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.

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Contents

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 directed 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.

2024 Utilization Management Approved Criteria Sets and Guidelines

Measurable, objective and evidence-based decision-making criteria ensure that decisions are fair, impartial and consistent. Kaiser Permanente utilizes and adopts nationally recognized UM criteria sets, regionally developed Medical Coverage Policies (MCP) and nationally developed Kaiser Permanente Transplant Referral Guidelines. Additionally, the clinical criteria is supported by current peer-reviewed literature and evaluated by specialty service chiefs and subject matter experts who are 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 patient (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.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 3*

Types of UM Criteria in Use:

A. Behavioral Health UM Criteria

- **Nationally recognized UM criteria**
  - Milliman Care Guidelines (MCG) 28th edition
  - 2024 InterQual Criteria for Applied Behavioral Analysis (ABA) Treatment
  - American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder (SUD)
  - Department of Medical Assistance Services (DMAS)

- **Internally developed UM criteria**
  - Medical Coverage Policy (MCP)

B. Non-Behavioral UM Criteria

- **Nationally recognized UM criteria**
  - MCG 27th edition
  - 2024 InterQual Level of Care Criteria for Transplant related services
  - Adult and Pediatric CMS Coverage Database for National (NCD) and Local Coverage Determination (LCD) for DME and Supplies
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines
  - 2024 InterQual Level of Care Criteria for Transplant Services

- **Guidelines:**
  - Center for Medicare and Medicaid Services (CMS) Benefit Policy Manual, Chapter 8 Coverage of Extended Care (SNF) Services under Hospital Insurance
  - State of Maryland Department of Health and Mental Hygiene (DHMH), Maryland Medical Assistance Program, Nursing Home Transmittal # 213

- **Internally developed UM criteria**
  - MCP
  - National Transplant Services (NTS) Transplant Patient Selection Criteria

2024 Utilization Management Criteria and Guidelines

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	NCD-LCD	MCG	MCG
Ambulance Services	KPMAS MCP	NCD-LCD	KPMAS-MCP	KPMAS-MCP

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 4*

Referral Service Type Approved criteria sets are used in order of hierarchy.	Commercial & Exchange Jurisdiction	Medicare	Medicaid (VA Medicaid and FAMIS)	Medicaid (MD HealthChoice)
Applied Behavioral Analysis (ABA)	MCG Determination of Medical Necessity InterQual® Determination of Hours/Units of Service ***March 2024 Release, BH: Behavioral Health Services; Applied Behavior Analysis Program***	MCG Determination of Medical Necessity InterQual® Determination of Hours/Units of Service ***March 2024 Release, BH: Behavioral Health Services; Applied Behavior Analysis Program***	DMAS Determination of Medical Necessity InterQual® Determination of Hours/Units of Service ***March 2024 Release, BH: Behavioral Health Services; Applied Behavior Analysis Program***	Not Applicable
Behavioral Health: Substance Use Disorder (SUD) specifically *All Levels, i.e., IP, OP, RTC, PHP, IOP	MCG ASAM-Maryland	MCG	ASAM 4/1/2017[1]	Not Applicable
Behavioral Health: Inpatient	MCG	MCG	MCG	Not Applicable
Behavioral Health: Outpatient *Excludes SUD	MCG	NCD-LCD	MCG	Not Applicable
Behavioral Health: Partial Hospitalization *Excludes SUD	MCG	NCD-LCD	MCG	Not Applicable
Behavioral Health: Mental Health Services (MHS) Covered Services	Not Applicable	Not Applicable	DMAS criteria	Not Applicable
Durable Medical Equipment (DME) and Supplies	KPMAS MCP MCG NCD-LCD	NCD-LCD	KPMAS MCP MCG NCD-LCD	KPMAS MCP MCG NCD-LCD
Orthotics and Prosthetics	KPMAS MCP MCG NCD-LCD	NCD-LCD	KPMAS MCP MCG NCD-LCD	KPMAS MCP MCG NCD-LCD

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 5*

Referral Service Type Approved criteria sets are used in order of hierarchy.	Commercial & Exchange Jurisdiction	Medicare	Medicaid (VA Medicaid and FAMIS)	Medicaid (MD HealthChoice)
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	Not Applicable	Not Applicable	EPSDT	EPSDT
Home Health Services	MCG	NCD-LCD	MCG	MCG

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 (CMHRS) Criteria
- 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

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 6*

Virginia Medicaid Behavioral Health and SUD Addiction and Recovery Treatment Services (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
Mental Health Skill Building Services	DMAS Service Auth
Psychosocial Rehab	DMAS Service Auth
Applied Behavior Analysis	DMAS Service Auth
Intensive Outpatient Program	DMAS Service Auth
Functional Family Therapy	DMAS Service Auth
Multisystemic Therapy	DMAS Service Auth

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 7*

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 for Mental Health Services (MHS) formerly referred to as Community Mental Health Rehabilitative Services (CMHRS)

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 6*

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 Optima Health's Behavioral Health Services
DMAS criteria: **MHS**, (formerly called CMHRS) Chapter IV of the DMAS Manual, provides 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).

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 7*

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
Inpatient Services	MCG	MCG	MCG	MCG
Neonatal Care	MCG	Not Applicable	MCG	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	CMS Chapter 8 Benefit Policy Manual	MCG *For VA FAMIS only*	Medicaid Transmittal #213
Transplant Services	NTS IQ®	NTS IQ ®	NTS IQ ®	NTS IQ ®

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 9*

Non-Behavioral Health

A. MCG Guidelines 28th Edition/Cite CareWeb QI 16.0 Release

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 28th edition was released on in February 2024, after systematic, evidence-based review by MCG. The new edition is scheduled to go live in KP-MAS during the 3rd quarter of 2024. 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.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 10*

- **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, 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 a focus on skilled nursing interventions, rehabilitation therapy, or a combination of both.

