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

Maryland Dual Special Needs Plan (DSNP) – Arriving January 1, 2026

Kaiser Permanente is excited to announce the upcoming launch of a new DSNP for members who are dually eligible for Medicare and Medicaid in Maryland. Available starting January 1, 2026, the DSNP offers benefits that are specifically targeted to dual eligible members, ensuring that they receive coordinated care and comprehensive support.

For members enrolled in this DSNP, Medicare will be the primary payer for most medical services. Medicaid will assist with any remaining costs as a secondary payer, including Medicare deductibles and copayments, depending on eligibility. Providers may not collect any copay or coinsurance from these members at the point of service and should bill Medicaid for any listed cost-shares, as applicable.

In addition to the copay collection requirements, providers are required to complete the DSNP Model of Care training by December 31, 2025. These training materials will detail the specifics of the DSNP, including eligibility requirements, coordination of benefits, cost-sharing, and billing procedures.

Upcoming Actions and Key Dates

- Plan Launch: The new DSNP will be open for applications starting on October 15, 2025. The first DSNP members will be effective in Maryland on January 1, 2026. The plan will be available to new Kaiser Permanente members as well as existing members who meet eligibility criteria.
- Provider Notification: On October 31, 2025, Kaiser Permanente will send Medicare contracted providers an official announcement about the new plan.
- Provider Training: The required SNP Model of Care 2025 Training will be included in the October mailing.
- Provider Manual Updates: At the end of the year, Kaiser Permanente's provider manuals will be updated with information about the DSNP ahead of its launch.

We encourage all providers to verify beneficiary eligibility and consult the forthcoming training materials for further details. As always, if you have any questions about a member's eligibility, please contact Member Services at 800-777-7902.

We look forward to partnering with you to deliver exceptional care to our dually eligible members in the Mid-Atlantic region.

2026 Medicare Plan Changes: Provider Guidance for Member Support

To continue delivering high quality care in every market we serve, Kaiser Permanente is making thoughtful plan adjustments to ensure our Medicare program remains sustainable for 2026 and beyond. These changes include the closure of some plans effective January 1, 2026

The purpose of this article is to explain the scope of these changes so providers can help support our members through this transition.

Members with plan closures

A subset of individual Medicare plan members across Maryland, Virginia, and Washington, D.C. will be affected by plan closures and **must re-enroll in a new Kaiser Permanente Medicare plan by December 31, 2025** to avoid gaps in KP Medicare Advantage coverage and continue seeing their providers. Kaiser Permanente will continue to offer Medicare Advantage plans in all counties of our current Medicare service areas.

What Providers Need to Know

- Member Communication Timeline: As of October 1, 2025, members are receiving information about these changes through letters, calls, and emails with instructions to re-enroll. Providers should be ready for member questions because of this outreach.
- Enrollment Deadlines: All affected members must re-enroll by December 31, 2025, to maintain uninterrupted coverage.
- Re-enrollment Options:
  - Online: kp.org/medicare
  - Phone: (877) 370-8714
- Providing Support: Providers should be prepared to direct members who have Medicare health plan questions or are ready to enroll to visit kp.org/medicare or call Kaiser Permanente at (877) 370-8714 (TTY 711)
- **Providers will not be expected to proactively communicate with patients about these changes.**

Kaiser Permanente recognizes the critical role that providers play in helping members navigate these transitions and minimizing any potential disruption in care. Thank you for supporting Kaiser Permanente's ongoing commitment to providing our members with integrated, high-quality, and sustainable care.

Applied Behavior Analysis (ABA) Service Authorization Change for VA Medicaid – Unbundling of Services Under CPT Code 97155

Effective October 15, 2025, the Virginia Department of Medical Assistance Services (DMAS) will require the "unbundling" or specification of the number of units requested for each type of ABA service.

As a result of this change, providers will no longer be able to request authorizations for the total number of units for any ABA services under the 97155 CPT code. Instead, providers will be required to submit service authorizations that include units for each separate treatment procedure code (97153, 97154, 97155, 97156, 97157, 97158, and 0373T).

DMAS has released a new ABA Initial Service Authorization Request Form with updated instructions to support this change. Providers can find this form on the "Provider Resources" page of the DMAS website. While existing authorizations will continue through the authorization end date, all new authorizations with start dates of October 15, 2025, or later must be requested using the new form.

DMAS will be mailing ABA providers the details of this change directly, and more information can be found on the "Medicaid Memos & Bulletins" page of the DMAS website.

As a reminder, for prior authorizations related to Virginia Medicaid, Kaiser Permanente follows DMAS' guidelines, as established in the Behavioral Health Redesign for Access, Value, & Outcomes (Project BRAVO). More information about Kaiser Permanente's ABA processes can be found in the ABA chapter of our provider manuals, accessible on the "Provider Information" page of our Community Provider Portal.

