

Kaiser Permanente Maryland HealthChoice Participating Provider Manual

Introduction to the Provider Manual

Maryland HealthChoice is Maryland's Medicaid managed care program. Overseen by the Maryland Department of Health and Mental Hygiene (DHMH), the Maryland HealthChoice program serves over 1 million individuals. These individuals are enrolled in one of the participating managed care organizations (MCOs). Each MCO has policies and procedures that providers who deliver services to recipients must adhere to. Any questions a provider has about the policies of individual MCOs should be addressed by the provider information supplied by the MCO they participate in.

While each Maryland HealthChoice MCO has its own policies and procedures, many program elements apply to all providers, regardless of the MCO. The purpose of this manual is to explain those elements and be a useful reference for providers who participate in the Maryland HealthChoice program. The manual is divided into six sections:

Section I - General Information. This section provides general descriptive information on the Maryland HealthChoice program including, but not limited to, program eligibility, MCO reimbursement policies, continuity of care and transportation.

Section II - Provider Responsibilities. This section discusses expectations of all providers, regardless of MCO affiliation.

Section III - Maryland HealthChoice Benefits and Services. This section provides a listing of the benefits that are and are not the responsibility of all MCOs that participate in Maryland HealthChoice. This section briefly outlines some of the optional benefits that Kaiser Permanente may provide. This section also identifies benefit limitations and services that are not the responsibility of Kaiser Permanente.

Section IV - Specialty Mental Health Services. Individuals eligible for the Maryland HealthChoice program who are receiving specialty mental health services may receive some or all of their services outside of Kaiser Permanente's Participating Provider Network. This section details the services.

Section V - Rare and Expensive Case Management (REM). Members with certain diagnoses may disenroll from Kaiser Permanente and receive their services through the REM program. This section details the REM program.

Section VI - DHMH Quality Improvement Program and MCO Oversight Activities. DHMH conducts numerous quality improvement activities for the Maryland HealthChoice program. This section reviews DHMH's quality improvement activities. These activities are separate from quality improvement activities that Kaiser Permanente may engage in.

Maryland HealthChoice Provider Manual

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Section I

GENERAL INFORMATION HEALTHCHOICE PROGRAM

THE MARYLAND HEALTHCHOICE PROGRAM

Maryland HealthChoice is Maryland's Medicaid managed care program. Almost three-quarters of the Medicaid population and the Maryland Children's Health Program (MCHP) are enrolled in this Program. The Maryland HealthChoice Program's philosophy is based on providing quality cost-effective and accessible health care that is patient-focused.

MARYLAND HEALTHCHOICE ELIGIBILITY

All individuals qualifying for Maryland Medical Assistance or MCHP are enrolled in the Maryland HealthChoice Program, except for the following categories:

- Individuals who receive Medicare;
- Individuals age 65 or over;
- Individuals who are eligible for Medicaid under spend down;
- Medicaid recipients who have been or are expected to be continuously institutionalized for; more than 30 successive days in a long term care facility or in an institution for mental; disease (IMD);
- Individuals institutionalized in an intermediate care facility for intellectually disabled persons (ICF-MR);
- Recipients enrolled in the Model Waiver;
- Recipients who receive limited coverage, such as women who receive family planning; services through the Family Planning Waiver or Employed Individuals with Disabilities Program;
- Inmates of public institutions, including a State operated institution or facility;
- A child receiving adoption subsidy who is covered under the parent's private insurance;
- A child under State supervision receiving adoption subsidy who lives outside of the State; or
- A child who is in an out-of-State placement.

All Medicaid recipients who are eligible for the Maryland HealthChoice Program, without exception, will be enrolled in an MCO or in the Rare and Expensive Case Management Program (REM). The REM program is discussed in detail in Section V.

Medicaid-eligible individuals who are not eligible for Maryland HealthChoice will continue to receive services in the Medicaid fee-for-service system.

PROVIDER REIMBURSEMENT

Payment for covered services is made in accordance with your Participating Provider Agreement **with** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Inc., and/or the Mid-Atlantic Permanente Medical Group, P.C. In accordance with the Maryland Annotated Code, Health General Article 15-1005, we must mail or transmit payment to our providers eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, we shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. We shall pay interest on the amount of the clean claim that remains unpaid 30

days after the claim is filed. You must verify through the Eligibility Verification System (EVS) that recipients are assigned to Kaiser Permanente before rendering services.

Reimbursement for Maryland hospitals and other applicable provider sites will be in accordance with Health Services Cost Review Commission (HSCRC) rates.

Kaiser Permanente is not responsible for payment of any remaining days of a hospital admission that began prior to a Medicaid recipient's enrollment in our MCO. We are however, responsible for reimbursement to providers for professional services rendered during the remaining days of the admission.

MEDICAL RECORD DOCUMENTATION

Participating Providers are responsible for maintaining the full medical records of members who elect to receive health services at their offices. Kaiser Permanente has developed specific criteria for maintaining medical records for members. These standards are evaluated and are part of the periodic review conducted within our Participating Provider offices. The standards for medical record-keeping practices and the documentation requirements for medical charts are as follows:

Standards for Medical Record- Keeping Practices

- Medical records are maintained in a confidential manner, maintained in a secure location and out of public view
- The medical record shall be safeguarded against unauthorized use, damage, loss, tampering, and alteration
- Each patient has an individual medical record. Individual medical records can be easily retrieved from files.
- Each page is identified with name of patient and birth date, or medical record number
- The medical record of a patient is confidential communication between the health care provider and the patient and shall not be released without appropriate authorization.
- Federal and state statutes require that when correcting the inaccuracy of a medical record entry, information shall not be eradicated or removed.

Documentation Standards for Medical Records for Medical Charts:

- Clearly identifiable member information on each page:
 - Name
 - Date of birth/age
 - Sex
 - Medical record number
 - Physician name
 - Physician identification number
- All progress notes will:
 - Be dated (including the year)
 - Clearly identify the provider

- Include appropriate signatures and credentials
- Patient biographical/personal data are present
- Notes are legible
- Patient's chief complaint or purpose for visit is clearly documented by the physician.
- Working diagnoses are consistent with findings
- There is clear documentation of the medical treatment received by the patient
- Plans of action and treatment are consistent with diagnosis
- Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate.
- Unresolved problems from previous visit are addressed
- There is evidence of continuity and coordination of care between primary and specialty physicians
- Consultant summaries, laboratory, and imaging study results reflect ordering physician review as evidenced by:
 - Initials of the referring PCP following review
 - Recorded date of review
 - Comments recorded in progress note regarding interpretation and findings
 - Indication of treatment notice to patient
- Allergies and adverse reactions to medications are prominently displayed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- There is documentation of past medical history as it regards diagnoses of permanent or serious significance, and past surgeries or significant procedures. Pediatric patients will have similar documentation and/or prenatal and birth information.
- If a consultation is requested, there is a note from the consultant in the record
- Significant illnesses and medical conditions are indicated on the problem list
- There is a notation concerning use/non-use of cigarettes, alcohol, and substance abuse for patients 12 years of age and over.
- The history and physical document examination results with appropriate subjective and objective information for presenting complaints
- There is evidence that preventive screening and services are offered in accordance with Kaiser Permanente's practice guidelines
- The care appears to be medically appropriate
- There is a completed immunization record for patients 18 years of age and under.
- An updated problem list is maintained.
- An updated medication list is maintained.

SELF-REFERRED AND EMERGENCY SERVICES

Kaiser Permanente will reimburse out-of-plan providers for the following services:

- Emergency services provided in a hospital emergency facility;
- Family planning services except sterilizations;
- School-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP who will be responsible for filing the form in the child's medical record. A school based health center reporting form can be found in Section VI;
- Pregnancy-related services when a member has begun receiving services from an out-of-plan provider prior to enrolling in an MCO;
- Initial medical examination for children in state custody;
- Annual Diagnostic and Evaluation services for recipients with HIV/AIDS;
- Renal dialysis provided at a Medicare-certified facility;
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge;
- An initial assessment for substance abuse;
- Substance abuse services such as individual and group counseling, detoxification inpatient care when provided by an ADAA certified provider and ASAM criteria is met; and
- Services performed at a birthing center, including an out-of-state center located in a contiguous state.

Self-REFERRED Services for Children with Special Healthcare Needs

Children with special healthcare needs may self-refer to providers outside of Kaiser Permanente's Participating Provider Network under certain conditions. Self-referral for children with special needs is intended to insure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in Kaiser Permanente. Medical services directly related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- **New Member:** A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment into Kaiser Permanente and we approve the services as medically necessary.
- **Established Member:** A child who is already enrolled in Kaiser Permanente when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We are obliged to grant the member's request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

If we deny, reduce, or terminate the services, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, we may reimburse for services provided.

PRIMARY CARE PROVIDER (PCP) CONTRACT TERMINATIONS

If you are a PCP and we terminate your contract for any of the following reasons, the members assigned to you may elect to change to another MCO in which you participate by calling the Enrollment Broker within 90 days of the contract termination:

- For reasons other than the quality of care or your failure to comply with contractual requirements related to quality assurance activities; or
- Kaiser Permanente's reduction of your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to Kaiser Permanente by the Department, and Kaiser Permanente and you are unable to negotiate a mutually acceptable rate.

CONTINUITY OF CARE

As part of the Maryland HealthChoice Program design, we are responsible for providing ongoing treatments and patient care to new recipients until an initial evaluation is completed and we develop a new plan of care.

The following steps are to be taken to ensure that members continue to receive necessary health services at the time of enrollment into Kaiser Permanente:

- Appropriate service referrals to specialty care providers are to be provided in a timely manner.
- Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those that the member was receiving upon enrollment into Kaiser Permanente are to be continued during this transition period.
- If, after the member receives a comprehensive assessment, we determine that a reduction in or termination of services is warranted, we will notify the recipient of this change at least 10 days before it is implemented. This notification will tell the member that he/she has the right to formally appeal to the MCO or to the Department by calling the MCO or the Member Help Line at 1-800-284-4510. In addition, the notice will explain that if the member files an appeal within ten days of our notification, and requests to continue receiving the services, then we will continue to provide these services until the appeal is resolved. You will receive a copy of this notification.

SPECIALTY REFERRALS

- We will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits as required by COMAR 10.09.66 and 10.09.67.
- If a specialty provider cannot be identified, contact Kaiser Permanente Provider Relations at 1-877-806-7470 or the Provider Hotline (800-766-8692) for assistance.

TRANSPORTATION

You may contact the Local Health Department (LHD) to assist members in accessing non-emergency transportation services. Kaiser Permanente will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD.

We will provide non-emergency transportation necessary for our members to access a covered service if we choose to provide the service at a location that is outside of the closest county (or Baltimore City) in which the service is available.

Section II

PROVIDER RESPONSIBILITIES

REPORTING COMMUNICABLE DISEASE

You must ensure that all cases of reportable communicable disease that are detected or suspected in a member by either a clinician or a laboratory are reported to the LHD as required by Health - General Article, 18-201 to 18-216, Annotated Code of Maryland and COMAR 10.06.01 Communicable Diseases.

