for services at a time

13.4. Re-Authorization

In order to avoid breaks in treatment, the ABA provider shall submit a request for prior authorization (PA) no more than four (4) weeks prior to the end of the approved treatment

period and data dating back no more than 45 days before the end of the authorization. Authorization requests will not be backdated. The PA request shall include an updated ABA Treatment Plan that is a re-evaluation that assesses progress toward treatment goals as well as a completed Re-evaluation checklist. The follow-up ABA Treatment Plan and the Re-evaluation checklist are to be submitted after five (5) full months of therapy to determine if the individual is making progress. Subsequent authorization periods are not to exceed six (6) months. KPMAS may continue to authorize ABA services for an individual when all the following criteria are met:

a) Measured present levels of performance that is compared to baseline, as shown in the graphs, in the following skill domain areas: social, communication, cognitive, adaptive, and functioning
b) Include anticipated timeline and hours for the mastery of the treatment goals and objectives address
c) The member and family/ caregiver are actively involved in treatment
d) Re-evaluation is done no later than 24 weeks after the initial course of treatment has begun
e) There is a reasonable expectation the individual will improve significantly with the continuation of ABA services

13.5. Criteria for Discharge

a) No significant, measurable improvement has been documented in the individual's targeted behavior(s) and this is reasonably attributable to the services provided; or if after a period of 6 months of optimal treatment (assessed at 1 month prior to the end of the authorization), there is no reasonable expectation that termination of the current treatment would put the individual at risk for decompensation or the recurrence of signs and symptoms that necessitated treatment.
a. For changes to be "significant", they must result in improved function, be durable over time, and be generalizable outside the treatment setting
b) Treatment is making the symptoms persistently worse
c) The member has achieved adequate stabilization of the challenging behavior and less-intensive modes of therapy are appropriate
d) The member demonstrates an inability to maintain long-term gains from the proposed plan of treatment
e) The member's parent/legal guardian have not been present and actively participating at each treatment session
f) On discharge, KPMAS should be notified in writing

13.6. Addendums to Current Authorizations

There are times when issues arise in the middle of a six-month authorization that require a change to treatment. For any requests to change approved ABA services, the ABA provider must submit an addendum.

Addendums should:

- Include a list of codes and units to be changed
- Include list of remaining weeks and units that should remain in the authorization
- Clinical justification for the requested changes
- Any additional goals to be included following the noted changes
- Be submitted by fax to BHUM at 855-414-1703

13.7. CPT Codes for ABA

See the KPMAS contract for fee schedule and code modifiers.

Service Name	Description	Provider Level(s) Associated
Behavior Identification Assessment	Face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan, 15 minutes each.	BCBA or BCaBA
Behavior Identification Supporting Assessment	Administered by one Technician under the direction of a QHP, face-to-face with patient, 15 minutes each.	RBT
Adaptive Behavior Treatment by Protocol	Administered by a Technician under the direction of a QHP, face-to-face with one patient, 15 minutes each.	RBT, BCaBA or BCBA
Group Adaptive Behavior Treatment by Protocol	Administered by a Technician under the direction of a QHP, face-to-face with two or more patients, 15 minutes each.	RBT or BCaBA
Adaptive Behavior Treatment with Protocol Modification	Administered by a QHP, which may include simultaneous direction of Technician, or face-to-face with one patient, 15 minutes each.	BCBA or BCaBA
Multiple-Family Group Adaptive Behavior Treatment Guidance	Administered by a QHP (without patient present), face-to-face with multiple sets of guardians/caregivers, 15 minutes each.	BCBA or BCaBA
Group Adaptive Behavior Treatment with Protocol Modification	Administered by a QHP, face-to-face with multiple patients, 15 minutes each	BCBA
Treatment Planning by QHP	Administered by a QHP, indirect services related to updating and reviewing developmental protocols	BCBA or BCaBA

