network news

For practitioners and providers of Kaiser Permanente
Produced by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in partnership with the Mid-Atlantic Permanente Medical Group, P.C.

October 2022

COVID-19 Updates

For the latest updates on COVID-19 FAQs and reference guides, go to our Community Provider Portal at www.kp.org/providers/mas.

Contents

Behavioral Health Referrals

There has been a growing demand for mental health services. To help meet that demand, we have expanded the list of procedures that do not require pre-authorization. This is effective immediately, and we will update the list if any changes are made in the future.

Kaiser Permanente members may contact a Behavioral Health provider directly for an appointment. ***Pre-authorization is not required for the initial consultation and some routine care services.*** Please see below for the complete list of authorization-waived CPT codes and their corresponding description.

CPT Code	Description
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION
90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES
90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN
90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES
90836	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES
90838	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS
90849	MULTIPLE FAMILY GROUP PSYCHOTHERAPY
90853	GROUP PSYCHOTHERAPY
99202	OFFICE/OUTPATIENT NEW SF MDM 15-29 MINUTES
99203	OFFICE/OUTPATIENT NEW LOW MDM 30-44 MINUTES
99204	OFFICE/OUTPATIENT NEW MODERATE MDM 45-59 MINUTES
99205	OFFICE/OUTPATIENT NEW HIGH MDM 60-74 MINUTES
99211	OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP
99212	OFFICE/OUTPATIENT ESTABLISHED SF MDM 10-19 MIN
99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN
99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30-39 MIN
99215	OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40-54

If it is determined that a Kaiser Permanente member requires additional care beyond the services in this list, per the *Kaiser Permanente Participating Provider Manual, Section 14.2: Referrals and Authorizations for Behavioral Health Services* (www.kp.org/providers/mas) please submit a completed **Uniform Treatment Plan** (https://k-p.li/3r4oiw4) and fax it to Behavioral Health Utilization Management at 1-855-414-1703 for authorization of continuing care.

Behavioral Health Referrals - *Continued from page 2*

Treatment plans will be reviewed by a member of Kaiser Permanente's Behavioral Health Utilization Management team. A Kaiser Permanente Behavioral Health provider may contact the treating provider if further clarification of the member's clinical status and progress of the member's condition is necessary. Should you have any questions regarding the member's treatment plan or if you would like to discuss special patient circumstances, please contact our Behavioral Health Utilization Management team at 301-552-1212.

Specialized services or programs such as rehabilitation, partial hospitalization programs, or procedures such as TMS or ECT will still require a completed **Uniform Treatment Plan** (https://k-p.li/3r4oiw4) sent to Behavioral Health Utilization Management for referral authorization prior to care. Referrals are not required for the initial consultation for services such as outpatient therapy or medication management.

When prescribing medication to our members, refer to the Kaiser Permanente drug formulary for a list of preferred drugs. Our formulary can be found on our Community Provider Portal at www.kp.org/providers/mas. Members may conveniently fill their prescriptions at any Kaiser Permanente pharmacy located within our medical centers.

We appreciate your support for our members in providing ongoing medication refills, urgent access and on-call needs as well as completion of forms such as FMLA. To support ongoing care coordination, please encourage your patients to complete a release of information form so we can share medical records with you.

Members with questions about their behavioral health care should be directed to contact our Member Services Department at 1-877-218-7749, (301) 879-6380, TTY, Monday through Friday from 7:30 am to 5:00 pm.

Our goal is to make this process as easy and seamless as possible for both you and our members. Please reach out to our Provider Experience team at 1-877-806-7470 with any questions or concerns.

DMAS Required PRSS Enrollment

In April 2022, the Virginia Department of Medical Assistance Services (DMAS) launched a new portal to manage provider enrollment – the Provider Services Solution (PRSS). Medicaid providers will use the PRSS portal, located on the Medicaid Enterprise System (MES) website, to complete enrollment and maintenance processes. This platform will be more efficient and make it easier for you to access the information you need as a Medicaid provider. All Medicaid managed care network providers must enroll through PRSS to satisfy and comply with federal requirements in the 21st Century Cures Act. Those network providers that are currently enrolled as FFS in Medicaid do not have to re-enroll in PRSS.

As a Kaiser Permanente Virginia Premier participating provider, you will need to initiate enrollment through the new PRSS Enrollment Wizard: https://virginia.hppcloud.com/. Go to "Enroll as a new provider" or "check your enrollment status". Only one enrollment application is necessary in PRSS, even if you participate with more than one MCO. The application process allows for selection of one or more MCO plans. Once approved, providers will need to create a PRSS portal online account in order to revalidate their enrollment, make changes to personal or business information and check member eligibility. You may be asked to provide evidence of your submission.

DMAS Required PRSS Enrollment - *Continued from page 3*

You can find helpful training resources on the MES website: https://vamedicaid.dmas.virginia.gov/training/providers

Questions? Contact PRSS Provider Enrollment Helpline at (804) 270-5105 or (888) 829-5373 and Provider Enrollment email address at: vamedicaidproviderenrollment@gainwelltechnologies.com. For questions related to non-enrollment, please work with your health plan.

Provider Education and Training Courses

Managed care network providers can get ready to use the new Provider Services Solution (PRSS) portal by using training resources on the Medicaid Enterprise System (MES) website. DMAS offers a variety of live and pre-recorded training opportunities to help prepare providers to receive the maximum benefits from the PRSS portal. Please encourage your staff to register for virtual instructor-led courses to make sure your organization is ready to use the new portal. Please visit the MES website for a comprehensive listing of current courses.

Training Schedule and Registration

You must register to participate in live webinars. Webinar participants must use a computer with internet access and a telephone line to dial in. Registered participants will have the chance to engage with the trainer and ask specific questions.

As you review training options, PLEASE be sure to register for the following three courses:

- **PRSS-111 Provider Enrollment Application**
  This training course explains the provider enrollment process, identifies the different enrollment types and offers guidance on the documentation that providers need to prepare before enrolling. The training also includes an overview of what the provider enrollment application looks like and how to submit a provider enrollment application.
- **PRSS-118 Introduction to Provider and MCO Portal Delegate Management**
  The goal of this virtual training is to offer instructions on this important process for providers, authorized administrators of providers, and delegates of providers. In PRSS, a provider's primary account holder and/or delegate administrators must register their delegates and assign them permission to access the provider portal to complete enrollments and other tasks.
- **PRSS-120- Introduction to the Provider Portal**
  The goal of this virtual training is to introduce the provider portal registration process and the functions, features, and basic navigation within the provider portal.

There is also an optional working session available (**PRSS-111-WS Working Session: Provider Enrollment Support**) that provides real-time support from our trainer as you work through one or more provider enrollment applications.

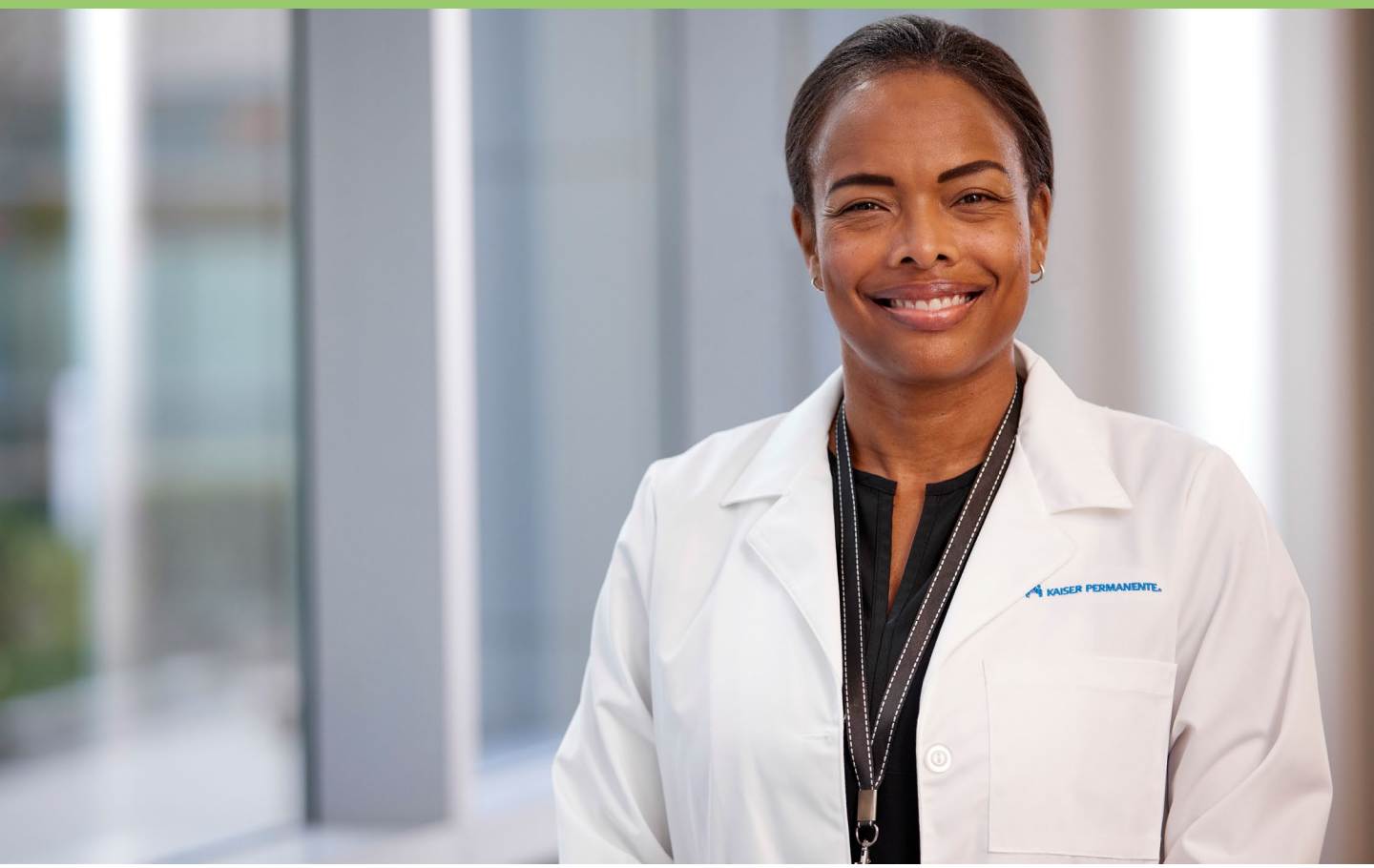
To register for any training, please visit the MES Provider Training Registration page https://vamedicaid.dmas.virginia.gov/training/providers to choose a date and time that works best for you.