Changes in the MCG 28th Edition

1. General Content Enhancements and Changes

The Summary of Changes identifies the number of guidelines and resources in each content solution. 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 27th edition and the newly released 18th edition.

- Content Changes Relevant to Medicare Populations: Updates have been made to the Inpatient & Surgical Care (AC), General Recovery Care (GRC), Multiple Condition Management (MCM), Ambulatory Care (AC), and Recovery Facility Care (RFC) guidelines to provide greater detail around evidence used to support medical necessity criteria.
    - These changes provide insight into how MCG's content aligns with published regulations such as CMS' 2024 Medicare Advantage Final Rule (CMS-4201-F)
    - Based on the selected guideline, this new content may be included in the Care Planning – Inpatient Admission and Alternatives, the Operative Status Criteria, and the Evidence Summary sections of applicable guidelines.
    - MCG CareWeb clients who would like to suppress the Supplemental Medicare Criteria section can submit a request to their MCG Account Representative. Customers who would like to suppress this content within MCG's software solutions can do so within the software's administrative settings.
- Activities of Daily Living (ADL) Scoring Tool Changes: This calculator tool is included in the General Treatment Course of Home Care and Recovery Facility Care guidelines and is also accessible from the Care Management Tools section of all solutions. The calculator now uses scoring measures based on Medicare's standardized patient assessment data elements (SPADEs) to estimate the patient's level of ADL performance.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 10*

2. Benchmarks & Data:

- Benchmarking Data Date Ranges: MCG's 28th edition benchmarking reflects data through December 31, 2022, for Commercial and Medicaid populations, and data through December 31, 2021, for the Medicare population.
- Recovery Facility Care: The Statistical Companion includes length of stay statistics by Health Insurance Prospective Payment System (HIPPS) rate code relevant to the Patient-Driven Payment Model (PDPM).
- Home Care: Now includes a new Statistical Companion.
- Behavioral Health Care: Utilization Models and Level of Care Statistics now include visit statistics for Applied Behavioral Analysis (B-806-T).
- Social Vulnerability Index Dashboard: This new dashboard and accompanying Excel file are now available on the Benchmarks and Data Website. Data are presented on the social vulnerabilities faced by the US population by zip code, county, and state. The information, based on the Centers for Disease Control and Prevention data, is presented on four social vulnerabilities: Socioeconomic Status, Household Characteristics, Racial & Ethnic Minority Status, and Housing Type & Transportation. Puerto Rico's data on vulnerability by the various themes will be included in the dashboard and Excel file.

3. Inpatient & Surgical Care

- Extended Stay Bullet Added: The Extended Stay section of Optimal Recovery Guidelines includes a new indication which reads, "Failure to meet discharge criteria (Recovery Milestones within final day in Optimal Recovery Course)." This bullet refers to the patient who does not meet other Extended Stay reasons but is simply not recovering rapidly enough to meet the guideline's discharge Recovery Milestones by the identified Goal Length of Stay.
- New Tachypnea and Tachycardia Footnote: A new Footnote has been added to the Tachypnea and Tachycardia Definitions. The intent of this Footnote is to focus the reviewer on both the technical definition of a vital sign as well as patient-specific factors such as patient's baseline vitals, medications, and the clinical impact of the current respiratory and/or heart rate.
- Operative Status Criteria Updated: The Operative Status Criteria section in surgical guidelines now includes a clarifying note stating ambulatory procedures can include one postoperative overnight stay in a facility. Therefore, a Goal Length of Stay (GLOS) of Ambulatory refers to patients discharged on the day of or the day after the procedure.

4. Multiple Condition Management

- Changes to Multiple Condition Management content directly correlate to changes made in the Inpatient & Surgical Care guidelines.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 10*

5. General Recovery Care

- Neonatology (PG-NEO) Scope Clarified: Guideline PG-NEO is intended for medical care of neonates (corrected gestational age 28 days or less) who *re-present* after birth admission discharge (example, re-present to the emergency department to evaluate need for inpatient admission). By comparison, the Inpatient & Surgical Care diagnosis-specific neonatology Optimal Recovery Guidelines are intended to be used for neonates during their birth admission. Appropriate use of the ISC vs. GRC neonatology guidelines is addressed in the Content Guides to Inpatient & Surgical Care and General Recovery Care. In addition, Footnotes embedded in applicable guidelines also provide clarifying details.
- Operative Status Criteria Updated: The Operative Status Criteria section in surgical guidelines now includes a clarifying note stating ambulatory procedures can include one postoperative overnight stay in a facility. Therefore, a Benchmark Length of Stay (BLOS) of Ambulatory refers to patients discharged on the day of or the day after the procedure.
- Benchmark Length of Stay Clarified: BLOS is derived from hospital discharge database analysis combined with review by MCG physician editors and pertains to a specific ICD-10 diagnosis code or CPT®-4 procedure code. In the 28th edition, there will no longer be a BLOS of 1 day for surgical or procedural CPT® codes. The lowest inpatient procedural BLOS will be 2 days.
- New Tachypnea and Tachycardia Footnote: A new Footnote has been added to the Tachypnea and Tachycardia Definitions. The intent of this Footnote is to focus the reviewer on both the technical definition as well as patient-specific factors such as patient's baseline vital signs, medications, and the clinical impact of the current respiratory and/or heart rate.

6. Medicare Compliance

- MCG updates its Medicare Compliance (MCR) content throughout the year to reflect the policy statements written by the Centers for Medicare & Medicaid Services (CMS) or Medicare Administrative Contractors. To view a list of the most recently published changes in the MCR content, refer to the Summary of Changes for Medicare Compliance page, which is accessible from the MCR Table of Contents. This page will be updated with each release and should serve as a reference listing of the changes published to MCR.

