Kaiser Permanente Baltimore Harbor Medical Center

Kaiser Permanente is pleased to announce the opening of our new Baltimore Harbor Medical Center located at 815 East Pratt St., Baltimore, MD 21202. The new Baltimore Harbor facility opened November 9, 2015, and is now serving Kaiser Permanente members.

The 19,000 square foot state-of-the-art facility provides a convenient location for the large and growing number of Kaiser Permanente members in the Inner Harbor of Baltimore. It will be located at the corner of President & Pratt Street and will include ample on-site parking in a five story parking garage on top of the facility. Kaiser Permanente is constantly investing in the communities it serves to offer its unique model of delivery which produces high quality committed physicians and services at an affordable cost.

For more information about our Baltimore Harbor Medical Center please visit our provider website at providers.kaiserpermanente.org/mas. Should you have any questions, please contact Provider Relations at (877) 806-7470 and look
for our mailings on up and coming new Medical Centers. Services now available at our new state-of-the-art facility in the Baltimore Harbor:

- Internal Medicine/Family Practice
- Laboratory
- OB/GYN
- Radiology
- Mammography
- X-ray
- Pharmacy
- Pediatrics (at a later date)

Days’ supply limitations for Schedule II (CII) to Schedule V (CV) Opioid-containing products now in effect

Effective September 1, 2015, prescriptions for Schedule II (CII) to Schedule V (CV) opioid-containing products will be limited to a 30-days’ supply for all Kaiser Permanente Mid-Atlantic States (KPMAS) members in all lines of business.

Opioid overdose continues to be a major public health problem. In 2010, the Centers for Disease Control (CDC) reported that almost 60% of drug overdose deaths involved pharmaceuticals and of this 60%, three out of every four deaths involved opioid analgesics such as hydrocodone, methadone, and oxycodone.

Given the significant potential for misuse, abuse, and diversion of opioids, KPMAS will limit prescriptions for Schedule II to Schedule V opioid-containing products to a 30-day supply within a 30-day period, effective September 1, 2015.

Examples of commonly prescribed Schedule II to Schedule V opioid-containing products are included in the following table:

<table>
<thead>
<tr>
<th>Commonly prescribed opioid-containing products</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>Hydrocodone/Ibuprofen</td>
</tr>
<tr>
<td>Codeine/Acetaminophen</td>
<td>Hydromorphone</td>
</tr>
<tr>
<td>Codeine/Butalbital/Acetaminophen/Caffeine</td>
<td>Methadone</td>
</tr>
<tr>
<td>Codeine/Butalbital/Aspirin/Caffeine</td>
<td>Morphine sulfate</td>
</tr>
<tr>
<td>Codeine/Guaifenesin</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>Codeine/Promethazine</td>
<td>Oxycodone/Acetaminophen</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Tramadol</td>
</tr>
<tr>
<td>Hydrocodone/Acetaminophen</td>
<td>Tramadol/Acetaminophen</td>
</tr>
</tbody>
</table>

Best practices for responsible opioid prescribing include ordering the lowest effective dose for the shortest duration of therapy to manage the patient’s condition.
Medical Coverage Policy updates III - 2015

The following Medical Coverage Policies (MCPs) and National Transplant Patient Selection Criteria standards were approved and published for use in June – September 2015.

MCPs are developed in collaboration with specialty service chiefs and clinical subject matter experts. MCPs specify clinical criteria supported by current peer reviewed literature and are intended to guide use of health care services such as devices, drugs, and procedures. The policies are reviewed and updated annually, reviewed for approval by the Regional Utilization Management Committee (RUMC), and filed with the Maryland Insurance Administration. Our MCPs are primarily applicable only to commercial members, except where noted.