ABA Authorization Request Form

Service Category	Total Daily Hours/Days per Week	Total Weekly Hours	Total Hours, 6 Months	Code	Provider Level	Request by Code for 6-month Period	Notes
Example	2 hours/5 days	10 hours	260 hours	97153	RBT	1040 units	
Behavior Identification Assessment				97151HN	BCaBA		Initial Assessment up to 8 hours; 6-month re-authorization up to 6 hours *Face-to-face and indirect*
				97151HO	BCBA		
Behavior Identification Supporting Assessment				97152	RBT		Request needs medical necessity justification and is approved for no more than 8 hours per authorization period *Face-to-face*
Adaptive Behavior Treatment by Protocol				97153	RBT		*Face-to-face*
				97153HN	BCaBA		
				97153HO	BCBA		
Group Adaptive Behavior Treatment by Protocol				97154	RBT		*Face-to-face*
				97154HN	BCaBA		
Adaptive Behavior Treatment with Protocol Modification				97155HN	BCaBA (Supervision)		Up to 15% of total RBT hours; can concurrently bill with 97153/ 97154 if a BCBA is not providing direct therapy *Up to 50% may be virtual*
				97155HO	BCBA (Supervision)		
Family Adaptive Behavior Treatment Guidance				97156HN	BCaBA		*Face-to-face or telehealth*
				97156HO	BCBA		
Multiple-Family Group Adaptive Behavior Treatment Guidance				97157HN	BCaBA		*Face-to-face or telehealth*
				97157HO	BCBA		

Service Category	Total Daily Hours/Days per Week	Total Weekly Hours	Total Hours, 6 Months	Code	Provider Level	Request by Code for 6-month Period	Notes
Example	2 hours/5 days	10 hours	260 hours	97153	RBT	1040 units	
Group Adaptive Behavior Treatment with Protocol Modification				97158HO	BCBA		*Face-to-face*
Treatment Planning by QHP				H0032HN	BCaBA		5% of the total RBT direct treatment hours *Indirect*
				H0032HO	BCBA		

14. PROVIDER APPEALS AND DISPUTES

14.1. Provider Appealing on Behalf of a Member

Refer to Sections 5.6 and 9.25

14.2. Provider Payment Disputes

Providers who disagree with a Health Plan decision not to pay a claim in full or in part may file a payment dispute request. Payment disputes must be filed within one hundred eighty (180) days of the date of the denial and/or explanation of payment. The dispute process applies only to clean claims as outlined in Section 8.2 – Clean Claims of this Manual.

You may request a dispute online, via phone or by mail. Please provide the following information when requesting a dispute:

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

Online

To submit electronically, please visit kp.org/providers/mas, and locate *Online Provider Tools* from the *Provider Resources* section. When you submit disputes online, you will receive an acknowledgement letter and resolution letter in your Online Affiliate in-basket.

For help with Online Affiliate enrollment or navigation, please submit a support case at https://kpnationalclaims.my.site.com/support/s/.

Phone

A participating provider may initiate a payment dispute by calling ☎ 877-806-7470.

Mail

A payment dispute request may also be submitted in writing and sent to:

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

Administrative Appeal

Kaiser Permanente provides a decision on all provider disputes within forty-five (45) days. Any "action" or reconsideration decision rendered by Kaiser Permanente may be appealed by the provider to the Department of Medical Assistance Services (DMAS) Appeals Division after the provider has exhausted Kaiser Permanente's reconsideration process. All provider appeals to DMAS must be submitted in writing and within thirty (30) days of Kaiser Permanente's last date of denial. Provider appeals to DMAS will be conducted in accordance with the requirements set forth in 12 VAC 30-20-500 *et.seq.* The DMAS appeals process for provider appeals includes two (2) different levels of appeals: informal and formal. The informal appeal is before an informal appeals agent employed by DMAS. The formal appeal is before a hearing officer appointed by

the Supreme Court of Virginia, and an administrative hearing representative employed by DMAS helps present DMAS' position.

A written request to appeal the decision with DMAS should be sent to:

Provider Appeals Division
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

A decision to uphold or reverse the decision made by Kaiser Permanente will be issued by DMAS.

Timely Filing Requirements and Appeal of Timely Filing
All claims must be received within the timeframes defined under Section 8.2 – Timely Filing Requirements 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 frames outlined in Section 8.2 – Timely Filing Requirements of this Manual. Acceptable proof of timely filing may include the documentation and/or situations in the table in Section 8.9.

14.3 Provider/Practitioner Credentialing and Re-Credentialing Appeals

Practitioner credentialing applications and re-credentialing decisions are reviewed by Kaiser Permanente's Mid-Atlantic States Credentialing and Privileges Committee (MASCAP). MASCAP includes physicians of various surgical and medical specialties, including primary care, allied health professionals as well as representation from Health Plan. Participating providers are required to meet and maintain Kaiser Permanente credentialing standards to provide care to members.

In the event of an adverse credentialing or re-credentialing decision, a provider may have the right to appeal the decision within (30) thirty days from the date of written notification. To request an appeal a practitioner or their authorized representative should respond in accordance with the written notification to our Practitioner and Provider Quality Assurance Department (PPQA) at ☎ 301-816-5853.