7. Ambulatory Care

- Genetic Counseling Indication Changes: The genetic counseling indication in Genetic Medicine guidelines addressing germline (hereditary) mutations has been condensed and simplified to better represent the most critical components of genetic counseling. In addition, several guidelines now include different genetic counseling indications that better reflect the more limited genetic counseling used for universal prenatal screening or universal carrier testing.
- Rehabilitation Guidelines and Non-Quantitative Treatment Limitations (NQTL): Rehabilitation guidelines have been modified to avoid any assumption of treatment limitations between different types of therapies. A new Clinical Indication has been added to 21 Ambulatory Care rehabilitation guidelines to provide consistency with a rehab guideline included in MCG's Behavioral Health Care solution.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 10*

8. Behavioral Health Care

- American Society of Addiction Medicine (ASAM) Updates: The Behavioral Health Care guidelines were updated to reflect ASAM Criteria, Fourth Edition, for the adult population and ASAM Criteria, Third Edition, for the child and adolescent population.
- "Whole Person Care" Language Update: Language was added to the Behavioral Health Level of Care Guidelines to emphasize the use of a "whole person care" approach for care coordination.
- Applied Behavioral Analysis Guideline Benchmarking and Language Changes: Utilization Models and Level of Care Statistics now include visit statistics for Applied Behavioral Analysis. The data is provided by procedure code for commercial and Medicaid populations. A note has been added to guideline B-806-T's Clinical Indications directing users to the new data. Also, a minor language change was made to eliminate any assumption of non-quantitative treatment limitations.
- New Scoring Tools Added: Two scoring tools have been added: Behavioral Health Level of Care Scoring Tool, Adult and Behavioral Health Level of Care Scoring Tool, Child or Adolescent. The scoring tools, or calculators, support the assessment of the patient across multiple behavioral health dimensions. Tools can be used to evaluate admission, concurrent stay, and discharge. These tools were added to support New York state regulatory requirements and can be accessed from the State-Specific Tools section of the Behavioral Health Care Table of Contents page.

9. Recovery Facility Care

- Clinical Indications for Admission Changes: The clinical indications for skilled care treatments have been further developed to detail admission requirements that are rehabilitation focused and those associated with a maintenance therapy program or skilled restorative nursing. Criteria were added or realigned within this section to better reflect and define these therapy modalities. 4) Job Aid: 28th Edition Summary of Changes
- General Treatment Course Changes: Clinical Status *Stage 2* bullets have been revised to focus on patient care progression. The Interventions *Stage 3* section of the General Treatment Course has been updated to include information on when it is safe to go home and transition into the community or to an alternate level of care.
- Statistical Companion to Recovery Facility Care Updated: The Statistical Companion to Recovery Facility Care includes Medicare claims data for each Subacute/Skilled Nursing Facility Optimal Recovery Guideline. The data are categorized by CMS' Patient-Driven Payment Model (PDPM) to provide more granular details (such as functional score, restorative nursing services) that align with an average length of stay.

10. Home Care

- Visit Data Updates: The Visit Goal Tables are now based on different time frames than previously identified. This revision is due to payment period changes by the Health Insurance Prospective Payment System (HIPPS). The commercial and Medicare visit data displays the number of visits that should occur within that episode. A commercial episode of care is based on a continuous period of home care service with a gap of no more than 30 days. A Medicare episode of care is based on a 30-day payment period.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 10*

- New Guideline Layout: The Home Care primary guideline sections have been reformatted to better align with the Recovery Facility Care guideline layout. This change was made to reflect greater consistency across post-acute care solutions.
- Extended Visits Bullet Added: The Extended Visits section includes a new indication which reads, "Failure to meet discharge criteria (Recovery Milestones within final stage of General Treatment Course).” This bullet reflects the need for a brief visit extension that would be expected in instances when Recovery Milestones are not met within the final day of the General Treatment Course.

11. Chronic Care

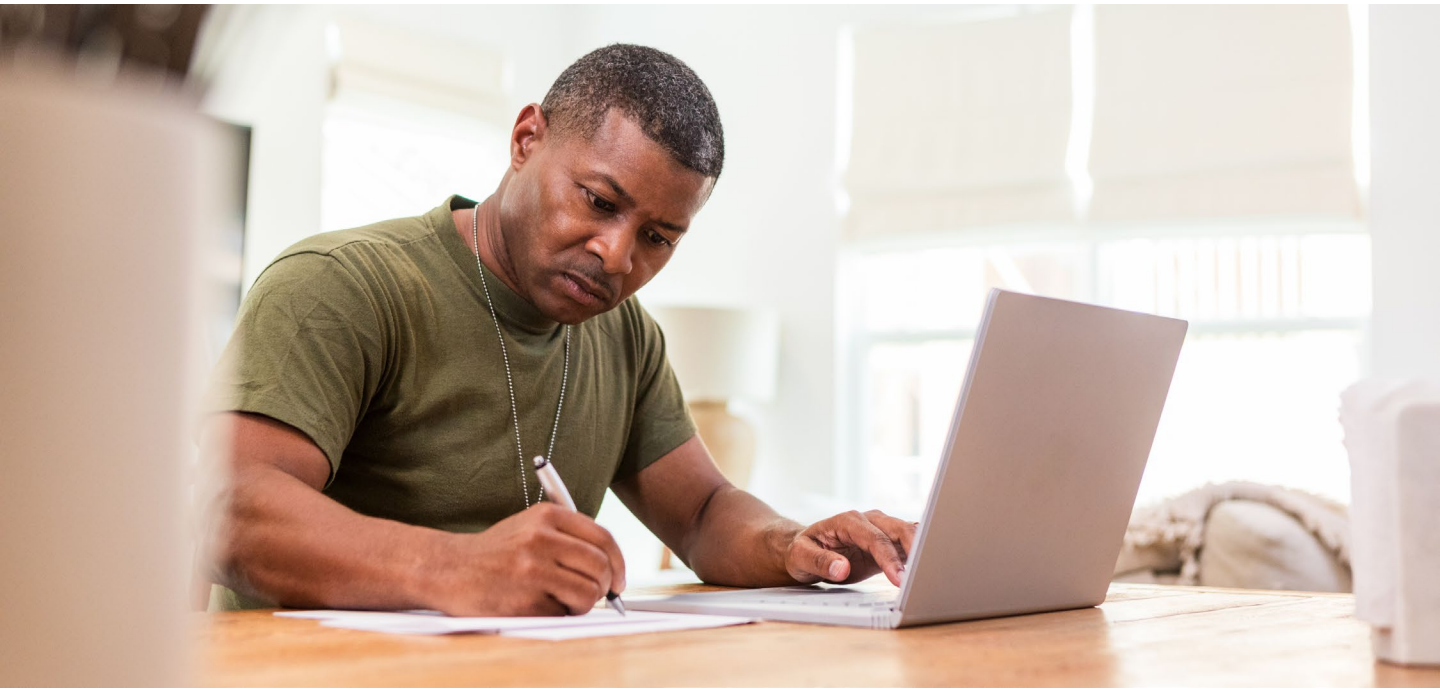
- Table of Contents Updated: The Self-Management and Low Intensity Disease Management sections with the heading Thoracic Surgery and Pulmonary Disease have been renamed “Pulmonary Disease.” The Self-Management and Low Intensity Disease Management sections with the heading Cardiovascular Surgery have been renamed “Cardiology.” Existing assessments in the sections remain the same.

