Virginia Premier Kaiser Permanente Medicaid Program Participating Provider Manual
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1.0 INTRODUCTION: VIRGINIA PREMIER KAISER PERMANENTE MEDICAID PROGRAM

Kaiser Permanente has entered into an innovative collaboration with Virginia Premier, the second largest Medicaid managed care organization in Virginia, to create a fully integrated health care experience. Unless members choose otherwise, starting October 1, 2018, current Kaiser Permanente Medicaid members will continue to receive Kaiser Permanente’s integrated health care.

Formed in 1995 as a Medicaid HMO, Virginia Premier is the only Commonwealth affiliated, non-profit managed care organization in Virginia, now serving roughly 220,000 members statewide. Virginia Premier is a mission-driven, major Managed Care Organization with a long-standing history of providing access to care throughout the Commonwealth. It shares our values of quality, innovation, education, affordability, and service to our members and communities. Virginia Premier is a wholly-owned subsidiary of the Virginia Commonwealth University Health System and is uniquely aligned with the Commonwealth’s health policy.

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.

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 UMOC call (800) 810-4766, fax (301) 879-6192, or send a referral message by logging on to KP HealthConnect AffiliateLink at www.providers.kaiserpermanente.org/mas.

Authorization services for planned inpatient and outpatient care are available Monday-Friday from 8:30 A.M. to 5:00 P.M. On weekends and holidays, nurses can be reached from 8:30 A.M. to 5:00 P.M. at UMOC Weekend and Holiday Line: 301-960-1436. Urgent preservice referrals are managed seven days a week, including holidays from 8:30 A.M. to 5:00 P.M.

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 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.

You can reach the UMOC 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
• Speak to a UM physician on any adverse medical necessity denial decision 📞 (1-800-810-4766 and select the appropriate option when prompted)

1.6 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 Permanente Medical Centers
• Maps, driving directions, and other Kaiser Permanente literature
• Status or payment information related to a claims submission
• 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
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 provider website at www.providers.kaiserpermanente.org/mas, 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

<table>
<thead>
<tr>
<th>Medical Center</th>
<th>Address</th>
<th>City, State ZIP</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashburn Medical Center</td>
<td>43480 Yukon Drive, Suite 100</td>
<td>Ashburn, VA 20147</td>
<td>(701) 252-6000</td>
</tr>
<tr>
<td>Manassas Medical Center</td>
<td>10701 Rosemary Drive</td>
<td>Manassas, VA 20109</td>
<td>(703) 257-3000</td>
</tr>
<tr>
<td>Burke Medical Center</td>
<td>5999 Burke Commons Road</td>
<td>Burke, VA 22015</td>
<td>(703) 249-7700</td>
</tr>
<tr>
<td>Reston Medical Center</td>
<td>1890 Metro Center Drive</td>
<td>Reston, VA 20190</td>
<td>(703) 709-1500</td>
</tr>
<tr>
<td>Fair Oaks Medical Center</td>
<td>12255 Fair Lakes Parkway</td>
<td>Fairfax, VA 22033</td>
<td>(703) 934-5700</td>
</tr>
<tr>
<td>Springfield Medical Center</td>
<td>6501 Loisdale Court</td>
<td>Springfield, VA 22150</td>
<td>(703) 922-1000</td>
</tr>
<tr>
<td>Falls Church Medical Center</td>
<td>201 North Washington Street</td>
<td>Falls Church, VA 22046</td>
<td>(703) 237-4000</td>
</tr>
<tr>
<td>Tysons Corner Medical Center</td>
<td>8008 Westpark Drive</td>
<td>McLean, VA 22102</td>
<td>(703) 287-6400</td>
</tr>
<tr>
<td>Fredericksburg Medical Center</td>
<td>1201 Hospital Drive</td>
<td>Fredericksburg, VA 22401</td>
<td>(540) 368-3700</td>
</tr>
<tr>
<td>Woodbridge Medical Center</td>
<td>14139 Potomac Mills Road</td>
<td>Woodbridge, VA 22192</td>
<td>(703) 490-840</td>
</tr>
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### 2.2 Kaiser Permanente Medical Centers – District of Columbia

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<th>Medical Center</th>
<th>Address</th>
<th>City, State ZIP</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Capitol Hill Medical Center</td>
<td>700 Second Street, NE</td>
<td>Washington, DC 20002</td>
<td>(202) 346-3000</td>
</tr>
<tr>
<td>Physicians’ Office Building-Washington Hospital Center</td>
<td>106 Irving Street, NW, Suite 108</td>
<td>Washington, DC 20010</td>
<td>(202) 877-9835</td>
</tr>
<tr>
<td>Northwest Medical Center</td>
<td>2301 M Street, NW</td>
<td>Washington, DC 20037</td>
<td>(202) 419-6200</td>
</tr>
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## 2.3 Kaiser Permanente Medical Centers – Maryland

<table>
<thead>
<tr>
<th>Medical Center</th>
<th>Address</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Camp Springs Medical Center</td>
<td>6104 Old Branch Avenue, Temple Hills, MD 20748</td>
<td>(301) 702-6100</td>
</tr>
<tr>
<td>Physician’s Office Building-Holy Cross Hospital</td>
<td>1400 Forest Glen Road, Silver Spring, MD 20910</td>
<td>(301) 905-3500</td>
</tr>
<tr>
<td>Gaithersburg Medical Center</td>
<td>655 Watkins Mill Road, Gaithersburg, MD 20879</td>
<td>(240) 632-4000</td>
</tr>
<tr>
<td>Prince George’s Medical Center</td>
<td>6525 Belcrest Road, Hyattsville, MD 20782</td>
<td>(301) 209-6000</td>
</tr>
<tr>
<td>Frederick Medical Center</td>
<td>7190 Crestwood Boulevard, Frederick, MD 21703</td>
<td>(240) 529-1700</td>
</tr>
<tr>
<td>Shady Grove Medical Center</td>
<td>1396 Piccard Drive, Rockville, MD 20850</td>
<td>(301) 548-5700</td>
</tr>
<tr>
<td>Kensington Medical Center</td>
<td>10810 Connecticut Avenue, Kensington, MD 20895</td>
<td>(301) 929-7100</td>
</tr>
<tr>
<td>Silver Spring Medical Center</td>
<td>12201 Plum Orchard Drive, Silver Spring, MD 20904</td>
<td>(301) 572-1000</td>
</tr>
<tr>
<td>Largo Medical Center</td>
<td>1221 Mercantile Lane, Largo, MD 20774</td>
<td>(301) 618-5500</td>
</tr>
<tr>
<td>Summit Mental Health Center</td>
<td>10500 Summit Avenue, Kensington, MD 20895</td>
<td>(301) 897-2500</td>
</tr>
<tr>
<td>Marlow Heights Medical Center</td>
<td>5100 Auth Way, Suitland, MD 20746</td>
<td>(301) 702-5000</td>
</tr>
</tbody>
</table>
2.4 Kaiser Permanente Medical Centers – Maryland (Baltimore)

<table>
<thead>
<tr>
<th>Medical Centers</th>
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<tbody>
<tr>
<td><strong>Annapolis Medical Center</strong></td>
<td><strong>South Baltimore County Medical Center</strong></td>
</tr>
<tr>
<td>888 Bestgate Road, Suite 102</td>
<td>1701 Twin Springs Road</td>
</tr>
<tr>
<td>Annapolis, MD 21401</td>
<td>Haletherpe, MD 21227</td>
</tr>
<tr>
<td>📞 (410) 571-7300</td>
<td>📞 (410) 737-5000</td>
</tr>
<tr>
<td><strong>City Plaza Medical Center</strong></td>
<td><strong>Towson Medical Center</strong></td>
</tr>
<tr>
<td>10 Hopkins Plaza</td>
<td>1447 York Road, Suite 100</td>
</tr>
<tr>
<td>Baltimore, MD 21201</td>
<td>Lutherville, MD 21093</td>
</tr>
<tr>
<td>📞 (443) 263-7300</td>
<td>📞 (410) 339-5500</td>
</tr>
<tr>
<td><strong>Columbia Gateway Medical Center</strong></td>
<td><strong>White Marsh Medical Center</strong></td>
</tr>
<tr>
<td>7070 Samuel Morse Drive</td>
<td>4920 Campbell Boulevard</td>
</tr>
<tr>
<td>Columbia, MD 21046</td>
<td>Nottingham, MD 21236</td>
</tr>
<tr>
<td>📞 (410) 309-4600</td>
<td>📞 (410) 933-7600</td>
</tr>
<tr>
<td><strong>Severna Park Medical Center</strong></td>
<td><strong>Woodlawn Medical Center</strong></td>
</tr>
<tr>
<td>8028 Ritchie Highway, Suite 134</td>
<td>7141 Security Boulevard</td>
</tr>
<tr>
<td>Pasadena, MD 21122</td>
<td>Baltimore, MD 21244</td>
</tr>
<tr>
<td>📞 (410) 553-2400</td>
<td>📞 (443) 663-6000</td>
</tr>
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2.5 Kaiser Permanente Participating Hospitals – Virginia

<table>
<thead>
<tr>
<th>Hospitals</th>
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<tbody>
<tr>
<td><strong>Virginia Hospital Center</strong></td>
<td><strong>Reston Hospital Center</strong></td>
</tr>
<tr>
<td>1701 N. George Mason Drive</td>
<td>1850 Town Center Parkway</td>
</tr>
<tr>
<td>Arlington, VA 22205</td>
<td>Reston, VA 20190</td>
</tr>
<tr>
<td>📞 (703) 558-5000</td>
<td>📞 (703) 689-9000</td>
</tr>
<tr>
<td><strong>Mary Washington Hospital</strong></td>
<td><strong>Stafford Hospital Center</strong></td>
</tr>
<tr>
<td>1001 Sam Perry Boulevard</td>
<td>101 Hospital Center Boulevard</td>
</tr>
<tr>
<td>Fredericksburg, VA 22401</td>
<td>Stafford, VA 22554</td>
</tr>
<tr>
<td>📞 (540) 741-1100</td>
<td>📞 (540) 741-9000</td>
</tr>
</tbody>
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* MAPMG providers available at hospital/facility

2.6 Kaiser Permanente Participating Hospitals – MD

<table>
<thead>
<tr>
<th>Hospitals</th>
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<tbody>
<tr>
<td><strong>Greater Baltimore Medical Center</strong></td>
<td><strong>Saint Agnes Hospital</strong></td>
</tr>
<tr>
<td>6701 N. Charles Street</td>
<td>900 Caton Avenue</td>
</tr>
<tr>
<td>Baltimore, MD 21204</td>
<td>Baltimore, MD 21236</td>
</tr>
<tr>
<td>📞 (410) 828-2015</td>
<td>📞 (410) 368-6000</td>
</tr>
<tr>
<td><strong>Suburban Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>8600 Old Georgetown Road</td>
<td></td>
</tr>
<tr>
<td>Bethesda, MD 20814</td>
<td></td>
</tr>
<tr>
<td>📞 (301) 530-3100</td>
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### 2.7 Kaiser Permanente Participating Hospitals – Washington, DC