- **Bariatric surgery, Maryland**: Defines coverage requirements for initial and repeat bariatric surgery for Maryland members, reflecting Maryland law.
- **Bariatric surgery for DC/Federal and Virginia**: Defines coverage and presurgical requirements for non-Maryland members, including initial and repeat bariatric surgery.
- **Circumcision**: Defines coverage for routine coverage of newborn circumcision plus coverage of circumcision for adopted males at any age. Also provides indications and evaluation requirements of circumcision coverage for conditions of infection or obstruction.
- **Cochlear implant**: Expands coverage of cochlear implants to include moderate levels of hearing loss and outlines replacement of existing components prior to complete component failure. Note: criteria for Auditory Brainstem Implants was removed from this policy as Kaiser Permanente Mid-Atlantic States now uses MCG criteria to evaluate Auditory Brainstem Implants.
- **Compression garment for upper and lower extremities**: Provides indications and evaluation requirements for use of compression garments for lymphedema, venous stasis ulcers, hypertrophic scarring, and post amputation compression therapy.
• **Continuous glucose monitors:** Provides indications and evaluation requirements for use of continuous glucose monitors for both adult and pediatric populations.

• **Hyperbaric oxygen:** Provides indications and wound management requirements for use of hyperbaric oxygen treatments.

• **Insulin infusion pumps:** Provides indications for coverage and management of external insulin pumps.

• **Pelvic floor rehabilitation:** New Outlines use of Pelvic Floor rehabilitation for condition of chronic myofascial pelvic pain only. All other conditions referred for pelvic floor rehabilitation are reviewed under MCG criteria.

• **Preimplantation Genetic Diagnosis (PGD):** New Outlines indications and coverage of PGD testing for congenital anomalies of the embryo.

• **Transgender surgery for District of Columbia (DC) members only:** New Provides coverage indications and services for DC contract members, per DC regulations to align with the WPATH standards.

• **Varicose veins:** Outlines indications and coverage of venous surgery for venous insufficiency.

• **Vitiligo, treatment of:** Outlines indications and coverage of phototherapy for patients who have not responded to topical and/or systemic corticosteroid therapy or tacrolimus pimecromlimus.

Access to MCPs is only two clicks away in Health Connect. Click on the Clinical Library section on the right side of the KPHC Home page and then type in “medical coverage policy” in the search box. All medical coverage policies will be displayed.

If you would like to receive a hard copy of a Medical Coverage Policy please contact the Utilization Management Operations Center (UMOC) at (800) 810-4766 and follow the prompts.

If you have clinical questions on use of our criteria, please feel free to contact:

* Claudia Donovan M.D.
  Physician Referral Reviewer
  Claudia.K.Donovan@kp.org

If you have general questions concerning use of our criteria, please contact:

* Robin S. Boltz R.N.
  Compliance & Program Manager
  robin.s.boltz@kp.org
  (301) 816-5656
New technology

Gregory Alexander, M.D., F.A.A.F.P.
Physician Director, Referrals and Medical Policies

The Kaiser Permanente Technology Review and Implementation Committee (TRIC) reviews new and emerging technologies that are pertinent to the Kaiser Permanente Mid-Atlantic States (KPMAS) delivery system. The comments and recommendations made for adoption of the new technologies listed below were approved by the committee in August-September 2015.

Tenex Health TX for percutaneous tenotomy or fasciotomy
- There is insufficient evidence to determine whether Tenex Health TX for Percutaneous Tenotomy or Fasciotomy is a medically appropriate treatment option for any patient.

Mesenchymal Stem Cells (MSCs) for orthopedic indications
- There is insufficient evidence to determine whether mesenchymal stem cell (MSC) transplantation is a medically appropriate treatment option for any patient with osteoarthritis of the knee.

DaTscan for the diagnosis/management of Parkinson’s disease
- DaTscan is a medically appropriate diagnostic option for some highly selected patients with symptoms that may be related to Parkinsonian syndrome. Test may be considered for coverage on a case by case basis with review by KPMAS neurology service chief.