12. Transitions of Care

- Table of Contents Updated: Existing assessments have been categorized and arranged to highlight existing Social Determinants of Health content, to place Condition Self-Management content into groups, and to organize general content into more specific groupings.

13. Patient Information

- Handout Changes: There have been several additions, deletions, and handout name changes in the 28th edition of Patient Information. Refer to the Summary of Changes for specific details.



2024 UM Approved Criteria Sets and Guidelines – *Continued from page 10*

14. MCG 28th Edition Summary of Changes

While all MCG content has undergone an annual review and many guidelines include content revisions, we have flagged the following guidelines as having significant content changes:

Guideline Title Inpatient & Surgical Care (ISC)	Guideline Code	Summary of Change
Abdominal Pain, Undiagnosed	M-05 P-05	Criteria regarding pain, NPO, and bacteremia status revised and modified.
Apparent Life-Threatening Event (Brief Resolved Unexplained Event)	P-12 OC-070 (NEW)	Criteria moved to the new companion Observation Care Guideline as the vast majority of infants do not require care beyond observation.
Asthma	M-60 P-60 OC-004	Criteria regarding peak flow measurements and response to initial treatment revised.
Atrial Fibrillation Supraventricular Arrythmias	M-505 M-510 P-510	Some anticoagulation therapy content has been modified based on new guidance from prominent specialty societies. Note details in Footnotes and Definitions.
Bronchiolitis	P-80	Criteria expanded regarding severe or persistent symptoms.
Cardiac Septal Defect: Atrial, Transcatheter Closure	S-282	Indications for closure of patent foramen ovale in cryptogenic stroke have been expanded.
Cardiac Valve Replacement or Repair	S-290	Expanded to include criteria specific to transcatheter procedures for mitral regurgitation. No changes were made to open surgical procedure for primary or secondary mitral regurgitation.
Chronic Obstructive Pulmonary Disease	M-100 OC-10 M-100-HAH	Expanded hypoxemia and hypercarbia criteria, quantified dyspnea, added severe signs of respiratory fatigue, and removed criteria related to comorbid illness and procedural needs.
Croup	P-130	Replaced altered mental status with lethargy criteria. Also clarified need for sustained response to treatment.
Diabetes	M-130 M-132 P-140 OC-014	Guidelines now recognize diabetic ketoacidosis (DKA) without hyperglycemia (euglycemic DKA), incorporate use of anion gap as a measure of metabolic acidosis, and include pediatric specific indicators for more severe DKA.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 10*

Guideline Title	Guideline Code	Summary of Change
Failure to Thrive	P-187 CCC-023	Narrowed parameters to malnutrition criteria.
Gastrointestinal Bleeding	M-180 M-182 P-200 OC-020 OC-021 OC-046	Enhanced clarity regarding colonoscopy and revised level of care regarding coagulopathy criteria.
Hemophilia	P-204 OC-069 (NEW)	Criteria moved to the new companion Observation Care Guideline. Clarified criteria regarding testing, treatment, and monitoring prior to inpatient admission.
Hyperemesis Gravidarum	M-195 OC-025	Clarified abnormal lab results and need for hospital-based care.
Hysterectomy	S-650 S-660 S-665	Criteria revised and clarified regarding abnormal uterine bleeding and cervical intraepithelial neoplasia grade.
Immune Thrombocytopenia (ITP), Pediatric	P-207 OC-071 (NEW)	Criteria moved to the new companion Observation Care Guideline. Also, criteria related to severe presentations expanded.
Left Atrial Appendage Closure, Percutaneous	M-333	New specialty society guidance describes indications related to treatment of atrial fibrillation. Refer to extensive new or changed Footnotes.
Liver Transplant	S-795 P-795	Significant changes to criteria and Footnotes.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 13*

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

The **2024 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 Adult Criteria -** determines the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are age 18 or older. InterQual Acute Adult Criteria are organized by primary condition in this new "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.
    - 2024 InterQual Level of Care – General Surgical, Acute Criteria – Adult & Pediatrics
    - 2024 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)
    - 2024 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Adult
    - 2024 InterQual Level of Care – Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT), Acute Criteria – Pediatrics

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 14*

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.

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.