<table>
<thead>
<tr>
<th>Children’s National Medical Center</th>
<th>Medstar Washington Hospital Center*</th>
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<tbody>
<tr>
<td>111 Michigan Avenue, NW</td>
<td>110 Irving Street, NW</td>
</tr>
<tr>
<td>Washington, DC 20010</td>
<td>Washington, DC 20010</td>
</tr>
<tr>
<td>☎ (202) 884-5000</td>
<td>☎ (202) 877-7000</td>
</tr>
</tbody>
</table>

* MAPMG providers available at hospital/facility

<table>
<thead>
<tr>
<th>Medstar Georgetown University Hospital</th>
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<tbody>
<tr>
<td>3800 Reservoir Road, NW</td>
</tr>
<tr>
<td>Washington, DC 20007</td>
</tr>
<tr>
<td>☎ (202) 444-2000</td>
</tr>
</tbody>
</table>

### 2.8 Kaiser Permanente Ambulatory Surgery Centers

<table>
<thead>
<tr>
<th>Capitol Hill Medical Center</th>
<th>Largo Medical Center</th>
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<tbody>
<tr>
<td>700 Second Street, NE</td>
<td>1221 Mercantile Lane</td>
</tr>
<tr>
<td>Washington, DC 20002</td>
<td>Largo, MD 20774</td>
</tr>
<tr>
<td>☎ (202) 346-3000</td>
<td>☎ (301) 618-5500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gaithersburg Medical Center</th>
<th>South Baltimore County Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>655 Watkins Mill Road</td>
<td>1701 Twin Springs Road</td>
</tr>
<tr>
<td>Gaithersburg, MD 20879</td>
<td>Baltimore, MD 21227</td>
</tr>
<tr>
<td>☎ (240) 632-4000</td>
<td>☎ (410) 339-5000</td>
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<table>
<thead>
<tr>
<th>Kensington Medical Center</th>
<th>Tysons Corner Medical Center</th>
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</thead>
<tbody>
<tr>
<td>10810 Connecticut Avenue</td>
<td>8008 Westpark Drive</td>
</tr>
<tr>
<td>Kensington, MD 20895</td>
<td>McLean, VA 2210</td>
</tr>
<tr>
<td>☎ (301) 929-7100</td>
<td>☎ (703) 287-6400</td>
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### 2.9 Kaiser Permanente Urgent Care Centers

<table>
<thead>
<tr>
<th>Capitol Hill Medical Center</th>
<th>South Baltimore County Medical Center</th>
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<tbody>
<tr>
<td>700 Second Street, NE</td>
<td>1701 Twin Springs Road</td>
</tr>
<tr>
<td>Washington, DC 20002</td>
<td>Baltimore, MD 21227</td>
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</table>

<table>
<thead>
<tr>
<th>Camp Springs Medical Center</th>
<th>White Marsh Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>6104 Old Branch Avenue</td>
<td>4920 Campbell Boulevard</td>
</tr>
<tr>
<td>Temple Hills, MD 20748</td>
<td>Nottingham, MD 21236</td>
</tr>
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<table>
<thead>
<tr>
<th>Gaithersburg Medical Center</th>
<th>Reston Medical Center</th>
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<tbody>
<tr>
<td>655 Watkins Mill Road</td>
<td>1890 Metro Center Drive</td>
</tr>
<tr>
<td>Gaithersburg, MD 20879</td>
<td>Reston, VA 20190</td>
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<table>
<thead>
<tr>
<th>Kensington Medical Center</th>
<th>Tysons Corner Medical Center</th>
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<tbody>
<tr>
<td>10810 Connecticut Avenue</td>
<td>8008 Westpark Drive</td>
</tr>
<tr>
<td>Kensington, MD 20895</td>
<td>McLean, VA 2210</td>
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<tr>
<td>☎ (301) 929-7100</td>
<td>☎ (703) 287-6400</td>
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<tr>
<td>Location</td>
<td>Address</td>
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</tr>
<tr>
<td>10810 Connecticut Avenue</td>
<td>8008 Westpark Drive</td>
</tr>
<tr>
<td>Kensington, MD 20895</td>
<td>McLean, VA 22102</td>
</tr>
<tr>
<td><strong>Largo Medical Center</strong></td>
<td><strong>Woodbridge Medical Center</strong></td>
</tr>
<tr>
<td>1221 Mercantile Lane</td>
<td>14139 Potomac Mills Road</td>
</tr>
<tr>
<td>Largo, MD 20774</td>
<td>Woodbridge, VA 22192</td>
</tr>
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</table>
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 Medallion 4.0, 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
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 KP HealthConnect AffiliateLink at www.providers.kaiserpermanente.org/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, Target, Wal-Mart, and Kmart. 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 KP HealthConnect AffiliateLink may also verify eligibility and benefit information online by logging on at www.providers.kaiserpermanente.org/mas. If you do not have access to KP HealthConnect AffiliateLink and would like to enroll, please contact Provider Experience at (877) 806-7470.

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 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 Department of Social Services 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 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.

4.9 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 Central Processing Unit (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 of 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 claims 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: 1 (855) 249-5019
TTY for the hearing impaired: (866) 513-0008

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 kp.org/espanol or kp.org to access La Guía en Español (the Guide in Spanish). Members can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in La Guía en Español.

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

• **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.

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 ☏(855) 249-5019; ☏ (866) 513-0008, 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.
Attention: Appeals and Correspondence Unit
2101 East Jefferson Street
Rockville, MD  20852

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 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 (855) 249-5019; (866) 513-0008, TTY/TDD, or

An appeal can also be sent in writing to:
Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 671860
Denver, CO 80237-9998

A written appeal letter should include:
- The member’s name
- KP 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 9.21 – 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:
(855) 249-5019, toll-free
(866) 513-0008, 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 **External Review 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 DMAS.

Medicaid members may file a complaint at any time once an initial determination has been made by Health Plan. It is not necessary for Medicaid members to exhaust Health Plan’s complaint and appeal process prior to filing an appeal to DMAS.

**Medicaid State Fair Hearing**
Appeals Division
Department of Medical Assistance Services (DMAS)
600 East Broad Street, Suite 1300
Richmond, VA 23219
Fax: (804) 371-8491

Appeals must be submitted in writing and can be filed at any time after an initial adverse 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.

**FAMIS**
FAMIS External Review
Department of Medical Assistance Services
600 East Broads Street
Richmond, VA 23219
FAX 804-786-5799
Appeal must be submitted in writing and filed within (30) 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 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 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 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 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 DMAS (the “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 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 10.8 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:
  o Hemoglobin/Hematocrit/EP
  o Hereditary/Metabolic screening
  o Urinalysis
  o Tuberculin test for high risk
  o Blood lead testing
  o 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 OB/GYNs, you agree to advise every pregnant member of the value of 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 health 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 10.32 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 KP case management services as needed, including women experiencing a high-risk pregnancy and members with complex medical needs.

6.3 Access and Appointment Standards

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

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Kaiser Permanente Standard FAMIS</th>
<th>Kaiser Permanente Standard Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine primary care (excludes health assessments and regularly scheduled visits to monitor chronic conditions)</td>
<td>Within 2 weeks of request</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Health assessments, preventive care, initial health assessments for new members</td>
<td>Within 30 calendar days of request</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Maternity – During the first trimester</td>
<td>Within 14 calendar days of request</td>
<td>Within 14 calendar days of request</td>
</tr>
<tr>
<td>Maternity – During the second trimester</td>
<td>Within 7 calendar days of request</td>
<td>Within 7 calendar days of request</td>
</tr>
<tr>
<td>Maternity – During the third trimester</td>
<td>Within 3 business days of request</td>
<td>Within 3 business days of request</td>
</tr>
</tbody>
</table>
Maternity – If determined as high-risk pregnancy
Within 3 business days or immediately if an emergency exists

Urgent care
Within 24 hours of the request

Emergency services
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 on the basis of race, religion or any other factor prohibited by law. In addition, Participating Providers may not discriminate in the provision of medical services on the basis of 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.

**LogistiCare Reservation Requirements**

- KP 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](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 (HAP)

Effective December 1, 2014, the Virginia Department of Medical Assistance Services 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 21 years old for medical necessary EPSDT service. Participating Provider will ensure children receive routine check-ups, screenings, evaluations and treatments. Participating Provider 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 six (6) 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 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 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 TextMessaging 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 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 or not 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 CFR 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: If this authorization pertains to alcohol or drug information, 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 Health Information Management Services Department (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.

8.1 Billing Procedures for Fee-For-Service Claims
All patient services must be billed on a fully completed CMS 1500 or UB-04 form, unless otherwise indicated by contract. Go to www.cms.hhs.gov to obtain these and other forms.

All claims/bills requiring authorization to be considered for processing and payment must have an authorization number reflected on the claim form or a copy of the referral form may be submitted with the claim.

All claims/bills should be mailed to:
Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

Kaiser Permanente also has the ability to receive your claims electronically through the Emdeon Clearinghouse.

The Kaiser Permanente Mid-Atlantic States payor ID is: 52095

In the event a paper claim (CMS 1500 or UB-04) or an electronic claim has been rejected, denied and/or requires additional supporting documentation for processing (i.e., Medicare Summary Notice (MSN), commercial Explanation of Benefits or Payment (EOB or EOP), operative report, etc.), Participating Providers may submit the appropriate documentation to our Claims Department at the address listed above.

If you have any questions regarding submitting your claims electronically, please contact Provider Experience at (877) 806-7470. Should you require technical assistance with Electronic Data Interface (EDI), contact EDI Technical Support at (301) 879-5453.

Payment is generally made within thirty (30) days of receiving the claim/bill. Participating Providers may check the status of a claim/bill submitted for payment by calling (855) 249-5019, select the Claims prompt to speak to a Member Services representative.
If you have a question regarding a previously submitted claim, billing or utilization, please contact our Member Services Call Center at ☏ (855) 249-5019 and select the Claims prompt to speak to a Member Services representative. If no resolution is received after thirty (30) days, please feel free to contact Provider Experience Department at ☏ (877) 806-7470.

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 submitted on the appropriate CMS form (1500 or UB-04), using current coding standards to complete form fields, and including the attachments that provide information necessary in the processing the claim.

Definition: A “clean” claim is one that does not require the payer to investigate or develop external to their Virginia Medicaid operation on a prepayment basis. Clean claims must be filed in the timely filing period. A clean claim has all basic information necessary to adjudicate the claim, and all required supporting documentation.

- Current industry standard data coding;
- Attachments appropriate for submission and procedural circumstance;
- Completed data element fields required for the CMS 1500 or the CMS form UB-04.

A claim is not considered to be “Clean” or payable if one or more of the following conditions exists, due to a good faith determination or dispute regarding:

- The standards or format used in the completion or submission of the claim
- The eligibility of a person for coverage
- The responsibility of another payor for all or part of the claim
- The amount of the claim or the amount currently due under the claim
- The benefits covered
- The manner in which services were accessed or provided
- The claim was submitted fraudulently

Requirements for Clean Claim Submission

Correct Form – Kaiser Permanente requires claims for professional services to be submitted using the CMS form 1500 and claims for hospital services (or appropriate ancillary services) should be submitted using the CMS form UB-04.