Applied Behavior Analysis (ABA) Chapter Added to Commercial and Virginia Medicaid Provider Manuals

Over the past year, we have engaged our ABA providers through mailings, emails, and townhalls to review ABA procedures, policies, and educational resources. In April, we notified our ABA providers about a new ABA chapter to be added to our Commercial and Virginia Medicaid provider manuals on June 11, 2025.

This chapter reflects the ABA procedures and policies outlined in our other previously published ABA educational materials. As always, our approach to caring for our members with autism spectrum disorder (ASD) which is driven by industry-standard guidelines that incorporate medical necessity, comprehensive clinical and progress documentation, effective therapy practices, active family engagement, and valuable feedback from ABA therapists.

Providers can access our provider manuals along with the KPMAS ABA Provider Reference Guide, ABA Authorization Request Form, and other resources on our Community Provider Portal at www.kp.org/providers/mas.

Should you have any questions, please contact our ABA Program Coordinators at ariel.x.wells@kp.org or katie.x1.williams@kp.org.

Revised List of Authorization-Waived Behavioral Health CPT Codes

In 2022, to meet the growing demand for therapy and medication management for mental health conditions, we temporarily lifted the authorization requirement for initial consultations and some routine care services.

Now that we have stabilized our internal services and access, as well as our contracted provider network, we will work with our patients to internalize their care for some services including medication management and psychiatric follow-up care to the Mid-Atlantic Permanente Medical Group (MAPMG).

Effective June 11, 2025, the following CPT codes will once again require authorization and will be removed from the list of authorization-waived services:

CPT Code	Description
H0014	ALCOHOL AND/OR DRUG SERVICES; AMBULATORY DETOXIFICATION
G2068	MEDICATION ASSISTED TREATMENT, BUPRENORPHINE; WEEKLY
90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN
90836	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN
90838	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN
99202	OFFICE/OUTPATIENT NEW SF MDM 15-29 MINUTES
99203	OFFICE/OUTPATIENT NEW LOW MDM 30-44 MINUTES
99204	OFFICE/OUTPATIENT NEW MODERATE MDM 45-59 MINUTES
99205	OFFICE/OUTPATIENT NEW HIGH MDM 60-74 MINUTES
99211	OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP
99212	OFFICE/OUTPATIENT ESTABLISHED SF MDM 10-19 MIN
99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN
99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30-39 MIN
99215	OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40-54

Revised List of Authorization-Waived Behavioral Health CPT Codes – Continued from page 4

Pre-authorization will still not be required for initial consultations and some services. The full list of authorization-waived CPT codes and their descriptions are listed below.

Please Note – These services must be billed on a CMS-1500 form for the waive to apply as this list applies to professional services.

CPT Code	Description
H0020	ALCOHOL AND/OR DRUG SERVICES; METHADONE ADMIN/SERVICE
G2067	MEDICATION ASSISTED TREATMENT, METHADONE; WEEKLY
G2078	TAKE HOME SUPPLY OF METHADONE; UP TO 7 ADD DAY SUPPLY
S0109	5 MG ORAL DOSE OF METHADONE
90791	PSYCHIATRIC DIAGNOSTIC EVAL
90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES
90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS
90849	MULTIPLE FAMILY GROUP PSYCHOTHERAPY
90853	GROUP PSYCHOTHERAPY
90839	PSYCHOTHERAPY FOR CRISIS
90840	EACH ADDITIONAL 15” FOR CRISIS
G0176	ART THERAPY
96127	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT
99307	SUBSEQUENT NURSING FACILITY CARE (10 MIN)
99308	SUBSEQUENT NURSING FACILITY CARE (15 MIN)
99309	SUBSEQUENT NURSING FACILITY CARE (25 MIN)
99310	SUBSEQUENT NURSING FACILITY CARE (35 MIN)

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

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

Specialized services or programs such as rehabilitation, partial hospitalization programs, or procedures such as TMS or ECT will still require a completed **Uniform Treatment Plan** (https://k-p.li/3r4oiw4) sent to Behavioral Health Utilization Management for referral authorization prior to care.

Launch of Commonwealth Coordinated Care Plus (CCC+)

Effective July 1, 2025, Virginia Medicaid expanded its coverage to include Long Term Services and Supports (LTSS) through a program known as Commonwealth Coordinated Care Plus (CCC+). This new membership and benefit program serves individuals aged 65 or older, as well as disabled children and adults who meet the criteria for nursing facility-level care and who choose to receive services at home or in community settings instead of institutional placement.