Tumor-treating fields (Optune) for glioblastoma
- Due to the lack of additional treatment options for patients that have failed all other glioblastoma treatments (chemotherapy, surgery, and radiation), KPMAS recommends tumor treating fields (Optune) as a medically appropriate treatment for patients with recurrent glioblastoma, following current FDA use and indications.

Oral capsules fecal microbiota transplantation for C Diff
- We will delay approval of the Fecal Microbiota Transplantation (FMT) Frozen donor stool capsules until additional published data on FMT is available. However, since this capsule route for FMT delivery has ease and cost effectiveness, KPMAS has planned a controlled study comparing FMT capsules provided by the manufacturer to a standard enema delivered microbiota preparation from another manufacturer. Until further data and study results are available, KPMAS will follow the current protocol of enema delivery of FMT as the first treatment option followed by nasogastric tube or salvage colonoscopy.

Alpha-defensin and leukocyte esterase tests for diagnosis of periprosthetic joint infection
- The diagnostic alpha-defensin dip stick test is in use to rule out septic arthritis or periprosthetic joint infections of the knee or hip. There is insufficient evidence to determine whether alpha-defensin testing is a medically appropriate diagnostic option for patients with suspected periprosthetic joint infection of other joints such as shoulder, or elbow.

Neuropace for epilepsy
- Responsive neurostimulation (RNS) is a medically appropriate adjunctive treatment option to reduce the frequency of disabling seizures in highly select patients with medically refractory epilepsy.

Femtosecond laser assisted cataract surgery
- There is not adequate evidence to support additional technology capital investment that would not add value to the good outcomes already obtained.

Continuing Care HUB

The Continuing Care HUB supports members in home Palliative Care and Hospice Services

Fax number 301-388-1758 will be changing to 855-414-1691 effective December 9, 2015. For questions please call 301-562-6683.
obtained with conventional cataract surgery. The current medical evidence does not support use of Femtosecond laser as superior to conventional cataract surgery.

**Corneal collagen cross-linking (CXL) for treating keratoconus** – Evidence is adequate of CXL as effective for early keratoconus and for corneal ectasia. After final FDA approval, KPMAS will move forward with independent review of coverage extension for CXL, following FDA use and indications.

**WATCHMAN™ left atrial appendage closure (LAAC) therapy for stroke prevention in patients with non-valvular atrial fibrillation** – KPMAS recommends WATCHMAN LAAC as a medically appropriate treatment for patients with non-valvular atrial fibrillation. WATCHMAN™ may be covered, following current FDA use and indications, for patients with non-valvular atrial fibrillation, on a case by case basis, as reviewed and approved by a KPMAS cardiology service chief.

For clinical comments or questions on these updates, please contact Dr. Gregory Alexander or Dr. Claudia Donovan via the Kaiser Permanente Paging Operator at (888) 989-1144.

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**Coming soon**

Kaiser Permanente is proud to announce a new claims system scheduled to be implemented early next year. The new claims system will provide enhancements such as the ability to view claims and check status online. In order to access the new features, you will need to be registered as a user on our Online Affiliate site. If you are not already registered, you may do so online at providers.kaiserpermanente.org/mas under Online Affiliate Registration. Along with these changes, the claim submission address and provider dispute and appeals address will also be changing. Check our website for up-to-date information and be on the lookout for more information as we get closer to implementation.
Coding for chronic diagnoses based on ICD-10 guidelines

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s). Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Documentation suggestions
- If diagnosis is not established, document signs or symptoms
- Always document a rule out or probable or possible diagnoses, but never code them
- Document all diagnoses, or problems that you are managing or must consider at the current encounter/service
- Document status of condition: resolved, unresolved, stable, unstable, controlled, uncontrolled
- The Diagnoses or problems, signs or symptoms must be documented in every note… “each note stands alone”

Note: When a patient is currently being treated/managed for a specific condition the problem is current. DO NOT indicate “history of……

Diagnosis basics
- The first listed diagnosis in the assessment should be the diagnosis, condition, or other reason for the encounter/service.
- The 1st listed should indicate the condition that is chiefly responsible for the encounter/service that day.
- Include as a secondary diagnosis only those conditions that affect the risk level (medical decision making) of the current visit.
- Secondary diagnoses can help show medical necessity for services and explain the increased risk levels for that encounter.