Standard Coding – All fields should be completed using industry standard coding as outlined below.
**Applicable Attachments** – Attachments should be included in your submission when circumstances require additional information.

**Completed Field Elements for CMS Form 1500 Or CMS Form UB-04** - All applicable data elements of CMS forms should be completed.

**Forms**
Participating Physicians will submit CMS 1500 or UB-04 forms for all services rendered to members, according to jurisdictional requirements.

**Professional Services** – Kaiser Permanente requires claims for professional services to be submitted using the CMS form 1500.

**Facility and Hospital Services** – Kaiser Permanente requires claims for hospital services (or the appropriate ancillary services) to be submitted using the CMS form UB-04.

**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, it is important to realize 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.

<table>
<thead>
<tr>
<th>Code Set</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT- 4</strong></td>
<td>Maintained and distributed by the American Medical Association, including its codes and modifiers, and codes for anesthesia services</td>
</tr>
<tr>
<td>(Current Procedure Terminology)</td>
<td></td>
</tr>
<tr>
<td><strong>CDT- 1</strong></td>
<td>Maintained and distributed by the American Dental Association</td>
</tr>
<tr>
<td>(The Code on Dental Procedures and Nomenclature)</td>
<td></td>
</tr>
<tr>
<td><strong>ICD-10 CM</strong></td>
<td>Maintained and distributed by the National Center for Health Statistics- Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>(International Classification of Diseases, Clinical Modification)</td>
<td></td>
</tr>
<tr>
<td><strong>HCPCS and Modifiers</strong></td>
<td>Maintained and distributed by the U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>(CMS Common Procedure Coding System)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>NDC</strong> (National Drug Codes)</td>
<td>Prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td><strong>ASA</strong> (American Society of Anesthesiologists)</td>
<td>Anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists</td>
</tr>
<tr>
<td><strong>DSM-IV</strong> (American Psychiatric Services)</td>
<td>For psychiatric services, codes distributed by the American Psychiatric Association</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>For facilities, use the national or state uniform billing data elements specifications</td>
</tr>
</tbody>
</table>
**Attachments to Include in Claims Submission**

**Attachments** – The following attachments should be included in your submission when the circumstances below apply. You may elect to submit any additional attachments that may assist in receiving prompt payment.

<table>
<thead>
<tr>
<th>ATTACHMENT</th>
<th>WHEN SHOULD IT BE USED?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A REFERRAL</strong></td>
<td>For Specialty Services – when you have received a consultant treatment plan or referral from a member’s PCP, another Participating Provider or a MAPMG provider.</td>
</tr>
<tr>
<td><strong>AN EXPLANATION OF BENEFITS STATEMENT FROM A PRIMARY CARRIER</strong></td>
<td>For members with other primary coverage – when you have received reimbursement or denial from a member’s primary carrier.</td>
</tr>
<tr>
<td><strong>MEDICAL RECORD AND DESCRIPTION OF PROCEDURES</strong></td>
<td>When the service rendered has no corresponding Current Procedural Terminology (CPT) or HCPCS code</td>
</tr>
<tr>
<td><strong>OPERATIVE NOTES</strong></td>
<td>For multiple surgeries – when using modifiers 22, 58, 62, 66, 78, 80, 81, or 82</td>
</tr>
<tr>
<td><strong>ANESTHESIA RECORDS</strong></td>
<td>For report on service and time spent – when using modifiers P4 or P5</td>
</tr>
<tr>
<td><strong>INVOICES AND OTHER ATTACHMENTS</strong></td>
<td>For global contracts – when you have agreed to submit an attachment and/or invoice to describe services, supplies or pricing</td>
</tr>
<tr>
<td><strong>AMBULANCE TRIP REPORT</strong></td>
<td>For ambulance companies licensed by the Commonwealth of Virginia</td>
</tr>
<tr>
<td><strong>OFFICE NOTES</strong></td>
<td>For prolonged and unusual services – when using modifier 21 or 22 or when our audit has determined patterns of improper billing</td>
</tr>
<tr>
<td><strong>PHYSICIAN NOTES</strong></td>
<td>For professional services – when the services provided are outside the time and scope of the authorization obtained from Kaiser Permanente</td>
</tr>
</tbody>
</table>
### ADMITTING NOTES

| For inpatient services – when the services provided are outside the time and scope of the authorization obtained from Kaiser Permanente |

### ITEMIZED BILLS

| For inpatient service – when there is no prior authorization or the admission is inconsistent with Kaiser Permanente concurrent review |

**Fields of the CMS 1500 to Complete**

**APPROPRIATE DATA ELEMENTS COMPLETED (CMS FORM 1500)** – The following are field data elements required for clean claim submission

<table>
<thead>
<tr>
<th>Field Location</th>
<th>Essential Data Elements Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 1</td>
<td>Type of Insurance</td>
</tr>
<tr>
<td>Field 1a</td>
<td>Insured’s plan ID number</td>
</tr>
<tr>
<td>Field 2</td>
<td>The patient’s name</td>
</tr>
<tr>
<td>Field 3</td>
<td>The patient’s date of birth and gender</td>
</tr>
<tr>
<td>Field 4</td>
<td>Insured’s name</td>
</tr>
<tr>
<td>Field 5</td>
<td>The patient’s address (state or P.O. Box, city, and zip code)</td>
</tr>
<tr>
<td>Field 6</td>
<td>The patient’s relationship to insured</td>
</tr>
<tr>
<td>Field 7</td>
<td>Insured’s address (state or P.O. Box, city, and zip code)</td>
</tr>
<tr>
<td>Field 8</td>
<td>Patient status</td>
</tr>
<tr>
<td>Field 9</td>
<td>Other Insured’s name</td>
</tr>
<tr>
<td>Field 9a</td>
<td>Other Insured’s policy or group number</td>
</tr>
<tr>
<td>Field 9b</td>
<td>Other Insured’s date of birth</td>
</tr>
<tr>
<td>Field 9c</td>
<td>Employers name or school name</td>
</tr>
<tr>
<td>Field 9d</td>
<td>Insurance plan name or program name</td>
</tr>
<tr>
<td>Field 10a-c</td>
<td>Is Patient’s condition related to:</td>
</tr>
<tr>
<td>Field 10d</td>
<td>Reserved for local use</td>
</tr>
<tr>
<td>Field 11</td>
<td>Insured’s policy, group or FECA number</td>
</tr>
<tr>
<td>Field 11a</td>
<td>Insured’s birth date and gender</td>
</tr>
<tr>
<td>Field 11b</td>
<td>Employer’s name or school name</td>
</tr>
<tr>
<td>Field 11c</td>
<td>Insurance plan name or program name</td>
</tr>
<tr>
<td>Field 11d</td>
<td>Is there another health benefit plan?</td>
</tr>
<tr>
<td>Field 12</td>
<td>The patient’s or authorized person’s signature or notation that the signature is on file with the health care practitioner</td>
</tr>
<tr>
<td>Field 13</td>
<td>Insured’s or authorized person’s signature or notation that the signature is on file with the health care practitioner or person entitled to reimbursement, if applicable</td>
</tr>
<tr>
<td>Field 14</td>
<td>The date of current illness, injury, or pregnancy</td>
</tr>
<tr>
<td>Field 15</td>
<td>Except in the case of a health care practitioner for emergency services, whether the patient has had the same or a similar illness</td>
</tr>
<tr>
<td>Field 16</td>
<td>Dates patient unable to work in current occupation</td>
</tr>
<tr>
<td>Field 17</td>
<td>Name of the referring physician</td>
</tr>
<tr>
<td>Field 18</td>
<td>The hospitalization dates related to current services, if applicable</td>
</tr>
<tr>
<td>Field 19</td>
<td>Reserved for local use</td>
</tr>
<tr>
<td>Field 20</td>
<td>Outside lab?</td>
</tr>
<tr>
<td>Field 21</td>
<td>The diagnosis codes or nature of the illness or injury</td>
</tr>
<tr>
<td>Field 22</td>
<td>Medicaid resubmission (list of original reference number for resubmitted claims)</td>
</tr>
<tr>
<td>Field 24a</td>
<td>The date of service</td>
</tr>
<tr>
<td>Field 24b</td>
<td>The place of service code</td>
</tr>
<tr>
<td>Field 24c</td>
<td>EMG</td>
</tr>
<tr>
<td>Field 24d</td>
<td>Procedure, services or supplies</td>
</tr>
<tr>
<td>Field 24e</td>
<td>Diagnosis pointer</td>
</tr>
<tr>
<td>Field 24f</td>
<td>The charge for each listed service</td>
</tr>
<tr>
<td>Field 24g</td>
<td>The number of days, the time (minutes), the start and stop time or units</td>
</tr>
<tr>
<td>Field 24h</td>
<td>EPSDT, family planning</td>
</tr>
<tr>
<td>Field 24i</td>
<td>NPI number or ID qualifier</td>
</tr>
<tr>
<td>Field 24j</td>
<td>Rendering Provider Id</td>
</tr>
<tr>
<td>Field 25</td>
<td>The health care practitioner’s or person entitled to reimbursement’s federal tax ID number</td>
</tr>
<tr>
<td>Field 26</td>
<td>The patient’s account number</td>
</tr>
<tr>
<td>Field 27</td>
<td>Accept Assignment?</td>
</tr>
<tr>
<td>Field 28</td>
<td>The total charge</td>
</tr>
<tr>
<td>Field 29</td>
<td>Amount paid</td>
</tr>
<tr>
<td>Field 30</td>
<td>Balance Due</td>
</tr>
<tr>
<td>Field 31</td>
<td>For claims <strong>submitted electronically</strong>, a <strong>computer printed name as the signature</strong> of the health care practitioner or person entitled to reimbursement.</td>
</tr>
<tr>
<td>Field 31</td>
<td>For claims <strong>not submitted electronically</strong>, the <strong>signature</strong> of the health care practitioner who provided the service, or notation that the signature is on file with Kaiser Permanente</td>
</tr>
<tr>
<td>Field 32</td>
<td>Service facility location information</td>
</tr>
<tr>
<td>Field 32a</td>
<td>NPI #</td>
</tr>
<tr>
<td>Field 32b</td>
<td>Other ID#</td>
</tr>
<tr>
<td>Field 33</td>
<td>Billing provider info and phone #</td>
</tr>
<tr>
<td>Field 33a</td>
<td>NPI#</td>
</tr>
<tr>
<td>Field 33b</td>
<td>Other ID#</td>
</tr>
</tbody>
</table>
Fields of the CMS UB-04 to Complete

- **APPROPRIATE DATA ELEMENTS COMPLETED (CMS FORM UB-04)** – The following are field data elements required for clean claim submission