Registration is now open. Courses began on May 31, 2022, and spaces are filling quickly. Register early. Please help us spread the word about this upcoming training opportunity. If you have questions related to training, please contact DMAS_VA_MESregistrations@briljent.com.

Access to Utilization Management Criteria

There are several ways to access the utilization management (UM) criteria sets, national guidelines and medical coverage policies:

- UM approved criteria set, and medical coverage policies can be accessed by UM staff and Kaiser Permanente physicians through Kaiser Permanente HealthConnect and the Clinical Library.
- Contracted network and community physicians and providers can access Kaiser Permanente HealthConnect and Clinical Library through their Online Affiliate access at https://cl.kp.org/mas/home.html.
- Hard copies of the criteria or Medical Coverage Policy or rule or protocol are available free of charge, please contact the Utilization Management Operations Center (UMOC) at 800-810-4766 (follow the prompts). Behavioral Health (BH) inquiries may be called to 301-552-1212.
- The above number may also be used to reach a UM physician to discuss UM medical coverage policies related to medical necessity decisions.
- Emerging technology and regionally based medical technology assessment reports are communicated internally through the Kaiser Permanente Mid-Atlantic States (KPMAS) Provider Network Newsletter, Kaiser Permanente HealthConnect messaging and through regional emails. Current standings on new technologies related to medical necessity decisions can be discussed with a UM physician at the Utilization Management Operations Center at 800-810-4766.
- Updates to medical coverage policies, UM criteria and new technology reports are featured in “Network News,” our quarterly participating network provider newsletter. You can also access current and past editions of “Network News” on our provider website by visiting online at Provider Information | Community Provider Portal | Kaiser Permanente.



2022 Utilization Management Approved Criteria Sets and Guidelines

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, evidence-based clinical criteria supported by current peer reviewed literature are evaluated by specialty service chiefs and subject matter experts certified in their specific field of medical practice in the guideline development and renewal process.

All criteria sets are reviewed and updated annually, then approved by the Regional Utilization Management Committee (RUMC) as delegated by the Regional Quality Improvement Committee (RQIC). Our Utilization Management (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 practitioner bases their determination on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of individual patients (e.g., age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. The approved UM criteria sets, and guidelines are listed below.

2022 UM Approved Criteria Sets and Guidelines – *Continued from page 6*

Types of UM Criteria in Use:

A. Behavioral Health UM Criteria

- **Nationally recognized UM criteria**
  - Milliman Care Guidelines (MCG) 26th edition
  - Mental Health Services (MHS) formerly called Community Mental Health and Rehabilitation Services (CMHRS) for Virginia Premier's Behavior Health Services
  - American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder (SUD)
  - Addiction Recovery and Treatment Services (ARTS)
- **Internally developed UM criteria**
  - MCP

B. Non-Behavioral UM Criteria

- **Nationally recognized UM criteria**
  - MCG 26th edition
  - CMS Coverage Database for National (NCD) and Local Coverage Determination (LCD) for DME and supplies
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines
  - 2022 InterQual Level of Care Criteria for Transplant Services
- **Internally developed UM criteria**
  - MCP
  - National Transplant Services (NTS) Transplant Patient Selection Criteria

2022 UM Approved Criteria Sets and Guidelines – *Continued from page 7*

Behavioral Health

2022 UM Criteria

Referral Service Type Approved criteria sets are used in order of hierarchy.	Commercial & Exchange Jurisdiction	Medicare	Medicaid (VA Medicaid and FAMIS)	Medicaid (MD HealthChoice)
Behavioral Health: SUD specifically *All levels, i.e., IP, OP, RTC, PHP, IOP	MCG ASAM	MCG	ASAM	Not Applicable
Behavioral Health: Inpatient	MCG	MCG	MCG	Not Applicable
Behavioral Health: Outpatient *Excludes SUD	MCP MCG	MCG	MCG	Not Applicable
Behavioral Health: Partial Hospitalization *Excludes SUD	MCG	NCD-LCD	MHS	Not Applicable
Behavioral Health: CMHRS Covered Services	Not Applicable	Not Applicable	MHS	Not Applicable

2022 UM Approved Criteria Sets and Guidelines – *Continued from page 8*

Virginia Medicaid Behavioral Health and SUD

MHS and ARTS

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

CMHRS	UM Criteria
Mental Health (MH) Case Management	Registration Only
MH Peer Support – Individual	DMAS SA after Initial Registration
MH Peer Support – Group	DMAS SA after Initial Registration
Mobile Crisis Response	DMAS Registration
23 Hour Crisis Stabilization	DMAS Registration
Community Stabilization	DMAS SA after Initial Registration
Residential Crisis Stabilization	DMAS after Initial Registration
Assertive Community Treatment	DMAS after Initial Registration
Intensive In-Home	DMAS Service Auth
Therapeutic Day Treatment for Children School Day	DMAS Service Auth
Therapeutic Day Treatment for Children After School	DMAS Service Auth
Therapeutic Day Treatment for Children Summer	DMAS Service Auth
Partial Hospital Program	DMAS Service Auth
MH Skill Building Services	DMAS Service Auth
Psychosocial Rehab	DMAS Service Auth
Applied Behavior Analysis	DMAS Service Auth
Intensive Outpatient Program	DMAS Service Auth
Functional Family Therapy	DMAS Service Auth
Multisystemic Therapy	DMAS Service Auth

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

Sources:

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

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

[3] * Source: VA Medicaid Contract Medallion 4.0 and FAMIS

[4] DMAS criteria: MHS formerly called CMHRS

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Virginia Medicaid Behavioral Health and SUD

MHS and ARTS

1. ASAM Criteria for SUD

The **ASAM Criteria** are outcome-oriented treatment and recovery services, designed by the ASAM and funded by the U.S. Substance-Abuse and Mental Health Services Administration (SAMHSA) to enhance the use of multidimensional assessments in developing patient-centered plans and to guide clinicians, counselors and care managers in making objective decisions on patient admissions, continuing care, and transfer/discharge for addictive substance-related, and co-occurring conditions and various levels of care intended to encourage further patient-matching and placement research. The result-based clinical care guidelines reflect a clinical consensus of adult and adolescent addiction treatment specialists, developed through the incorporation of extensive field review comments.

- The **ASAM criteria** is used for all **Virginia Medicaid** chemical dependency level of care decisions and referral determinations, as required by the Virginia DMAS effective April 1, 2017.
- The **ASAM criteria** is applied to all SUD for **Maryland Individual and Group Commercial and Federal health plans effective 01/01/2020**. MCG criteria is no longer used for Maryland Commercial Members SUD in 2020.

2. Virginia Medicaid

MHS for Virginia Premier's Behavioral Health Services
DMAS criteria: MHS formerly called CMHRS Chapter IV of the DMAS Manual provide details on eligibility criteria & coverage requirements for behavioral health interventions that provide clinical treatment to individuals with significant mental illness or emotional disturbances.

ARTS
ARTS – are comprehensive continuum of addiction and recovery treatment services based on the ASAM Patient Placement Criteria. This will include: (i) inpatient services to include withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv) intensive outpatient treatment and (v) peer recovery supports. Providers will be credentialed and trained to deliver these services consistent with ASAM's published criteria and using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

2022 UM Approved Criteria Sets and Guidelines – *Continued from page 11*

Non-Behavioral Health

Note: Commercial and Exchange includes District of Columbia, Maryland, and Virginia jurisdictions.

Referral Service Type Approved criteria sets are used in order of hierarchy.	Commercial & Exchange Jurisdiction	Medicare	Medicaid (VA Medicaid and FAMIS)	Medicaid (MD HealthChoice)
Acute Rehabilitation (Inpatient)	MCG	MCG	MCG	MCG
Ambulance Services	KP-MAS MCP	NCD-LCD	KP-MAS MCP	KP-MAS MCP
Durable Medical Equipment (DME) and Supplies	KP-MAS MCP MCG NCD-LCD	NCD-LCD	KP-MAS MCP MCG NCD-LCD	KP-MAS MCP MCG NCD-LCD
Orthotics and Prosthetics	KP-MAS MCP MCG NCD-LCD	NCD-LCD	KP-MAS MCP MCG NCD-LCD	KP-MAS MCP MCG NCD-LCD
EPSDT Services	Not Applicable	Not Applicable	EPSDT	EPSDT
Home Health Services	MCG	NCD-LCD	MCG	MCG
Hospice (inpatient and outpatient)	MCG	MCG	MCG	MCG
Inpatient Services	MCG	MCG	MCG	MCG
Neonatal Care	MCP/MCG	Not Applicable	MCP/MCG	MCP/MCG
Outpatient Services	KP-MAS MCP MCG	NCD-LCD	KP-MAS MCP MCG	KP-MAS MCP MCG
PT/OT/ST	KP-MAS MCP MCG	NCD-LCD KP-MAS MCP MCG	KP-MAS MCP MCG	KP-MAS MCP MCG
Skilled Nursing Facility	MCG	MCG/NCD-LCD	MCG	MCG
Transplant Services	NTS IQ®	NTS IQ ®	NTS IQ ®	NTS IQ ®

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Key to Abbreviations

- MCP/MCG™: NICU and Neonatal Care Admission and Discharge (Revised MCG® Neonatal Intensive Care Unit Levels)
- MCG™: formerly called Milliman Care Guideline
- ASAM: American Society of Addiction Medicine
- IQ: InterQual® Criteria
- Mental Health Services Criteria: formerly Community Mental Health Rehabilitative Services
- IOP: Intensive Outpatient Program
- MCP: Medical Coverage Policies (Locally developed)
- NCD-LCD: Medicare Coverage Policies-National and Local Coverage Determination
- NTS: KP National Transplant Network Services Patient Selection Criteria
- RTC: Residential Treatment Center
- PHP: Partial Hospitalization Program
- SUD: Substance Use Disorder
- OP: Outpatient
- IP: Inpatient

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Non-Behavioral Health

A. MCG Guidelines 26th Edition/14.0 Release[5]

MCG are evidence-based clinical guidelines that span the continuum of care. They provide best practices criteria and content for healthcare professionals in most healthcare settings, supporting decisions and easing patient transitions between settings.