Any health care provider with reason to suspect that a member has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the provider cares for the member.

- The provider report must identify the disease or suspected disease and demographics on the member including the name, age, race, sex, address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH1140) as directed by COMAR 10.06.01.
- With respect to patients with tuberculosis, you must:
 - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours.
 - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by DHMH.

Other Reportable Diseases and Conditions

- A single case of a disease of known or unknown etiology that may be a danger to the public health, as well as unusual manifestation(s) of a communicable disease, are reportable to the local health department.
- An outbreak of a disease of known or unknown etiology that may be a danger to the public health is reportable immediately by telephone.

Reportable Communicable Diseases - Laboratory Providers

Providers of laboratory services must report positive laboratory results as directed by Health - General Article 18-205, Annotated Code of Maryland.

In order to be in compliance with the Maryland HIV/AIDS reporting Act of 2007, Laboratory providers must report HIV positive members and all CD4 test results to the Health Department by using the member's name. The State of Maryland HIV/CD4 Laboratory Report Form DHMH 4492 must be used. The reporting law and the revised reporting forms may be found at the following website:

[Http://mmcp.dhmh.maryland.gov/ehr/sitepages/laboratory-reporting.aspx](http://mmcp.dhmh.maryland.gov/ehr/sitepages/laboratory-reporting.aspx)

Laboratories that perform mycobacteriology services located within Maryland, must report all positive findings to the Health Officer of the jurisdiction in which the laboratory is located. For out-of-state laboratories licensed in Maryland and performing tests on specimens from Maryland, the laboratory may report to the Health Officer of the county of residence of the patient or to the Maryland DHMH, Division of Tuberculosis Control within 48 hours by telephone (410) 767-6698 or fax (410) 669-4215.

We cooperate with LHDs in investigations and control measures for communicable diseases and outbreaks.

Following is a list of reportable communicable diseases:

- Amebiasis
- Anaplasmosis
- Animal bites
- Anthrax
- Arboviral infections
- Babesiosis
- Botulism
- Brucellosis
- Campylobacter infection
- Chancroid
- Chlamydia infection
- Cholera
- Coccidioidomycosis
- Creutzfeldt-Jakob disease
- Cryptosporidiosis
- Cyclosporiasis
- Dengue fever
- Diphtheria
- Ehrlichiosis
- Encephalitis
- Epsilon toxin of Clostridium perfringens
- Escherichia coli O157:H7 infection
- Giardiasis
- Glanders
- Gonococcal infection
- Haemophilus influenzae, invasive disease
- Hantavirus infection
- Harmful algal bloom related illness
- Hemolytic uremic syndrome, post-diarrheal
- Hepatitis, Viral (A, B, C, Delta, non-ABC, E, F, G, undetermined)
- Influenza-associated pediatric mortality
- Isosporiasis
- Kawasaki syndrome
- Legionellosis
- LaCrosse virus infection
- Leprosy
- Leptospirosis
- Listeriosis
- Lyme disease
- Malaria
- Measles (rubeola)
- Melioidosis
- Meningitis, infectious
- Meningococcal invasive disease
- Microsporidiosis
- Mumps (infectious parotitis)
- Mycobacteriosis, other than tuberculosis and leprosy
- Novel influenza A virus infection
- Pertussis
- Pesticide related illness
- Pertussis vaccine adverse reactions
- Plague
- Pneumonia in a healthcare worker resulting in hospitalization
- Poliomyelitis
- Psittacosis
- Q Fever
- Rabies
- Ricin toxin
- Rocky Mountain spotted fever
- Rubella (German measles) and congenital Rubella syndrome

- Salmonellosis (non-typhoid fever types)
- Septicemia in newborns
- Severe acute respiratory syndrome (SARS)
- Shiga-like toxin producing enteric bacterial infections
- Shigellosis
- Smallpox and other Orthopoxvirus infections
- Staphylococcal enterotoxin B
- Streptococcal invasive disease, Group A
- Streptococcal invasive disease, Group B
- Streptococcus pneumoniae, invasive disease
- Syphilis
- Tetanus
- Trichinosis
- Tuberculosis and suspected tuberculosis
- Tularemia
- Typhoid fever (case or carrier, or both, of Salmonella typhi)
- Vancomycin-intermed Staph Aureus (VISA)
- Vancomycin-resistant Staph (VRSA)
- Varicella (chickenpox), fatal cases only
- Vibriosis, non-cholera types
- Viral hemorrhagic fever (all types)
- Yellow fever
- Yersiniosis

APPOINTMENT SCHEDULING AND OUTREACH REQUIREMENTS

In order to ensure that Maryland HealthChoice members have every opportunity to access needed health related services, as specified under COMAR 10.09.66, PCPs must develop collaborative relationships with the following entities to bring members into care:

- Kaiser Permanente;
- Specialty care providers;
- The Administrative Care Coordination Units (ACCU) at the LHD; and
- DHMH Provider Hotline staff as needed.

We will, before referring an adult member to the local health department, make documented attempts to ensure that follow-up appointments are scheduled in accordance with the member's treatment plan by attempting a variety of contact methods, which may include written correspondence, telephone contact and face-to-face contact.

Prior to any appointment for a Maryland HealthChoice recipient you must call EVS at 1-866-710-1447 to verify recipient eligibility and MCO enrollment. This procedure will assist in ensuring payment for services.

The Centers for Medicare and Medicaid Services (CMS), prohibits providers from billing Medicaid recipients for missed appointments. See Transmittal #52 dated April 14, 2004.

Initial Health Appointment for Maryland HealthChoice Members

Maryland HealthChoice members must be scheduled for an initial health appointment within 90 days of enrollment, unless one of the following exceptions applies:

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to two years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.
- For pregnant and post-partum women who have not started to receive care, the initial health visit must be scheduled and the women seen within 10 days of a request.
- As part of the enrollment process the State conducts a Health Risk Assessment (HRA) and screens each Maryland HealthChoice recipient for conditions requiring expedited intervention by providers. Maryland HealthChoice recipients who screen positive must be seen for their initial health visit within 15 days of Kaiser Permanente's receipt of the completed HRA.

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age appropriate physical exam.

In addition, at the initial health visit, initial prenatal visit, or when physical status, behavior of the member, or laboratory findings indicate possible substance abuse, you are to perform a substance abuse screening using approved Substance Abuse and Mental Health Services Administration (SAMSA) screening instrument and appropriate for the age of the member.

SERVICES FOR CHILDREN

For children younger than 21 years old, we shall assign the member to a PCP who is certified by the EPSDT Program, unless the member or member's parent, guardian, or care taker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified. In this case the non-EPSDT provider is responsible for ensuring that the child receives well childcare according to the EPSDT schedule.

Wellness Services for Children Under 21 Years

Providers shall refer children for specialty care as appropriate. This includes:

- Making a specialty referral when a child is identified as being at risk of a developmental delay by the developmental screen required by EPSDT; is experiencing a delay of 25% or more in any developmental area as measured by appropriate diagnostic instruments and procedures; is manifesting atypical development or behavior; or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; and
- Immediately referring any child thought to have been abused physically, mentally, or sexually to a specialist who is able to make that determination.

You are to follow the rules of the Maryland Healthy Kids Program to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The Program requires you to:

- Notify members of their due dates for wellness services and immunizations.
- Schedule and provide preventive health services according to the State's EPSDT Periodicity Schedule and Screening Manual.
- Refer infants and children under age 5 and pregnant women to the Supplemental Nutritional Program for Women Infants and Children (WIC). Provide the WIC Program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.
- Participate in the Vaccines For Children (VFC) Program. Many of the routine childhood immunizations are furnished under the VFC Program. The VFC Program provides free vaccines for health care providers who participate in the VFC Program. When new vaccines are approved by the Food and Drug Administration, the VFC Program is not obligated to make the vaccine available to VFC providers. Therefore, under the Maryland HealthChoice formulary requirement (COMAR 10.09.67.04D (3)), we will pay for new vaccines that are not yet available through the VFC.

Members under age 21 are eligible for a wider range of services under EPSDT than the adult population. PCPs are responsible for understanding these expanded services (see Section III Benefits) so that appropriate referrals are made for services that prevent, treat, or ameliorate physical, mental or developmental problems or conditions.

Appointments must be scheduled at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.

Healthy Kids (EPSDT) Outreach and Referral to LHD

For each scheduled Healthy Kids appointment, written notice of the appointment date and time must be sent by mail to the child's parent, guardian, or caretaker, and attempts must be made to notify the child's parent, guardian, or caretaker of the appointment date and time by telephone.

For children from birth through 2 years of age who miss EPSDT appointments and for children under age 21 who are determined to have parents, care givers or guardians who are difficult to reach, or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care:

- Document outreach efforts in the medical record. These efforts should include attempts to notify the member by mail, by telephone, and through face-to-face contact.
- Notify our case management unit at (301) 321-5126 or toll free at (866) 223-2347 for assistance with outreach as defined in the Provider Agreement.
- Schedule a second appointment within 30 days of the first missed appointment. Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian, or caretaker by making a referral to the ACCU of the LHD. Use the Local Health Services form (see www.mmcp.dhmh.maryland.gov)

- After referring to the ACCU, work collaboratively with the ACCU and Kaiser Permanente to bring the child into care. This collaborative effort will continue until the child complies with the EPSDT periodicity schedule or receives appropriate follow-up care.

SPECIAL NEEDS POPULATIONS

The State has identified certain groups as requiring special clinical and support services from their MCO. These special needs populations are:

- Pregnant and postpartum women
- Children with special health care needs
- Individuals with HIV/AIDS
- Individuals with a physical disability
- Individuals with a developmental disability
- Individuals who are homeless
- Individuals with a need for substance use disorder
- Children in State-supervised care

Services Every Special Needs Population Receives

In general, to provide care to a special needs population, it is important for the PCP and Specialist to:

- Demonstrate their credentials and experience to us in treating special populations.
- Collaborate with our case management staff on issues pertaining to the care of a special needs member.
- Document the plan of care and care modalities and update the plan annually.

Individuals in one or more of these special needs populations must receive services in the following manner from us and/or our providers:

- Upon the request of the recipient or the PCP, a case manager trained as a nurse or a social worker will be assigned to the recipient. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care, but will help keep track of the health care services the member receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. PCPs should follow the referral protocols established by us for sending Maryland HealthChoice members to specialty care networks.
- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals.

- All of our providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations promulgated under it).

Special Needs Population - Outreach and Referral to the LHD

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care may be referred to the local health department for specific outreach efforts, according to the process described below.

If the PCP or specialist finds that a member continues to miss appointments, Kaiser Permanente must be informed. We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the local health department in the jurisdiction where the member lives.