<table>
<thead>
<tr>
<th>Field Location</th>
<th>Essential Data Elements Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 1</td>
<td>The hospital’s name and address and telephone number</td>
</tr>
<tr>
<td>Field 2</td>
<td>Pay to address if different than Field 1</td>
</tr>
<tr>
<td>Field 3a</td>
<td>The patient’s control number</td>
</tr>
<tr>
<td>Field 3b</td>
<td>Medical Record Number</td>
</tr>
<tr>
<td>Field 4</td>
<td>The type of bill code</td>
</tr>
<tr>
<td>Field 5</td>
<td>The hospital’s federal tax ID number</td>
</tr>
<tr>
<td>Field 6</td>
<td>The beginning and ending date of claim period</td>
</tr>
<tr>
<td>Field 7</td>
<td>Administrative Necessary Days</td>
</tr>
<tr>
<td>Field 8</td>
<td>The patient’s name</td>
</tr>
<tr>
<td>Field 9</td>
<td>The patient’s address</td>
</tr>
<tr>
<td>Field 10</td>
<td>The patient’s date of birth</td>
</tr>
<tr>
<td>Field 11</td>
<td>The patient’s gender or sex</td>
</tr>
<tr>
<td>Field 12</td>
<td>Admission Date</td>
</tr>
<tr>
<td>Field 13</td>
<td>Admission Hour</td>
</tr>
<tr>
<td>Field 14</td>
<td>Admit Type</td>
</tr>
<tr>
<td>Field 15</td>
<td>Source of Admission</td>
</tr>
<tr>
<td>Field 16</td>
<td>Discharge Hour</td>
</tr>
<tr>
<td>Field 17</td>
<td>Patient Discharge Status</td>
</tr>
<tr>
<td>Field 18-28</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>Field 29</td>
<td>Accident State</td>
</tr>
<tr>
<td>Field 31-34</td>
<td>Occurrence Codes and Dates</td>
</tr>
<tr>
<td>Field 35-36</td>
<td>Occurrence Span</td>
</tr>
<tr>
<td>Field 38</td>
<td>Responsible Party Name and Address</td>
</tr>
<tr>
<td>Field 39-41</td>
<td>Value Code and Amount</td>
</tr>
<tr>
<td>Field 42</td>
<td>Revenue Code</td>
</tr>
<tr>
<td>Field 43</td>
<td>Revenue Code Description</td>
</tr>
<tr>
<td>Field 44</td>
<td>HCPC</td>
</tr>
<tr>
<td>Field 45</td>
<td>Service Date</td>
</tr>
<tr>
<td>Field 46</td>
<td>Service Units</td>
</tr>
<tr>
<td>Field 47</td>
<td>Total Charges</td>
</tr>
<tr>
<td>Field 48</td>
<td>Non-Covered Charges</td>
</tr>
<tr>
<td>Field 50</td>
<td>Payer</td>
</tr>
<tr>
<td>Field 51</td>
<td>Health Plan ID</td>
</tr>
<tr>
<td>Field 52</td>
<td>Release of Information</td>
</tr>
<tr>
<td>Field 53</td>
<td>Assignment of Benefits</td>
</tr>
<tr>
<td>Field 54</td>
<td>Prior Payments</td>
</tr>
</tbody>
</table>
8.4 Addiction and Recovery Treatment Services (ARTS) Billing

Covered ARTS services:

<table>
<thead>
<tr>
<th>ASAM Level of Care</th>
<th>ASAM Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>Medically Managed Intensive Inpatient</td>
</tr>
</tbody>
</table>
| 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 |

Note: Failure to include all information will result in a delay in claim processing and payment and it will be returned for any missing information. A claim missing any of the required information will not be considered a clean claim.
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%202012132016.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:

<table>
<thead>
<tr>
<th>ASAM Level</th>
<th>Billing Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>1.0</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>2.1</td>
<td>CMS-1500 or UB</td>
</tr>
<tr>
<td>2.5</td>
<td>CMS-1500 or UB</td>
</tr>
<tr>
<td>3.1</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>3.3</td>
<td>UB</td>
</tr>
<tr>
<td>3.5 Residential</td>
<td>UB</td>
</tr>
<tr>
<td>3.5 Inpatient</td>
<td>UB</td>
</tr>
<tr>
<td>3.7 Residential</td>
<td>UB</td>
</tr>
<tr>
<td>3.7 Inpatient</td>
<td>UB</td>
</tr>
<tr>
<td>4.0</td>
<td>UB</td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Office Based Opioid Treatment</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Substance Use Case Management</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Substance Use Care Coordination</td>
<td>CMS-1500</td>
</tr>
</tbody>
</table>
8.5 Multiple Procedure Reimbursement Policy*

Multiple procedures 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% of respective rates.

*This policy applies to the professional service component only

8.6 Description and Justification of Processing and Adjudication Edits

Kaiser Permanente continuously makes enhancements to our claim processing system to ensure accurate and timely payment of claims for health care services provided to our members. Kaiser Permanente utilizes the McKesson Claims Xten claim editing software to evaluate the accuracy and adherence of (professional) medical claims to accepted CPT/HCPCS coding practices. The coding and billing practices are defined by the Centers for Medicare and Medicaid Services (CMS) Correct Coding Initiative (CCI).

The purpose of these processing edits is to make reimbursement guidelines and policies more readily available to our Participating Providers, and to respond to the increasingly complex developments in medical technology and procedure coding used to process reimbursement to practitioners. Kaiser Permanente continually evaluates its claim processing policies and payment methodologies including how reimbursement is determined for specific procedures and code sets to confirm adherence with generally accepted guidelines (e.g., AMA CPT Code Book, CMS/CMS Correct Coding Initiative).

Claims Xten Processing Edits and Explanation of Payment Codes

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>EOP EX Code</th>
<th>Reason Type</th>
<th>Reason Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X0002</td>
<td>TB</td>
<td>NC</td>
<td>Deny, outpatient consult billed w/DOS &lt;6mos</td>
</tr>
<tr>
<td>X0003</td>
<td>TC</td>
<td>NC</td>
<td>Deny, confirmatory consult billed w/DOS &lt;6mos</td>
</tr>
<tr>
<td>X0004</td>
<td>TD</td>
<td>NC</td>
<td>Deny, initial consult billed&gt;max time period</td>
</tr>
<tr>
<td>X0005</td>
<td>TE</td>
<td>NC</td>
<td>Deny, Consult billed by PCP</td>
</tr>
<tr>
<td>X0006</td>
<td>TF</td>
<td>NC</td>
<td>Deny, new patient code billed within past 3 years</td>
</tr>
<tr>
<td>X0007</td>
<td>TG</td>
<td>NC</td>
<td>Deny, E&amp;M billed within procedure follow-up period not payable</td>
</tr>
<tr>
<td>X0008</td>
<td>TH</td>
<td>NC</td>
<td>Deny, supplies billed same day as surgery</td>
</tr>
<tr>
<td>X0009</td>
<td>TI</td>
<td>NC</td>
<td>Deny, procedure identified as unbundled</td>
</tr>
<tr>
<td>Code</td>
<td>Vendor</td>
<td>Status</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>X0010</td>
<td>TJ</td>
<td>NC</td>
<td>Deny, anesthesia code billed by a non-anesthesiologist</td>
</tr>
<tr>
<td>X0011</td>
<td>TK</td>
<td>NC</td>
<td>Deny, not billed on Sunday/Federal holiday or after hours</td>
</tr>
<tr>
<td>X0012</td>
<td>TL</td>
<td>NC</td>
<td>Deny, procedure code not consistent with gender</td>
</tr>
<tr>
<td>X0013</td>
<td>TM</td>
<td>NC</td>
<td>Deny, procedure code not generally covered</td>
</tr>
<tr>
<td>X0014</td>
<td>TN</td>
<td>NC</td>
<td>Deny, unlisted CPT code</td>
</tr>
<tr>
<td>X0015</td>
<td>TO</td>
<td>NC</td>
<td>Deny, duplicate claim/service</td>
</tr>
<tr>
<td>X0016</td>
<td>TP</td>
<td>NC</td>
<td>Deny, modifier required</td>
</tr>
<tr>
<td>X0017</td>
<td>TQ</td>
<td>NC</td>
<td>Deny, procedure billed does not require service of assistant surgeon</td>
</tr>
<tr>
<td>X0019</td>
<td>TS</td>
<td>NC</td>
<td>Deny, deleted or expired HCPCS or CPT code</td>
</tr>
<tr>
<td>X0020</td>
<td>TT</td>
<td>NC</td>
<td>Deny, add-on billed w/o primary procedure</td>
</tr>
<tr>
<td>X0021</td>
<td>TU</td>
<td>NC</td>
<td>Deny, bilateral billed inappropriately</td>
</tr>
<tr>
<td>X0022</td>
<td>TV</td>
<td>NC</td>
<td>Deny, incorrect bilateral modifier</td>
</tr>
<tr>
<td>X0023</td>
<td>TW</td>
<td>NC</td>
<td>Deny, base code billed with Quantity&gt;1</td>
</tr>
<tr>
<td>X0024</td>
<td>TX</td>
<td>NC</td>
<td>Deny, diagnosis not consistent with gender</td>
</tr>
<tr>
<td>X0025</td>
<td>TY</td>
<td>NC</td>
<td>Deny, always bundled</td>
</tr>
<tr>
<td>NEX54</td>
<td>G3</td>
<td>NC</td>
<td>Denied, professional component not payable</td>
</tr>
<tr>
<td>NEX75</td>
<td></td>
<td>NC</td>
<td>Denied, quantity billed exceeds the maximum allowed per day</td>
</tr>
<tr>
<td>NEX76</td>
<td></td>
<td>NC</td>
<td>Denied, global procedure previously paid</td>
</tr>
</tbody>
</table>

**Claim Adjudication Edits, Policy Concepts and Descriptions**

**Supplies on the same day as surgery** - Identifies supplies on the same day as a 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 Supply and 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.

Certain procedure and diagnosis codes are exclusive to either the male or female gender.

**Duplicate Line Items** – Identifies duplicate line items. Duplicate line items are determined based on matches on certain key fields. The fields used for matching are customizable by the payor.

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

**Global Surgical Package** – Identifies Evaluation & Management (E&M) codes and supplies billed within the global period.

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.

**Procedure Code Not Covered, or Not Generally Covered** – Identifies procedure codes that are not typically covered. The procedure codes that are not covered may be based on CMS regulations, industry standards, or may be specific to Kaiser Permanente guidelines and/or policy. CMS guidelines or industry accepted standards establish that certain procedures are not covered.

**Missing Modifier 26** – Identifies situations where a modifier 26, denoting professional component, should have been reported for the procedure performed at the noted place of service.

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 for Established Patient** – Identifies new patient visits that are billed for established patients.

The AMA has established that a provider practice can only bill a patient code as new once every three years.
**Procedure Maximum Frequency Per Day** – Identifies a service that is billed with a frequency exceeding a given norm in a 24-hour period.

Procedure codes have maximum quantities allowed within a 24-hour period. These quantities have been derived by broadly accepted industry sources.

**Consult (Outpatient) Maximum Frequency** – Identifies inappropriate billing of Outpatient Consultation codes. Outpatient Consultations should be performed only upon provider request and follow-up visits in the physician consultant’s office that are initiated by the physician consultant should be reported using office visit codes for established patients.