The MCG 26th edition was released on February 25, 2022, after systematic evidence-based review by MCG. The new edition went live in KPMAS on June 28, 2022. The MCG's care guidelines that are licensed for KPMAS are the following:

- **Ambulatory Care (AC)** - authorize established and emerging outpatient clinical procedures and technologies. The AC product covers procedures and diagnostic tests; imaging studies; injectable and other pharmacologic agents; durable medical equipment, prosthetics, orthotics and supplies; rehabilitation evaluations, services, and modalities and referral management.
- **Home Care (HC)** - maintain quality and efficiency beyond healthcare facility walls. The HC product enables well-defined and coordinated care plans to support patients at home, including therapy visit goals.
- **Behavioral Health Care (BHC)** - address specific psychological, behavioral, and pharmacologic therapies. This product covers 15 diagnosis groups at seven levels of care to help integrate behavioral health care with other utilization management efforts.
- **Inpatient and Surgical Care (ISC)** - anticipate appropriate clinical resources and identify the next steps in proactive care for inpatients. This product provides detailed care pathways, admission and discharge criteria, goal lengths of stay, and other decision-support tools.
- **General Recovery Care (GRC)** - provides care guideline when no Inpatient & Surgical Care Optimal Recovery Guideline appears applicable or to assist in care management of complex, multifaceted clinical situations with the purpose to identify and describe evidence-based elements of patient care that will assist in the delivery of quality healthcare and efficient resource management.

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- **Recovery Facility Care (RFC)** - address two primary level of care which are inpatient rehabilitation facilities (acute rehabilitation) and sub-acute/skilled nursing facilities (SNF). The appropriate level of care that which determines patient's placement is correlated to patient's clinical condition, functional status, therapeutic goals, preference and potential to reach optimal functioning and independence. The care guideline provides recovery facility admission care and discharge criteria, including complete discharge plans, coordinating plans for moving patients to and through recovery facilities to other appropriate care settings.

    a. **Inpatient rehabilitation facilities** or **acute rehabilitation** provides highly intensive rehabilitation services for ongoing assessment and management of the patient to achieve optimal functioning while being monitored for changing medical or physical status. The care guideline is intended for patients who require and can tolerate extensive physical rehabilitation, and who demonstrate the ability to make progress in the therapeutic program with access to 24-hour nurse support, close physician monitoring, and frequent intensive rehabilitation services.

    b. **Subacute/SNF** is a level of care intended for patients who require ongoing skilled medical interventions that cannot be provided at a lower level of care and can perform rehabilitation therapy but not at a highly intensive level. It requires* provision of ongoing skilled medical treatments and moderate to low-level intensive therapy with focus on skilled nursing interventions, rehabilitation therapy, or a combination of both.

Changes in the MCG 26th edition

General Content Enhancements and Changes

Number of Guidelines in the Content: The Summary of Changes document lists the number of guidelines and resources in each content area. This list demonstrates the wealth of MCG evidence-based guidelines that span the continuum of care and provides a comparison between the number of guidelines in the 26th edition and the newly released 26th edition.

Benchmarks & Data: Due to the pandemic, our 26th edition suite of resources reflect data from Medicare, Commercial and Medicaid populations through December 31, 2019. The exception to this data timeframe is COVID-19-related data. For the Viral Illness, Acute inpatient guidelines, the date range for hospital encounter data is January 1, 2020, through March 31, 2021.

Detailed List of Changes: A Detailed List of Changes resource (accessible from each content solution's table of contents page) has been added for all content volumes. This resource identifies guideline specific changes between the 25th and 26th editions.

Calculators: The Care Management Tools menu (accessible from each content solution's table of contents page) now includes a Calculators section. This section provides links to publicly accessible calculators often used as part of the patient assessment process.

Inpatient & Surgical Care

Hospital-at-Home (HaH) Guidelines: MCG is releasing new HaH content. These five guidelines were developed to assist with the identification of patients requiring inpatient care but who may be appropriate for care provided in the home setting. Patients participating in a HaH program would be appropriate for inpatient admission in a brick-and-mortal hospital if a HaH program wasn't available. HaH guidelines can be accessed from a link on the ISC table of contents page, or from within search results.

Observation Care Guidelines: Three new Observation Care guidelines have been added for pancreatitis, acute renal failure, and stroke.

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Assessments: Social Determinants of Health, Readmission Risk, and Extended Stay Assessments can now be accessed from each Guideline Day in the Optimal Recovery Course.

eGFR - Adult Calculator: To correct potential racial bias in assessment of kidney function with the previous equation, the eGFR - Adult calculator has been updated to incorporate the CKD-EPI equation. This change is defined in the Footnote associated with the calculator.

Definitions: To improve ease of use and provide additional clarification, new definitions were added for Anasarca, Multimodal Analgesia, Bacteremia, Troponin, Isolation, and Immunosuppressed.

Multiple Condition Management
Changes made to the Multiple Condition Management guidelines directly correlate to changes made in the Inpatient & Surgical Care guidelines, including addition of the Social Determinants of Health and Readmission Risk Assessments to all Guideline Days of the Optimal Recovery Course.

General Recovery Care
Advisory Code A-SDH: Some code searches return Advisory Codes because the code is not pertinent to an inpatient stay, does not clarify what inpatient care would be needed, or is ancillary to the patient's actual diagnosis/procedure. A new advisory code classification (A-SDH) has been added to accommodate ICD-10 Z-codes that pertain to social determinants of health.

Social Determinants of Health Assessment: This assessment can now be accessed from all Stages in the General Recovery Course for all General Recovery Care guidelines.

Ambulatory Care
Guideline Changes: Ten new guidelines have been added and 36 removed due to low usage, lack of evidence in medical literature, or content being moved to another guideline.

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Behavioral Health Care
Expand/Collapse Feature: To improve ease of use, new expand/collapse features have been added to the Level of Care guidelines, Eating Disorders and Substance-Related Disorders sections on the Table of Contents. The same expand/collapse functionality has also been added to the Clinical Indications for Admission at the "Adult" or "Child or Adolescent" level for all applicable diagnosis-specific Level of Care guidelines.

Clinical Indication Content: Content that was formerly used in the decision-making for Clinical Indications for Admission and was contained within hyperlinked definitions has been moved directly into the guideline content.

Recovery Course Content: The Social Determinants of Health Assessment can now be accessed from all Guideline Days and Stages in the Recovery Course. The last day of the Recovery Course has been standardized for consistency.

New Footnote: A Footnote was added to all Level of Care guidelines which summarizes MCG's approach in using multiple specialty society guidelines, particularly for those states that have legislation on this topic.

Recovery Facility Care
Telehealth Services Footnote/Definition: A Footnote regarding telehealth services was added that includes a definition link for telehealth services.

Expand/Collapse Feature: The expand/collapse feature was added at some bullet levels in the Discharge Planning section for both Subacute/SNF and Inpatient Rehab Facility (IRF) sections, as well as the IRF Extended Stay and Therapy (OT, PT, SLP) sections.

Activities of Daily Living (ADL) Scoring Tool Calculator: The ADL Scoring Tool Calculator was added to Stage 3 of the Clinical Status column in the General Treatment Course for all Recovery Facility Care guidelines to assist the clinician in determining the appropriateness or readiness for discharge.

Assessments: Social Determinants of Health, Readmission Risk, and Extended Stay
Assessments can now be accessed from each Guideline Day in the Optimal Recovery Course.

eGFR - Adult Calculator: To correct potential racial bias in assessment of kidney function with the previous equation, the eGFR - Adult calculator has been updated to incorporate the CKD-EPI equation. This change is defined in the Footnote associated with the calculator.

Definitions: To improve ease of use and provide additional clarification, new definitions were added for Anasarca, Multimodal Analgesia, Bacteremia, Troponin, Isolation, and Immunosuppressed.

New Footnote: A Footnote was added to all Level of Care guidelines which summarizes MCG's approach in using multiple specialty society guidelines, particularly for those states that have legislation on this topic.

Home Care
Face-to-Face Encounter Clinical Indication: Criteria addressing the CMS national guidelines' face-to-face encounter requirement was added. This Clinical Indication clarifies the physician or allowed non-physician practitioner (NPP) visit with details addressing time frame, types of acceptable visits and supporting documentation requirements.

Expand/Collapse Feature: The expand/collapse feature was added at some bullet levels in the General Treatment Course and Discharge Planning sections.

2022 UM Approved Criteria Sets and Guidelines – *Continued from page 17*

ADL Scoring Tool Calculator: The ADL Scoring Tool Calculator was added to Stage 3 of the Clinical Status column in the General Treatment Course for all Home Care guidelines to assist the clinician in determining the appropriateness or readiness for discharge.

Chronic Care
Calculators: Four calculators were added including Patient Health Questionnaire-9 (PHQ-9), Patient Health Questionnaire-2 (PHQ-2), General Anxiety Disorder-7 (GAD-7), and Edinburgh Postnatal Depression Scale (EPDS). The calculators can be accessed through guidelines that are specific to the calculator's intent and also in the Care Management Tools section.

Social Determinants of Health Z-Codes: Z-codes (a type of ICD-10 code) used to identify patients with non-clinical conditions associated with social determinants of health have been added to relevant assessments. This allows assessments to be searched for by entering Z-codes in Search.