Within 10 days of either the third consecutive missed appointment, or you becoming aware of the patient's repeated non-compliance with a regimen of care, whichever occurs first, you should make, a written referral to the LHD ACCU using the Local Health Services Request Form (See www.dhmh.state.md.us/mma/LHS/index). The ACCU will assist in locating and contacting the member for the purpose of encouraging them to seek care. After referral to the ACCU, Kaiser Permanente and our Participating Providers will work collaboratively with the ACCU to bring the member into care.

Services for Pregnant and Post-Partum Women

Kaiser Permanente and our providers are responsible for providing pregnancy-related services, which include:

- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form;
- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care);
- Development of an individualized plan of care, which is based upon the risk assessment and is modified during the course of care if needed;
- Case management services;
- Prenatal and postpartum counseling and education;
- Basic nutritional education;
- Special substance abuse treatment including access to treatment within 24-hours of request and intensive outpatient programs that allow for children to accompany their mother;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women;
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers;
- Post-partum home visits; and
- Referral to the ACCU.

The PCP, OB/GYN and **Kaiser Permanente** are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC) and the LHD's ACCU. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

Pregnancy-related service providers will follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times.

You must:

- Schedule prenatal appointments in a manner consistent with the ACOG guidelines.
- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-DHMH 4850 (sample attached) for each pregnant member and submit it to the LHD in the jurisdiction in which the member lives within 10 days of the initial visit.
- For pregnant members under the age of 21, refer them to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days for members who miss prenatal appointments.
- Refer to the WIC Program.
- Refer pregnant and postpartum members who are substance abusers for appropriate substance abuse assessments and treatment services.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- Instruct pregnant member to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit.
- Instruct the pregnant member to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant member's choice of pediatric provider in the medical record.
- Advise pregnant member that she should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns", DHMH 1184 and get the newborn enrolled in Maryland HealthChoice.

MARYLAND PRENATAL RISK ASSESSMENT

REFER TO INSTRUCTIONS ON BACK BEFORE STARTING

Today's Date: ___/___/___ NPI#-10 digits: _____

DEMOGRAPHIC INFORMATION

Provider Name: _____ Provider Phone Number: _____ - _____ - _____

Client Last Name: _____ First Name: _____ Middle: _____

House Number: _____ Street Name: _____ Apt: _____ City: _____

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

Home Phone#: _____ - _____ - _____ Cell Phone#: _____ - _____ - _____ Emergency Phone#: _____ - _____ - _____

SSN: _____ - _____ - _____ DOB: ___/___/___ Name & Relationship of Emergency Contact: _____

Race:
 African American or Black
 Alaskan Native American Native
 Asian More than 1 Race
 Native Hawaiian or other Pacific Islander
 Unknown White

Language Barrier? Yes ___ No ___
Specify Primary Language _____
Hispanic? Yes ___ No ___
Marital Status: Married ___ Unmarried ___
 Unknown ___

Payment Status (Mark all that apply):
 Private Insurance, Specify: _____
 MA/Health Choice
 MA #: _____
 Name of MCO (if applicable): _____
 Applied for MA Specify Date: ___/___/___
 Uninsured
 Unknown

Educational Level:
 Highest grade completed: _____
 Currently in school? Yes ___ No ___
 GED? Yes ___ No ___

ASSESSMENT INFORMATION

Date of initial prenatal visit: ___/___/___

Transferred from other source of prenatal care? Yes ___ No ___
 If YES, date care began: ___/___/___

Other source of prenatal care: _____

Trimester of 1st prenatal visit: ___ 1st ___ 2nd ___ 3rd

LMP: ___/___/___ Initial EDC: ___/___/___

OB History:
Complete all that apply **Check all that apply**

<input type="checkbox"/> # Full-term live births	<input type="checkbox"/> History of pre-term labor
<input type="checkbox"/> # Pre-term live births	<input type="checkbox"/> History of fetal death (> 20 wks)
<input type="checkbox"/> # Prior LBW births	<input type="checkbox"/> History of infant death w/in 1 yr of age
<input type="checkbox"/> # Spontaneous abortions	<input type="checkbox"/> History of multiple gestation
<input type="checkbox"/> # Therapeutic abortions	<input type="checkbox"/> History of infertility treatment
<input type="checkbox"/> # Ectopic pregnancies	<input type="checkbox"/> First Pregnancy
<input type="checkbox"/> # Children now living	

Psychosocial Risks: Check all that apply.

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

COMMENTS ON PSYCHOSOCIAL RISKS:

Medical Risks: Check all that apply.
Current Medical Conditions of this Pregnancy:

Age ≤ 15
 Age ≥ 45
 BMI < 18.5 or BMI > 30
 Hypertension (> 140/90)
 Anemia (Hgb < 10 or Hct < 30)
 Asthma
 Sickle cell disease
 Diabetes: Insulin dependent ___ Yes ___ No
 Vaginal bleeding (after 12 weeks)
 Genetic risk: specify _____
 Sexually transmitted disease, Specify _____
 Last dental visit over 1 year ago
 Prescription drugs, Specify _____
 History of depression/mental illness, Specify _____
 Depression assessment completed? ___ Yes ___ No
 Other medical risk (specify in comments box)
 None of the above

COMMENTS ON MEDICAL RISKS:

Form Completed By: _____
 Date Form Completed: ___/___/___
 DHMH 4850 revised 05/28/09

DO NOT WRITE IN THIS SPACE

9005

Maryland Prenatal Risk Assessment Form Instructions

Purpose of Form: Identifies pregnant woman who may benefit from local health department **Administrative Care Coordination (ACCU)** services and serves as the referral mechanism. ACCU services complement medical care and may be provided by public health nurses and social workers through the local health departments. Services may include resource linkage, psychosocial/environmental assessment, reinforcement of the medical plan of care, and other related services.

Form Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for ALL pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

- Print clearly; use black pen for all sections.
- Press firmly to imprint.
- White-out previous entries on original completely to make corrections.
- If client does not have a social security number, indicate zeroes.
- Indicate the person completing the form.
- Review for completeness and accuracy.

Faxing and Handling Instructions:

- Do not fold, bend, or staple forms. ONLY PUNCH HOLES AT TOP OF FORM IF NECESSARY
- Store forms in a dry area.
- Fax the MPRAF to the local health department in the client's county of residence.
- To reorder forms call the local ACCU.

Definitions (selected): Data may come from self-report, medical records, provider observation or other sources.

RISK	DEFINITION OF RISK
Alcohol use	is a "risk-drinker" as determined by a screening tool such as MAST, CAGE, TACE or 4Ps
Current history of abuse/violence	Includes physical, psychological abuse or violence within the client's environment within the past six months.
Exposure to long-term stress	for example: partner-related, financial, safety, emotional
Genetic risk	at risk for a genetic or hereditary condition
Illegal Substances	used illegal substances within the past 6 months (e.g. cocaine, heroin, marijuana, PCP) or is taking methadone/buprenorphine
Lack of social/emotional support	absence of support from family/friends, isolated
Language barrier	in need of interpreter, e.g. Non-English speaking, auditory processing disability, deaf
Oral hygiene	Last dental visit over 1 year ago
Preterm live birth	history of preterm labor (prior to the 37th gestational week)
Prior LBW birth	low birth weight birth (under 2,500 grams)
Sickle cell disease	documented by medical records
Tobacco use	used any type of tobacco products within the past 6 months

rev 05/09

Client's Local Health Department Addresses

Mailing Address	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 1 Harry S. Truman Parkway, Ste 200 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore HealthCare Access 201 E. Baltimore St, Ste. 1000 Baltimore, Maryland 21202	410-649-0526 Fax: 1-888-657-8712
Baltimore County ACCU 8501 LaSalle Rd., Ste. 103 Towson, MD 21286	410-887-8741 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomons Island Rd, P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7th St., P.O. Box 10 Denton, MD 21629	410-479-8023 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St, P.O. Box 845 Westminster, MD 21158-0845	410-876-4940 Fax: 410-876-4959
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5145 Fax: 410-996-5121
Charles County ACCU 4545 Crain Highway, P.O. Box 1050 White Plains, MD 20695	301-609-6803 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-228-3294 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3348 Fax: 301-600-3302
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7777 Fax: 301-334-7771
Harford County ACCU 34 N. Philadelphia Blvd Aberdeen, MD 21001	410-273-5626 Fax: 410-272-5467
Howard County ACCU 7180 Columbia Gateway Dr. Columbia, MD 21044	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7023 Fax: 410-778-7019
Montgomery County ACCU 1335 Piccard Drive, 2nd Floor Rockville, MD 20850	240-777-1616 Fax: 240-777-4645
Prince George's County ACCU 9201 Basil Court, Room 403 Largo, MD 20774	301-883-7231 Fax: 301-883-7572
Queen Anne's County ACCU 206 N. Commerce Street Centerville, MD 21617	443-262-4424 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St., P.O. Box 316 Leonardtown, MD 20650-0316	301-475-4951 Fax: 301-475-4110
Somerset County ACCU 7920 Crisfield Highway Westover, MD 21871	443-523-1723 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5691
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6568
Worcester County ACCU 9730 Healthway Drive Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

Dental Care for Pregnant Members

Dental services for pregnant women are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Please contact DentaQuest at 1-888-696-9596 if you have questions about dental benefits.

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:

- A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care; unless the 48 hour (uncomplicated vaginal delivery) / 96 hour (uncomplicated cesarean section) length of stay guaranteed by State law is longer than that required under the Guidelines.
- If a member must remain in the hospital after childbirth for medical reasons, and she requests that her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.
- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by State law, a home visit must be provided.
- When a member opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

Post-natal home visits are to be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a mother and newborn, and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse symptoms of the newborn;
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother;
- Blood collection from the newborn for screening, unless previously completed;
- Appropriate referrals; and
- Any other nursing services ordered by the referring provider.

If a member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

Unless we provide for the service prior to discharge, a newborn's initial evaluation by an out-of-network on-call hospital physician before the newborn's hospital discharge is covered as a self-referred service.

We are required to schedule the newborn for a follow-up visit within 2-3 days after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

Children with Special Health Care Needs

Kaiser Permanente will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers as specified in the special provisions and guidelines detailed on Page 9 of Section I.
- Log any complaints made to the State or to Kaiser Permanente about a child who is denied a service by us. We will inform the State about all denials of service to children. All denial letters sent to children or their representative will state that recipients can appeal by calling the State's Maryland HealthChoice Member Help Line.
- Work closely with the schools that provide education and family services programs to children with special needs.
- Ensure coordination of care for children in State-supervised care. If a child in State-supervised care moves out of the area and must transfer to another MCO, the State and Kaiser Permanente will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

Children with HIV/AIDS are eligible for enrollment in the REM Program. All other individuals with HIV/AIDS are enrolled in one of the Maryland HealthChoice MCOs.

The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care. To qualify as an HIV/AIDS specialist, a health care provider must meet the criteria specified under COMAR 10.09.65.10.B.
- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance abuse treatment within 24 hours of request.
- The right to ask us to send them to a site doing HIV/AIDS related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.