The AMA has established that follow-up visits in the physician consultant’s office or other outpatient facility that are initiated by the physician consultant are to be reported using office visit codes for established patients.

**Consults by PCP** – Identifies consultation codes that are billed by the member’s primary care physician (“PCP”).

Primary Care Providers cannot bill for consultations performed on his/her own primary care patients.

**Deny Base Code with quantity greater than one** – This rule identifies situations where the provider is billing a base code with quantity, rather than the appropriate add on code(s).

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.

**Consult (Outpatient) Maximum Frequency** – Identifies inappropriate billing of outpatient consultation codes. Outpatient consultations should be performed only upon Provider request. Follow-up visits in the physician consultant’s office that are initiated by the physician consultant’s office should be reported using office visit codes for established patients.

The AMA has established that follow-up visits in the physician consultant’s office or other outpatient facility that are initiated by the physician consultant are to be reported using office visit codes for established patients.

**Date of service not billed on Sunday/Federal Holiday** – Identifies procedure codes that are only allowed to be billed on holidays or Sundays but have been billed on other days of the week.
The AMA has designated CPT code 99054 to be reimbursed on holidays and Sundays.

**Inappropriate Diagnosis for Gender** – Identifies diagnosis codes that are inconsistent with the member’s gender.

Certain procedure and diagnosis codes are exclusive to either the male or female gender.

**Inappropriate CPT to Modifier Combination** – This rule denies inappropriate CPT to Modifier combinations.

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.

8.7 **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 reimburse for 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 Current Procedural Terminology (CPT) and other general industry-accepted guidelines.

8.8 **Evaluation and Management on Same Day as Surgery**

When a Kaiser Permanente Participating Provider performs an established evaluation and management (E&M) or inpatient/outpatient consult procedure on the same day a surgical procedure is performed, the E&M procedure is included in the fee for the surgical procedure. The fee for certain supplies associated with the procedure is also included in the reimbursement for the surgical procedure. In some cases, an appropriate modifier will override this adjustment.

8.9 **Global Surgical Package (GSP)**

A global period for surgical procedures is a long-established concept under which a “single fee” is billed and paid for all services rendered by a surgeon before, during, and after the procedure. According to CMS, the services included in the global surgical
package may be furnished in any setting (i.e., hospital, ambulatory surgery center, physician’s office).

Kaiser Permanente’s GSP policy follows CMS guidelines with respect to the timeframes assigned to each global surgical procedure. All procedures with an entry of 10 or 90 days in the Medicare Fee Schedule Database (MFSDB) are subject to Kaiser Permanente’s GSP Policy.

Under the GSP Policy, the fee for any evaluation and management procedure performed within the follow-up period is included in the reimbursement for the surgical procedure. The fee for the certain supplies associated with the procedure is also included in the reimbursement for the global surgical procedure if used within the follow-up period. If a Kaiser Permanente Participating Provider bills for such services and supplies separately, Kaiser Permanente will indicate on the claim that reimbursement for such services is included in the payment of the global surgical code.

8.10 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. The dispute process applies only to clean claims as outlined in Section 8.2 – Clean Claims. 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))

A Participating Provider may initiate a payment dispute by calling 📞 (877) 806-7470. 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 forty-five (45) 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
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 8.1 – Billing Procedures for Fee-for-Service Claims.

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 8.1. Acceptable proof of timely filing may include the following documentation and/or situations:

<table>
<thead>
<tr>
<th>Proof or Documentation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>System generated claim copies, account print-outs, or reports that indicate the original date that claim was submitted, and to which insurance carrier.</td>
<td>Account ledger posting that includes multiple patient submissions</td>
</tr>
<tr>
<td></td>
<td>Individual Patient ledger</td>
</tr>
<tr>
<td></td>
<td>CMS UB-04 or 1500 with a system generated date or submission.</td>
</tr>
<tr>
<td>*Hand-written or typed documentation is not acceptable proof of timely filing.</td>
<td></td>
</tr>
<tr>
<td>EDI Transmission report</td>
<td>Reports from a Provider Clearinghouse (i.e., Emdeon)</td>
</tr>
<tr>
<td>Lack of member insurance information. Proof of follow-up with member for lack of insurance or incorrect insurance information.</td>
<td>Copies of dated letters requesting information or requesting correct information from the member.</td>
</tr>
<tr>
<td></td>
<td>Original hospital admission sheet or face sheet with incomplete, absent, or incorrect insurance information.</td>
</tr>
<tr>
<td></td>
<td>Any type of demographic sheet collected by the provider from the member with incomplete, absent, or incorrect insurance information.</td>
</tr>
</tbody>
</table>

*Members are responsible for providing current and appropriate insurance information each time services are rendered by a provider.
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.

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.

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.
9.0 UTILIZATION MANAGEMENT AND AUTHORIZATION

Overview
Kaiser Permanente UM activities include complex case management, skilled nursing facility case management, renal case management, hospital utilization management, outpatient specialty referral management, home care, durable medical equipment, and rehabilitative therapy referral management. Collectively, these areas implement the UM Program for medical, surgical, pediatric, maternal health, geriatric and behavioral health care.

Kaiser Permanente UM is supported by board certified UM physician reviewers who hold a current license to practice without restrictions. These licensed physicians oversee UM decisions to ensure consistent and appropriate medical necessity determinations. Registered nurses perform concurrent review of members’ admission to both participating and non-participating hospitals and facilities as well as 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.

Utilization Management (UM) Decision Making
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 criteria or MCPs, the UM staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system.

9.2 Utilization Management Criteria

Guide for Selecting UM Criteria - Virginia Medicaid and FAMIS

- MCG™ – formerly called Milliman Care Guideline
- 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

<table>
<thead>
<tr>
<th>Referral Service Type – Virginia Medicaid and FAMIS</th>
<th>UM Approved Criteria Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Rehabilitation (inpatient)</td>
<td>MCG™</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>MCG™</td>
</tr>
<tr>
<td>Behavioral Health: Inpatient</td>
<td>MCG™</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD): Inpatient</td>
<td>ASAM as of April 1, 2017¹</td>
</tr>
<tr>
<td>Behavioral Health: Residential Treatment Center (RTC)</td>
<td>MCG™</td>
</tr>
<tr>
<td>SUD: Residential Treatment Center (RTC)</td>
<td>ASAM as of April 1, 2017¹</td>
</tr>
<tr>
<td>Behavioral Health: Partial Hospitalization Program (PHP)</td>
<td>MCG™</td>
</tr>
<tr>
<td>SUD: Partial Hospitalization Program (PHP)</td>
<td>ASAM as of April 1, 2017¹</td>
</tr>
<tr>
<td>Referral Service Type – Virginia Medicaid and FAMIS</td>
<td>UM Approved Criteria Sets</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Behavioral Health: Intensive Outpatient Program (IOP)</td>
<td>MCG™</td>
</tr>
<tr>
<td>SUD: Intensive Outpatient Program</td>
<td>ASAM as of April 1, 2017¹</td>
</tr>
<tr>
<td>Behavioral Health: Outpatient Services</td>
<td>MCG™</td>
</tr>
<tr>
<td>SUD: Outpatient Services</td>
<td>ASAM as of April 1, 2017¹</td>
</tr>
<tr>
<td>Behavioral Health: Partial Hospitalization</td>
<td>MCG™ ASAM as of April 1, 2017</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) and Supplies</td>
<td>1. MCP 2. MCG™ 3. NCD-LCD</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>1. MCP 2. MCG™ 3. NCD-LCD</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services</td>
<td>EPSDT² Guideline</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>MCG™</td>
</tr>
<tr>
<td>Hospice (In-patient/Out-patient)</td>
<td>MCG™</td>
</tr>
<tr>
<td>Inpatient (Concurrent Review) Services</td>
<td>MCG™</td>
</tr>
<tr>
<td>Neonatal Care</td>
<td>KP/ MCG™</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1. MCP 2. MCG™</td>
</tr>
<tr>
<td>PT/OT/Speech</td>
<td>1. KPMAS MCP 2. MCG™</td>
</tr>
<tr>
<td>Skilled Nursing Facility • For Virginia FAMIS only</td>
<td>MCG™</td>
</tr>
</tbody>
</table>

Sources:

¹ DMAS mandating use of ASAM criteria as of April 1, 2017 in concert with the implementation of Addiction, Recovery, and Treatment benefits that were previously carved out
² Federal EPSDT Medical Necessity Guidelines [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html)
³ Source: VA Medicaid Contract Medallion 4.0 and FAMIS
As a Participating Provider you can access our medical coverage policies online at:

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 online at:

9.3 Adopting Emerging Technology for UM Referral Management
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) collaborate with the Kaiser Permanente Interregional
New Technologies Committee (INTC) and Medical Technology Assessment Unit to
assist physicians and patients in determining whether or not a new drug, procedure, or
device is medically necessary and appropriate. TRIC recommends the inclusion or
exclusion of new technologies as covered benefits to Health Plan and tracks inquiries
for medical technology assessment. Together, they provide answers to important
questions about indications for use, safety, effectiveness, and relevance of new and
emerging technologies for the health care delivery system.

The INTC is comprised of physicians and non-physicians across Kaiser Permanente. If
compelling scientific evidence is found indicating a new technology 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
The Kaiser Permanente UM Department ensures that all members and providers have
access to UM staff, physicians and managers 24 hours a day, 7 days a week. You can
reach the Kaiser Permanente UM Department by calling 1-800-810-4766 (follow the
prompts). The table below provides the specific UM hours of operations and
responsibilities:
<table>
<thead>
<tr>
<th>UM Department Section</th>
<th>Hours of Operation</th>
<th>Core Responsibilities</th>
</tr>
</thead>
</table>
| Emergency Care Management (ECM)-Clinical Call Center       | 24 hours/day, 7 days/week, including holidays          | • Process transfer 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  
• Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities  
• Assist with repatriations from hospital to hospital  
• Support all cardiac transfers for level of care needed |
| Utilization Management Operations Center: Outpatient, Specialty Referrals and Clinical Research Trials | Monday through Friday: 8:30 A.M. to 5:00 P.M.  
Weekends and Holidays: 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 |
| Utilization Management Operations Center:                  | 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 |
| Durable Medical Equipment (DME)  
Home Care  
Rehabilitative Therapies  
Physical, Occupational and Speech Therapies | Seven days a week and Holidays 8:30 A.M. to 5:00 P.M. | Conduct concurrent review and transition care management |
## UM Department Section

<table>
<thead>
<tr>
<th>Skilled Nursing Facility (SNF) and, Rehabilitation Services and Long Term Acute Care Hospitals (LTACH)</th>
<th>Monday through Friday 8:00 A.M. to 4:30 P.M. Excluding weekends and major holidays</th>
<th>Conduct concurrent review and transition care management for members in the acute rehab and SNF settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>UM Hospital Services – Behavioral Health located at affiliated hospitals:</td>
<td>Seven days a week: 8:00 A.M. to 4:30 P.M. Including major holidays</td>
<td>Conduct concurrent review and transition care management services of behavioral health service</td>
</tr>
<tr>
<td>UM Outpatient Services – Behavioral Health</td>
<td>Monday to Friday: 8:00 A.M. to 4:30 P.M. Excluding weekends and major holidays</td>
<td>Conduct Pre-service and concurrent review of behavioral outpatient services</td>
</tr>
<tr>
<td>Outpatient Continuing Care, Complex Case Management and Renal Case Management</td>
<td>Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding weekends and major holidays</td>
<td>Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members</td>
</tr>
</tbody>
</table>

Source: UM Policy # 3, Section 5.0 approved by RUMC on 08/29/2017

Telecommunications Device for the Deaf (TDD) or teletypewriter (TTY) services are available for members who are deaf, hearing or speech impaired.