New Patient Education Handout: One handout has been added regarding COVID-19 vaccines.

Transitions of Care

New Patient Education Handout: One handout has been added regarding COVID-19 vaccines.

Patient Information

Handout Name Changes: Eight names of Discharge Information handouts and one name of an Inpatient Care Plan handout have been changed.

Source: Change HealthCare, Job Aid MCG 26th edition Summary of Changes

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Non-Behavioral Health

B. InterQual Level of Care for Transplant-Related Services, Adult and Pediatric

The **2022 InterQual Level of Care Criteria** is a commercially available criterion providing support for determining the medical appropriateness of hospital admission, continued stay and discharge. When a patient is admitted for transplant related services, except for kidney transplants, National Transplant Service (NTS) transplant coordinators follow the patient using InterQual as the inpatient continued stay criteria set. The criteria set is updated annually by McKesson Health Solutions and the transplant coordinators are tested annually to establish inter rater reliability.

1. **InterQual Acute Pediatric Criteria** - determines the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are less than 18 years of age. InterQual Pediatric Criteria also are organized by primary condition in a 'condition specific' model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.
2. **InterQual Acute Pediatric Criteria** - determines the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are less than 18 years of age. InterQual Pediatric Criteria also are organized by primary condition in a 'condition specific' model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.
    - 2022 InterQual Level of Care – General Surgical, Acute Criteria – Adult & Pediatrics
    - 2022 InterQual Level of Care – General Medical, Acute Criteria – Adult & Pediatrics
    - InterQual Level of Care Acute Criteria, Pediatric - General Transplant Section (General, Bone Marrow and Stem Cell Transplantation)
    - 2022 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Adult
    - 2022 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Pediatrics

C. Medicare Coverage Database for NCD and LCD for DME and Supplies

- UM will continue to use Centers for Medicare and Medicaid Services (CMS): National and Local Coverage Determinations as the primary criteria for Medicare Cost and Medicare Advantage members; and
- UM will continue to use CMS National and Local Coverage Determinations for DME, orthotic, and prosthetic devices and services ***only*** in the absence of MCG or MCP for Commercial and Medicaid members in Maryland and Virginia.

2022 UM Approved Criteria Sets and Guidelines – *Continued from page 19*

Non-Behavioral Health

Coverage is limited to DME items and supplies that are reasonable and necessary for the diagnosis or treatment of an illness or injury. NCDs are made through an evidence-based process, which includes CMS own research and is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development and Coverage Advisory Committee. In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on an LCD.

The Medicare Coverage Database (MCD) contains all NCDs and LCDs, local policy articles, and proposed NCD decisions. The database also includes several other types of national coverage policy related documents, including national coverage analyses, Medicare Evidence Development & Coverage Advisory Committee proceedings, and Medicare coverage guidance documents.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines

EPSDT is in use for Medicaid members in Maryland and Virginia as required by the federal government. The federal mandated services include screening, vision, dental, hearing, and diagnostic services in addition to health care treatment services for all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures. The federal requirements for children under age 21 who are enrolled in Medicaid may be found at Medicaid.gov, search EPSDT.

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 20*

Internally Developed UM Criteria

A. National Transplant Service (NTS) Transplant Patient Selection Criteria

The following NTS Transplant Patient Selection Criteria and KPMAS MCPs were approved in February 2021:

1. Bone Marrow Transplant
2. Liver Transplant
3. Intestinal Transplant and Intestine/Liver Transplant
4. Lung Transplant and Heart-Lung Transplant
5. Kidney Transplant
6. Simultaneous Pancreas Kidney (SPK) Transplant
7. Pancreas Transplant Alone (PTA) and Pancreas After Kidney (PAK) Transplant
8. Heart Transplant
9. Mechanical Circulatory Support Devices as a Bridge to Cardiac Transplant

B. New, Updated and Retired Medical Coverage Policies (MCP)

We develop MCPs in collaboration with specialty service chiefs and clinical subject matter experts. MCPs specify clinical criteria supported by current peer reviewed literature and are used to guide decisions related to request for health care services such as devices, drugs, and procedures. The policies are reviewed and updated annually, reviewed for approval by the Regional Utilization Management Committee (RUMC), and are periodically reviewed by regulatory and accrediting agencies. Except where noted, our MCPs are primarily applicable only to commercial members.

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) and Transplant Patient Selection Criteria were approved between **May 2022 to August 2022.**

1. **Lymphedema & Lipedema Surgical Treatment** – new policy
   Effective date: May 25, 2022

2. **Infertility diagnosis and treatment**
   Effective date: May 25, 2022
   Section IV, A-B: Definition of Infertility – language from:

   A. He or she (female is "*35 years or younger"*) is unable to conceive or produce conception after one year of frequent, unprotected heterosexual sexual intercourse OR

   B. For a female "*over age"* 35 years, she is unable to conceive or produce conception after six months of frequent, unprotected heterosexual sexual intercourse OR

   changed to

   A. He or she (female is *"younger than 35 ")* is unable to conceive or produce conception after one year of frequent, unprotected heterosexual sexual intercourse OR

   B. For a female 35 years "*of age or older*", she is unable to conceive or produce conception after six months of frequent, unprotected heterosexual sexual intercourse OR

3. **Knee Scooter**
   Effective date: May 25, 2022
   - References were updated

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 21*

4. **Hyperbaric Oxygen**
   Effective date: May 25, 2022
   - Section II, A – Clinical Indication & Requirements
     - #4: reference to Wagner grade located under "section II, A" replaced with "section IV, B"
     - #15: added: "*within 14 days of symptom onset*" to idiopathic sudden/acute sensorineural hearing loss
   - References were updated

5. **Home Oxygen Therapy**
   Effective date: May 25, 2022
   - References were updated

6. **Sialendoscopy (salivary gland endoscopy)**
   Effective date: May 25, 2022
   - IV.B, the word "*and*" was added and the words "*elastography, and endoscopic intracorporeal laser lithotripsy*" were deleted
   - References were updated

7. **Electrical Patient Lift**
   Effective date: May 25, 2022
   - References were updated
   - Section III.A.5: the words *"serious injury"* was replaced by *"severe injury."*
   - Section III.A.2: the words "in order" were removed
   - Section IV.B.1: the phrase*, "Electric lifts are not considered medically necessary unless a hydraulic lift weight capacity will not meet the patient's requirement due to weight"* was replaced by *"Electric lifts are not considered to be medically necessary unless the patient's weight exceeds hydraulic lift weight capacity".*

8. **Functional Electrical Stimulation (NMES/FES)**
   Effective date: May 25, 2022
   - References were updated

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 22*

9. Compression Garment and Device
Effective date: May 25, 2022

- Section II. A – Compression Garment and Device Therapy
  - *"Bandage wraps and compression garments"* replaced with "*Compression bandages and garments"*
- Section III. Clinical Indication
  - III. A & C 1-3 – deleted
  - III. B 1-4 - revised: Treatment of Lymphedema with Compression Garment & Device
- Section IV Exclusion
  - III. A-6 - added: # 6 Suspicion of undiagnosed acute DVT
  - III. B
    - Compression "stocking" replaced with "garment."
    - #4: added: *"prevention"* to Post thrombotic syndrome
  - III. C. deleted: *Non-medical grade stockings and other garments (<20 mmHG of compression compression) are not covered.*
- Table 1 Pressure Class – deleted
- Section V, A-B. Indications for Compression Bandages and Garments
  - Word "*patient"* replaced with *"member."*
- Section VII. Pneumatic Compression Extremity Pump
  - A, 1- 4**:** Non-Segmented or Segmented Pneumatic Pump without Calibrated Gradient Pressure (manual control) - deleted and replaced
  - B, 1 – deleted: reference to velcro day/night-time garments
- Section VIII.
  - VIII A-B Pneumatic Compression Extremity Pump (Night-time / Intermittent Use) – entire section has been replaced.
  - VIII. C. Exclusion
    - # 9 and 10: added: advanced Congestive Heart Failure or Right Sided CHF (NYHA Class III or IV) and metastatic liver or bone cancer with ascites, not under hospice care
    - # 2: added: (ABI<0.9) to peripheral arterial occlusive disease and arterial insufficiency.
- Section IX. Condition for repair or replacement of compression pumps replaced
- Section IX. A # 3 – deleted: description of segmented pneumatic pump with calibrated gradient pressure

10. Transgender Surgery, District of Columbia
Effective date: June 20, 2022

- Section II, B – "*penile implant*" replaced with "*penile prosthesis*"
- References were updated

11. Transgender Surgery, Maryland and Virginia
Effective date: June 20, 2022

- Section II, B – "*penile implant*" replaced with "*penile prosthesis*"
- References were updated

12. Pelvic Floor Rehab
Effective date: May 25, 2022

- References were updated

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 23*

13. Varicose Veins
Effective date: June 20, 2022
- References were updated

14. Circumcision Revision
Effective date: June 20, 2022
- References were updated

15. Transcutaneous Tibial Nerve Stimulator (TTNS)
Effective date: June 20, 2022
- References were updated

16. Cochlear Implant and Auditory Brain Stem Implants
Effective date: July 26, 2022
- New section added: VI,D – Candidacy criteria, Unilateral Cochlear Implantation for Single-Sided Deafness and Asymmetric Hearing Loss
- New section added: VII, A - Contraindication, Unilateral and Bilateral Cochlear Implantation for Single-Sided Deafness and Asymmetric Hearing Loss
- Section VII, B. External Component of Cochlear Implant – added: Medicare coverage criteria for upgrade and replacement of cochlear implant
- References were updated

17. Fertility Preservation for Iatrogenic Infertility
Effective date: July 26, 2022
- Section III. Fertility Preservation for Iatrogenic Infertility – deleted*: "All patients with a diagnosis that will cause iatrogenic infertility will be approved for a consultation visit for fertility preservation. All testing, procedures and medications are subject to a benefit check for fertility preservation"*
- References were updated

18. Laser Treatment/Electrolysis for Hair Reduction or Hair Removal
Effective date: July 26, 2022
- "Electrolysis" added to the title of policy.
- Section III-B and III-C Clinical Indications – added language on hair removal for transgender patients.
- Section IV-B Exclusions – added: "Laser treatment to alter gender-specific appearance for an individual with gender dysphoria" *not associated with an approved surgical procedure or medically necessary facial hair removal"*
- References were updated

19. PDL for Vascular Lesions
Effective date: July 26, 2022
- References were updated

20. External Insulin Pump
Effective date: July 26, 2022
- References were updated

21. Dermal Filter
Effective date: July 26, 2022
- References were updated

2021 UM Approved Criteria Sets and Guidelines – *Continued from page 24*

22. miraDry System
Effective date: July 26, 2022
- References were updated

23. Cologuard
Effective date: July 26, 2022
- Section IV, E has been deleted
- References were updated

24. Feeding Therapy
Effective date: August 31, 2022
- References were updated

25. Capsule Endoscopy
Effective date: August 31, 2022
- References were updated

26. Aquatic Therapy
Effective date: August 31, 2022
- References were updated

27. Purewick Therapy
Effective date: August 31, 2022
- References were updated

Access to MCPs is only two clicks away in Health Connect.