- The LHD will designate a single staff member to serve as a contact. In all instances, providers will maintain the confidentiality of client records and eligibility information, in accordance with all Federal, State and local laws and regulations, and use this information only to assist the recipient to receive needed health care services.

Case management services are covered for any member who is diagnosed with HIV. These services are to be provided, with the member's consent, to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected members with the full range of benefits (e.g. substance abuse treatment, primary mental health care, and somatic health care services), as well as referral for any additional needed services, including, specialty mental health services, social services, financial services, educational services, housing services, counseling and other required support services. HIV case management services include:

- Initial and ongoing assessment of the member's needs and personal support systems, including using a multi-disciplinary approach to develop a comprehensive, individualized service plan;
- Coordination of services needed to implement the plan;
- Periodic re-evaluation and adaptation of the plan, as appropriate; and
- Outreach for the member and the member's family by which the case manager and the PCP track services received, clinical outcomes, and the need for additional follow-up.

The member's case manager will serve as the member's advocate to resolve differences between the member and providers of care pertaining to the course or content of therapeutic interventions.

If a member initially refuses HIV case management services, the services are to be available at any later time if requested by the member.

Individuals with Physical or Developmental Disabilities

Before placement of an individual with a physical disability into an intermediate or long-term care facility, Kaiser Permanente will assess the needs of the individual and the community as supplemented by other Medicaid services. We will conduct a second opinion review of the case, performed by our medical director, before placement. If our medical director determines that the transfer to an intermediate or long-term care facility is medically necessary and that the expected stay will be greater than 30 days, we will obtain approval from the Department before making the transfer.

Providers who treat individuals with physical or developmental disabilities must be trained on the special communications requirements of individuals with physical disabilities. We are responsible for accommodating hearing impaired members who require and request a qualified interpreter. We can delegate the financial risk and responsibility to our providers, but we are ultimately responsible for ensuring that our members have access to these services.

Kaiser Permanente offers interpreter services for those who do not speak English or are hearing impaired. These services are offered free of charge. If a member needs an interpreter during his/her doctor visit, he/she should inform the appointment clerk when scheduling the appointment. If a Member presents to your office and requires interpreter services and you are not able to provide the service directly, please instruct the member to call Member Services at (855) 249-5019. A Member Services representative will provide an interpreter over the phone.

Our interpreter services are available at Kaiser Permanente facilities.

If the member is hearing or speech impaired or need a TTY/TDD line, please call (866) 513-0008.

Information is available in Spanish, Chinese (Traditional), Korean, and Vietnamese. There is no charge. If the member wants someone to read the information or would like a copy in one of these languages, please call Kaiser Permanente Member Services toll free at (855) 249-5019, (866) 513-0008 TTY/TDD. The member can also receive information in large print and/or Braille by calling Member Services.

Individuals in Need of Substance Use Disorder Treatment

As part of a member's initial health appraisal, first prenatal visit, and whenever you think it is appropriate, a substance use screen must be performed, using a formal substance use screening instrument that is:

- Appropriate for the detection of both alcohol and drug abuse; and
- Recommended by SAMHSA and appropriate for the age of the patient.

When the substance use screen yields a positive result, we will arrange for or the member may self-refer for a comprehensive substance use assessment performed by a qualified provider using either:

- The Problem Oriented Screening Instrument for Teenagers (POSIT), or
- The Addictions Severity Index (ASI)

If the comprehensive assessment indicates that the member is in need of substance use treatment, a placement appraisal to determine the appropriate level and intensity of care for the member must be conducted. Placement appraisal must be based on the current edition of The American Society of Addictions Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, or its equivalent, as approved by the Alcohol and Drug Administration.

Based on the results of a comprehensive assessment and a placement appraisal, the member is referred to, or the member may self-refer to an appropriate substance use treatment modality. Substance use treatment services covered for all members include:

- Individual, family, or group counseling;
- Detoxification (outpatient, or, if medically necessary, inpatient);

- Methadone maintenance;
- Intermediate Care Facility-Addictions (ICF-A) intermediate treatment for members younger than age 21;
- Partial Hospitalization; and
- Case management.

We will not deny substance use disorder treatment solely because the member has had a problem with substance use in the past. In addition, individuals in certain special populations are covered for some additional substance abuse services, specifically:

Pregnant and postpartum women:

- Access to treatment within 24 hours of request;
- Case management; and
- Intensive outpatient programs, including day treatment that allows for children to accompany their mother.

Individuals with HIV/AIDS:

Individuals with HIV/AIDS who are substance users will receive substance use treatment within 24 hours of request.

Individuals who are Homeless

If an individual is identified as homeless, we will provide a case manager to coordinate health care services.

Adult Members with Impaired Cognitive Ability/Psychosocial Problems

Support and outreach services are available for adult members needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the health care system.

KAISER PERMANENTE SUPPORT AND OUTREACH

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 includes a centralized team within our Clinical Contact Center that manages all outreach activities related to Maryland HealthChoice members, including but not limited to appointment reminders, appointment rescheduling, and member results outreach for events such as positive pregnancy tests.

Participating Providers are required to make the necessary outreach to members to ensure the timeliness of health care visits, screenings, and appointment monitoring. In the event, a member repeatedly misses a required health care appointment or care visit or you are unable to make contact with the member, please contact Provider Relations at 1-877-806-7470. The Provider Relations representative will report the care gap concern to the Kaiser Permanente Medicaid Office who will assist in bringing the member back into care.

KAISER PERMANENTE UTILIZATION MANAGEMENT

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

Kaiser Permanente UM is supported by board certified UM physician reviewers who hold a current license to practice without restrictions. These licensed physicians oversee UM decisions to ensure consistent and appropriate medical necessity determinations. Registered nurses perform concurrent review of members' admission to both participating and non-participating hospitals and facilities, review and processing of outpatient referrals, durable medical equipment, home care services, and coordination of emergency care and out-of-area admissions. Rehabilitative Therapy Utilization Coordinators (RTUC) are licensed physical therapists responsible for reviewing clinical appropriateness for members with functional and mobility needs who may require durable medical equipment or physical, occupational or speech therapies.

Utilization Management Affirmation Statement – Attestation Regarding Decision Making and Compensation

Kaiser Permanente staff and physicians make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of care and service, and the member's coverage. Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its physicians or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. Kaiser Permanente does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care or services. In order to maintain and improve the health of our members, all physicians and healthcare professionals should be especially diligent in identifying any potential underutilization of care or services.

UM Criteria, Medical Coverage Policies and Guidelines

Measurable and objective decision-making criteria ensure that decisions are fair, impartial, and consistent. Kaiser Permanente utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, and regionally developed Medical Coverage Policies (MCP). Additionally, the opinions of subject matter experts certified in the specific field of medical practice are sought in the guideline development process.

All criteria sets are reviewed and revised annually, then approved by the Regional Utilization Management Committee as delegated by the Regional Quality Improvement Committee. Our UM criteria is not designed to be the final determinate of the need for care but has been developed in alignment with local practice patterns and are applied based upon the needs and stability of the individual patient. In the absence of applicable criteria or

MCPs, the UM staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service.

The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system.

UM Criteria for Maryland HealthChoice

Service Type	UM Approved Criteria Sets
Acute Rehabilitation	MCG® (formerly Milliman Care Guidelines®)
Ambulance Services	Kaiser Permanente Medical Coverage Policy
Behavioral Health	MCG®
Durable Medical Equipment and Supplies	CMS National/Local Coverage Determination Policies
EPSDT Services	CMS Early and Periodic Screening, Diagnosis, and Treatment Criteria
Home Health Services	MCG®
Inpatient Services	MCG®
Neonatal Care	KP Revised Milliman Care Guidelines® NICU Levels
Outpatient Services	Kaiser Permanente Medical Coverage Policies MCG®
PT/OT/Speech	MCG®
Skilled Nursing Facility	MCG®
Transplant Services	National Transplant Network Services Patient Selection Criteria InterQual® Criteria – Transplant and Hematology/Oncology

As a Participating Provider you can access our medical coverage policies online at:

http://www.providers.kp.org/html/cpp_mas/coveragepolicies.html.

Hard copies of UM criteria or guidelines used in UM review are also available by calling the Utilization Management Operations Center (UMOC) at ☎ (800) 810-4766, and selecting the appropriate prompt. Updates to medical coverage policies, UM criteria and new technology reports are featured in “*Network News*”, our quarterly Participating Provider newsletter. You can also access current and past editions of “*Network News*” on our provider website by visiting online at:

http://www.providers.kaiserpermanente.org/html/cpp_mas/newsletters.html.

Adopting Emerging Technology for UM Referral Management

Medical research identifies new drugs, procedures, and devices that can prevent, diagnose, treat and cure diseases. The Kaiser Permanente Technology Review and Implementation

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

The INTC is comprised of physicians and non-physicians across Kaiser Permanente. If compelling scientific evidence is found indicating a new technology is comparable to the safety and effectiveness of currently available drugs, procedures, or devices, the committee will recommend the new technology be implemented internally by Kaiser Permanente and/or authorize for coverage from external sources of care for its indication for use. This technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

Accessibility of Utilization Management

The Kaiser Permanente UM Department ensures that all members and providers have access to UM staff, physicians and managers twenty-four (24) hours a day, seven (7) days a week. You can reach the Kaiser UM Department by calling the UMOC at ☎(800) 810-4766. The table below provides the UM hours of operations and responsibilities:

UM Department Section	Hours of Operation	Core Responsibilities
Utilization Management Operations Center (UMOC), Emergency Care Management	24 hours/day, 7 days/ week, including holidays	<ul style="list-style-type: none"> • Process transfer requests for members who need to be moved to a different level of care including emergency rooms, inpatient facilities, and Kaiser Permanente Medical Centers • Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities • Support all levels of transfers from Hospital to Hospital
Utilization Management Operations Center (UMOC): Outpatient, Specialty Referrals, Clinical Research Trials	Monday through Friday 8:00 A.M. to 4:30 P.M. Weekends and Holidays: 11A.M. to 1 P.M. for Urgent and emergent referrals only	<ul style="list-style-type: none"> • Conduct pre-service review of outpatient or inpatient services to include Clinical Research Trials • Weekends and holidays pre-service review of urgent/emergent referrals except Clinical Research Trials
Utilization Management Operations Center: Durable Medical Equipment (DME), Home Care, Rehabilitative Therapy: Physical Therapy, Occupational Therapy and Speech Therapy	Monday through Friday 8:30 A.M. to 5:00 P.M. Weekends and Holidays: 11:00 A.M. to 1:00 P.M for Urgent referrals.	<ul style="list-style-type: none"> • Conduct pre-service and concurrent review of Home Care, Durable Medical Equipment, Physical Therapy, Occupational Therapy and Speech Therapy, and post-service review

UM Department Section	Hours of Operation	Core Responsibilities
Patient Care Coordinators Medical/Surgical Cases Located at the following Participating Hospitals: <ul style="list-style-type: none"> • Children's National Medical Center • Greater Baltimore Medical Center • Holy Cross Hospital • St. Agnes Hospital • Suburban Hospital • Washington Hospital Center 	Monday to Friday, Weekends and Holidays 8:00 A.M. to 4:30 P.M.	Conduct concurrent inpatient review and transition care management
Skilled Nursing Facility (SNF) and Acute Rehabilitation Facility	Monday through Friday 8:00 A.M. to 4:30 P.M. Excluding holidays	Conduct concurrent review and transition care management for members in the acute rehab and SNF settings
UM Hospital Services – Behavioral Health Located at the following Participating Hospitals: Franklin Square Hospital Potomac Ridge	Monday to Friday: 8:00 A.M. to 4:30 P.M. Excluding holidays	Conduct concurrent inpatient review and transition care management services of behavioral health service
UM Outpatient Services – Behavioral Health	Monday to Friday: 8:30 A.M. to 5:00 P.M. Excluding holidays	Conduct Pre-service and concurrent review of behavioral health outpatient services
CareConnect/Complex Case Management Renal Case Management	Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding holidays	Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease (ESRD) Members

Kaiser Permanente will report EPSDT data for Maryland HealthChoice members to Department of Health and Mental Hygiene (DHMH) as per contract requirements to ensure compliance with the DHMH and the Center for Medicare and Medicaid Services (CMS)

Referral Requests

Please refer to **Attachment A** at the end of the Utilization Management section of this manual for the Uniform Referral Consultation Form.