Key details about CCC+ include:

- **Enrollment and Eligibility:** Enrollment in CCC+ is determined by the Virginia Department of Medical Assistance Services (DMAS), following a pre-admission screening (PAS) by an approved LTSS screening team. Members must meet specific financial and functional eligibility criteria, and DMAS will send Kaiser Permanente approved members' CCC+ enrollment information.
- **Care Coordination:** Each CCC+ member will be assigned a dedicated Care Coordinator through Kaiser Permanente to facilitate access to necessary services and support.
- **CCC+ Waiver:** Members enrolled in the CCC+ Waiver receive waiver-related services directly from Kaiser Permanente in addition to their standard medical services.
- **Covered Benefits:** Kaiser Permanente will cover both waiver and non-waiver services designed to offer alternatives to institutional care. CCC+ covered benefits include:
    - Adult Day Health Care
    - Personal Assistance Services (agency-directed and/or consumer-directed). Note: if the member selects consumer-directed care, they will also have access to Services Facilitation and F/EA management services.
    - Private Duty Nursing Services (up to 112 hours per week)
    - Personal Emergency Response System
    - Respite Care (agency-directed and/or consumer-directed)
    - Skilled Private Duty Respite Care (agency-directed)
    - Assistive Technology (up to $5,000 annually)
    - Environmental Modifications and Vehicle Modifications (up to $5,000 annually)
    - Transition services (for eligible members transitioning from nursing facilities or long-stay hospitals back to the community)
- **Patient Pay:** Members whose income exceeds a certain threshold will be required to contribute to their LTSS costs. This patient pay amount is determined by the local Department of Social Services (DSS). Providers should bill members directly for their patient pay amount per DMAS guidelines. Kaiser Permanente will reimburse providers, deducting the applicable patient pay amount as indicated in monthly files received from Sentara, our Virginia Medicaid business partner.

Launch of Commonwealth Coordinated Care Plus (CCC+) – *Continued from page 7*

- **Developmental Disability (DD) Waivers:** Members enrolled in a DD Waiver (Building Independence [BI], Community Living [CL], and Family and Individual Supports [FIS]) will receive their waiver services, targeted case management, and waiver-related transportation directly from Virginia Medicaid. Kaiser Permanente covers only their non-waiver medical services.

On July 1, 2025, we updated our Virginia Medicaid provider manual to reflect these changes. You can find all our provider manuals, other resources, and educational materials on our Community Provider Portal at www.kp.org/providers/mas.

More information about CCC Plus can be found on the Department of Medical Assistance Services (DMAS) website at the following link: https://www.dmas.virginia.gov/for-members/cardinal-care-members/cardinal-care-managed-care/archived-information/ccc-plus/.

Online Affiliate Enhancements to Prior Authorization Requests

Online Affiliate is receiving some updates to improve the clarity of the prior authorization information that providers can see on the platform. This article outlines some of these key enhancements.

What is changing?

You'll now see an Authorization Number that includes a dash and a number (e.g., -1 or -2) following the referral number. This format helps identify different parts of a single authorization. For example, if an authorization includes multiple services or is partially approved, it may be split into separate parts—each with the same base number but a different suffix. It's important to click into each part to view the full details of the determination.

A new Overall Authorization Status column has been added. This may include new status types such as Partially Authorized. For example, if your request includes multiple services and some are approved while others are denied, the overall status will show as Partially Authorized. The Overall Authorization Status column replaces the previous Referral Status column.

Why is this change happening?

In January 2024, the Centers for Medicare & Medicaid Services (CMS) released the Interoperability and Prior Authorization Final Rule (CMS-0057-F). This rule is designed to make health information more accessible and to streamline the prior authorization process—including how service lines are managed. A key goal of the rule is to move the industry toward fully electronic prior authorizations, reducing delays and improving care coordination.

At Kaiser Permanente, we're committed to supporting this transition. These changes help reduce administrative burden on patients, providers, and payers alike, while also advancing our sustainability efforts. We will continue to enhance our systems to align with CMS requirements and will keep you informed as new updates become available.

Do I need to change how I submit prior authorization requests to Kaiser Permanente?

No. The prior authorization request process remains the same.

Do I need to change how I submit a claim or authorization to Kaiser Permanente?

No. Our system can accept authorization numbers with or without the dash (-), so there's no need to adjust how you submit claims or authorizations.

Online Affiliates Enhancements to Prior Authorization Requests – Continued from page 9

What are the different statuses I may see and what do they mean?

Status Type	What it means
Authorized	Indicates that the Utilization Management (UM) department has reviewed the request and granted full approval.
Partially Authorized	Indicates that only a portion of the requested services or quantities has been approved. This may occur when fewer units are authorized than requested (e.g., 6 out of 9 physical therapy sessions approved) or when multiple services are submitted and each receives a different determination (e.g., one service line approved, another denied).
Denied	Indicates the UM department has reviewed the request and denied authorization.
Pending Review	Indicates that the request requires evaluation by the UM department before a decision can be made. This status is primarily used to identify authorizations that need to be routed to UM work queues for manual review.
No Auth Required	Indicates that review by the UM department is not necessary.
Closed	Indicates that the request has been canceled, deleted, or carved out. UM review is not required, as no decision needs to be made for the service.
Dismissed	Indicates that the UM department is not responsible for making a determination on the request.
Withdrawn	This status is typically used for duplicate submissions or entries made in error.

Still have questions?

If you need additional support or clarification regarding these recent updates, please contact the Utilization Management Operations Center at 1-800-810-4766 and follow the prompts.