For outpatient physician coding
Do not code diagnosis documented as “probable”, “rule-out”, “suspected”, etc. Instead code the condition using signs and symptoms, abnormal test results or other reason.

Do document the “probable”, “rule-out”, etc. diagnosis.
Example: Patient complains of dizziness and double vision: diagnosis for visit is: “rule-out” multiple sclerosis. Diagnosis codes for encounter are dizziness & double vision

**In the inpatient setting**
If a diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “rule out,” the condition should be coded as if it existed or was established. The basis for this guideline are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

**Symptoms followed by contrasting/comparative diagnoses**
When selecting the principal diagnosis in the inpatient setting, if a symptom is followed by contrasting/comparative diagnoses, the symptom code should be sequenced first and all of the contrasting/comparative diagnoses should be coded as suspected conditions per the guideline mentioned above concerning the coding of “suspected” inpatient diagnoses. For contrasting/comparative diagnoses involving secondary diagnoses in the inpatient setting, only the symptom should be coded. The contrasting/comparative diagnoses should not be coded. However, when a symptom is followed by contrasting/comparative diagnoses in an outpatient setting, only the symptom should be coded.

**News from the lab: New laboratory system requires ICD-10 DX codes for all lab orders**

Exciting changes are coming to the Mid-Atlantic States Laboratory in December 2015! The MAS Laboratory is moving from its current system, SunQuest, to a new up-to-date system, Cerner Millennium. With membership growing and technology advancing, Cerner Millennium is a National Kaiser Permanente investment in the soundness of the Lab’s infrastructure and KP’s integrated care model.

You might be wondering what this means for you. Cerner has been designed to ensure complete and compliant data collection for all lab orders. As such, ICD-10 diagnosis codes are required for all lab order entries. Orders without a diagnosis code will not be able to be entered in the system, so we are asking that you remember to always provide an ICD-10 diagnosis code when writing lab orders for Kaiser Permanente members. Please also note that with the new system, the Final Results reports you receive from us will look different. If you have any questions, please do not hesitate to contact us at LISSUPPORT@kp.org.

Thank you for helping MAS Laboratory better serve our members, and for your continued partnership in delivering excellent patient care in our community.
Pharmaceutical management information and updates

The KPMAS Regional Pharmacy & Therapeutics (P&T) Committee approves drug formularies for all lines of business, Commercial, Marketplace/Exchange, Medicare, Virginia Medicaid and MD HealthChoice (Medicaid).

The Regional P&T Committee, with expert guidance from various medical specialties, evaluates, appraises, and selects from available medications those considered to be the most appropriate for patient care and general use within the region. The purpose of the formulary is to promote rational, safe, and cost-effective drug use.

The formularies are updated monthly with additions and/or deletions approved by the Regional P&T Committee. For the most recent information on drug formulary updates or changes, please reference the online Community Provider Portal for affiliated practitioners available at providers. kaiserpermanente.org/html/cpp_mas/formulary.html. A printed copy of each drug formulary is available upon request from the Provider Relations department at (877) 806-7470.

Documentation of coordination of care with primary care physicians (PCPs)

Kaiser Permanente continues to be a leader in promoting the integration of behavioral and medical health care and views care coordination between Behavioral Health and Primary Care to be a critical aspect of treatment.