Referral Request for Non-Participating Providers

A referral to a non-participating provider may be appropriate if the member is diagnosed with a condition or disease that requires specialized medical care and when:

Kaiser Permanente does not have in its network a specialist with the professional training and expertise to treat the condition or disease; or
 Kaiser Permanente cannot provide timely access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

Participating Specialist Responsibilities

Participating specialists receive referrals to provide care to members from PCPs and /or other specialists. A member receiving care from a specialist must have an approved referral for each visit. A referral summary indicating approval will be faxed to participating specialist prior to the member's scheduled appointment. The member also receives an approval letter. Each Kaiser Permanente referral has a unique referral number. This referral number should be reflected on the claim/bill for appropriate processing and payment.

To assist us with timely and accurate referral processing, participating specialists should ensure that Kaiser Permanente has the most up-to-date demographic and contact phone/fax numbers for their practice.

Initial and Ongoing Visits

During the initial office visit, a participating specialist may perform the specific services indicated on the referral. The Participating Provider should ensure that services are:

- Rendered in accordance with the member's Maryland HealthChoice handbook
- Performed as listed on the referral

Each approved referral is valid only until the identified expiration date as noted on the Kaiser Permanente Referral Summary Report. Only one (1) visit is approved per referral, unless otherwise indicated on the authorized Referral Summary Report. We encourage our referring participating PCPs and specialists to use their clinical judgment and discretion in anticipating a reasonable number of visits required for a particular consultation with a participating specialist.

Requests for additional visits, care, or consultations

Should a member require additional visits or care with the treating specialist or other provider, the specialist must submit a new referral request by submitting a Uniform Consultation Referral Form to the UMOC by fax at ☎ (800) 660-2019 before the next visit and/or additional care is provided. The request should include any required and/or supporting clinical documentation.

In the event a member presents to your office for care without an approved referral, please call the UMOC at ☎ (800) 810-4766. Participating Providers with access to KP HealthConnect AffiliateLink may check the status and/or retrieve a copy of an approved referral in the AffiliateLink. Alternatively, the status of a referral may be checked by going to www.providers.kp.org/mas.

Emergency, Urgent, and Post Stabilization Care

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

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

Notification or referrals regarding an ED visit can be made by calling ☎(800) 810-4766, Option 1.

If a member requires inpatient admission after an ED visit, please be sure to notify UMOC of the admission within twenty four (24) hours of the admission. An exception to this policy is applied when it is not medically feasible to delay treatment due to the member's medical condition.

You may refer the member to call our 24-hour medical advice line. Additionally, you may also refer a member to a Kaiser Permanente or participating urgent care facility. For a full list of urgent care facilities in our network, go to www.kp.org/facilities.

Kaiser Permanente Urgent Care Facilities are available at:

- **Baltimore - Kaiser Permanente So. Baltimore Medical Center***
- Baltimore - Kaiser Permanente Woodlawn Medical Center
- **Montgomery County, MD - Kaiser Permanente Gaithersburg Medical Center***
- Montgomery County, MD - Kaiser Permanente Kensington Medical Center
- **Prince George's County, MD - Kaiser Permanente Largo Medical Center***
- Prince George's County, MD - Kaiser Permanente Camp Springs Medical Center
- **Washington, DC - Kaiser Permanente Capitol Hill Medical Center***
- **Northern Virginia - Kaiser Permanente Tysons Corner Medical Center***

*Indicates those facilities that provide care and services 24 hours a day, 7 days a week.

For the most up-to-date listing of hours and services available at Kaiser Permanente Urgent Care Facilities, please visit www.kp.org or contact Provider Relations at 1-877-806-7470.

Post Stabilization Care

The ultimate goal of the Kaiser Permanente utilization management program is to determine what resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner. To that goal, efforts will be made to transfer members to a participating hospital where services can be delivered by MAPMG doctors and/or Participating Providers. After it has been determined that a member is medically stable, Kaiser Permanente will make arrangements for safe transport to a Kaiser Permanente participating facility where a MAPMG doctor and/or Participating Provider will receive the member and resume care.

Post stabilization covers all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred. Post-stabilization coverage includes services subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.

Notification of Emergency Department Visits

Kaiser Permanente members may be directed and/or self-refer to a participating hospital or facility for emergency care. While prior authorization or referral approval is not required for reimbursement of covered emergency care services provided to a member, we request notification when a member presents to the Emergency Department for urgent and/or emergent care services. This notification will ensure that our members are being given the best coordination and follow-up care possible.

To report an emergency department visit: Contact UMOC at ☎ (301) 879- 6143, or ☎ (800) 810-4766. Follow the prompts to report the Emergency Department visit.

All ER notifications should include the following information:

- Member Name
- Member Medical Record Number (MRN)
- Name of the Referring Physician (if applicable)
- Name of Hospital or Facility
- Complaint/Diagnosis
- Date of Service

Direct Access - Standard Referrals to Specialist for Special Needs

Members with special health care needs are allowed direct access through a standing referral to specialists if they have a chronic, complex, or serious medical condition. The PCP must consult with the specialist and develop a treatment plan for a certain number of visits, allowing the member to be seen without additional referrals. The PCP must obtain authorization for the specialist referral beforehand using guidelines when creating a treatment plan for the member.

Referral Management Procedures

Some services may not require pre-authorization but will require a copy of the referral submitted to Health Plan to ensure proper claims payment. Refer to the “List of Services Requiring Authorization” on page 36 of this manual.

How to submit a copy of your referral

Step 1: Verify that the specialist named in the referral is a participating provider

Step 2: Verify that the requested procedure/service does not require authorization

Step 3: Fax a copy of the Uniform Referral or the referral request to UMOC:

Fax ☎ 1 (800) 660-2019

-OR-

Mail a copy of the Uniform Referral Form to:
Utilization Management Operations Center
Attention: Referral Management
11900-A Bournefield Way
Silver Spring, Maryland 20904

If no pre-authorization is required, give a copy of the referral form to the member to take to his/her appointment with the participating specialist.

If pre-authorization is required, all required clinical documentation should accompany the referral request. This includes lab, x-ray results, or pertinent medical records, and office fax numbers.

Please note: incomplete referrals will be returned to the participating or PCP/specialist office with request to provide required information.

Referring Members for Radiology Services

Kaiser Permanente provides members with access to radiology and imaging services at our Medical Centers, Imaging Centers, and through community-based providers within our Participating Provider network.

Following patient consultation, Participating Providers should follow the procedures below when referring a member for radiology services:

- Provide the member with a script for the necessary radiological/imaging service.
- Instruct the member to contact Kaiser Permanente to secure a radiology/imaging appointment.

The member may contact the Radiology Department at their preferred Kaiser Permanente Medical Center directly or call the Medical Advice/Appointment Line at ☎(800) 777-7904 to secure an appointment with a representative.

Referring Members for Laboratory Services

Members requiring laboratory services under care with your practice should be directed to a Kaiser Permanente Medical Center or participating laboratory. Laboratory procedures covered under a current Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a current CLIA Certificate of Provider-Performed Microscopy Procedures may be performed in your office.

Members should be given an order or signed script to present to the laboratory. The script or order must include the following:

- Provider name
- Provider address
- Practice phone and fax number
- Member name
- Member date of birth
- Description of test(s) requested
- ICD-9 codes (until ICD-10 becomes effective)

The laboratory results will be faxed to the number provided on your signed script or order. Participating Providers with access to KP HealthConnect AffiliateLink may obtain laboratory results via the web at www.providers.kp.org/mas.

List of Services Requiring Authorization

The following services require service authorization from Kaiser Permanente. Please go to Section III for detailed information on Maryland HealthChoice Benefits and Services – Covered Benefits and Services.

Inpatient/ Outpatient Services

- Inpatient Admissions
- Inpatient Substance Use Disorder Treatment
- Observation Services
- Outpatient Substance User Disorder Treatment
- Long Term Facility Services (LTC)
- Chronic Hospital
- Rehabilitative Hospital
- Nursing Facility

Elective Services

- Accidental Dental
- Anesthesia Services (oral surgery)
- Biofeedback
- Blepharoplasty
- Breast Surgery for any reason
- Chiropractor
- Clinical trials and services
- DME and Assistive Technology
- Gastric Bypass Surgery, Gastroplasty
- Home Health Services
- Hospice
- Infertility Assessment and Treatment
- Infusion Therapy and Injectables (Home IV)
- Intensity Modulated Radiation Therapy (IMRT)
- Investigational/Experimental Services

- Magnetic Resonance Imaging (MRI)
- Narrow Beam Radiation Therapy Modalities
- Cyberknife
- Gamma Knife
- Stereotactic Radiosurgery
- Nasal Surgery (Rhinoplasty or Septoplasty)
- Obstructive Sleep Apnea Treatment including Sleep Studies
- Oral Surgery for adults
- Orthognatic Surgery
- Orthotics and Prosthetics
- Pain Management Services
- Plastic and restorative surgery
- Podiatry
- Positron Emission Tomography (PET) Scan
- Post Traumatic (Accidental) Dental
- Rehabilitative Services (PT, OT, SPT)
- Sclerotherapy and Vein Stripping Procedures
- Temporo Mandibular Joint Evaluation and Treatment
- Transplant Services – Solid Organs and Renal Transplant Services
- Uvulopalatopharyngoplasty (UPPP)

Timeframes for Decision-Making and Notification

Medical Necessity Determinations

Measurable, objective, decision-making criteria ensure that decisions are fair, impartial and consistent. Kaiser Permanente UM utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, and regionally developed medical coverage policies. Additionally, the opinions of subject matter experts certified in the specific field of medical practice are sought in the guideline development process.