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.
- The public can access Kaiser Permanente's UM criteria via the Utilization Management public-facing website at kaiserpermanente.org.
- Hard copies of the utilization management criteria, or Medical Coverage Policies 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.

2025 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 guideline development and the renewal process.

All UM 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 applied based upon the needs of the individual patient.

In the absence of nationally recognized applicable UM criteria or internally developed medical policies, the UM staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. Medical determination by the reviewing practitioner is based 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.

2025 UM Approved Criteria Sets and Guidelines – *Continued from page 12*

Types of UM Criteria in Use:

A. Non-Behavioral UM Criteria

- **Nationally Recognized UM Criteria**
  - MCG
  - InterQual Level of Care Criteria for Transplant Services
    - 2025 General Surgical, Adult
    - 2025 General Surgical, Peds
    - 2025 Hematology/Oncology Treatments, Adult
    - 2025 Bone Marrow Transplant, Peds
  - 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

- **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 Referral Guidelines

B. Behavioral Health UM Criteria

- **Nationally Recognized UM Criteria**
  - MCG
  - InterQual for ABA Therapy
  - 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)

2025 UM Approved Criteria Sets and Guidelines – *Continued from page 13*

Non-Behavioral Health

A. MCG Guidelines 29th 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 29th edition was released in March 2025, after systematic, evidence-based review by MCG. The new edition is scheduled to go live in KP-MAS during the 3rd quarter of 2025. The MCG's care guidelines that are licensed for KPMAS are the following:

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

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- **Recovery Facility Care (RFC)** - address two primary level of care which are inpatient rehabilitation facilities (acute rehabilitation) and sub-acute/skilled nursing facilities (SNF). The appropriate level of care, 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/Skilled Nursing facilities (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.

B. InterQual Level of Care for Transplant-related Services, Adult and Pediatr

The **2025 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 UnitedHealth Group (UHG)and the transplant coordinators are tested annually to establish inter rater reliability.

InterQual Level of Care Criteria Description

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

2025 UM Approved Criteria Sets and Guidelines – *Continued from page 15*

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

C. Medicare Coverage Database for National (NCD) and Local Coverage Determination (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.

INTERNALLY DEVELOPED UM CRITERIA

A. National Transplant Service (NTS)' Transplant Referral Guidelines

1. Bone Marrow Transplant
2. Liver Transplant
3. Intestinal Transplant and Intestine/Liver Transplant
4. Lung Transplant and Heart-Lung Transplant
5. Kidney Transplant

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6. Simultaneous Pancreas Kidney (SPK) Transplant
7. Pancreas Transplant Alone (PTA) and Pancreas After Kidney (PAK) Transplant
8. Heart Transplant
9. Mechanical Circulatory Support Devices as a Bridge to Cardiac Transplant

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

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

Behavioral Health

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

A. American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder

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 Department of Medical Assistance Services (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.

B. 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.

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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).

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**	**Medicare**	**VA Medicaid or FAMIS**	**Medicaid (MD HealthChoice)**
Acute Rehabilitation (Inpatient)	MCG	MCG	MCG	MCG
Ambulance Services	MCP	NCD-LCD	MCG	MCP
Durable Medical Equipment (DME) and Supplies	1. MCP 2. MCG 3. NCD-LCD	NCD-LCD	1. MCP 2. MCG 3. NCD-LCD	1. MCP 2. MCG 3. NCD-LCD
Orthotics and Prosthetics	1. MCP 2. MCG 3. NCD-LCD	NCD-LCD	1. MCP 2. MCG 3. NCD-LCD	1. MCP 2. MCG 3. NCD-LCD
EPSDT Services	Not Applicable	Not Applicable	EPSDT *Excludes FAMIS	EPSDT[1]

1Federal EPSDT Medical Necessity Guidelines https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

2025 UM Approved Criteria Sets and Guidelines – *Continued from page 18*

Non-Behavioral Health (continued)

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**	**Medicare**	**VA Medicaid or FAMIS**	**Medicaid (MD HealthChoice)**
Home Health Services	MCG	NCD-LCD	MCG	MCG
Hospice (Inpatient/Outpatient)	MCG	1. NCD-LCD 2. MCG	MCG	MCG
Inpatient (Concurrent Review) Services	MCG	NCD-LCD	MCG	MCG
Neonatal Care	MCG	NCD-LCD	MCG	MCG
Outpatient Services	1. MCP 2. MCG	NCD-LCD	1. MCP 2. MCG	1. MCP 2. MCG
PT/OT/ST	1. MCP 2. MCG	1. NCD-LCD 2. MCP 3. MCG	1. MCP 2. MCG	1. MCP 2. MCG
Skilled Nursing Facility	MCG	CMS Chapter 8 Benefit Policy Manual	MCG *For VA FAMIS only*	Medicaid Transmittal #213
Transplant Services	National Transplant Network (NTN) Services Referral Guideline InterQual Criteria: Transplant and Hematology Oncology	National Transplant Network (NTN) Services Referral Guideline InterQual Criteria: Transplant and Hematology Oncology	National Transplant Network (NTN) Services Referral Guideline InterQual Criteria: Transplant and Hematology Oncology	National Transplant Network (NTN) Services Referral Guideline InterQual Criteria: Transplant and Hematology Oncologr