Language assistance is available for Non-English speaking members to discuss UM issues.

Communication after business hours:

- Communications received after normal business hours are returned on the next business day.
- Communications received after midnight on Monday-Friday are responded to on the same business day during normal business hours.
- The members’ first line of contact after business hours is through the Kaiser Permanente Member Services; members may also be 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 after business hours may contact the UMOCC toll-free number at 1 800-810-4766, Option 2 (Provider) and follow prompts to be directed to Call Center (available 24 hours, 7 days a week).

• Inbound communication on UM issues after normal business hours are received through the following:
  o Utilization Management Operations Center (UMOC) telephonic toll-free number 800-810-4766, Option 1 (Member) or Option 2 (Provider)
  o UMOC facsimile
  o Kaiser Permanente Health Connect Online Affiliate
  o Kaiser Permanente Health Connect messaging system – available to those providers linked to the KPHC system
  o Direct email to a UM staff person

Kaiser Permanente HealthConnect messaging system.

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 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 7.2 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 order 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/](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](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 Utilization Management Operations Center (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 Department of Medical
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

Assistance Services (DMAS) and the Center for Medicare and Medicaid Services (CMS).
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 to the UMOCC 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 UMOCC at (800) 810-4766. Participating Providers with access to KP HealthConnect AffiliateLink may check the status and/or retrieve a copy of an approved referral in the AffiliateLink. Alternatively, the status of a referral may be checked by going to www.providers.kaiserpermanente.org/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 Uniform Consultation Referral Form and fax it to the UMOCC at Fax (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 FDA-approved contraceptives) or family planning health education.

9.12 Home Health Care
Virginia Medicaid and FAMIS 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 Uniform Referral Form to UMOCC at fax (800) 660-2019.

9.13 Durable Medical Equipment (DME)
Kaiser Permanente covers medically necessary durable medical equipment, 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 Durable Medical Equipment, please fax a complete URF with required documentation to UMOC at ☎ (855) 414-1695.

9.14 Inpatient, Outpatient, and Rehabilitative Therapy: Physical, Occupational, and Speech
Authorization for physical, occupational, speech therapies 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 Uniform Consultation Referral Form to UMOC at ☎ (855) 414-1698.

9.15 Emergency, Urgent, and Post Stabilization Care
Participating PCPs are responsible for providing evaluation, triage, and telephone services twenty-four (24) hours a day, seven (7) days a week. If the participating PCP is unavailable, that participating PCP’s on-call back up will direct the member’s care based upon medical necessity.

If the member must be directed to a Hospital Emergency Department (ED), the participating PCP should instruct the member to go to the Emergency Department of the nearest hospital. The participating PCP should notify the ED physician that the member has been referred.

Notification or referrals regarding an ED visit can be done by simply using the UMOC ED Visit Notification Form. The form can be faxed to ☎ (855) 414-2634. Additionally, notification can be made by calling ☎ (800) 810-4766 Option 1 (Please reference Attachment B at end of Utilization Management section of this manual for the UMOC ED Visit Notification Form).
If a member requires inpatient admission after an ED visit, please be sure to notify UMOC of the admission within twenty-four (24) hours of the admission. An exception to this policy is applied when it is not medically feasible to delay treatment due to the member’s medical condition.

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, go to www.kaiserpermanente.org/facilities.

Fredericksburg Medical Center
1201 Hospital Drive
Fredericksburg, VA 22401
Hours: 5:30 p.m. – 1 a.m. M – F
9 a.m. – 5 p.m. Sat, Sun, Holidays

Manassas Medical Center
10701 Rosemary Drive
Manassas, VA 20109
Hours: 5:30 p.m. – 1 a.m. M – F
9 a.m. – 5 p.m. Sat, Sun, Holidays

Tysons Corner Medical Center
8008 Westpark Drive
McLean, VA 22102
Hours: 24 Hrs M – Sun

Reston Medical Center
1890 Metro Center Drive
Reston, VA 20190
Hours: 5:30 p.m. – 1 a.m. M – F
9 a.m. – 9 p.m. Sat, Sun, Holidays

Woodbridge Medical Center
14139 Potomac Mills Road
Woodbridge, VA 22192
Hours: 5 p.m. – 8:30 a.m. M – F
24 Hrs. Sat, Sun, Holidays

Post Stabilization Care
The ultimate goal of the Kaiser Permanente Utilization Management 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 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 Emergency Department 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 Emergency Department Visit Notification Form and fax to UMOC at (855) 414-2634. A copy of the Emergency Department Visit Notification Form can be located at the end of this section.

**Option 2**: Contact UMOC at (301) 879-6143, or (800) 810-4766. Follow the prompts to report the Emergency Department visit.

All emergency room notifications should include the following information:
- Member Name
- Member Medical Record Number (MRN)
- Name of the Referring Physician (if applicable)
- 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
- Outpatient behavioral health services
- 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 UMOC via Fax ☎️ 1 (800) 660-2019  
-OR-  
**MAIL**  
Mail a copy of the Uniform Referral Form to:  
Utilization Management Operations Center  
Attention: Referral Management  
11900-A Bournefield Way  
Silver Spring, MD 20904

*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.*

**Kaiser Permanente®**

September 2018
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.
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.

Members should be given an order or signed script to present to the 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 KP HealthConnect AffiliateLink 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 Utilization Management Operations Center (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
   23.1. Cyberknife
   23.2. Gamma Knife
   23.3. Stereotactic Radiosurgery
24. Nasal Surgery (Rhinoplasty or Septoplasty)
25. Non-Participating Provider Requests
26. Nuclear Medicine
27. Obstructive Sleep Apnea Treatment including Sleep Studies
28. Oral Surgery
29. Orthognatic Surgery
30. Outpatient Surgery – All Hospital Settings/Ambulatory Surgery Centers
31. Pain Management Services
32. Penile Implants
33. Positron Emission Tomography (PET) Scan
34. Podiatry Services
35. Post Traumatic (Accidental) Dental Services
36. Prosthetics/Braces/Orthotics/Appliances
37. Prostate Biopsies - Ambulatory Surgery Center or Outpatient Hospital Surgery Setting
38. Radiation Oncology
39. Radiology Services (all radiology and imaging services, including diagnostic plain films)
   39.1. Imaging studies requiring fiducial markers
40. Rehabilitation Therapies
   40.1. Cardiac Rehabilitation
   40.2. Occupational Therapy
   40.3. Physical Therapy
   40.4. Pulmonary Rehabilitation Therapy
   40.5. Speech Therapy
   40.6. Vestibular Rehabilitation
41. Scar Revision
42. Sclerotherapy and Vein Stripping Procedures
43. Screening Colonoscopy – Consultations
44. Uvulopalatopharyngoplasty (UPPP)
45. Social Work Services
46. Temporo Mandibular Joint Evaluation and Treatment
47. Transplant Services – Solid Organ and Bone Marrow

*Refer to Section 10.22

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.
<table>
<thead>
<tr>
<th>Service</th>
<th>VA Medicaid</th>
<th>VA FAMIS</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion services - when determined by DMAS to comply with federal and state laws and rules</td>
<td>✔️</td>
<td>✔️</td>
<td>Provider Helpline</td>
</tr>
<tr>
<td>Routine dental services</td>
<td>✔️</td>
<td>✔️</td>
<td>Smiles for Children</td>
</tr>
<tr>
<td>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.</td>
<td>✔️</td>
<td>✔️</td>
<td>Provider Helpline</td>
</tr>
<tr>
<td>Early intervention services through the Infant and Toddler Connection of Virginia. PCP must sign an Individualized Family Service Plan to get these services.</td>
<td>✔️</td>
<td>✔️</td>
<td>Infant and Toddler Connection</td>
</tr>
<tr>
<td>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</td>
<td>✔️</td>
<td>✔️</td>
<td>Provider Helpline</td>
</tr>
<tr>
<td>Assisted living services</td>
<td>✔️</td>
<td></td>
<td>Not a Covered Benefit</td>
</tr>
<tr>
<td>Service</td>
<td>VA Medicaid</td>
<td>VA FAMIS</td>
<td>Contact</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>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.</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
<td>Not a Covered Benefit Provider Helpline ☎ (800) 552-8627</td>
</tr>
<tr>
<td>Residential day and substance abuse treatment for pregnant women</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
<td>Not a Covered Benefit Provider Helpline ☎ (800) 552-8627</td>
</tr>
<tr>
<td>Personal care services for EPSDT eligible members if medically necessary —PCP must complete an assessment to qualify for personal care services. DMAS will notify PCP if request for personal care services is approved.</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
<td>Not a Covered Benefit Provider Helpline ☎ (800) 552-8627</td>
</tr>
<tr>
<td>Specialized infant formula for children and medical foods for individuals under 21 years old</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>Lead contamination investigations at home <em>Health plan will cover blood lead testing as part of well-baby/well child care</em></td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>Testing of fluoridation levels in water</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>Hospice</td>
<td>![Checkmark]</td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>![Checkmark]</td>
<td></td>
<td>![Checkmark]</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>Determination Timeframe</th>
<th>Telephonic or Oral/Verbal Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 24 hours of receipt of request</td>
<td>Within 24 hours of receipt of request</td>
<td>Within 24 hours of receipt of request</td>
</tr>
</tbody>
</table>

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


<table>
<thead>
<tr>
<th>Determination Timeframe</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 3 business days of receipt of request</td>
<td>Within 3 business days of receipt of request</td>
</tr>
</tbody>
</table>

**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 three (3) business days after receipt of the request for service.
Kaiser Permanente may extend the three (3) business day’s 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**

<table>
<thead>
<tr>
<th>Determination Timeframe</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within fourteen (14) calendar days of receipt of request</td>
<td>Within fourteen (14) calendar days of receipt of request</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Determination Timeframe</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 30 calendar days of receipt of request</td>
<td>Within 30 working days of receipt of request</td>
</tr>
</tbody>
</table>

**Sources:**
- National Committee for Quality Assurance (NCQA) UM Standard 5: Timeliness of UM Decisions
- Commonwealth of Virginia Department of Medical Assistance Services Medallion and Contract to provide managed care service for the Family Access to Medical Security Insurance (FAMIS) Program.