Processing of coverage determination also depends on the urgency of request, and on the type of review conducted: pre-service, concurrent, or post service review.

Tables A – D below summarizes the timeliness requirements for Maryland HealthChoice members.

Table A: Timeliness Guidelines for Urgent Concurrent Review and Notification

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of determination

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

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within 48 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of determination

Urgent care means health care services for a medical condition that manifests itself by symptoms of sufficient severity that the absence of medical attention within 48 hours could reasonably be expected, by a prudent layperson who possesses an average knowledge of health and medicine, to result in an emergency medical condition.

Table C: Timeliness Guidelines for Non-Urgent (Standard/Routine) Pre-Service Review and Notification

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within two (2) business days of receipt of request, but no later than seven (7) calendar days from the receipt of request	Within 24 hours of determination	Within 72 hours from the date of determination

Table D: Timeliness Guidelines for Post-Service Review and Notification

Determination Timeframe	Telephonic or Oral/Verbal Notification	Written Notification
Within 30 calendar days of receipt of request	Not Applicable	Within 30 business days of receipt of request

Denial and Appeal Process

In the event, a referral and/or authorization request is denied, you have the right to speak with a UM Physician to discuss the decision by calling ☎ (888) 989-1144 or ☎ (703) 359-7460. You may request to speak with the UM physician on-call within twenty-four (24) hours of the verbal notification of an adverse decision.

Refer to the Member Appeals, Member Grievance, Kaiser Permanente Member Complaint Process, and Kaiser Permanente Member Appeal Process sections for instructions.

Hospital Admission Notification Requirements

The hospital is responsible to notify Kaiser Permanente at the time the member is admitted. All urgent and emergent admissions require notification of the admission to UMOC by the participating PCP, his/her agent, or the participating hospital/facility at ☎ (800) 810-4766. Notification of an emergency admission within 24 hours of the admission ensures prompt payment. If the admitting physician is not the participating PCP, it is the admitting physician's responsibility to contact the participating PCP in order to authorize the admission and discuss plans for care.

Transition Care Management

Transition care management begins when the Member is admitted to the hospital or SNF and continues throughout the stay. Its purpose is to capitalize on inpatient admissions to kick off a new set of multidisciplinary activities that support care post discharge and ensures the Members safe transition between care venues while preventing readmissions and medication errors.

The Patient Care Coordinators work with the attending physician and the health care team to ensure the Member's transition needs are anticipated and met. The keys to safe and proactive transition management are:

- early assessment and needs identification/anticipation;
- development of a realistic and sound plan of care based on clinical evidence;
- establishing open communication with the Member and/or authorized representative and the health care team;
- coordination with all disciplines involved;
- ensuring members have a timely follow-up appointment with their PCP;
- ensuring post-acute services are delivered as ordered; and
- ensuring our high risk members who are discharged home have the opportunity for telephonic medication reconciliation with a Health Plan clinical pharmacist.

For continued inpatient stays, the patient care coordinator evaluates the patient's needs by partnering with the member and his/her family, the attending physician and the healthcare

team throughout the member's hospitalization. Transition of care is initiated on admission and regularly revisited based on the clinical status and specific needs of the patient.

During the transition of care process, the following factors are taken into consideration to ensure the member's clinical needs are assessed based on the characteristics of the local delivery system:

- Availability of long-term care facility/nursing facility services, home care, DME, palliative care or timely access to Kaiser Permanente's internal services to support the patient after hospital discharge where needed
- Local hospitals' ability to provide recommended services

Delays in Service Provided to Members in an Inpatient Setting

The table below outlines some of the most common instances or situations that would cause a delay in a service/procedure being provided to an inpatient member by a hospital, SNF or physician. Delays in service may result in a reduction in payment for covered services. For further questions, you may contact the utilization management representative assigned to your hospital.

Hospital Delays

Diagnostic Testing/Procedures

- MRI, CT scans delays (test performed/read/results available)
- Other radiology delays (test performed, read, results available)
- Laboratory tests delays (test performed/read/results available)
- Cardiac catheterization delays (including weekends and holidays)
- PICC line placement delays
- Echocardiograms delays
- GI diagnostic procedures (EGD, Colonoscopy, ERCP, etc.) delays
- Stress tests delays
- Technical delays (e.g., machine broken or machine is not appropriate for Member, causing delay)
- Dialysis not available
- Transfusions delays
- AFBs delays
- Pathology delays (test performed/read/results available)

Operating Room

- CABG delays
- No OR time
- Physician delay (e.g., lack of availability)

Ancillary Service

- No PT/OT/Speech evaluation
- No Social Work/Discharge Planning

Nursing

- Delay in carrying out or omission of physician orders
- Medications not administered
- NPO order not acknowledged
- Kaiser Permanente Utilization Management not notified that the Member refuses to leave when discharged

Skilled Nursing Facility (SNF) Delays

Diagnostic Testing/Procedures

- Laboratory test delays (test performed/read/results available)
- PICC line placement delays
- Radiology delays (test performed/read/results available)

Nursing

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

Ancillary Service

- Social Work/ Discharge Planning not available or delayed
- Delay in initiation of therapy services (PT/OT/Speech)
- Lack of weekend therapy services
- Delay in initiation of respiratory services
- Delay in pharmacy services

Attending or Consulting Physician Delays

Hospital

- Delays in specialty consultations (non-KP physician)
- Discharge paperwork for alternative placement
- Member not seen by attending physician or not seen in a timely manner.

SNF

- Physician delays in facilities that do not have Kaiser Permanente on-site reviewers. Making a referral for Case Management Services. You or the member may request case management services via the self-referral telephone line by calling ☎(301) 321-5126 or toll free ☎(866) 223-2347. This confidential self-referral line is available 24hours/7 days a week. Please leave a detailed message and contact information.

CareConnect Program for Complex Case Management

Kaiser Permanente CareConnect program supports the social and medical needs of our most vulnerable members with the goal of helping them make progress and stabilize their health status. The mission of CareConnect program is to assist members with an intense need for management and coordination of care or an extensive use of services. Core features of the program include consent from the member for participation, an extensive initial assessment and the development of a detailed care plan as well as a self-management plan.

Key to the success of CareConnect is the identification of appropriate members for enrollment in the program. The program makes use of two primary strategies to identify members, i.e. referrals (including self-referral) and data reports. CareConnect is available to all members who meet program criteria.

Renal Case Management (RCM)

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

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

Transplant Services

Health Plan contracts with local and national centers of excellence for transplant services. Referring Participating Providers should work with our transplant coordinators when they identify a member who may be a candidate for transplantation or requesting a referral for transplant from the PCP.

Transplant candidates should be routed through the Transplant Coordinator. Please call the National Transplant Services (NTS) Department at ☎ (301) 625-6201 to refer a member for an evaluation for a transplant or to receive additional information about the NTS.

Uniform Consultation Referral Form

Date of Referral:		Carrier Information:	
Patient Information:		Name: Kaiser Permanente	
Name: (Last First, MI)		Address:	
Date of Birth: (MM/DD/YY)	Phone: ()	Phone Number: 1-(800)-810-4766	
Member #:		Facsimile/Data #: 1-(800)-660-2019	
Site #:			
Primary or Requesting Provider:			
Name: (Last, First, MI)		Specialty:	
Institution/Group:	Provider ID#: 1	Provider ID#: 2 (If Required)	
Address: (Street #, City, State, Zip)			
Phone Number:		Facsimile/ Data Number:	
Consultant/Facility Provider			
Name: (Last, First, MI)		Specialty:	
Institution/Group:	Provider ID#: 1	Provider ID#: 2 (If Required)	
Address: (Street #, City, State, Zip)			
Phone Number:		Facsimile/ Data Number:	
Referral Information:			
Reason for Referral:			
Brief History, Diagnosis, Test Results:			
Services Desired: Provide Care as Indicated:		Place of Service:	
<input type="checkbox"/> Initial Consultation Only:		<input type="checkbox"/> Office	
<input type="checkbox"/> Diagnostic Test: (specify) _____		<input type="checkbox"/> Outpatient Medical/Surgical Center *	
<input type="checkbox"/> Consultation With Specific Procedures: (specify) _____		<input type="checkbox"/> Radiology <input type="checkbox"/> Laboratory	
<input type="checkbox"/> Specific Treatment:		<input type="checkbox"/> Inpatient Hospital *	
<input type="checkbox"/> Global OB Care & Delivery		<input type="checkbox"/> Extended Care Facility *	
<input type="checkbox"/> Other: (Explain)		<input type="checkbox"/> Other: (Explain)	
		* (Specific Facility Must be Named.)	
Number of Visits:	Authorization #:	Referral is Valid Until: (Date)	
If Blank, 1 Visit is assumed.	(If Required)	_____	
		(See Carrier Instruction)	
Signature: (Individual Completing This Form)		Authorizing Signature: (If Required)	

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

SUBMITTING CLAIMS

As a Participating Provider, you have agreed to a fee-for-service arrangement as defined in your Participating Agreement with Kaiser Permanente. The rate established in your Participating Agreement with Kaiser Permanente Maryland HealthChoice members constitutes payment in full for covered services provided. Members may not be balanced billed for the difference between the actual billed amount for covered services and your contracted reimbursement rate.

Billing Procedures for Fee-For-Service Claims

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

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

All claims/bills can be mailed to:
Kaiser Permanente
P.O. Box 6233
Rockville, MD 20849-6233

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

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

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

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

Payment is generally made within thirty (30) days of receiving the claim/bill. Participating Providers may check the status of a claim/bill submitted for payment by calling ☎ (855) 249-5019, select the Claims prompt to speak to a Member Services representative.

If you have a question regarding a previously submitted claim, billing or utilization, please contact our Member Services Call Center at ☎ (855) 249-5019 and select the Claims prompt to speak to a Member Services representative. If no resolution is received after thirty (30) days, please feel free to contact Provider Relations Department at ☎ (877) 806-7470.

Timely Filing Requirements

Claims/bills for services provided to Health Plan members must be received within twelve months (365 calendar days) of the date of service to be considered for processing and payment. However, we encourage you to submit claims within six (6) months for more expedited claims processing and reimbursement for covered services.

Clean Claim

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

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

A clean claim includes:

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

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

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

Requirements for Clean Claim Submission

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

Standard Coding – All fields should be completed using industry standard coding as outlined below.

Applicable Attachments – Attachments should be included in your submission when circumstances require additional information.

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

Claim Forms

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

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

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

Clean claims for covered benefits will be processed according to jurisdictional regulations and paid, unless covered under a capitation agreement. Inaccurate coding may result in claim processing and payment delays. As many factors are considered in the processing of a claim, it is important to realize that a pre-authorized referral does not guarantee payment, except under very limited conditions.