2025 UM Approved Criteria Sets and Guidelines – *Continued from page 19*

Behavioral Health

Note: Commercial and Exchange includes District of Columbia, MD, and VA 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)
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	MCG	ASAM	Not Applicable
Behavioral Health: Inpatient	MCG	MCG	MCG	Not Applicable
Behavioral Health: Outpatient ***Excludes SUD**	MCP MCG	MCG	MCG	Not Applicable
Behavioral Health: Partial Hospitalization *Excludes SUD	MCG	MCG	DMAS	Not Applicable
Behavioral Health: **Mental Health Services (MHS) Covered Services**	Not Applicable	Not Applicable	DMAS (see below for list of MHS services)	Not Applicable

2025 UM Approved Criteria Sets and Guidelines – *Continued from page 20*

MHS Covered Services – Virginia Medicaid and FAMIS
Mental Health Services (MHS)

Mental Health Servies (MHS)	Criteria, Services Auth(SA) or Registration
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 Service Auth
Intensive In-Home	DMAS Service Auth
Therapeutic Day Treatment for Children School Day	DMAS Service Auth
Therapeutic Day Treatment for Children After School	DMAS Service Auth
Therapeutic Day Treatment for Children Summer	DMAS Service Auth
Partial Hospital Program	DMAS Service Auth
Mental Health Skill Building Services	DMAS Service Auth
Psychosocial Rehab	DMAS Service Auth
Applied Behavior Analysis	DMAS Service Auth
Intensive Outpatient Program	DMAS Service Auth
Functional Family Therapy	DMAS Service Auth
Multisystemic Therapy	DMAS Service Auth

Addiction and Recovery Treatment Services (ARTS)	Criteria, Services Auth(SA) or Registration
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

2025 UM Approved Criteria Sets and Guidelines – *Continued from page 21*

Addiction and Recovery Treatment Services (ARTS)	Criteria, Services Auth(SA) or Registration
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

Key to Abbreviations:

- MCP/MCGTM: NICU and Neonatal Care Admission and Discharge (Revised MCG® Neonatal Intensive Care Unit Levels
- MCGTM – formerly called Milliman Care Guideline
- ASAM-American Society of Addiction Medicine
- IQ: InterQual® Criteria
- Mental Health Services (formerly CMHRS-Community Mental Health Rehabilitative Services) Criteria
- IOP: Intensive Outpatient Program
- IP: Inpatient
- 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

Sources:

1. Department of Medical Assistance Services (DMAS) criteria for Mental Health Services (MHS) formerly called as CMHRS- Community Mental Health Rehabilitative Services)
2. DMAS mandating use of ASAM criteria as of April 1, 2017 in concert with the implementation of ARTS benefits that were previously carved out
3. Federal EPSDT Medical Necessity Guidelines https://www.medicaid.gov/Medicaid-CHIP-Program-%20%20Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html
4. VA Medicaid Contract Medallion 4.0 and FAMIS

New/Emerging Technology and MCP Updates

New/Emerging Technology Review and Implementation

Kaiser Permanente, Mid-Atlantic States Region
2025 Summary of Emerging Medical and Surgical Treatment (New Technology) Report
Approved by Technology Review and Implementation Committee (TRIC): 06/10/2025
Approved by Regional Utilization Management Committee (RUMC): 06/18/2025
National New Technology Committee Summary

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.			
03/19/2025	Plasma Phosphorylated Tau 217 (p-tau217) for Patients Under Evaluation for Alzheimer's Dementia (AD)		X Do not recommend this for use in KPMAS without data documenting better clinical utility. Safety does not appear to be a significant concern.
03/19/2025	Antibacterial Envelopes for the Prevention of Cardiac Implantable Electronic Device (CIED) Related Infections		X There is low-certainty evidence on the effectiveness of antibacterial envelopes, versus no envelope, for the prevention of CIED related infections

New/Emerging Technology and MCP Updates – *Continued from page 23*

New and Updated Medical Coverage Policies

The following Kaiser Permanente Mid-Atlantic Medical Coverage Policies (MCPs) and Transplant Patient Selection Criteria were approved between **May 2025 to August 2025.**

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.