Behavioral Health providers are asked to obtain the member’s consent to communicate the following to the patient’s PCP within seven (7) days of the beginning of treatment:
- Date of initial service
- Patient’s diagnosis and brief assessment of their findings
- Treatment plan and recommendations
- Medications prescribed

If you are not sure how to contact the member’s PCP, you may mail or fax treatment information to the following address and we will make sure the PCP gets your report:

Kaiser Permanente
Regional HIMS
6526 Belcrest Road, Suite 207
Hyattsville, Maryland 20782
Fax: (301) 209-6065
Getting care away from home

Providing services to our members away from home
Kaiser Permanente members that travel to our service area from other regions that we service can receive some of the same types of care in the Mid-Atlantic Region that they can in their home region. Please always urge the member to call Member Services at (800) 777-7902 (TTY 711), Monday through Friday, 7:30 a.m. to 9 p.m. (except holidays), or the 24 hour medical advice line at (800) 777-7904 (TTY 711), for approval unless it is a medical emergency. If they have a medical emergency, urge them to seek care right away and go to a hospital or an urgent care facility.

How can a member get urgent care?
If a member needs urgent care outside a Kaiser Permanente service area in the United States, they can visit an urgent care clinic instead of a hospital emergency department. We’ll cover urgent care at non-Kaiser Permanente facilities as long as it can’t wait until they get back to a Kaiser Permanente service area.

Does the member need approval first?
For some services, they will need approval from their home service area. For other services, they may also need approval from the area they are visiting.

Urge them to call Member Services in the service area they are visiting for more information. If they are visiting a GHC service area, call (888) 901-4636.

How does a member submit a claim?
When they receive emergency or urgent care in the United States, you the provider may bill Kaiser Permanente directly. If you do, the member will not need to submit a claim and we will pay your practice directly. If the member pays out-of-pocket for their services, please provide them with an itemized bill, a copy of their medical records, and receipt for their payment. Please advise the member to keep these documents in order to submit a reimbursement from Kaiser Permanente.
MEMBER SERVICES PHONE NUMBERS

Here is a list of Member Services phone numbers for all of our regions.

**California**
(800) 464-4000 (TTY 711)
Open 24 hours a day, 7 days a week. Closed holidays and at 10 p.m. on Christmas Eve, New Year’s Eve, and the day after Thanksgiving.

**Colorado**
Denver/Boulder service area
(303) 338-3800 or 800-632-9700 (TTY 711)
Mon-Fri, 8 a.m.–6 p.m.

Northern Colorado service area
( Including Greeley, Fort Collins, and Loveland)
(844) 201-5824 (TTY 711)
Mon-Fri, 8 a.m.–6 p.m.

Southern Colorado service area
( Including Colorado Springs and Pueblo, as well as the Cañon City and Woodland Park communities)
(888) 681-7878 (TTY 711)
Mon-Fri, 8 a.m.–6 p.m.

District of Columbia, Maryland, and Virginia
(Mid-Atlantic States)
(800) 777-7902 (TTY 711)
Mon-Fri, 7:30 a.m.–9 p.m. (except holidays)

**Georgia**
Atlanta metro service area
(404) 261-2590 (from Atlanta metro area)
(800) 255-0056 (TTY)
Mon-Fri, 7 a.m.–7 p.m.

**Hawaii**
Islands of Oahu, Maui, Hawaii, Kauai, Lanai, and Molokai
(808) 432-5955 (from Oahu)
(800) 966-5955 (from other areas)
(877) 447-5990 (TTY)
Mon-Fri, 8 a.m.–5 p.m.; Sat, 8 a.m.–noon

**Oregon**
(503) 813-2000 (from Portland)
(800) 324-8010 (language interpreter)
Mon-Fri, 8 a.m.–6 p.m.

**Washington State**
Southwest area
(800) 813-2000 (TTY 711)
(800) 324-8010 (language interpreter)
Mon-Fri, 8 a.m.–6 p.m.

Group Health Cooperative (GHC)
Customer Service
(888) 901-4636
(800) 833-6388 (TTY)
Mon-Fri, 8 a.m.–5 p.m.