Coding Standards

Coding – All fields should be completed using industry standard coding as outlined below.

Code Set	Standard
CPT- 4 (Current Procedure Terminology)	Maintained and distributed by the American Medical Association, including its codes and modifiers, and codes for anesthesia services
CDT- 1 (The Code on Dental Procedures and Nomenclature)	Maintained and distributed by the American Dental Association
ICD-9 CM (International Classification of Diseases, Clinical Modification)	Maintained and distributed by the National Center for Health Statistics-Centers for Disease Control and Prevention
HCPCS and Modifiers (CMS Common Procedure Coding System)	Maintained and distributed by the U.S. Department of Health and Human Services
NDC (National Drug Codes)	Prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services
ASA (American Society of Anesthesiologists)	Anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists

DSM-IV (American Psychiatric Services)	For psychiatric services, codes distributed by the American Psychiatric Association
Revenue Code	For facilities, use the national or state uniform billing data elements specifications

Attachments to Include In Claims Submission

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

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

Fields of the CMS 1500 to Complete

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

Field Location	Essential Data Elements Required
Field 1	Type of Insurance
Field 1a	Insured's plan ID number
Field 2	The patient's name
Field 3	The patient's date of birth and gender
Field 4	Insured's name
Field 5	The patient's address (state or P.O. Box, city, and zip code)
Field 6	The patient's relationship to insured
Field 7	Insured's address (state or P.O. Box, city, and zip code)
Field 8	Patient status
Field 9	Other Insured's name
Field 9a	Other Insured's policy or group number
Field 9b	Other Insured's date of birth
Field 9c	Employers name or school name
Field 9d	Insurance plan name or program name
Field 10a-c	Is Patient's condition related to:
Field 10d	Reserved for local use
Field 11	Insured's policy, group or FECA number
Field 11a	Insured's birth date and gender
Field 11b	Employer's name or school name
Field 11c	Insurance plan name or program name
Field 11d	Is there another health benefit plan?
Field 12	The patient's or authorized person's signature or notation that the signature is on file with the health care practitioner
Field 13	Insured's or authorized person's signature or notation that the signature is on file with the health care practitioner or person entitled to reimbursement, if applicable
Field 14	The date of current illness, injury, or pregnancy
Field 15	Except in the case of a health care practitioner for emergency services, whether the patient has had the same or a similar illness
Field 16	Dates patient unable to work in current occupation
Field 17	Name of the referring physician
Field 18	The hospitalization dates related to current services, if applicable
Field 19	Reserved for local use
Field 20	Outside lab?
Field 21	The diagnosis codes or nature of the illness or injury
Field 22	Medicaid resubmission (list of original reference number for resubmitted claims)
Field 24a	The date of service
Field 24b	The place of service code
Field 24c	EMG
Field 24d	Procedure, services or supplies

Field 24e	Diagnosis pointer
Field 24f	The charge for each listed service
Field 24g	The number of days, the time (minutes), the start and stop time or units
Field 24h	EPSDT, family planning
Field 24i	NPI number or ID qualifier
Field 24j	Rendering Provider ID
Field 25	The health care practitioner's or person entitled to reimbursement's federal tax ID number
Field 26	The patient's account number
Field 27	Accept Assignment?
Field 28	The total charge
Field 29	Amount paid
Field 30	Balance due
Field 31	For claims submitted electronically , a computer printed name as the signature of the health care practitioner or person entitled to reimbursement.
Field 31	For claims not submitted electronically , the signature of the health care practitioner who provided the service, or notation that the signature is on file with Kaiser Permanente
Field 32	Service facility location information
Field 32a	NPI #
Field 32b	Other ID#
Field 33	Billing provider info and phone #
Field 33a	NPI#
Field 33b	Other ID#

Fields of the CMS UB-04 to Complete

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

Field Location	Essential Data Elements Required
Field 1	The hospital's name and address and telephone number
Field 2	Pay to address if different than Field 1
Field 3a	The patient's control number
Field 3b	Medical Record Number
Field 4	The type of bill code
Field 5	The hospital's federal tax ID number
Field 6	The beginning and ending date of claim period
Field 7	Administrative Necessary Days
Field 8	The patient's name
Field 9	The patient's address
Field 10	The patient's date of birth
Field 11	The patient's gender or sex
Field 12	Admission Date
Field 13	Admission Hour
Field 14	Admit Type
Field 15	Source of Admission
Field 16	Discharge Hour
Field 17	Patient Discharge Status
Field 18-28	Condition Codes
Field 29	Accident State
Field 31-34	Occurrence Codes and Dates
Field 35-36	Occurrence Span
Field 38	Responsible Party Name and Address
Field 39-41	Value Code and Amount
Field 42	Revenue Code
Field 43	Revenue Code Description
Field 44	HCPC
Field 45	Service Date
Field 46	Service Units
Field 47	Total Charges
Field 48	Non Covered Charges
Field 50	Payer
Field 51	Health Plan ID
Field 52	Release of Information
Field 53	Assignment of Benefits
Field 54	Prior Payments
Field 55	Estimated Amount Due
Field 56	National Provider Identifier Billing Provider
Field 57	Other Provider Identifier
Field 58	Insured's Name

Field 59	Patient's Relation to Insured
Field 60	Insured's Unique Identifier
Field61	Group Name
Field 62	Insurance Group Number
Field 63	Treatment Authorization Number
Field 64	Document Control Number
Field 65	Employer Name
Field 66	Diagnosis and Procedure Code Qualifier
Field 67A	Q other Diagnosis Code
Field 68	Admitting Diagnosis Code
Field 70	Patient's Reason for Visit
Field 71	PPS Code
Field 72	External Cause of Injury Code
Field 74	Principal Procedure Code and Date
Fields 74A-E	Other Procedure Codes
Field 76	Attending Provider Name and Identifiers (NPI)
Field 77	Operating Physician Name and Identifiers (NPI)
Field 78-79	Other Provider Name and Identifiers (NPI)
Field 80	Remarks Field/Signature
Field 81cc	Code-Code Field (NPI)

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

Multiple Procedure Reimbursement Policy*

Multiple procedures performed in the same operative session will be reimbursed at 100% of the rate indicated for the first procedure from the highest payment group. All other procedures will be paid at 50% of respective rates.

**This policy applies to the professional service component only*

Description and Justification of Processing and Adjudication Edits

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

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

Claims Xten Processing Edits and Explanation of Payment Codes

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

Claim Adjudication Edits, Policy Concepts and Descriptions

Supplies on the same day as surgery – Identifies supplies on the same day as a surgery. CMS has established that certain supplies should be denied when billed on the same day as surgical procedures for which the concept of the global surgical package applies.

Bundled Service – Identifies procedures indicated by CMS as always bundled when billed with any other procedure. According to CMS, certain codes are always bundled when billed with other services on the same date of service.

Deleted Supply and Procedure Codes – Identifies deleted service and procedure codes that were in past editions of the CPT and HCPCS books. CMS does not permit reimbursement of AMA deleted codes when they are submitted after the deletion date and beyond the permitted submission period.

Inappropriate Procedure for Gender – Identifies procedures that are inconsistent with the member's gender. Certain procedure and diagnosis codes are exclusive to either the male or female gender.

Duplicate Line Items – Identifies duplicate line items. Duplicate line items are determined based on matches on certain key fields. The fields used for matching are customizable by the payor. Duplicate claim lines are those claim lines that match previously submitted claim lines.

Global Surgical Package – Identifies Evaluation & Management (E&M) codes and supplies billed within the global period. Procedure codes have a time frame associated with them which includes services and supplies associated with the procedure. The time frames are set by both CMS and broadly accepted industry sources.

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

Missing Modifier 26 – Identifies situations where a modifier 26, denoting professional component, should have been reported for the procedure performed at the noted place of service. According to CMS or industry accepted standards, the professional component modifier should have been reported for services rendered in this place of service.

New Patient Code for Established Patient – Identifies new patient visits that are billed for established patients. The AMA has established that a provider practice can only bill a patient code as new once every three years.

Procedure Maximum Frequency Per Day – Identifies a service that is billed with a frequency exceeding a given norm in a 24-hour period. Procedure codes have maximum quantities allowed within a 24-hour period. These quantities have been derived by broadly accepted industry sources.

Consult (Outpatient) Maximum Frequency – Identifies inappropriate billing of Outpatient Consultation codes. Outpatient Consultations should be performed only upon provider request and follow-up visits in the physician consultant's office that are initiated by the physician consultant should be reported using office visit codes for established patients. The AMA has established that follow-up visits in the physician consultant's office or other outpatient facility that are initiated by the physician consultant are to be reported using office visit codes for established patients.

Consults by PCP – Identifies consultation codes that are billed by the member's PCP. PCPs cannot bill for consultations performed on his/her own primary care patients.

Deny Base Code with quantity greater than one – This rule identifies situations where the provider is billing a base code with quantity, rather than the appropriate add on code(s). According to AMA, add-on procedures are to be listed in addition to the primary (base code) procedure. Primary (base code) procedures are typically billed with a quantity of one. When a provider is billing a primary (base code) procedure with quantity of one, those additional services beyond the primary (base code) procedure should be billed as add-on codes.

Consult (Outpatient) Maximum Frequency – Identifies inappropriate billing of outpatient consultation codes. Outpatient consultations should be performed only upon Provider request. Follow-up visits in the physician consultant's office that are initiated by the physician consultant's office should be reported using office visit codes for established patients. The AMA has established that follow-up visits in the physician consultant's office or other outpatient facility that are initiated by the physician consultant are to be reported using office visit codes for established patients.

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

Inappropriate Diagnosis for Gender – Identifies diagnosis codes that are inconsistent with the member's gender. Certain procedure and diagnosis codes are exclusive to either the male or female gender.

Inappropriate CPT to Modifier Combination – This rule denies inappropriate CPT to Modifier combinations. Certain procedure codes and modifier combinations are not appropriate.

Component Billing – Identifies a component procedure (technical or professional) billed when the comprehensive procedure has been previously billed

Professional Component Not Allowed – Identifies pathology/laboratory procedures billed with a professional component when no such component applies per CMS guidelines

Reimbursement Policy for Comprehensive and Component Codes

When two or more related procedures are performed on a patient during a single session or visit, there are instances when a claim is submitted with multiple codes instead of one comprehensive code that fully describes the entire service. Kaiser Permanente will reimburse for the comprehensive procedure code.

The specific procedure code relationships in this Reimbursement Policy are modeled after the Correct Coding Initiative (CCI) administered through CMS, AMA Current Procedural Terminology (CPT) and other general industry-accepted guidelines.

Evaluation and Management on Same Day as Surgery

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

Global Surgical Package (GSP)

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

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

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

Timely Filing Requirements and Appeal of Timely Filing

All claims must be received within the timeframes defined under the Timely Filing Requirements section of this manual.