1. **Knee Scooter**
   Effective Date: 05/27/2025
   - References were updated

1. **Home O2 Therapy**
   Effective Date: 5/27/2025
   - References were updated

3. **Hyperbaric Oxygen**
   Effective Date: 05/27/2025
   - References were updated

4. **Transcutaneous Tibial Nerve Stimulator (TTNS)**
   Effective Date: 05/27/2025
   - References were updated

5. **Pluvicto**
   Effective Date: 05/27/2025
   - References were updated

6. **Aquablation**
   Effective Date: 05/27/2025
   - References were updated

7. **Osteogenic Stimulator**
   Effective Date: 05/27/2025
   - Section VI. Contraindications and Exclusion – Added
     - Active infections
       - Osteomyelitis
       - Overlying cellulitis
   - References were updated

New/Emerging Technologies and MCP Updates – *Continued from page 24*

8. Infertility Procedures and Services
Effective Date: 05/27/2025
- Section IV. Definition of Infertility
  - *"Polycystic ovary syndrome"* deleted as an example of infertility disease condition
- Section IV, A & B. Initial Referrals: Female & Male Factor Work-up – Updated
- Section V. Exclusions for Infertility Consultation - Added
- Section IX. Female Infertility Treatment – Updated
- Section XII. Definition
  - Definition of *"normal semen parameters"* - Updated
- Section XIII. Surrogacy - Added
- References were updated

9. Hyperhidrosis Treatment
Effective Date: 06/18/2025
- Policy title changed from *"Microwave Thermolysis with miraDry System for Axillary Hyperhidrosis"* to *"Hyperhidrosis Treatment*.
- Section II. Scope of Policy – Added
- Section IV. Palmar and Plantar Hyperhidrosis Treatment: Iontophoresis - Added
- References were updated

10. Cologuard
Effective Date: 06/18/2025
- Section IV. Benefit Coverage
  - Section D. Transplant patient exclusion - Added

11. Circumcision Initial Review and Revision
Effective Date: 06/18/2025
- Policy title changed from *"Circumcision Revision"* to *"Circumcision Initial Procedure or Revision"*
- References were updated

12. Pelvic Floor Rehabilitation
Effective Date: 06/18/2025
- Policy title changed from *"Pelvic Floor Rehabilitation for Myofascial Pelvic Pain"* to *"Pelvic Floor Rehabilitation"*
- References were updated

13. Varicose Vein Treatment
Effective Date: 06/18/2025
- References were updated

14. Dermal Fillers
Effective Date: 06/18/2025
- References were updated

New/Emerging Technologies and MCP Updates – *Continued from page 25*

15. External Insulin Pump and Supplies
Effective Date: 06/18/2025
- References were updated

16. Cochlear and Brain Stem Auditory Implant
Effective Date: 06/18/2025
- Grammatical correction without substantive change
- References were updated

17. Aquatic Therapy
Effective Date: 06/18/2025
- References were updated

18. Hospital Bed Therapy_NEW
Effective Date: 06/18/2025

19. PET-CT Oncology Use_NEW
Effective Date: 06/18/2025

20. PET-CT Non-Oncology Use_NEW
Effective Date: 06/18/2025

21. Nidra Therapy_NEW
Effective Date: 07/22/2025

New/Emerging Technologies and MCP Updates – *Continued from page 26*

22. Capsule Endoscopy
Effective Date: 07/22/2025
- Section II. Clinical Indication – Language Updated
    - B. Diagnosis of Suspected Crohn's Disease (Regional Enteritis)
        - One of the following test series outcomes
            - Upper GI with small bowel follow through does not reveal an obstruction – Added: *"or stricture (patients with a suspected fistula or stricture will need an UFI with small bowel follow through);"*
- References were updated

23. Laser Tx (PDL) of Vascular Lesions
Effective Date: 07/22/2025
- References were updated

24. Pediatric Feeding Therapy
Effective Date: 07/22/2025
- References were updated

25. Mastectomy External Prosthesis
Effective Date: 07/22/2025
- References were updated

26. Cardiac Rehabilitation
Effective Date: 07/22/2025
- References were updated

27. Breast Reduction and Gynecomastia Surgery
Effective Date: 07/22/2025
- Grammatical update
- References were updated

28. Breast Pump
Effective Date: 07/22/2025
- References were updated

29. Skin Substitute_NEW
Effective Date: 08/28/2025

30. Pharmacogenetic Testing
Effective Date: 08/28/2025
- Policy title changed from *"Pharmacogenetic Testing for Behavioral Health Disorders"* to *"Pharmacogenetic Testing"*
- Section II, A-D. Coverage/Exclusion - Updated

New/Emerging Technologies and MCP Updates – *Continued from page 27*

31. Bariatric Surgery

Effective Date: 08/28/2025

- Title of policy changed from *"Bariatric Surgery, Adolescents and Adults"* to *"Bariatric Surgery and Endobariatric Procedures, Adolescents and Adults"*
- *"Endobariatric procedure"* added to bariatric surgery as referred procedure throughout the policy
- Section VII, C. Contraindication: High surgical risks including HbA1C edited from *"> 9%"* to *"> 8% or per bariatric surgeon's discretion*
- Section VIII, B. Therapeutic measures to complete prior to referral for initial bariatric surgery or endobariatric procedures – Adult bariatric surgery candidates
    - #1 Requirement edited to watch from "3" to "2" EMMI videos
        - Deleted: *"Bariatric Informed Decision Making"*
        - Added: Endobariatric procedure candidates are exempt from watching EMMI videos as a requirement
    - #3 Added: Bariatric gastroenterologist in addition to bariatric surgeon as medical specialist, to evaluate and approve patients who are a suitable candidate to participate in bariatric surgery or endobariatric procedure program
- Section XI, E-G. Added: endoscopic bariatric methods for weight loss
- References were updated