MCPs can be accessed through the KP Clinical Library by using the web link below:
https://clm.kp.org/wps/portal/cl/MAS/search_iframe?query=medical+coverage+policy&x=0&y=0.

Click on the Clinical Library section on the right side of the KPHC Home page and then type in “medical coverage policy” in the search box. All medical coverage policies will be displayed.

Please contact the UMOC at 1-800-810-4766 to receive a copy of the UM guideline or criteria related to a referral**.**

All Practitioners have the opportunity to discuss any non-behavioral health and/or behavioral health UM medical necessity denial (adverse) decisions with a Kaiser Permanente Physician reviewer (UM Physicians).

Christine Assia, M.D.
Physician Director of Medical Policies, Benefits and Technology Assessment
Emergency Physician, Advanced Urgent Care/ECM/UMOC
Christine C Assia <Christine.C.Assia@kp.org>

If you have administrative questions concerning accessing or using our criteria, please contact:

Marisa R Dionisio, RN
Marisa.R.Dionisio@kp.org
240-620-7257

2022 Utilization Management Affirmative Statement for Kaiser Permanente Mid-Atlantic States Health Plan Staff and Practitioners

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

2022 Practitioner/Provider Utilization Management (UM) Notification

UM/Resource Stewardship Program

At Kaiser Permanente our UM program is a collaborative partnership between the Mid-Atlantic Permanente Medical Group (MAPMG) and Health Plan leadership and staff designed to ensure our members receive the right care, in the right place, at the right time.

The scope of UM encompasses quality management and resource stewardship across the care continuum. It consists of five major categories: Concurrent Review, Continuing Care, Transitions Care, Case Management and Referral Management, which includes Pre-authorization and Post Service Review. UM is organized around three Service Areas: Baltimore, District of Columbia/Suburban Maryland (DCSM) and Northern Virginia (NOVA). UM activities in each service area include inpatient utilization review and management, transitions care and complex case management. Throughout these service areas, UM staff partner with the health care team to deliver medical, surgical and behavioral health care services to Kaiser Permanente Mid-Atlantic States (KPMAS) members. The Utilization Management Operations Center (UMOC) is a centralized telephonic UM and Referral Management hub designed to assist MAPMG practitioners, community-based practitioners and applicable staff to coordinate health care services for our members.

Registered nurses and Durable Medical Equipment (DME) coordinators review and process outpatient referrals, requests for DME, and home care services. Nurses work collaboratively with licensed, board-certified UM physician managers and practitioners to safely and effectively execute the referral management process within the specified time frame depending on the type and nature of the referral.

Practitioners and providers may contact the UMOC toll free for any inquiries and/or questions regarding UM issues and processes at 800-810-4766: follow the appropriate prompts.

The UMOC staff also assist with the following:

- Provide information regarding UM processes
- Check the status of a referral or an authorization
- Provide copies of the specific criteria/guidelines utilized for decision-making, free of charge
- Answer questions regarding a benefit denial decision.

All practitioners are able to discuss any non-behavioral health and/or behavioral UM medical necessity adverse determinations (denial decision) with a Kaiser Permanente Physician Reviewer (a UM Physician). Kaiser Permanente Physician Reviewers are available to speak with practitioners to discuss pre-service or concurrent medical necessity decisions during business hours: 8:30 a.m. to 5 p.m., Monday through Friday, except holidays.

Practitioners are notified about adverse determinations through verbal or electronic notification followed by a written letter. Medical necessity denial decisions can be discussed with the UM Physician by calling the UMOC at 800-810-4766 and select the appropriate prompt number.

2022 Utilization Management Accessibility, Communication and Hours of Operation

Accessibility of Utilization Management (UM) Operations

Accessibility is important to our members and providers. 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. Staff is identified by name, title and organization name when they initiate or return calls regarding UM issues. The following table provides the specific UM hours of operations and main responsibilities.

UM staff is available eight hours a day during normal business hours for inbound collect or toll-free calls to 800-810-4766 regarding UM issues.

Communication After Business Hours

Communication received after normal business hours is addressed the next business day.

After business hours, our member's first line of contact is through the Kaiser Permanente Member Services Department. Members are instructed to follow prompts to be directed to the call center. The phone number is listed on the member's ID card.

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

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

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

Communication Services to Members with Special Needs

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

Non-English-speaking members may discuss UM related issues, requests and concerns through the KPMAS language assistance program offered by an interpreter, bilingual staff, or the language assistance line. The UMOC staff have the Language Line programmed into their phones to enhance timely communication with non-English-speaking members. Language assistance services are provided to members free of charge. The following table describes the access and hours of operations for UM services.

2022 UM Accessibility, Communication and Hours of Operations – *Continued from page 28*

UM Department Section	Hours of Operation	Core Responsibilities
Emergency Care Management (ECM) - Clinical Call Center Department • Emergency Room Notifications and Admissions	24 hours/day, 7 days/ week and holidays ECM Support Line: 844-552-0009	• 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 repatriation from hospital to hospital • Support all cardiac transfers for level of care needed
UMOC: • Outpatient Referrals • Specialty Referrals • Clinical Research Trials	Monday through Friday: 8:30 a.m. to 5 p.m. except Clinical Trials: Clinical Trials 8 a.m. to 4:30 p.m. Call 800-810-4766 Weekends and Holidays, except Clinical Trials: 8:30 a.m. to 5 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
UMOC: • Durable Medical Equipment (DME) • Home Care • Rehabilitative Therapies • Physical, Occupational and Speech Therapies (PT/OT/ST)	Monday through Friday: 8:30 a.m. to 5 p.m. Call 800-810-4766 Weekends and Holidays: 8:30 a.m. to 5 p.m. for urgent and routine discharge care coordination referrals DME HOTLINE 855-632-8279 RN Weekend: Call 301-960-1436	• Conduct pre-service and concurrent review of Home Care, DME, PT/OT/ST • Post-service review provided to Kaiser Permanente members outside a Kaiser Permanente medical facility

2022 UM Accessibility, Communication and Hours of Operations – *Continued from page 29*

UM Department Section	Hours of Operation	Core Responsibilities
Continuing Care Hub	Monday through Friday: 8:30 a.m. to 4:30 p.m. Weekends/Holidays: 8:30 a.m. to 4:30 p.m.	• Conduct pre-service and concurrent review of Home Hospice/Inpatient Hospice and Palliative Care services • Skilled nursing facility (SNF) placement for members from the Community • Coordinate and transition members from long-term care (LTC) by entering referrals to transition them home • Center for QICs to notify of new appeals or appeals decisions
UM Hospital Services Non-Behavioral Health located at affiliated hospitals	Seven days a week & holidays 7 a.m. to 5:30 p.m. *Limited Evening hours* 3 p.m. to 11:30 p.m. at the following Premier Hospitals only: • Holy Cross, Silver Spring • Washington Hospital Center • Virginia Hospital Center	Conduct concurrent review and transition care management
Skilled Nursing Facility (SNF) and, Rehabilitation Services and Long-Term Acute Care Hospitals (LTACH)	Monday through Friday 8 a.m. to 4:30 p.m. Excluding weekends and major holidays Fax: 855-414-4707	Conduct concurrent review and transition care management for members in the acute rehab and SNF settings
UM Hospital Services – Behavioral Health (BH) located at affiliated hospitals	Seven days a week: 8 a.m. to 4:30 p.m. Including weekends and major holidays BH Status Line: 301-552-1212 Fax: 855-414-1703	Conduct concurrent review and transition care management services of behavioral health service

2021 UM Accessibility, Communication and Hours of Operations – *Continued from page 30*

UM Department Section	Hours of Operation	Core Responsibilities
UM Outpatient Services – BH	Monday to Friday: 8 a.m. to 4:30 p.m. Excluding weekends and major holidays BH Status Line: 301-552-1212 Fax: 855-414-1703	Conduct pre-service and concurrent review of behavioral outpatient services
Outpatient Continuing Care: Complex Case Management Renal Case Management Virtual Home Care Program (VHCP)	Monday through Friday 8:30 a.m. to 5 p.m. Excluding weekends and major holidays VHCP: 8 a.m. to 12:30 a.m. Seven days per week, including weekends and holidays Self-Referral Line 301-321-5126 or 866-223-2347	Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members

2022 Adopting Emerging Technology for Utilization Management (UM) Referral Management

Medical research identifies new drugs, procedures, medical devices and other treatments that can prevent, diagnose, treat and cure diseases. The Kaiser Permanente Mid-Atlantic States' Technology Review and Implementation Committee (TRIC) collaborates with the Kaiser Permanente Interregional New Technologies Committee (INTC), Emerging Therapeutics Committee and Regional Utilization Management Committee (RUMC), to assist physicians, other clinicians and members in determining whether a new drug, procedure or medical device is medically necessary and appropriate. Upon completion of an evidence-based review, TRIC recommends the inclusion or exclusion of new technologies as covered benefits to the 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.