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 15*

Internally Developed UM Criteria

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

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/Emerging Technologies, Transplant Referral Guidelines, and MCP Updates

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 2023 to July 2023.**

1. **Continuous Glucose Monitor**
   Effective Date: May 23, 2024
   - Section III-B. Clinical Indications for Pediatric Use
     - Diagnosis of Type 1 diabetes as a requirement for pediatric members removed
   - Section III-D. Exclusions - updated
   - References were updated

2. **Compression Garments & Devices**
   Effective Date: May 23, 2024
   - Section II
     - Added categories of compression garments
   - Section V. Indications - updated
   - Sections VI, VII, and IX
     - Added “lymphedema therapist”
   - References were updated

3. **Knee Scooter**
   Effective Date: May 23, 2024
   - References were updated

New/Emerging Technologies and MCP Updates – *Continued from page 16*

4. **Electric Patient Lift**
   Effective Date: May 23, 2024
   - Section IV-B. Exclusions - updated
   - References were updated

5. **Home O2 Therapy**
   Effective Date: May 23, 2024
   - References were updated

6. **Hyperbaric Oxygen**
   Effective Date: May 23, 2024
   - References were updated

7. **Transcutaneous Tibial Nerve Stimulator (TTNS)**
   Effective Date: May 23, 2024
   - References were updated

8. **Osteogenic Stimulator**
   Effective Date: May 23, 2024
   - Section II. Specialties
     - Added: Podiatry
   - Section IV-B. Ultrasonic Osteogenic Stimulator
     - Added: Inclusion Criteria
   - New section added – Section V (Additional Requirements for Ultrasonic and Electrical/Electromagnetic Osteogenic Stimulator)
   - References were updated

9. **Pluvicto**
   Effective Date: May 23, 2024
   - References were updated

10. **Aquablation_NEW**
    Effective Date: May 23, 2024
    - References were updated

11. **Circumcision Revision**
    Effective Date: June 25, 2024
    - References were updated

12. **Pelvic Floor Rehabilitation**
    Effective Date: June 25, 2024
    - References were updated

13. **Varicose Veins Treatment**
    Effective Date: June 25, 2024
    - References were updated

New/Emerging Technologies and MCP Updates – *Continued from page 17*

14. Microwave Thermolysis with MiraDry System
Effective Date: June 25, 2024
- References were updated

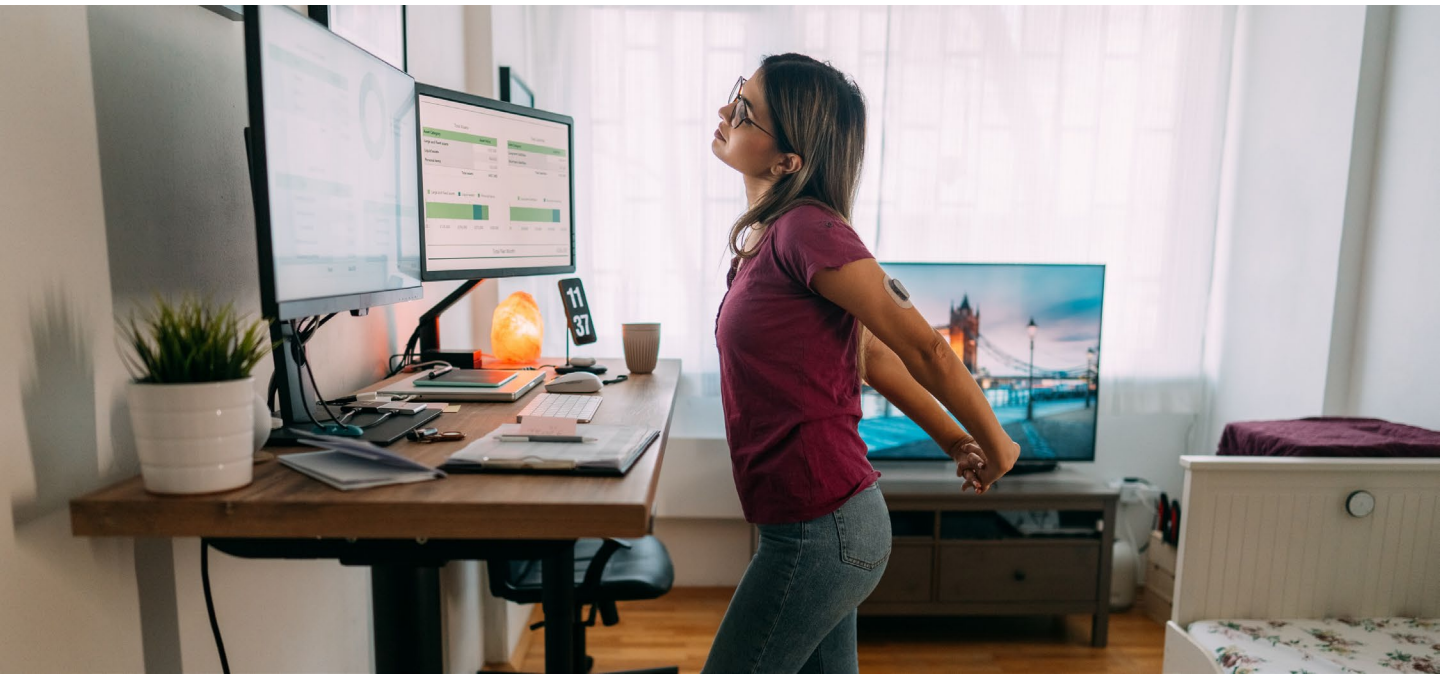
15. Dermal Fillers
Effective Date: June 25, 2024
- References were updated

16. External Insulin Pumps and Supplies
Effective Date: June 25, 2024
- References were updated

17. Cochlear and Brain Stem Implant
Effective Date: June 26, 2023
- Section VI-A #1. Unilateral Cochlear Implantation for Single-Sided Deafness and Asymmetric Hearing Loss
    - For children between 9 months and 18 years of age: sensorineural hearing loss updated from “bilateral” to “unilateral”
- References were updated

18. Aquatic Therapy
Effective Date: June 25, 2024
- References were updated

19. Habilitative Services_NEW
Effective Date: June 25, 2024, and July 24, 2024
- Each section of the policy has been updated