32. Hypoglossal Nerve Stimulator

Effective Date: 08/28/2025

- Section III, A. Clinical Indications for Referral
    - #5, a & b. Definition of "PAP failure," "PAP machine-derived compliance," and "PAP intolerance" - Updated
- Section III, B. Documentation
    - #4. Required sleep study result edited from *"12"* to *"24"* months
- Section IV, A. – *"Limitations"* replaced with *"Exclusions"*
- Section IV, B #1. Contraindication: BMI of *"40 kgm^2 or >"* edited to *"35 kg/m^2"*
- References were updated

33. Space OAR

Effective Date: 08/28/2025

- Title of policy changed from *"Spaced OAR"* to *"Trans-Perineal Placement of Absorbable Peri-Rectal Spacer (SpaceOAR) for Prostate Cancer Radiotherapy"*
- Section III. Description of Procedure - Updated
- References were updated

34. Benign Skin Lesion Treatment

Effective Date: 08/28/2025

- References were updated

35. Orthosis, Spinal

Effective Date: 08/28/2025

- References were updated

New/Emerging Technologies and MCP Updates – *Continued from page 28*

36. ASD Evaluation
Effective Date: 08/28/2025
- References were updated

37. High Frequency Flutter Valve
Effective Date: 08/28/2025
- References were updated

38. Purewick
Effective Date: 08/28/2025
- References were updated

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

MCPs can be accessed through the **KP Clinical Library** by using the web link below:
https://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

2025 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.

2025 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: Prospective Review (Prior Authorization) Referral Management, Concurrent Review, Continuing Care, Transitions Care, and Case Management. 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 (KP-MAS) 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.

2025 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 following table 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.

2025 UM Accessibility, Communication and Hours of Operations – *Continued from page 32*

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

2025 UM Accessibility, Communication and Hours of Operations – *Continued from page 33*

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	Provides a comprehensive approach to care coordination throughout the care continuum by providing assistance to members, caregivers, and specialty care teams, to provide the best care coordination to ensure our high-risk, most vulnerable members receive the assistance necessary to achieve their optimal health.

2025 UM Accessibility, Communication and Hours of Operations – *Continued from page 34*

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

2025 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 disease conditions. 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 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, 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 there is sufficient evidence to establish that the new/emerging technology is 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 37*

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 38*

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.

Board Certification Policy

All Kaiser Permanente providers and contracted providers who work for us are required to obtain a board certification (if applicable) 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
- American Association of Critical Care Nurses
- (AACN)
- American Speech-Language-Hearing Association
- Behavioral Analyst Certification Board (BACB)
- National Certification Commission for Acupuncture and Oriental Medicine

Kaiser Permanente providers must obtain and maintain board certification in a recognized specialty throughout the life of their contract or employment with Kaiser Permanente. Physicians and podiatrists who fail to obtain board certification within five years of completion of training will be terminated 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. (Hourly/pool Kaiser Permanente physicians are not granted a grace period.) 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 40*

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:

Email: ppqa-mas@kp.org

Fax: 855-414-2630

Mail:

Kaiser Permanente
Practitioner and Provider Quality Assurance (PPQA)
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 44*

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 45*

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 46*

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 48*

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.

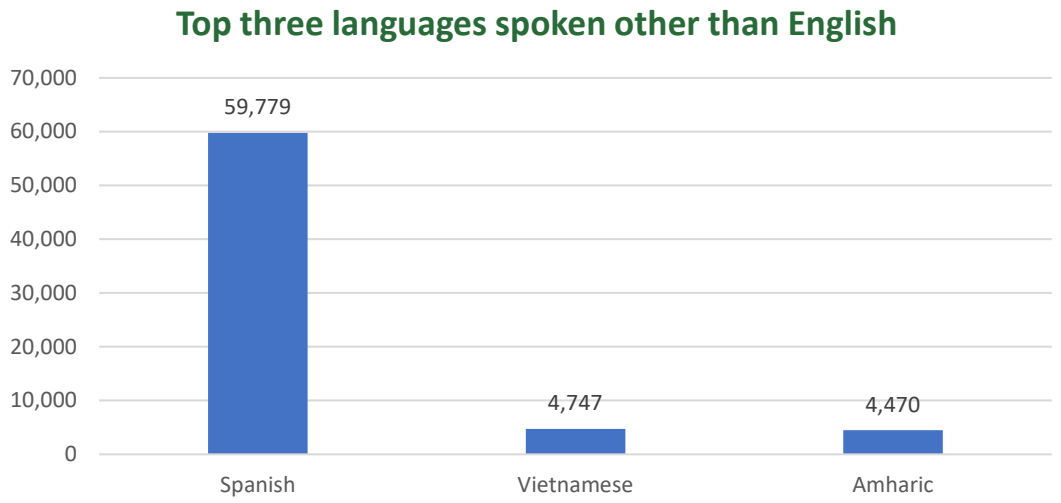
CLAS Standards – *Continued from page 50*