INTC, a national new technology reviewing committee, 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 national committee will provide regional recommendation of the implementation of the new technology by Kaiser Permanente and/or authorize coverage of the new technology from external sources of care for appropriate clinical indication or use. The technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

Communicating Population Care Management Programs to Practitioners

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

These programs are designed to engage your patients to help care for themselves, better understand their condition(s), update them on new information about their disease, and help manage their disease with assistance from your health care team and the Mid-Atlantic Permanente Medical Group (MAPMG) Quality department. This information and education is designed to reinforce your treatment plan for your patient.

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

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

Your patients do not have to enroll in the programs; they are automatically identified into a registry. If you have patients who have not been identified for program inclusion, or who have been identified as having a condition but do not actually have the condition, submit a Kaiser Permanente HealthConnect “registry update request” in basket message to the P Clinical Content team. Community providers who want to add or remove members from the program, or members who choose not to participate or want to self-enroll can call 703-359-7878 (TTY 711) in the Washington Metro area or 800-777-7904 (TTY 711) outside of the Washington, D.C. Metro area.

Integration of Care in KPMAS Patient Centered Medical Home

The concept of a "Patient Centered Medical Home (PCMH)" incorporates a commitment of primary care practitioners to work closely with patients and their families to provide whole-person oriented care that is continuous, well-coordinated, effective, culturally competent and tailored to meet the needs of each patient. The PCMH model develops relationships between primary care practitioners and providers, their patients and their patients' families. In the PCMH model, primary care teams promote cohesive coordinated care by integrating the diverse, collaborative services a patient may need. This integrative approach allows primary care practitioners to work with their patients in making healthcare decisions. These decisions are based on the fullest understanding of information in the context of a patient's values and preferences.

Appropriate care coordination depends in large measure on the complexity of needs of each individual patient or population of patients. Factors that increase complexity of care include multiple chronic care conditions, acute physical health problems, the social vulnerability of the patient, and the involvement of a large number of primary and specialty care practitioners and providers involved in the patient's care. Patients' preferences, self-care management abilities, and caregiver ability can also affect the need for support and care coordination.

The medical home team or PCMH Health Care Team (HCT), that may consist of nurses, pharmacists, nurse practitioners, medical assistants, case managers, educators, behavioral health therapists, social workers, care coordinators, and others, is led by the primary care physician who takes the lead in working with the patient to define their needs, develop and update plans of care, and coordinate care plans with the PCMH HCT.

Care coordination, within the Kaiser Permanente Mid-Atlantic States (KPMAS) PCMH model, includes the following components:

Determining and updating care coordination needs: coordination needs are based on a patient's individual health care needs and treatment recommendations and care plan that reflect physical, psychological, cultural, linquistic, and social factors. Coordination needs are also determined by the patient's current health and health history; functional status; self-management knowledge and behaviors; and need for support services.

Create and update a proactive plan of care: establish and maintain a plan of care, jointly created and managed by patients, their families and/or caregivers, and their health care team led by the primary care physician. The patient-centered plan of care outlines the patient's current and long-term needs and goals for care, identifies coordination needs, and addresses potential gaps. The care plan anticipates routine needs and tracks current progress towards patient goals using evidence-based medicine.

Communication: Communication allows for the exchange of information, preferences, goals, and experiences among participants in a patient's care. Including communication across clinical resources and facilities and leveraging access to direct scheduling and referral systems. Communication about care needs may take place in person, by phone, in writing, and/or electronically and includes translation or interpretation, as necessary, to ensure communication in the patient's language of preference. Communication is especially critical during transitions in care. Primary care practitioners and providers are included in the transfer of information during transitions. Examples of transition include from the inpatient hospital or skilled nursing facility (SNF) to the ambulatory setting (i.e., physician's office).

Integration of Care in KPMAS PCMH – *Continued from page 34*

Align resources with population needs: Assess the needs of populations to identify and address gaps and disparities in services and care, including disparities based on age, gender, language preference, race, and/or ethnicity. Care coordination and feedback from practitioners, providers and patients should be used to identify opportunities for improvement (i.e., smoking cessation, weight management, self-management for diabetes, or health coaching).

KPMAS' PCMH model of care is designed to improve the quality, appropriateness, timeliness, and efficiency of care coordination including clinical decisions and care plans. An overall performance goal is to improve the quality and efficiency of health care for members with complex and chronic conditions.

To provide the care our PCMH vision requires, our primary care providers play a pivotal role in guiding the PCMH HCT to provide timely, comprehensive, well-coordinated care.

KPMAS is responsible for identifying patients who qualify for its disease management and complex case management programs, notifying the PCMH HCT of qualifying members, and maintaining a tracking mechanism to monitor these members. Notification to the PCMH HCT is conducted for each patient when they qualify for the disease management or complex case management programs, if they are identified outside of the PCMH. The PCMH HCT and care coordinators of respective disease management or complex case management use KPMAS electronic health record (KP HealthConnect) to document care plans and provide that information as needed to coordinate patient care. In addition, patients, their family members, or anyone on the health care team, may refer a patient for complex case management or disease management programs.

Network providers, Kaiser Permanente Members / Caregivers can take advantage of these services by calling the Case management Referral Telephone Line at 301-321-5126 or toll free 866-223-2347, 24 hours a day, 7 days a week. Messages are checked Monday - Friday during business hours by our case managers.

2022 Board Certification Policy

If not already board certified, all Kaiser Permanente physicians and contracted physicians and podiatrists who work for us are required to obtain a board certification in their contracted specialty by a recognized organization. KPMAS recognizes the following boards:

- American Board of Medical Specialties (ABMS)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Oral and Maxillofacial Surgeons
- American Board of Podiatric Medicine (ABPM)
- American Board of Podiatric Surgery (ABPS)
- American Midwifery Certification Board
- American Osteopathic Association (AOA) Directory of Osteopathic Physicians
- ANCC Certification for Nurse Practitioners
- NCC Certification for Nurse Practitioners
- NCCPA Certification for Physician Assistants
- Pediatric Nursing Certification Board (PNCB)
- American Academy of Nurse Practitioners
- American Association of Nurse Anesthetists

Kaiser Permanente physicians and network physicians and podiatrists must obtain and maintain board certification in a recognized specialty throughout the life of their contract or employment with Kaiser Permanente. Failure to obtain board certification within five years of completion of training will result in termination from the Health Plan.

Physicians and podiatrists whose certification lapses during the course of their contract or employment will be given two years following the expiration of their board certification to obtain recertification. (This does not apply to hourly/pool Kaiser Permanente 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.

Practitioner and Provider Quality Assurance and Credentialing

The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners under contract with the Mid-Atlantic Permanente Medical Group (MAPMG) and Kaiser Foundation Health Plan of the Mid- Atlantic States, Inc. (KPMAS) are qualified, appropriately educated, trained, and competent.

All participating practitioners must be able to deliver health care according to KPMAS standards of care and all appropriate state and federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA) and KPMAS.

Provider responsibilities

Provision of a current certificate of insurance when initiating a credentialing application.

A certificate of insurance must also be submitted at annual renewal.

Cooperation with pre-credentialing site and medical record-keeping review process

Provide a minimum of 90 days notification to health plan of intent to terminate contract.

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 an application within 30 days including:

- 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

Integration of Care in KPMAS PCMH – *Continued from page 37*

Provider rights

Provider rights in the credentialing process include:

- being provided a copy of the Mid-Atlantic States Credentialing and Privileging Committee (MASCAP) policies and procedures upon written request
- reviewing the information contained in your credentials file, with the exception of peer references, recommendations, and peer-review protected information
- correcting erroneous information contained in your credentialing file within 10 days upon notification of a discrepancy. These corrections should be sent in writing to ppqa-mas@kp.org. The organization is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.
- being informed of the status of your application, upon request. You will be informed the stage of the process your application is in within two business days. The response will be provided in the way you made the request.
- appealing decisions of the MASCAP Committee if you are denied credentialing, had your participation status changed, been placed on a performance improvement plan or have any other adverse actions taken against you.

These rights may be exercised by contacting the Kaiser Permanente Practitioner and Provider Quality Assurance Department at:

Phone: 301-816-5853

Fax: 855-414-2630

Email: ppqa-mas@kp.org

Mail:

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

Maryland HealthChoice Access Standards and Outreach

As Kaiser Permanente Maryland HealthChoice Participating Providers, there are special requirements and outreach activities that you along with us must adhere to per the Maryland Department of Health (MDH). Participating providers are required to adhere to the appointment and access standards for Maryland HealthChoice members as defined by MDH. This table shows the appointment type and the associated access standard:

Type of Appointment	Access Standard
Initial health assessment appointment (upon enrollment)	Within ninety (90) days of enrollment
Children under the age of 21	Within thirty (30) days of enrollment
Maternity care – pregnant or post-partum	Within ten (10) days of enrollment
Members with Health Risk Assessment (HRA) that screen positive requiring expedited intervention	Within fifteen (15) days from the date of receipt of the completed HRA
Urgent care	Within twenty-four (24) hours of the request
Emergency services	Available immediately upon request

In addition to meeting appointment and access standards, Participating Providers must effectively manage and implement outreach activities. Kaiser Permanente conducts outreach activities designed to ensure Maryland HealthChoice members get the medical care needed. In addition, Kaiser Permanente provides a dedicated on-boarding process that ensures a quality experience for new Maryland HealthChoice members. Our support and outreach services include a centralized team within our Clinical Contact Center that manages all outreach activities related to Maryland HealthChoice members, including but not limited to appointment reminders, appointment rescheduling, and member results outreach for events such as positive pregnancy tests.

Participating providers are required to make the necessary outreach to members to ensure the members are seen within the required timeframes for initial health care assessment and evaluation for ongoing health needs (e.g., timeliness of health care visits, screenings, and appointment monitoring). In the event, a member after two (2) unsuccessful attempts are made and documented to bring the member in for care, please contact Provider Experience at 877-806-7470. The Provider Experience representative will report the care gap concern to the Kaiser Permanente Medicaid office. Medicaid office will engage Case management for assistance. After additional attempts are made to bring members into care are unsuccessful the Medicaid office will notify the local/county health department for assistance.