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**Did you know?**

- Soon you will be able to look up Claims Status on our AffiliateLink Provider Website
- Kaiser no longer accepts Paper Enrollment to our Provider Website. All enrollment into our Provider Website is electronic; go to providers.kp.org/mas to register for Online Affiliate Access.

Please call us with any questions you may have at (877) 806-7470.
Industry and governmental criteria sets approved and in use

In September-October 2015, the KPMAS approved and adopted the continuing use of the following industry and governmental criteria sets.

• **McKesson Interqual standards, 15th edition**, was reviewed and approved as the ongoing standard criteria to manage the transplant related care of both pediatric and adult transplant patients. You may obtain a copy of these Interqual standards by contacting the Utilization Management Operations Center (UMOC) at (800) 810-4766.

• **The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements** of the federal government will continue to be in use for our Medicaid populations in both Maryland and Virginia. The federal mandated services include screening, vision, dental, hearing, and diagnostic services plus the treatment health care services for all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures. The EPSDT federal requirements for children under age 21 who are enrolled in Medicaid may be found at Medicaid.gov, search EPSDT.

Keeping the provider directory up to date

Please use the sample letter format on the next page to update us with any changes you may have throughout the year. It is very important that we have the most accurate information when we pull our data for the directory.

Changes may be made by fax to: (855) 414-2623, email Provider.Relations@kp.org, or by mail:
Kaiser Foundation Health Plan of The Mid-Atlantic States, Inc.
Provider Relations; Flr 2 East
2101 East Jefferson St.
Rockville, MD 20852

If you would like to request a provider directory please contact Member Services at:
• Within the Washington, D.C., metro area call (301) 468-6000, (301) 879-6380 TTY
• All other areas outside of Washington, D.C., metro area call (877) 777-7902, (800) 700-4901 TTY

Medical record documentation standards

Medical record documentation standards are based on and adopted from several risk management and quality improvement sources. Medical record documentation is required to report pertinent facts, findings, and observations about an individual’s physical or mental health history (including present illnesses and/or chronic conditions and past medical, surgical and social histories), examinations, tests, treatments, and outcomes.

The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. Payers have a contractual obligation to enrollees and may require reasonable documentation that services are consistent with coverage provided.

Validation may include the following information:
• Location of service.
• Medical necessity and appropriateness of diagnostic and/or therapeutic services.
• Services provided have been correctly coded and reported based on supporting documentation in the medical record.

Kaiser Permanente of Mid-Atlantic States has adopted the following medical record documentation standards:

Continued on page 14
Date __ / __ / ___

Requestor: ____________________________________________________________________________

Correspondence address: __________________________________________________________________

Phone __________________________ Email __________________________

Tax ID __________________________ Effective date of change(s) ___ / ___ / ___

REASON FOR THE REQUEST

☐ Address change ☐ Practice location (☐ Add ☐ Delete) ☐ Billing address (☐ Add ☐ Delete)

Previous address ______________________________________________________

(STREET, CITY, STATE, ZIP, PHONE, FAX AND NPI)

New address ___________________________________________________________

(STREET, CITY, STATE, ZIP, PHONE, FAX AND NPI)

☐ Adding a provider to an existing group ☐ Deleting a provider from an existing group:

First name __________________________ Middle initial ___ Last name __________________________

Gender ☐ M ☐ F Title or Degree __________________________ NPI # __________________________

CAQH # __________________________ UPIN or SSN __________________________

Medicare # __________________________ Medicaid # __________________________

Medicaid participation State(s) __________________________

Primary specialty (include secondary specialty if applicable) __________________________

Practice location address _____________________________________________

(STREET, CITY, STATE, ZIP)

Billing/Payment address _____________________________________________

Management correspondence address _______________________________________

(Street, City, State, Zip)