New/Emerging Technologies and MCP Updates – *Continued from page 18*

20. Habilitative Services including ABA Services DC Jurisdiction_RETIRED
Effective Date: June 25, 2024

21. Habilitative Services including ABA Services MD Jurisdiction_RETIRED
Effective Date: June 25, 2024

22. Habilitative Services including ABA Services VA Small Group & KPIF Jurisdiction_RETIRED
Effective Date: June 25, 2024

23. Laser Treatment of Vascular Lesions
Effective Date: July 25, 2024
- References were updated

24. Purewick Urinary Collection System
Effective Date: July 25, 2024
- References were updated

25. Capsule Endoscopy
Effective Date: July 25, 2024
- References were updated

26. Pediatric Feeding Therapy
Effective Date: July 25, 2024
- References were updated

27. Mastectomy External Prosthesis
Effective Date: July 25, 2024
- Section III. Clinical Indications - updated
- Section IV. Limitation
    - "Custom-fabricated breast prosthesis" language updated
- References were updated

28. Cardiac Rehabilitation
Effective Date: July 25, 2024
- Section IV-B. Cardiac conditions that qualify for cardiac rehabilitation
    - Deleted: Sustained ventricular tachycardia or ventricular fibrillation; Class III or IV Congestive Heart Failure unresponsive to medical therapy
    - Added: Class II-IV CHF, EF < 35%, without admission in the past 6 weeks or planned procedures in the next 6 months
- Section V. Contraindication
    - Deleted: Ventricular dysfunction, with a history of previous heart illness prior to a recent cardiac event
- Section VI.E. Duration and Frequency – Acceptable exit criteria
    - Deleted: The stress test is not positive during exercise (A positive stress test in this context implies an ECG with a junctional depression of 2 mm or more associated with slowly rising, horizontal, or down sloping ST segment
- References were updated

New/Emerging Technologies and MCP Updates – *Continued from page 18*

29. Orthosis, Lower Extremity and Soft Goods
Effective Date: August 28, 2024
- Utilization Alert was updated
- References were updated

30. Orthosis, Spinal and Soft Goods
Effective Date: August 28, 2024
- References were updated

31. Space OAR
Effective Date: August 28, 2024
- References were updated

32. Breast Reduction and Gynecomastia Surgery
Effective Date: August 28, 2024
- Section V. Therapeutic Measures Prior to Referral - updated
- References were updated

33. Breast Pump
Effective Date: August 28, 2024
- Section IV. Indications for Coverage of Hospital Grade Breast Pump - updated
- References were updated

34. Benign Skin Lesion Treatment
Effective Date: August 28, 2024
- Section IV-B. Exclusions
    - Added: Lesions would be approved for removal if they met the medical necessity criteria as reflected in section III-B.
- References were updated

35. Autistic Spectrum Disorder (ASD) Evaluation_NEW
Effective Date: August 28, 2024

36. Hypoglossal Nerve Stimulator for OSA
Effective Date: September 26, 2024
- Section III-A #2-3. Clinical Indications - updated
- Section IV-A. Limitations – updated
- Section IV-B. Contradictions - updated
- References were updated

37. Bariatric Surgery
Effective Date: September 26, 2024
- Policy title of "*Morbid Obesity/Bariatric Surgery Adolescents and Adults"* replaced with *"Bariatric Surgery Adolescents and Adults"*
- References were updated

New/Emerging Technologies and MCP Updates – *Continued from page 18*

38. High Frequence Flutter Valves and Oscillator Vest (HFOV)
Effective Date: September 26, 2024
- Utilization Alert was updated
- References were updated

39. Endobronchial Vale
Effective Date: September 26, 2024
- Section V-B. Precaution
    - "zephyr" has been replaced with the word "endobronchial"
- References were updated

40. Preimplantation Genetic Test (PGT)
Effective Date: September 26, 2024
- References were updated

41. Spinal Cord Stimulation for Pain Management
Effective Date: September 26, 2024
- References were updated

42. Wound Supplies
Effective Date: September 26, 2024
- References were updated

43. Nutritional Support
Effective Date: September 26, 2024
- Section IV-B. Pediatric Conditions: Pediatric formulas and medical foods criteria for coverage
    - Deleted: "*Inability to maintain adequate nutrition through oral intake"*
    - Added: *"Approval of amino acid formulas for mild protein enteropathies requires documentation that the member has tried and failed extensively hydrolyzed formula."*
- Section VI. Coverage for DC Situs Members - updated
- References were updated

44. Laser Therapy for Hair Reduction or Hair Removal
Effective Date: July 25, 2024
- Section III-B
    - Non-covered in SNF was replaced with LTC
- References were updated

Effective Date: September 26, 2024
- Section III. Clinical Indication
    - Added: Recurrent/recalcitrant Pilonidal Disease

New and Emerging Technologies

Approved by the KP-MAS Technology Review Implementation Committee (TRIC): July 26, 2024
Approved by the Regional Utilization Management Committee (RUMC): August 28, 2024

INTC Presentation Date	National Interregional New Technology Committee (INTC) Conclusion http://cl.kp.org/pkc/national/cpg/intc/specialty.html	KP-MAS Recommendation - Adopt the use of technology Sufficient evidence	KP-MAS Recommendation – Do not recommend Inconclusive or Insufficient evidence
Sufficient evidence: Quality and quantity of evidence is good, should be used in most cases where indications are met.			
Insufficient evidence: Quality and/or quantity is low or moderate, further research or trials are needed. Can be used in selected cases but not for general use for this diagnosis or indication.			
04/19/2024	**Galleri Multi-Cancer Early Detection Test**		X
04/19/2024	**Paradise and Spyral Renal Denervation (RDN) for Hypertension**	X The evidence reviewed was of low certainty for effectiveness and very low certainty for safety primarily due to the quality of the research studies available. But the consensus among experienced subject matter experts was that technology itself has shown promise. Recommend the use of this technology within KP-MAS	

2024 UM Approved Criteria Sets and Guidelines – *Continued from page 21*

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://cl.kp.org/mas/home/search.html?q=medical%20coverage%20policy.