More information regarding access standards and outreach can be found on our website at www.kaiserpermanente.org/providers/mas in the Kaiser Permanente Maryland HealthChoice Participating Provider Manual.

Provider Access to Health Education Materials

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

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

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

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

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

Member Rights and Responsibilities: Our Commitment to Each Other

Kaiser Permanente is committed to providing you and your 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 your health care services.

Member rights

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

RECEIVE INFORMATION THAT EMPOWERS YOU TO BE INVOLVED IN HEALTH CARE DECISION MAKING

This includes your right to do the following:

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.

Member Rights and Responsibilities – *Continued from page 41*

e. Refuse treatment, provided that you accept the responsibility for 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, a living will, or another 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.

RECEIVE INFORMATION ABOUT KAISER PERMANENTE AND YOUR PLAN

This includes your right to the following:

a. Receive the information you need to choose or change your primary care physician, including the names, professional levels and credentials of the doctors assisting or treating you.

b. 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.

c. Receive information about financial arrangements with physicians that could affect the use of services you might need.

d. Receive emergency services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

e. Receive covered, urgently needed services when traveling outside the Kaiser Permanente service area.

f. Receive information about what services are covered and what you will have to pay and examine an explanation of any bills for services that are not covered.

g. File a complaint, a grievance, or an appeal about Kaiser Permanente, 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.

RECEIVE PROFESSIONAL CARE AND SERVICE

This includes your right to the following:

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.

Member Rights and Responsibilities – *Continued from page 42*

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.

Member responsibilities

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

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.

Member Rights and Responsibilities – *Continued from page 43*

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 contract. 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.

PROMOTE RESPECT AND SAFETY FOR OTHERS

a. Extend the same courtesy and respect to others that you expect when seeking health care services.

b. Ensure a safe environment for other members, staff and physicians by not threatening or harming others.

Member Complaint Procedures

We encourage members to let us know about the excellent care they receive as a member of Kaiser Permanente or about any concerns or problems they have experienced. Member Services representatives are dedicated to answering questions about members' health plan benefits, available services, and the facilities where they can receive care. For example, they can explain how to make members first medical appointment, what to do if members move or need care while traveling, or how to replace an ID card. They can also help members file a claim for emergency and urgent care services, both in and outside of our service area, or file an appeal. Also, members always have the right to file a compliment or complaint with Kaiser Permanente.

Local Member Services Representatives are available at most Kaiser Permanente medical office buildings administration offices, or members can call the Member Service Contact Center @ 800-777-7902, 8:00 a.m. to 8:00 p.m., 7 days a week (TTY users may call 711).

Written compliments or complaints should be sent to:

Kaiser Permanente
Attention: Appeal & Grievance Operations
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736
Fax: 404-949-5001

All complaints are investigated and resolved by a Member Services/Member Relations representative through coordinating with the appropriate departments.

Members have the right to file an appeal if they disagree with the Health Plan's decision not to authorize medical services or drugs or not to pay for a claim.

Medically Urgent Situations

Expedited appeals are available for medically urgent situations. In these cases, call the Member Service Contact Center @ 800-777-7902, 8:00 a.m. to 8:00 p.m., 7 days a week (TTY users may call 711).

Fax: 404-949-5001

Members must exhaust the internal appeal process before requesting an external review/ appeal. However, an external review/appeal may be requested simultaneously with an expedited internal review/appeal when:

- Services denied based on experimental/ investigational may be expedited with written notice by the treating physician that services would be less effective if not initiated promptly.
- The denial involves medical necessity, appropriateness, healthcare setting, level of care, or effectiveness denials.
- The Health Plan fails to render a standard internal appeal determination within 30 (pre-service) or 60 (post-service) days and the member has not requested or agreed to a delay.

Member Complaint Procedures – *Continued from page 45*

Members may also initiate an appeal for non-urgent services in writing. When doing so, please include:

- The member's name and medical record number.
- A description of the service or claim that was denied.
- Why members believe the Health Plan should authorize the service or pay the claim.
- A copy of the denial notice members received.

Send member's appeal to:

Kaiser Permanente
Appeal & Grievance Operations
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736
Fax: 404-949-5001

Any member request will be acknowledged by an appeals analyst who will inform each member of any additional information that is needed and help obtain the information. The analyst will conduct research and prepare the members' request for review by the appeals/grievances committee. The analyst will also inform the member of the Health Plan's decision regarding the members' appeal/ grievance request along with any additional levels of review available to members. Detailed information on procedures for sharing compliments and complaints or for filing an appeal/grievance is provided in the members' Evidence of Coverage.

Other Assistance

We are committed to ensuring that member concerns are fairly and properly heard and resolved. Members have the right to contact one of the following regulatory agencies to file a complaint about care or services that they believe have not been satisfactorily addressed by the Health Plan.

In Maryland

Health Education and Advocacy Unit
Consumer Protection Division Office
of the Attorney General
200 St. Paul Place
Baltimore, MD 21202
877-261-8807 (toll free)
oag.state.md.us
E-mail: consumer@oag.state.md.us

Maryland Insurance Administration
Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2000, 1-800-492-6116 (toll free)
410-468-2270 (TTY), 800-735-2258 (toll free TTY)
410-468-2260 (fax)
mdinsurance.state.md.us

Member Complaint Procedures – *Continued from page 46*

In Virginia

Office of the Managed Care Ombudsman Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
877-310-6560
(toll free) 804-371-9032 (Richmond metropolitan area) scc.virginia.gov/division/boi/webpages/boiombudman.asp
E-mail: ombudsman@scc.virginia.gov

State Corporation Commission Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
804-371-9691, 800-552-7945 (toll free), TDD 804-371-9206
scc.virginia.gov

The Office of Licensure and Certification Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463
804-367-2106, 800-955-1819 (toll free)
804-527-4503 (fax)
vdh.state.va.us/olc
E-mail: mchip@vdh.virginia.gov

In the District of Columbia

Department of HealthCare Finance
Office of the Health Care Ombudsman and Bill of Rights
899 North Capital Street, N.E., 6th Floor
Washington, DC 20002
202-724-7491
202-535-1216 (fax)
healthcareombudsman.dc.gov

For federal employees

United States Office of Personnel Management Insurance Services
Programs Health Insurance Group 3
1900 E St., NW
Washington, DC 20415-3630
202-606-0755
opm.gov

How to contact us

Member Services — Practitioners, providers or members can speak with a Member Services representative if assistance is needed with, or have questions about, the Health Plan or specific benefits. A Member Services representative is available by calling the Member Service Contact Center @ 800-777-7902, 8:00 a.m. to 8:00 p.m., 7 days a week (TTY users may call 711).

CLAS Standards

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The standards are organized by four themes:

- Principal Standard
- Governance, Leadership and Workforce (Standards 2-4)
- Communication and Language Assistance (Standards 5-8)
- Engagement, Continuous Improvement and Accountability (Standard 9-15)

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

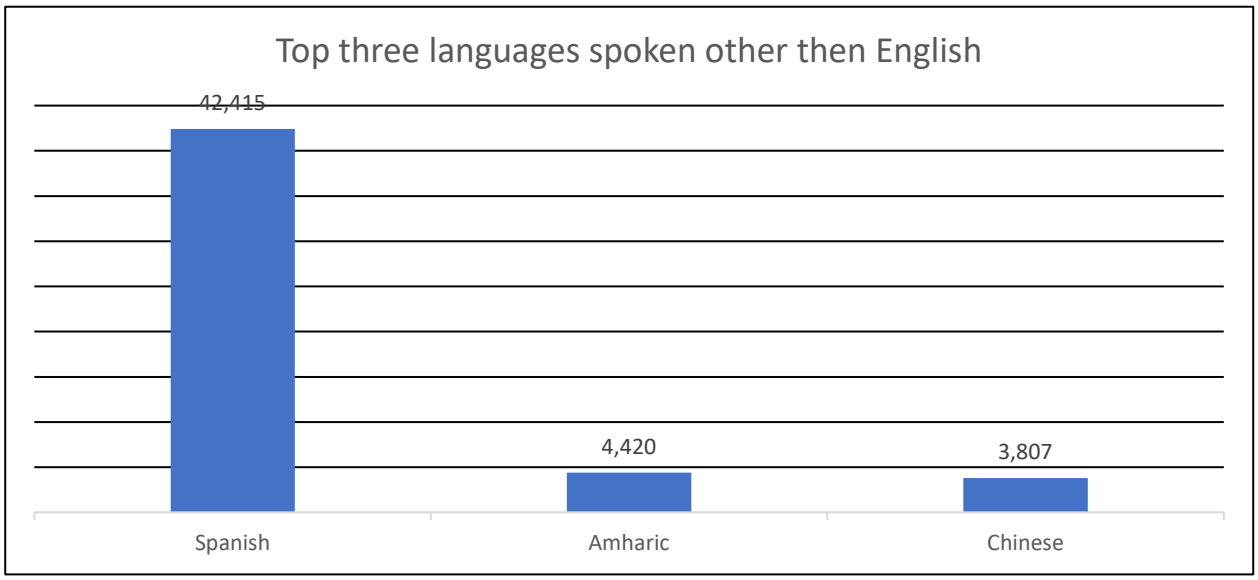
CLAS Standards – *Continued from page 48*

Engagement, Continuous Improvement and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: U.S. Department of Health & Human Services, Office of Minority Health (OMH).

The Enhanced National CLAS Standards address demographic trends and changes and brings relevance to new national policies and legislation, such as the Affordable Care Act. Kaiser Permanente has voluntarily adopted the federal CLAS standards to help ensure we are respectful of and responsive to the health beliefs, practices, and needs of diverse patients.



Source: Equity, Inclusion, & Diversity Annual Report January 1, 2021 – December 31, 2021. Data shows the demographic profile by language for overall Kaiser Permanente members.