### 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 emergency admissions within 24 hours of the admission. Notification must be made to the Utilization Management department via phone: 1-800-810-4766, 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 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 1 (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 Utilization Management 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 Utilization Management nurses by telephone. Failure to provide the clinical information within the required timeframe may result in an administrative denial due to lack of information. The Participating Hospital cannot hold the member financially responsible for the denial. The Utilization Management nurse may contact the attending physician if further clarification of the member’s clinical status and treatment plan is necessary. The Utilization Management 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 Utilization Management Physician. Once the Utilization Management Physician reviews the case, the Utilization Management 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 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 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 skilled nursing facilities, 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 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.

Virginia Medicaid members who require a skilled nursing facility will be dis-enrolled from Kaiser Permanente; however the service will be covered by DMAS. Please contact DMAS on how to access these services.

**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.

Virginia Medicaid members who require hospice services will be dis-enrolled from Kaiser Permanente; however the service will be covered by DMAS. Please contact DMAS on how to access these services.

**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)
- PICC Line placement
- Echocardiograms
- GI Diagnostic procedures (EGD, Colonoscopy, ERCP, etc.)
- Stress tests
- Technical delays (i.e., machine broken or machine is not appropriate for patient, causing delay)
- Dialysis

**Operating Room**
- 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
- NPO order not acknowledged
- Kaiser Utilization Management not notified that the patient refuses to leave when discharged
SNF Delays

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

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

**Ancillary Service**
- Social Work/Discharge Planning
- Delay in initiation of therapy services (PT/OT/Speech)
- Lack of weekend therapy 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
- 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 with diagnoses
- Daily emergency department visits converted to observation
- Daily current inpatient census

### 9.32 Making a referral for Case Management Services
You or the member may request case management services via the self-referral telephone line by calling (301) 321-5126 or toll free (866) 223-2347. This confidential self-referral line is available 24 hours/7 days a week. Please leave a detailed message and contact information.
CareConnect Program for Complex Case Management
Kaiser Permanente CareConnect 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 of CareConnect 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 CareConnect 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. CareConnect is available to all members who meet program criteria.

Renal Case Management (RCM)
The RCM program is designed as an outcome-based, continuous quality improvement model that requires physician collaboration and inter-agency cooperation in order to utilize disease management tools, including multidisciplinary pathways and guidelines. Clinical practice guidelines published by the National Kidney Foundation, Kidney Disease Outcomes Quality Initiative (KDOQI) provide the evidence-based framework for Kaiser Permanente renal case management protocols. The goals of the program are: (1) to improve quality of life and continuity of care; (2) maximize member self-care and health-preserving behaviors, and (3) decrease costs associated with avoidable member morbidities and system inefficiencies. Currently, case management interventions are initiated for the member population with a Glomerular Filtration Rate (GFR) of < 30.

To refer members to the Renal Case Management Program, please call (301) 816-5955 or (800) 368-5784 Extension 8897 5955.

9.33 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 Department at (301) 625-6201 to refer a member for an evaluation for a transplant or to receive additional information about the NTS.

9.34 Pre-Natal and Infant Program Overview
At Kaiser Permanente, we provide a comprehensive prenatal and postnatal program to support positive outcomes for mothers and babies. Our program is designed to support maximum health of mothers to help reduce infant mortality and morbidity. To support mothers 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.

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

The Comprehensive Perinatal Program consists of:

**Early Start:** provides support for pregnant women experiencing issues of substance abuse (including ETOH and tobacco)

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

**High-Risk Case Management:** provides information and referrals for pregnant women with specific social determinants that might increase their risk of delivering a pre-term, low birth weight or otherwise compromised babies (i.e. homelessness, inadequate food, domestic violence, transportations barriers and unemployment)

**High–Risk Case Management**
Our commitment to the health and well-being of Moms and their babies continues after a baby is born. For babies or Moms who need extra assistance to make the transition home from the hospital can be referred to our Pediatric Case Management Department for follow-up.
### Attachment A

**Uniform Consultation Referral Form**

<table>
<thead>
<tr>
<th>Date of Referral:</th>
<th>Carrier Information:</th>
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<tbody>
<tr>
<td></td>
<td>Name: Kaiser Permanente</td>
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<td></td>
<td>Address:</td>
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<th>Patient Information:</th>
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<tr>
<td>Name: (Last First, MI)</td>
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<tr>
<td>Date of Birth: (MM/DD/YY)</td>
</tr>
<tr>
<td>Member #:</td>
</tr>
<tr>
<td>Phone Number: 1-(800)-810-4766</td>
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<th>Primary or Requesting Provider:</th>
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<td>Name: (Last, First, MI)</td>
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<tr>
<td>Institution/Group:</td>
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<td>Address: (Street #, City, State, Zip)</td>
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<td>Phone Number:</td>
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<th>Consultant/Facility Provider</th>
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<td>Address: (Street #, City, State, Zip)</td>
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<td>Phone Number:</td>
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<tr>
<th>Referral Information:</th>
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<tr>
<td>Reason for Referral:</td>
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<td>Brief History, Diagnosis, Test Results:</td>
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<th>Services Desired: Provide Care as Indicated:</th>
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<tr>
<td>☐ Initial Consultation Only:</td>
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<td>☐ Diagnostic Test: (specify)</td>
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<tr>
<td>❌ Consultation With Specific Procedures: (specify)</td>
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<td>☐ Specific Treatment:</td>
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<tr>
<td>☐ Global OB Care &amp; Delivery</td>
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<td>☐ Other: (Explain)</td>
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<td>☐ Outpatient Medical/Surgical Center *</td>
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<td>☐ Radiology</td>
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<tr>
<td>☐ Laboratory</td>
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<tr>
<td>☐ Inpatient Hospital *</td>
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<td>☐ Extended Care Facility *</td>
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<td>☐ Other: (Explain)</td>
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<td>* (Specific Facility Must be Named.)</td>
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<tr>
<th>Number of Visits: If Blank, 1 Visit is assumed.</th>
<th>Authorization #: (If Required)</th>
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<th>Referral is Valid Until: (Date)</th>
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<td>(See Carrier Instruction)</td>
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| Signature: (Individual Completing This Form) | Authorizing Signature: (If Required) |

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*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: (855) 414-2634  
Name/Department  
Telephone Number: (301) 879-6143 or (800) 810-4766  
Date __________ Fax Number ____________  
Telephone Number ____________

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>KP Medical Record Number</th>
<th>Date of Birth</th>
<th>Date of Service</th>
<th>Complaint/Diagnosis</th>
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</table>

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 ________________

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**Kaiser Permanente**  
September 2018
10.0 QUALITY RESOURCE MANAGEMENT

10.1 Quality Resource Management Program
The Kaiser Permanente Quality of Care and Service Program (the “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
2101 East Jefferson Street
Rockville, MD 20852

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 KP 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.providers.kaiserpermanente.org/mas under Provider Information and Clinical Library or by contacting the Quality Department at 301-816-5763.

10.3 Contracted Provider Participation
Participating Providers are required through their Kaiser Permanente contract to comply with the KPMAS Quality Improvement Program. 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 Quality Improvement 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 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 Regional Medical Director for Legal Affairs, Risk Management, and Patient Safety, and Health Plan’s Vice President of Quality Resource 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 KP ambulatory surgery and moderate sedation privileges for whom re-credentialing occurs every two years. All Participating Providers must satisfactorily complete the re-credentialing process to maintain an active status. This process is described in detail below in Section 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:

- Be provided a copy of the MASCAP policies and procedures upon written request.
- Reviewing the information contained in his or her credentials file.
- Correcting erroneous information contained in his or her credentials file.
- Being informed, upon request, of the status of their application.
- Appealing decisions of the Credentialing Committee if he/she has been denied re-credentialing, has had their participating status changed, been
placed under a performance improvement plan, or had any adverse action taken against them.

These rights may be exercised by contacting the Practitioner and Provider Quality Assurance Department (PPQA) at ☎️ (301) 816-5853 or by fax at (301) 816-7133. Written correspondence may also be sent to:

Kaiser Permanente
Practitioner and Provider Quality Assurance- 6 West
2101 East Jefferson Street
Rockville, MD 20852

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
- Out-of-state 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
- NPDB Query
- HIPDB Query
- Work History
- Medicare and Medicaid Status and Sanctions
- List of Excluded Individuals/Entities (LEIE)
- Office Visit Report
- Mid-Level Practitioner Practice Agreement
- Site Visits
Kaiser Permanente participating Primary Care Physicians (“PCP”), 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 Mid-Atlantic States Credentialing and Privileging Committee (MASCAP) and Regional Quality Assurance/Quality Improvement Committee (RQIC) use 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 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 Board of Oral & Maxillofacial Surgeons
- American Podiatric Medical Association (APMA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Academy of Nurse Practitioners
- American Association of Nurse Anesthetists
- American Midwifery Certification Board
- ANCC Certification for Nurse Practitioners
- NCCPA Certification for Physician Assistants
- Pediatric Nursing Certification Board (PNCB)
10.6 Re-credentialing Process

After initial credentialing, Kaiser Permanente Participating Providers will be re-credentialled every three (3) years except for those with Kaiser Permanente ambulatory surgery and moderate sedation privileges who shall be re-credentialled 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
- Out-of-state license sanctions
- DEA Certificate in each jurisdiction where the practitioner provides services
- CDS Certificate
- Board Certification and Maintenance of Board Certification
- Hospital Privileges
- Professional Liability Coverage (1 million, 3 million coverage)
- Claims History
- NPDB Query
- HIPDB Query
- Medicare and Medicaid Status and Sanctions
- Mid-Level Practitioner Practice Agreement
- Practitioner Quality Profile

Notification

It is incumbent upon Participating Providers to notify the Practitioner and Provider Quality Assurance Department at ☎ (301) 816-5853 within 30 days of the occurrence, regarding any updates or changes to their application or credentials. 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 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.

**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 DMAS contract including those listed below.

- Childhood Immunization Status (Combo 2) and each vaccine must be reported separately as well.
- Childhood Immunization Status (Combo 3) and each vaccine must be reported separately as well.
- Lead Screening in Children
- Timeliness of Prenatal Care
- Postpartum Care
- Well-Child Visits in the First 15 Months of Life and each number of visits listed separately.
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
• Adolescent Well-Care Visit
• Comprehensive Diabetes Care (all age categories set forth by the HEDIS technical specifications for these diabetes measures only)
• HbA1c Testing
• HbA1c Control
• Eye Exams
• LDL Screenings
• LDL Control
• BP Control < 140/90
• Asthma – Appropriate use of medication (all age categories set forth by the HEDIS technical specifications)

10.8 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: (is the following supposed to be off of this bullet?)
• 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

10.9 Health Education, Health Promotion, and Women’s Health
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. The following class topics are currently available:

• Prevention
• Disease Management
• Prenatal and Parenting 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 www.cl.kp.org.

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 Center. The Center’s 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 call the centralized wellness coaching phone number at ☎ (866) 862-4295, Monday through Friday, 7 a.m. to 8 p.m. Coaching is offered in both English and Spanish and in other languages using Language Select.

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. Physicians and nurse practitioners use the reports to encourage members to seek appropriate health screenings, immunizations, and other medical care. 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](http://www.kaiserpermanente.org).