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 Utilization Management Operations Center (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).

If you have clinical questions on the use of our criteria, please contact:

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

2024 Utilization Management Affirmative Statement

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

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

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

2024 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 outpatient and 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 behavioral and non-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 in UMOC 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:

- Providing information regarding UM processes;
- Checking the status of a referral or an authorization;
- Providing copies of the specific criteria/guidelines utilized for decision-making, free of charge; and
- Answering 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 5:00 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 selecting the appropriate prompt number.

2024 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 are identified by name, title and organization name when they initiate or return calls regarding UM issues. The table on the next page provides the specific UM hours of operations and main responsibilities.

UM staff are 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 members is available through the 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.

2024 UM Accessibility, Communication and Hours of Operations – *Continued from page 24*

UM Department Section	Hours of Operation	Core Responsibilities
Emergency Care Management (ECM) Department	24 hours/day, 7 days/ including holidays	• Process transfer and admission requests for Members who need to be moved to a different level of care including emergency rooms, inpatient facilities, SNF, LTAC, Acute Rehab, Home, and Kaiser Permanente Medical Office Buildings • Assist with repatriation from hospital to hospital • Support all cardiac transfers for level of care needed
Utilization Management (UM): Outpatient, Specialty Referrals and Clinical Research Trials	Monday through Friday: 8:30 A.M. to 5:00 P.M. **Except Clinical Trials:** 8:00 A.M. to 4:30 P.M. **Weekends and Holidays,** *except Clinical Trials:* 8:30 A.M. to 5:00 P.M. for Urgent and emergent referrals and care coordination referrals	• Conduct pre-service review of specialty referrals (outpatient and inpatient) to include external clinical trial requests • Weekends and holidays pre-service review of urgent/emergent referrals except clinical research trials
UM: • Durable Medical Equipment (DME) • Home Care • Rehabilitative Therapies • Physical, Occupational and Speech Therapies	Monday through Friday: 8:30 A.M. to 5:00 P.M. Weekends and Holidays: 8:30 A.M. to 5 P.M. for Urgent and routine discharge care coordination referrals	• Conduct pre-service and concurrent review of Home Care, Durable Medical Equipment, Physical Therapy, Occupational Therapy and Speech Therapy • Post-service review provided to Kaiser members outside a Kaiser medical facility

2024 UM Accessibility, Communication and Hours of Operations – *Continued from page 25*

UM Department Section	Hours of Operation	Core Responsibilities
UM Hospital Services- Non Behavioral Health located at affiliated hospitals	Seven days a week and Holidays 7:00 A.M. to 5:30 P.M. *Limited Evening hours* 3:00 P.M. to 11:30 P.M. at the following Premier Hospitals only: • Holy Cross Silver Spring • Washington Hospital Center • Virginia Hospital Center	Conduct concurrent review and transition care management
Skilled Nursing Facility (SNF) and, Rehabilitation Services	Monday through Friday 8:00 A.M. to 4:30 P.M. Including weekends and major holidays	Conduct Pre-services and concurrent review for members in SNF
Long Term Acute Care Hospitals (LTACH)	Monday through Friday 8:00 A.M. to 4:30 P.M. Including weekends and major holidays	Conduct concurrent review and transition care management for members in Acute Rehab
UM Hospital Services – Behavioral Health	Seven days a week: 7:30 A.M. to 5:00 P.M. Including weekends and major holidays	Conduct concurrent review and transition care management services of behavioral health service
UM Outpatient Services – Behavioral Health	Monday to Friday: 7:30 A.M. to 5:00 P.M. Excluding weekends and major holidays	Conduct Pre-service and concurrent review of behavioral outpatient services
Outpatient Continuing Care: Complex Case Management	Monday through Friday 8:30 A.M. to 4:30 P.M. Excluding weekends and major holidays	Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members
Renal Case Management	Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding weekends and major holidays	Coordinates care to slow progression of kidney disease, facilitates early intervention, educates members regarding kidney failure, and dialysis modalities. Collaborates with external dialysis centers, supports members receiving dialysis and monitors program goals.

2024 UM Accessibility, Communication and Hours of Operations – *Continued from page 26*

UM Department Section	Hours of Operation	Core Responsibilities
Advanced Care At Home (ACAH)	24 hours/day, 7 days/ including holidays /day, 7 days/ week, including holidays	• Offers Virtual Physician and nurse follow up for members who have been recently discharged from the hospital. • Bridges gap between hospital discharge and follow up with PCP • Admission avoidance by providing acute care in the home

2024 Adopting Emerging Technology for Utilization Management (UM) Referral Management

Medical research identifies new medical procedures, treatments, and medical devices 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), Southern California (KPSC) Medical Technology Management Process (MTMP), Emerging Therapeutics Committee, and Regional Utilization Management Committee (RUMC), to review a select number of behavioral and non-behavioral health new and emerging medical treatments, procedures, and devices for the purpose of making recommendations regarding benefit coverage, with the exception of pharmaceuticals and biologics which are reviewed by KP Pharmacy & Therapeutics committee.

The new and emerging technology committees assist physicians, other clinicians, and members to determine whether behavioral and non-behavioral new or emerging procedures, treatments, or medical devices are medically necessary and appropriate for the intended clinical indication based on evidence and subject matter experts' review, as well as consideration of the clinical judgment of the treating physician for the treatment of select patients.

The review and assessment process provides answers to important questions regarding clinical indications for use, safety, effectiveness, and relevance of new and emerging medical technologies for the health care delivery system. The technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

Upon determination that sufficient evidence establishes the new/emerging technology to be comparable to the safety and effectiveness of currently available treatments, procedures or devices, the Kaiser Permanente TRIC and RUMC committees provide recommendations to the Health Plan in regard to whether to adopt or not to consider the use and possible inclusion of the technology as a covered benefit for the Mid-Atlantic States region.