Foreign languages ______________________________________________________

☐ Changing the Tax Identification Number and/or the name of an existing group

Previous Tax ID number __________________________ Tax ID number __________________________

Previous Group name __________________________ New group name __________________________

Effective date ___ / ___ / ___ Please include a signed and dated copy of the new W-9

Billing/Payment address _____________________________________________

(STREET, CITY, STATE, ZIP)

Management correspondence address _______________________________________

(STREET, CITY, STATE, ZIP)

Email your letter to the Provider Relations Department at Provider.Relations@kp.org or fax to (855) 414-2623.
Medical record documentation standards (continued)

1. All entries are legible.
2. All entries are authenticated by the author with signature, credentials and date of entry.
3. Medication allergies and adverse reactions are prominently listed or noted as “none” or “NKA.”
4. There is an immunization summary for patients 18 years and younger.
5. There is a problem list with significant illnesses and conditions listed in the medical record.
6. Chronic conditions and significant illnesses are listed.
7. Past surgical history is documented or noted as “none” on the problem list or face sheet.
8. Family history is documented or noted as “none” on the problem list or face sheet.
9. For patients 14 years and older, there is documentation of the following in either the progress note or face sheet.
   a. Alcohol use or lack thereof
   b. Substance use or lack thereof
   c. Tobacco use or lack thereof
   d. Sexual behavior
10. There is a chief complaint documented for each encounter visit.
11. There is a history of present illness documented for each encounter visit.
12. There is an examination documented in the progress note relevant to the chief complaint.
13. There is a treatment plan documented for each encounter visit.
14. Follow-up instructions are documented in the encounter and include follow-up instructions and time frame for follow-up.
15. For laboratory orders written during the encounter, the results indicate signature and date of ordering provider’s review.
16. Radiology orders written during the encounter being reviewed, the results indicate signature and date of ordering provider’s review.
17. If a referral or order for services (procedure or diagnostic testing-internal or external) is requested during the encounter being reviewed, there is a written report or results from the consultant/provider in the record.
18. If a consultation is requested, there is a written summary report reflecting the practitioner review with date of review and signature.
19. Abbreviations used within the encounter are listed on the approved “Abbreviation List” located in the physician’s office.

Maryland Prenatal Risk Assessment for Medicaid members

Kaiser Permanente is committed to ensuring the best possible care experience to our members, and our pregnant moms are no exception. As part of the regulations from DHMH, we are required to submit Maryland Pre-Natal Risk Assessment (MPRA) forms to the respective Local Health Departments (LHDs) for every pregnant member in order to evaluate for high-risk pregnancies and subsequently coordinate outreach services if necessary.

To better track our pregnant moms, the Medicaid Office at Kaiser Permanente collects out-bound correspondence to LHDs from our OB/GYN providers. In addition to faxing the MPRA forms to the LHD, we request that a copy of all MPRA forms be faxed to our Medicaid Care Delivery Specialist, Kirsten Bickford. Her contact information is listed below for your convenience.

Kirsten Bickford, Medicaid Care Delivery Specialist
kirsten.l.bickford@kp.org
Office: (301) 816-6691
Fax: (301) 388-1796

A sample of the MPRA form is on the next page for your reference, which has LHD contact information included. To obtain additional quantities of MPRA forms, contact the LHD Administrative Care Coordination Unit (ACCU) in which county the member resides.
# MARYLAND PREGNATAL RISK ASSESSMENT

**Refer to instructions on back before starting**

**Date of Visit:** __/__/__

**Provider Name:** ______________________________  **Provider Phone Number:** ___________ ___________

**Provider NPI:** ______________________________  **Site NPI:** ______________________________

**Client Last Name:** __________________________  **First Name:** ___________________  **Middle:** ________

**House Number:** ____________________________  **Street Name:** ____________________________  **Apt:** ________  **City:** ____________________________

**County (If patient lives in Baltimore City, leave blank):** ____________________________  **State:** ____________________________  **Zip Code:** __________