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, 2024 – December 31, 2024. 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 52*

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 Kaiser Permanente 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:

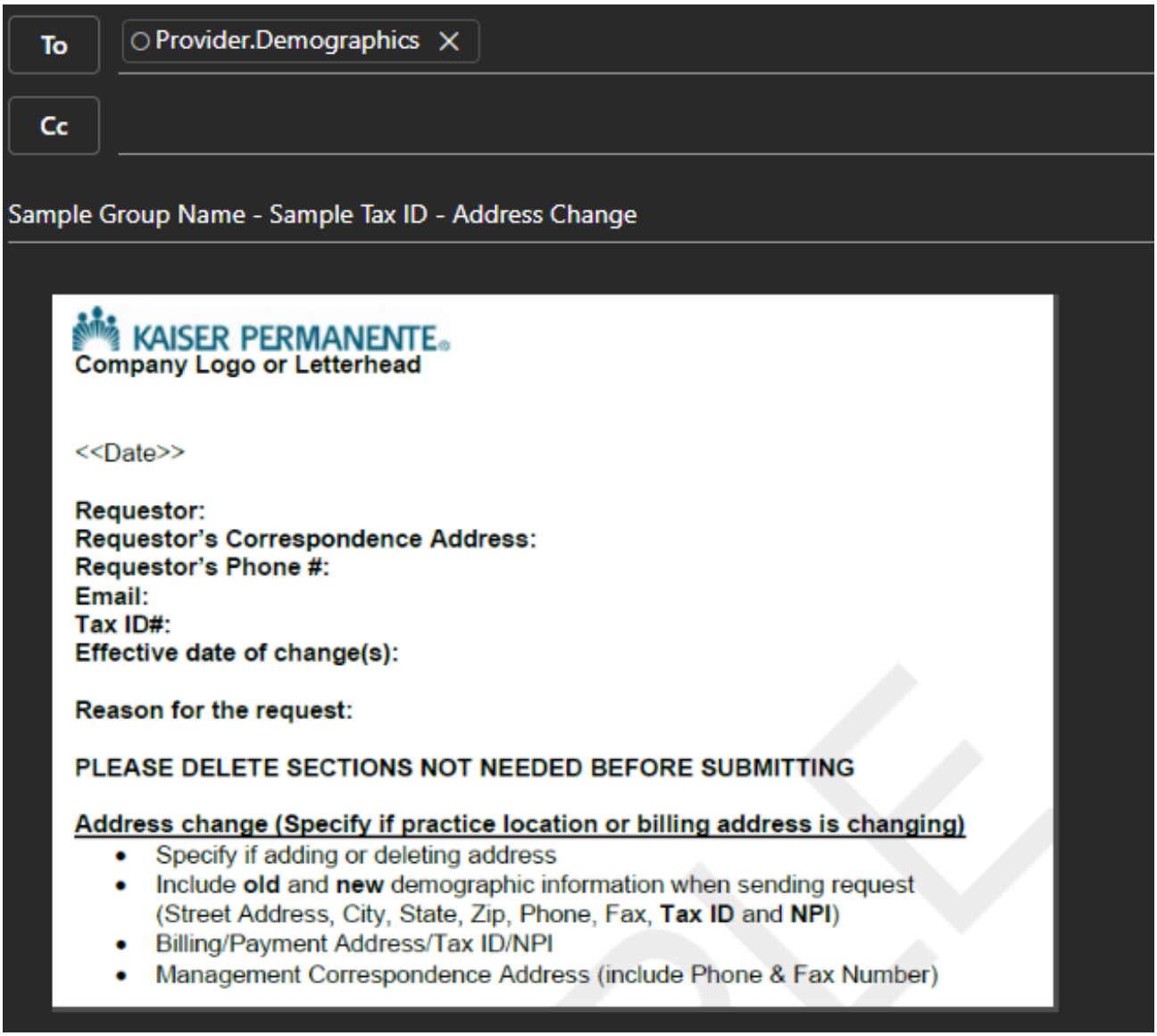
Fax: 855-414-2623
Email: Provider.Demographics@kp.org
Mail: Kaiser Permanente
Provider Experience
4000 Garden City Drive
Hyattsville, MD 20785

Email Template for Provider Requests

Our team remains committed to serving providers and the members they care for. To ensure that we can address requests promptly, we kindly ask that providers follow the guidelines below when emailing Provider.Relations@kp.org or Provider.Demographics@kp.org:

Please use the following format in the subject line of your emails:
Group Name - Tax ID - Type of Request (Termination/Add/Change/Update/etc.)

Include the details for your request in the body of your email. See the example below:



Thank you for your cooperation and for continuing to provide excellent care to our members.

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.
Provider Experience
4000 Garden City Drive
Hyattsville, MD 20785