We continue to meet the challenges of serving diverse communities and provide high-quality services and care by tailoring services to an individual's culture and providing care in their preferred language. In this way, health professionals can help bring about positive health outcomes for diverse populations.

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 TRS access numbers that they can use to make an appointment or talk with an advice nurse or member services representative or with you.
- **Sign language interpreter services**. These services are available for appointments. In general, advance notice of two or three business days is required to arrange for a sign language interpreter; availability cannot be guaranteed without sufficient notice.
- **Video Remote Interpretation (VRI).** VRI provides on-demand access to American Sign Language & Spoken Language interpretation services at medical centers for members. It meets the need in the care experience of walk-in deaf patient and those in need of urgent care.
- **Educational materials**. Health education materials can be made available in languages other than English by request. To access Spanish language information and many educational resources go to **kp.org/espanol** or **kp.org** to access La Guía en Español (the Guide in Spanish). Members can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in La Guía en Español.
- **Prescription labels**. Upon request, the Kaiser Permanente of the Mid-Atlantic States pharmacist can provide prescription labels in Spanish for most medications filled at the Kaiser Permanente pharmacy.
- **After Visit Summary (AVS)**. AVS can be printed on paper and available electronically via kp.org for KP members after their appointment. If the member's preferred written communication is documented in KP HealthConnect for a non-English language, the AVS automatically prints out in that selected language. This includes languages such as Spanish, Arabic, Korean, and several others.

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

Diversity – *Continued from page 50*

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

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

In conclusion, research has shown that medical treatment is more effective when the patient's race, ethnicity and primary language are considered.

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

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

Referring Patients to KP for Specialty Care

Referring your patients to Kaiser Permanente brings the advantages of the integrated care experience to our members as well as to you - the Participating Provider. Members referred to Kaiser Permanente providers for specialty care are seen by Mid-Atlantic Permanente Medical Group, P.C. physicians. With our recent expansions in specialty care services, members referred to a specialist within Kaiser Permanente are frequently seen more quickly than those referred to a specialist within our Participating Provider Network. In addition, all services rendered at a Kaiser Permanente medical center including lab, pharmacy, and radiology orders are documented within KP HealthConnect, our state-of-the art electronic medical record and care management system. The electronic capabilities and technology available through KP HealthConnect allow us to keep you and the patient connected with all aspects of the care that he/she receives within Kaiser Permanente. Members may access health information related to their Kaiser Permanente care at kp.org. Participating PCPs with access to KP HealthConnect AffiliateLink have real-time access to their patient's encounters/ visits, charts, lab results and more via the web at **kp.org/providers/mas.**

If you do not have access to KP HealthConnect or Online Affiliate and would like to enroll, you may download an enrollment package at **kp.org/providers/mas** or contact Provider Experience at 877-806-7470 for assistance.

Language Services and Accessibility Requirements

ALL HEALTHCARE PROVIDERS AND INSURERS that receive federal funding, including our contracted/network providers and physicians, are required to comply with applicable federal civil rights laws and not discriminate, exclude people, or treat them differently when providing services. This includes providing language access services to non-English speaking patients for interpretation and translation of vital documents necessary for meaningful access.

Kaiser Permanente is legally required to and requires its contracted providers to provide language services for all patients with communication barriers to ensure they have equal access to services and information. This includes individuals with a primary language other than English and individuals who are deaf, deaf blind, and hard of hearing, and applies to everyone, from members seeking care, to members of the community seeking information. This includes:

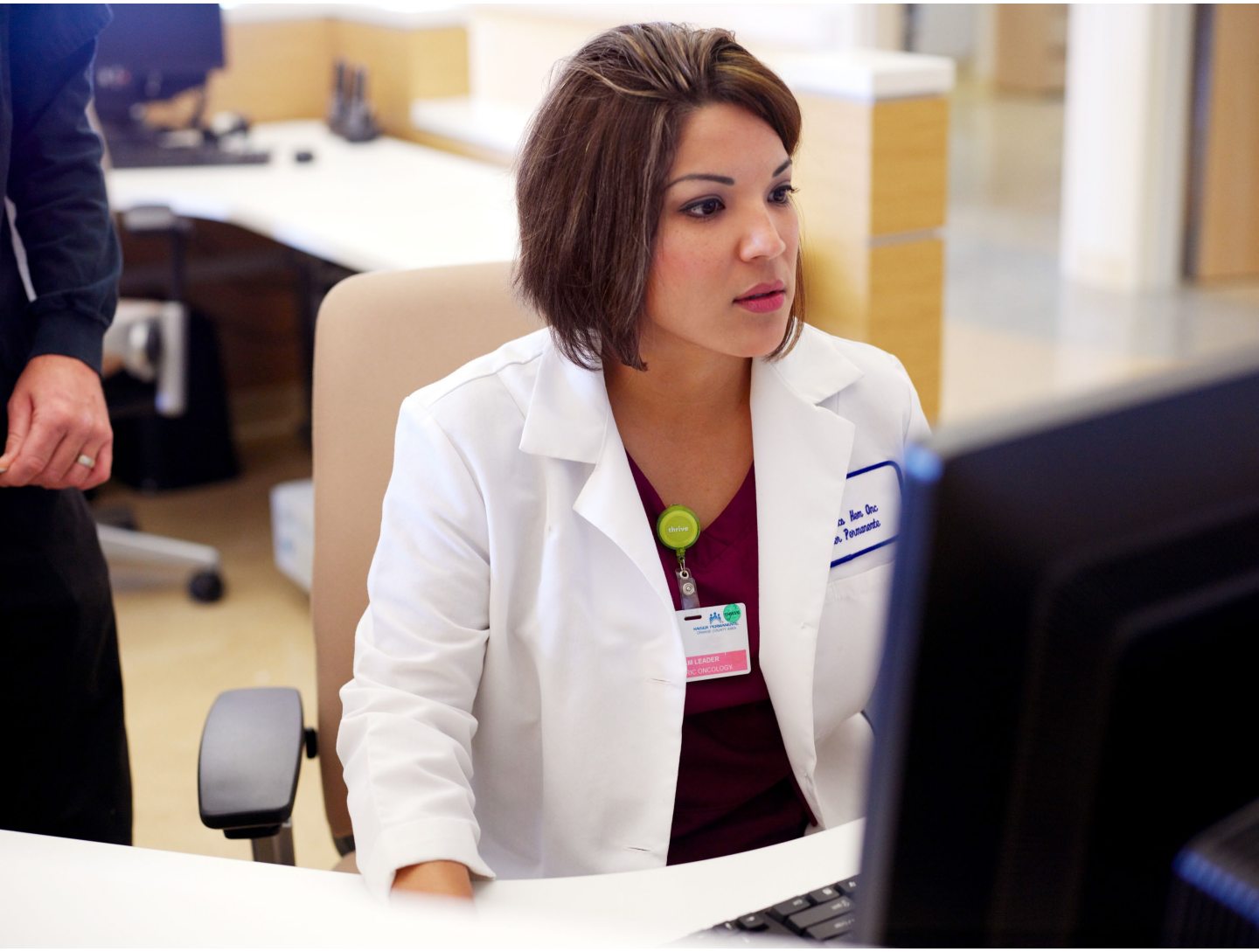
- Providing free aids and services to people with disabilities to help ensure effective communication, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, braille, and accessible electronic formats)
  - Assistive devices (magnifiers, pocket talkers, and other aids)
- Providing free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- Contract and Network providers/physicians must provide language services for all interactions with the member and staff. This includes, but is not limited to:
  - All appointments with any provider for any covered services
  - Emergency services
  - All steps necessary to file complaints and appeals

Keeping Your Provider Data Updated

Be sure to submit any changes to your practice to Kaiser Permanente. Keeping Kaiser Permanente updated will ensure that our provider directory and data systems are accurate and help us to provide an excellent healthcare experience to our members. To access our provider directory online, go to kp.org. For your convenience, a sample form letter can be found on our Community Provider Portal at www.providers.kp.org/mas and on the following page. Utilize the sample to submit updates throughout the year.

Updates may be submitted to Provider Experience via:

Fax: 855-414-2623
Email: Provider.Demographics@kp.org
Mail: Kaiser Permanente
Provider Experience
2101 East Jefferson St., 2 East
Rockville, MD 20852



Sample Provider Data Update Form Letter

Company Letterhead Logo

<<Date>>
Requestor:
Requestor's Correspondence Address:
Requestor's Phone #:
Requestor's Email:
Tax ID#:
Effective date of change(s):
Reason for the request:

***PLEASE DELETE SECTIONS NOT NEEDED**

Address change (Specify if practice location or billing address is changing)

- Specify if adding or deleting address
- Include **old** and **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, **Tax ID** and **NPI**)
- Billing/Payment Address/Tax ID/NPI
- Management Correspondence Address (include Phone & Fax Number

Practice location addition

- Include **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, **Tax ID** and **NPI of Location**)
- Billing/Payment Address/Tax ID/NPI

Adding a provider to or deleting a provider from an existing group

- Specify if adding or deleting provider
- Include the information listed below if adding or deleting a provider:
    - First Name, Middle Initial, and Last Name
    - Gender
    - Title (*MD, CRP, CRNP, PA etc.)*
    - Date of Birth
    - NPI #
    - CAQH #
    - UPIN or SSN
    - Medicare #
    - Medicaid Participation State(*s*)
    - Medicaid #
    - Practicing Specialty
    - **Practicing Location(s) (*include phone & fax numbers*)**
        - Indicate whether practicing location is hospital based or office based
    - Billing/Payment Address (*include W-9*)
    - Management Correspondence Address (*include phone & fax number*)
    - Hospital Privileges
    - Foreign Languages
    - Effective Date
    - Provider Panel Status: Open or Closed
- ***A copy of provider licenses in all practicing states is required***

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

- Include **old** and **new** tax ID number and/or group name
- Include effective date of the new tax ID number and/or group name
- Include NPI number
- Include a signed and dated copy of the new W-9
- Billing/Payment Address
- Management Correspondence Address (include phone & fax number)

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Provider Experience
2101 E. Jefferson Street
Rockville, MD 20852