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 - click on “Provider Information” and select “Clinical Library.” Or call the Health Education Information Line at (301) 816-6565 and press “2” to leave a message.

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.

Integration of Care in KPMAS Patient Centered Medical Home – *Continued from page 30*

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 31*

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.

2024 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 (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

Practitioner and Provider Quality Assurance of Credentialing – *Continued from page 34*

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
4000 Garden City Drive
Hyattsville, MD 20785

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 forty-eight (48) 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 onboarding outreach activities related to Maryland HealthChoice members, including but not limited to assisting with kp.org registration, first appointment scheduling, PCP assignments, clinical pharmacy, and reviewing case management screeners.

Participating providers are required to make the necessary outreach to members to ensure the members are seen within the required timeframes for initial health care assessment and evaluation for ongoing health needs (e.g., timeliness of health care visits, screenings, and appointment monitoring). In the event 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 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 the patient visit.

Content can be viewed through the centralized internal “Clinical Library” which is an electronic inventory of health education information that can be used for all visit types. Health education content and links to education videos, education webpages, and other resources are also embedded into KP HealthConnect for inclusion in the 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 at 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 38*

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 39*

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 40*

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 a member's 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 at 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 at 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 42*

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.

How to contact us

Member Services — Practitioners, providers or members can speak with a Member Services representative if assistance is needed with, or there are questions about the Health Plan or specific benefits. A Member Services representative is available by calling the Member Service Contact Center at 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.

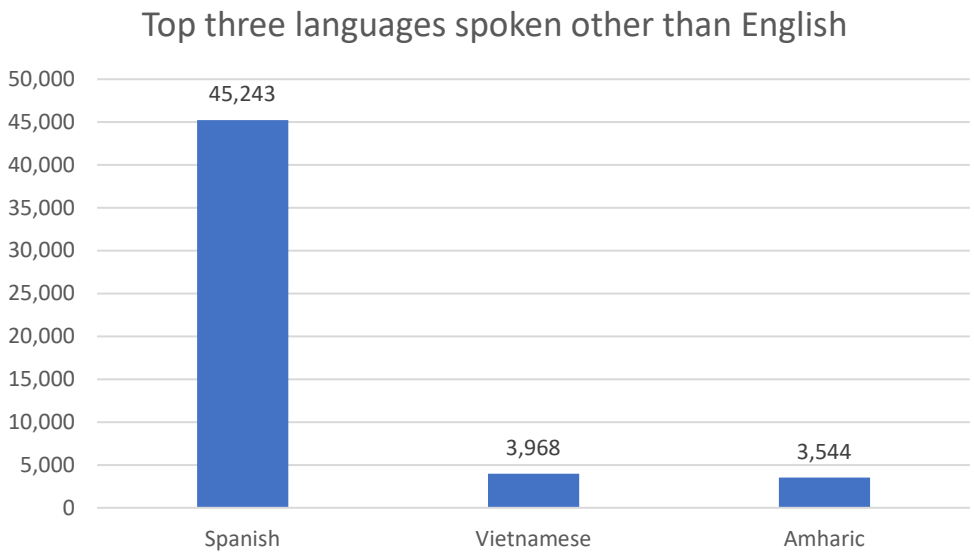
CLAS Standards – *Continued from page 44*

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, 2022 – December 31, 2022. 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, large print, or audio**. Blind or vision impaired members can request for documents in Braille or large print or in audio format.
- **Telecommunications Relay Service (TRS).** If members are deaf, hard of hearing, or speech impaired, we have the 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 patients 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 46*

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

DMAS Required PRSS Enrollment

In accordance with Federal requirements in the 21st Century Cures Act, all Virginia Medicaid managed care providers must enroll directly with DMAS through PRSS. Licensed Providers and Healthcare Professionals in the Commonwealth of Virginia can register with PRSS at the following link: https://virginia.hppcloud.com/. Providers must include valid National Provider Identifier (NPI), Tax ID, and Office Location information for successful enrollment.

Providers who fail to enroll in PRSS will no longer receive payments for Virginia Medicaid members enrolled in managed care.

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

Provider Directory Validation Surveys

The Kaiser Permanente provider directory validation survey is designed to adhere to the Center for Medicare and Medicaid Services (CMS) regulations and the new Consolidated Appropriations Act of 2021, also known as the No Surprises Act. The objectives of both are to ensure that members have access to accurate provider information. The survey not only addresses directory accuracy but also accuracy of our other provider data systems.

In accordance with these regulations, provider data must be validated at least every 90 days. Therefore, Kaiser Permanente sends this provider directory validation survey each quarter, and providers are required to respond. Instructions are contained along with the survey, and **providers are reminded to return all pages with their response before the stated deadline.**

If you have any questions or concerns, please contact Provider Experience at 1-877-806-7470 or email us at provider.demographics@kp.org with the subject line: “Provider Directory Validation.”

Thank you for communicating all data changes in a timely manner. We appreciate your cooperation!

Keeping Your Provider Data Updated

Keeping Kaiser Permanente updated with changes, adds, and terminations to your practice will ensure that our directory and data systems are accurate and help us provide an excellent healthcare experience to our members.

It is imperative that you ensure your information is current by notifying us in a timely manner of demographic changes, provider terminations, and/or provider additions to your practice. **If a provider is being added to your practice, your information must be communicated and updated in our system before treating our members.**

Please utilize the provider update form to submit updates throughout the year. For your convenience, the form can be found on the following page as well as on our Community Provider Portal at the following link:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/mas/ever/sample-add-change-letter-en.pdf.

These updates may be submitted to Provider Experience via:

Fax: 855-414-2623
Email: Provider.Demographics@kp.org
Mail: Kaiser Permanente
Provider Experience
4000 Garden City Drive
Hyattsville, MD 20785

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 Foundation Health Plan of the Mid-Atlantic States, Inc.
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