**Home Phone #:** ___________  **Cell Phone#:** ___________  **Emergency Phone#:** ___________

**SSN:** ___________  **DOB:** ___________  **DCB:** ___________  **Emergency Contact:** __________________________

**Race:**
- African-American or Black
- Asian
- American Indian
- Asian
- Native Hawaiian or Other Pacific Islander
- Other
- Unknown

**Language Barrier?**  Yes  No

**Specify Primary Language:**

**Hispanic?**  Yes  No

**Marital Status:**
- Single
- Married
- Unmarried
- Unknown

**Educational Level**

**Highest grade completed:**

**GED?**  Yes  No

**Currently in school?**  Yes  No

**Transferred from other source of prenatal care?**  Yes  No

**If yes, date care began:** ___________  ___________

**Other source of prenatal care:** ____________________________

**Trimester of 1st prenatal visit:**
- 1st
- 2nd
- 3rd

**LMP:** ___________  ___________  Initial EDC: ___________  ___________

**Medical Risks:**

**Current Medical Conditions of this Pregnancy:**
- Age ≤15
- Age ≥ 45
- BMI < 18.5 or BMI > 30
- Hypertension (> 140/90)
- Anemia (Hgb < 12 or Hct < 30)
- Asthma
- Sick cell disease
- Diabetes: Insulin dependent  Yes  No
- Vaginal bleeding (after 12 weeks)
- Genetic risk: Specify
- Sexually transmitted disease: Specify
- Last dental visit over 1 year ago
- Prescription drugs
- History of depression/mental illness: Specify
- Depression assessment completed?  Yes  No
- Other medical risk (specify in comment box)

**Comments on medical risks:**

**Psychosocial Risks:**

**Check all that apply:**
- Current pregnancy unintended
- Less than 1 year since last delivery
- Late registration (more than 20 weeks gestation)
- Disability (mental/physical/developmental): Specify
- History of abuse/violence within past 6 months
- Tobacco use: Amount
- Alcohol use: Amount
- Illegal substances within past 6 months
- Resides in home built prior to 1978: Rent  Own
- Homelessness
- Lack of social/emotional support
- Exposure to long-term stress
- Lack of transportation
- Other psychosocial risk (specify in comments box)
- None of the above

**Comments on psychosocial risks:**

Form Completed By: __________________________

Date Form Completed: ___________  ___________

DHMH 4850  revised March 2014

DO NOT WRITE IN THIS SPACE  9005
Participating provider communication resources and fax number updates effective December 9, 2015.

- **Provider Relations**
  - Phone number (877) 806-7470
  - Fax number (855) 414-2623
  - Email Provider.Relations@kp.org
- **KP HealthConnect AffiliateLink**
  - Fax number (855) 414-2624
- **Provider contracting**
  - Fax number (855) 414-2621
- **Provider appeals**
  - Fax number (855) 414-2622
- **Provider field operations specialists**
  - Fax number (855) 414-2620
- **Community provider portal website:** providers.kaiserpermanente.org/mas.

**Fax numbers to request pre-authorizations**

The Utilization Management Operation Center (Kaiser Permanente’s Pre-authorization Department) will be undergoing a fax gateway update and fax numbers used to request authorizations for care and provide clinical updates will be changing for the following services:

- **Continue faxing Unified Referral Forms (URFs) to:**
  - Main Fax Number
  - Toll Free (800) 660-2019
- **Reauthorization requests and clinical updates for home health**
  - Toll Free (855) 414-1695

- **Outpatient PT/OT/ST**
  - Toll Free (855) 414-1698
- **Continuity of care forms**
  - Toll Free (855) 414-1699
- **Clinical research trials**
  - Toll Free (855) 414-1692

**Questions?**

Please Contact the Utilization Management Operation Center

Toll Free (800) 810-4766

Select Provider and Follow the prompts