For members who have access to the internet, Kaiser Permanente’s web site, [www.kaiserpermanente.org](http://www.kaiserpermanente.org), offers customized online programs for health risk appraisal (total health assessment), weight management/physical activity, nutrition, stress management, caring for pain, and tobacco cessation. Kaiser Permanente promotes completion of the total health assessment to augment health assessment visits.

### 10.10 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 when they are initially identified as having one of these conditions and mailings and/or phone calls periodically thereafter, including care gap reminders. The mailings and additional multi-media resources introduce the programs and provide education on topics such as the latest information on managing their condition, physical activity, tobacco cessation, medication adherence, planning for visits and knowing what to expect, and coping with multiple diseases. Participating Providers may receive member-level information to help manage their panel, and quality process and outcome information to help improve practices. In addition, you can receive tools, including posters and pocket cards.

Call the Population Care Management message line anytime at (703) 536-1465 in the Washington Metro area to refer your patient. Or, to obtain information and tools to care for your members with chronic diseases, register at [www.mapmgonline.com](http://www.mapmgonline.com) or contact Population Care Management at (301) 816-7122, or the Provider Experience Department at (877) 806-7470.
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 Kaiser Permanente Medical Center Pharmacy Prescription Guidelines
Complete patient information on the prescription is required. This includes member’s name, Kaiser Permanente Membership ID number, provider number (or printed last name), and special instructions. The most frequent errors incurred on prescriptions are omission errors or incorrect ID numbers. To reduce medication errors, it is recommended that all Participating Providers write-out specific instructions on all prescriptions. It is advised 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 30-60 day supply each time the prescription is dispensed.
- Members may receive up to a 90 day supply for refills of medications for chronic conditions.
- Processing time for prescriptions that have no refills remaining is 24 to 48 hours.
- Processing time for prescriptions that have refills is 24 hours.
- Generic medications are used whenever possible in Kaiser Permanente pharmacies.
- Unless otherwise specified in the formulary or by the Regional Pharmacy & Therapeutics Committee ("Committee"), 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.
• Participating Providers are requested to report any suspected bioavailability problems to Health Plan’s Regional Pharmacy Administration at (301) 816-6553.

11.3 Formulary System

Formulary
The Kaiser Permanente Drug Formulary is a compilation of drugs approved for general use by the P&T Committee. 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.

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 on the basis of 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.

*Prior Authorization:* The following drug classes have a Prior Authorization (PA) process. The PA criteria are reviewed at least annually by KPMAS P&T Committee:

• Agents when used for weight loss;
• Agents when used as growth hormones;
• Agents when used for Hepatitis C treatment; and
• Agents when used for their LDL lowering effect otherwise known as PCSK9 inhibitors.
Prescribing Recommendations: Kaiser Permanente may recommend drugs in certain classes to be used once a diagnosis and a decision to treat has been made. Prescribing Recommendations are informational only and not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by Participating Providers in any particular set of circumstances for each patient. The P&T Committee approves Prescribing Recommendations that are developed with input from the appropriate Regional Chiefs-of-Service. In addition, the advice of individual subspecialties or selected expert physician groups may be solicited.

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, 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 for affiliated practitioners available at http://providers.kaiserpermanente.org/html/cpp_mas/formulary.html. To view the P&T Memos, you will be redirected to the KPMAS Clinical Library, a secured network, and asked to sign in and/or register for access.

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.

11.4 Non-Formulary 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 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 and coinsurance information by member benefit plan type on the KP HealthConnect AffiliateLink, 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. If you do not have access to KP HealthConnect AffiliateLink and would like to gain access, please contact Provider Experience at 1-877-806-7470 Monday through Friday, 8:30 a.m. to 5:30 p.m. EST for assistance.

11.5 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. The pharmacy also stocks Aerochambers with masks for those members who cannot seal their lips tightly around a mouthpiece.

**Blood Glucose Monitors:** Monitors and strips that are currently covered are manufactured by Lifescan Inc.; products include, One Touch Verio IQ monitor, One Touch Verio test strips, One Touch Ultra test strips, One Touch Delica lancets, and One Touch Ultrasoft lancet. The strips are covered under the prescription benefit with a prescription from the provider. The monitor is dispensed free of charge or at a nominal fee depending upon the member benefit.

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

11.6 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: 1 (888) 989-1144
Hours of Operation: M-F: 7:00 am – 6:00 pm

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. 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 of medication is to be given in a controlled setting, such as in a Kaiser Permanente Medical Center, Hospital, or Nursing Home.

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 PCA (patient controlled analgesia)
• 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 Health Connect 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.

11.7 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 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 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:

- **Urgent Requests:** If the prior authorization request is submitted to Kaiser Permanente telephonically or in an alternate method directed by Kaiser Permanente for urgent requests, Kaiser Permanente will respond to the prescriber or designee within 24 hours of an urgent prior authorization request.

- **Fully Completed Requests:** Kaiser Permanente must communicate electronically, telephonically, or by facsimile to the prescriber or designee within two (2) business days of a submission of a fully completed prior authorization request.

- **Provider Responses for Supplementation to Kaiser Permanente:** Kaiser Permanente must communicate electronically, telephonically, or by facsimile to the prescriber or designee within two (2) business days of a submission of a properly completed supplementation from the provider or designee, that the request is approved or denied.

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.

The following drug classes will have a Prior Authorization (PA):

- Agents when used for weight loss
- Agents when used as growth hormones
- Hepatitis C therapy; Antihepaciviral, NS5A Inhibitor; Antihepaciviral, Polymerase Inhibitor (Anti-HCV)
• Agents when used for their LDL lowering effect otherwise known as PCSK9 inhibitors
• All long acting opioids, all Fentanyl products, any short acting opioid prescribed for > 7 day supply and > 14 days in 60 days, individual opioid > 90 MME, cumulative opioid daily dose > 120 MME/day
• Benzodiazepine-Opioid concurrent use
• Buprenorphine mono or combination oral therapy used for management of Substance Use Disorders and prescribed by physicians other than a "Gold Card" physician (physicians specialized in the management of substance use disorders and recognized as “Gold Card" physicians by Virginia Department of Medical Assistance Services)
• Buprenorphine mono and combination therapy when maximum daily dose exceeds 16 mg/day regardless of the prescriber's 'gold card' status

**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 Medallion and Managed Care Technical Manual (MCTM).

1. 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: Buprenorphine containing product: therapy in the past 30 days – **AUTOMATIC ENROLLMENT IN PUMS** (no review needed)
2. High average daily dose: > 120 morphine milligram equivalents per day over the past 90 days
3. Opioids and Benzodiazepines concurrent use—at least 1 opioid claim and 14 days 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 dependence.
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

Health Plan members have direct access to mental health and chemical dependency services. Primary Care Physicians (“PCPs”) may refer members for behavioral health care services, but a referral is not required. Members can arrange services independently by calling the Behavioral Health Access Unit where licensed clinicians (social workers and nurses) and intake schedulers assist members in arranging appropriate services.

Members call:
Kaiser Permanente Behavioral Access Unit at 1(866) 530-8778.

All Providers arranging for behavioral health services for members call:
Kaiser Permanente Behavioral Health Unit at 1(866) 530-8778.
Select Prompt # 6 for non-urgent inquiries
Select Prompt #9 for Emergency Services

If you have an administrative question or issue regarding member or benefit coverage, please call Member Services at (855) 249-5019.
12.2 Referrals and Authorizations for Behavioral Health Services

When members call the Behavioral Health 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 with in a Kaiser Permanente Medical Center Behavioral Health department and chooses to see a Kaiser Permanente Virginia Medicaid network provider the member may contact Membership Services and/or go to www.kp.org for assistance. The member is advised to call the Behavioral Health Utilization Management Confirmation Mailbox at (301) 625-5561, after scheduling their initial appointment to advise Kaiser Permanente of the name and number of the provider selected. This process ensures that the appropriate authorization is entered into the Kaiser Permanente Referral System. Once the member notifies Kaiser Permanente that they have contacted a Participating Provider, that provider is sent a KP External Referral authorizing the service for the member.

Each referral contains a brief description of the patient’s condition along with the following information:
- Member’s Name
- Referral ID Number
- Number of visits authorized
- Expiration date

All treating providers must ensure that they receive an approved referral prior to the member’s visit. If a referral has not been received for the member, please contact the Behavioral Health Referral Management Assistant for assistance at (301) 625-5561.

Continuing Consultations and Treatment
Prior to the last approved visit or the expiration date on the referral, the treating provider must submit a treatment plan for the member.

The treatment plan must be faxed to the attention of the Behavioral Health Utilization Review Nurse at 1 (855) 414-1703. Upon receipt of the treatment plan, the Behavioral Health Utilization Review Department will fax or mail a Continuing Treatment Authorization form indicating the review determination.

12.3 Addiction and Recovery Treatment Services (ARTS) Program

Effective April 1, 2017, Kaiser Permanente will offer Addiction and Recovery Treatment Services (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. 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), 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 BHSA for fee-for-service enrolled members. The chart describes the ARTS service coverage by ASAM Level of Care.

<table>
<thead>
<tr>
<th>ASAM Level of Care</th>
<th>ASAM Description</th>
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<tbody>
<tr>
<td>4.0</td>
<td>Medically Managed Intensive Inpatient</td>
</tr>
<tr>
<td>3.7</td>
<td>Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)</td>
</tr>
<tr>
<td>Level</td>
<td>Description</td>
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<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>3.5</td>
<td>Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)</td>
</tr>
<tr>
<td>3.3</td>
<td>Clinically Managed Population-Specific High-Intensity Residential Services (Adults)</td>
</tr>
<tr>
<td>3.1</td>
<td>Clinically Managed Low-Intensity Residential Services</td>
</tr>
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<td>Partial Hospitalization Services</td>
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<td>Opioid Treatment Program (OTP)</td>
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<td>Office-Based Opioid Treatment (OBOT)</td>
</tr>
<tr>
<td>0.5</td>
<td>Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)</td>
</tr>
<tr>
<td>n/a</td>
<td>Substance Use Case Management</td>
</tr>
</tbody>
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- The ARTS specific procedure codes and reimbursement structure is posted online at: [http://www.dmas.virginia.gov/Content_atchs/bh/ARTS%20Reimbursement%20Structure%202016.pdf](http://www.dmas.virginia.gov/Content_atchs/bh/ARTS%20Reimbursement%20Structure%202016.pdf)

### 12.4 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.

### 12.5 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.

### 12.6 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 psychiatric problems present as medical conditions and many medical conditions present with psychiatric 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.

12.7 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.

Intensive Outpatient Program (IOP)
Intensive Outpatient Treatment programs are located at many Kaiser Permanente BH 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. PROVIDER APPEALS AND DISPUTES

13.1. Provider Appealing on Behalf of a Member
Refer to Sections 5.6 and 9.24

13.2. 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.

A payment dispute request should include:
- 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)).

A provider may initiate a payment dispute by calling (877) 806-7470. 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 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
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 8.1 – Billing Procedures for Fee-for-Service Claims 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 8.1- Billing Procedures for Fee-for-Service Claims of this Manual. Acceptable proof of timely filing may include the documentation and/or situations in the table in Section 8.9.

13.3 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.