Resubmitted claims along with proof of initial timely filing received within six (6) months of the original date of denial or explanation of payment will be allowed for reconsideration of claim processing and payment. Any claim resubmissions received for timely filing reconsideration beyond six (6) months of the original date of denial or explanation of payment will be denied as untimely submitted.

Proof of Timely Filing

Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frames. Acceptable proof of timely filing may include the following documentation and/or situations:

Proof or Documentation	Examples
<p>System generated claim copies, account print-outs, or reports that indicate the original date that claim was submitted, and to which insurance carrier.</p> <p>*Hand-written or typed documentation is not acceptable proof of timely filing.</p>	<ul style="list-style-type: none"> • Account ledger posting that includes multiple patient submissions • Individual patient ledger • CMS UB-04 or 1500 with a system generated date or submission
<p>EDI Transmission report</p>	<ul style="list-style-type: none"> • Reports from a provider clearinghouse (i.e., Emdeon)
<p>Lack of member insurance information. Proof of follow-up with member for lack of insurance or incorrect insurance information.</p> <p>*Members are responsible for providing current and appropriate coverage information each time services are rendered by a provider.</p>	<ul style="list-style-type: none"> • Copies of dated letters requesting information, or requesting correct information from the member. • Original hospital admission sheet or face sheet with incomplete, absent, or incorrect insurance information. • Any type of demographic sheet collected by the provider from the member with incomplete, absent, or incorrect insurance information.

Claim Overpayment

In the case of an overpayment of a claim, Kaiser Permanente will provide the Participating Provider with a written notice of explanation. The Participating Provider should send the appropriate refund to Kaiser Permanente within thirty (30) days of receiving the overpayment notice or when the Participating Provider confirms that he/she is not entitled to the payment, whichever is earlier.

If for some reason the Participating Provider's refund is not received within thirty (30) days of receiving the overpayment notice, Kaiser Permanente may deduct the refund amount from future payments.

Coordination of Benefits

There are many instances in which a member's episode of care may be covered by more than one insurance carrier. Maryland HealthChoice will always be the payor of last resort. Kaiser Permanente Participating Providers are responsible for determining the primary payor and for billing the appropriate party.

Section III

MARYLAND HEALTHCHOICE BENEFITS AND SERVICES

OVERVIEW

- **Kaiser Permanente** must provide a complete and comprehensive benefit package that is equivalent to the benefits that are available to Maryland Medicaid recipients through the Medicaid fee-for-service delivery system. Carve-out services (which are not subject to capitation and are not **Kaiser Permanente's** responsibility) are still available for Maryland HealthChoice recipients. Medicaid will reimburse these services directly, on a fee-for-service basis.
- A Maryland HealthChoice PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member.
- A member has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. We are responsible for reimbursing out-of-plan providers who have furnished these services to our members. (See Self-Referred and Emergency Services Section - Page 9)
- Only benefits and services that are medically necessary are covered.
- Maryland HealthChoice members may not be charged any co-payments, premiums or cost sharing of any kind, except for the following:
 - Up to a \$3.00 co-payment for brand-name drugs;
 - Up to a \$1.00 co-payment for generic drugs; and
 - Any other charge up to the fee-for-service limit as approved by the Department.
- We do not impose pharmacy co-payments on the following:
 - Family planning drugs and devices;
 - Individuals under 21 years old;
 - Pregnant women; and
 - Institutionalized individuals who are inpatient in long-term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs.
- Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program
- The pharmacy cannot withhold services even if the recipient cannot pay the co-payment. The recipient's inability to pay the co-payment does not excuse the debt and they can be billed for the co-payment at a later time. We will not restrict our members' access to needed drugs and related pharmaceutical products by requiring that members use mail-order pharmacy providers.

COVERED BENEFITS AND SERVICES

(Listed Alphabetically)

Audiology Services for Adults

These services are only covered when part of an inpatient hospital stay

Blood and Blood Products

Blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.

Case Management Services

Case management services are covered for members who need such services including, but not limited to, members of special needs populations, which consist of the following non-mutually exclusive populations:

- Children with special health care needs;
- Individuals with a physical disability;
- Individuals with a developmental disability;
- Pregnant and post-partum women;
- Individuals who are homeless;
- Individuals with HIV/AIDS;
- Individuals with a need for substance use disorder services; and
- Children in State supervised care.

If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by the MCO.

A case manager will perform home visits as necessary as part of Kaiser Permanente's case management program and will have the ability to respond to a member's urgent care needs during this home visit.

Dental Services for Children and Pregnant Women*

These services are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Contact them at 1-888-696-9596 if you have questions about dental benefits.

Refer to "Optional Services Provided by Kaiser Permanente" for additional dental benefits.

Diabetes Care Services

Kaiser Permanente covers all medically necessary diabetes care services. We cover diabetes care services for members who have been diagnosed with diabetes and/or discharged from a hospital inpatient stay for a diabetes-related diagnosis. This includes:

- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related durable medical equipment and disposable medical supplies, including:

- Blood glucose meters for home use;
 - Finger sticking devices for blood sampling;
 - Blood glucose monitoring supplies; and
 - Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood.
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Dialysis Services

Members in Maryland HealthChoice who suffer from End Stage Renal Disease (ESRD) are eligible for REM. To be REM-eligible on the basis of ESRD, members must meet one of the following sets of criteria:

- Children (under 21 years old) with chronic renal failure (ICD-9 code 585.1-585.6) diagnosed by a pediatric nephrologist; and
- Adults (ages 21-64) with chronic renal failure with dialysis (ICD-9 code 585.6, V45.11 and 585.9).

For those members needing dialysis treatment who are enrolled in **Kaiser Permanente**, dialysis services are covered, either through MAPMG providers, other Participating Providers or, at the member's option, non-participating providers.

Durable Medical Equipment and Supplies

- Authorization for DME and/or DMS will be provided in a timely manner so as not to adversely affect the member's health and within two (2) business days of receipt of necessary clinical information but not later than seven (7) calendar days from the date of the initial request.
- Disposable medical supplies are covered, including incontinency pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the member.
- Durable medical equipment is covered when medically necessary including but not limited to all equipment used in the administration or monitoring of prescriptions by the member. We pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from Kaiser Permanente as long as the member remains Medicaid eligible during the 90-day time period.
- Speech augmenting devices are paid for by the State on a fee-for service basis.

To refer a member for DME, please fax a complete URF with required documentation to UMOC at ☎ (301) 388-1632.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

For members under 21 years of age, all of the following EPSDT services are covered:

Well-child services provided in accordance with the EPSDT periodicity schedule by an EPSDT-certified provider, including:

- Periodic comprehensive physical examinations;
- Comprehensive health and developmental history, including an evaluation of both physical and mental health development;
- Immunizations;
- Laboratory tests including blood level assessments;
- Vision, hearing, and dental screening; and
- Health education.

EPSDT partial or interperiodic well-child services and health care services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions, which services are sufficient in amount, duration, and scope to treat the identified condition, and are subject to limitation only on the basis of medical necessity, including:

- Chiropractic services;
- Nutrition counseling;
- Audiological screening when performed by a PCP;
- Private duty nursing;
- Durable medical equipment including assistive devices; and
- Any other benefit listed in this section.

Providers are responsible for making appropriate referrals for publicly funded programs not covered by Medicaid, including Head Start, the WIC nutritional program, early intervention services, School Health-Related Special Education Services, vocational rehabilitation, and Maternal and Child Health Services (located at local health departments).

When a secondary review is needed, the primary care pediatrician or specialist will fax 📠 (800) 660-2019 the URF or call 📞 (800) 810-4766 (UMOC).

Family Planning Services

Comprehensive family planning services are covered, including:

- Office visits for family planning services;
- Laboratory tests including pap smears;
- Contraceptive devices; and
- Voluntary sterilization.

Home Health Services

Home health services are covered when the member's PCP or attending physician certifies that the services are necessary on a part-time, intermittent basis by a member who requires home visits. Covered home health services are delivered in the member's home and include:

- Skilled nursing services including supervisory visits;

- Home health aide services (including biweekly supervisory visits by a registered nurse in the member's home, with observation of aide's delivery of services to member at least every second visit);
- Physical therapy services;
- Occupational therapy services;
- Speech pathology services; and
- Medical supplies used in a home health visit.

To refer a member for Home Health Care, please fax a URF to UMOC at ☎ (301) 888-1632

Hospice Care Services

Hospice care services are covered for members who are terminally ill with a life expectancy of six (6) months or less. Hospice services can be provided in a hospice facility, in a long-term care facility, or at home.

Hospice providers should inform their Medicaid members (or patients applying for Medicaid coverage) as soon as possible after they enter hospice care about the MCOs with whom they contract so that members can make an informed choice.

We do not require a hospice care member to change his/her out of network hospice provider to an in-network hospice provider. Hospice providers should make members aware of the option to change MCOs. DHMH will allow new members who are in hospice care to voluntarily change their MCO if they have been auto-assigned to a MCO with whom the hospice provider does not contract. If the new member does not change their MCO, then the MCO, which the new member is currently enrolled must pay the out-of-network hospice provider.

Inpatient Hospital Services

Inpatient hospital services are covered.

For special rules for length of stay for childbirth (See Childbirth Related Provisions – Page 23).

Laboratory Services

Diagnostic services and laboratory services performed by providers who are CLIA certified or have a waiver of a certificate registration and a CLIA ID number are covered. However, viral load testing, genotypic, phenotypic, or HIV/AIDS drug resistance testing used in treatment of HIV/AIDS are reimbursed directly by the Department and must be rendered by a Department approved provider and be medically necessary.

Long-Term Care Facility Services/Nursing Facility Services

Long-term care facilities include chronic hospitals, chronic rehabilitation hospitals, and nursing facilities. The first thirty (30) days in a long-term care facility are the responsibility of Kaiser Permanente subject to specific rules.

When a member is transferred to a long-term care facility and the length of the member's stay is expected to exceed thirty (30) days, medical eligibility approval of the DHMH for long-term institutionalization must be secured as soon as possible.

We cover the first thirty (30) days or until DHMH medical eligibility approval is obtained, whichever is longer. If required disenrollment procedures are not followed, our financial responsibility continues until the State's requirements for the member's disenrollment are satisfied. In order for a member to be disenrolled from Kaiser Permanente based on a long-term care facility admission, all of the following must first occur:

- An application, DHMH 3871, for a Departmental determination of medical necessity must be filed (If a length of stay of more than thirty (30) days is anticipated at the time of admission, the application should be filed at the time of admission).
- DHMH must determine that the member's long-term care facility admission was medically necessary in accordance with the State's criteria.
- The member's length of stay must exceed thirty (30) consecutive days.
- We must file an application for disenrollment with DHMH, including documentation of the member's medical and utilization history, if requested.

Once an individual has been disenrolled from Kaiser Permanente, the services they receive in a qualifying long-term care facility will be directly reimbursed by the Maryland Medical Assistance program, as long as the recipient maintains continued eligibility.

Inpatient acute care services provided within the first thirty (30) days following admission to a long-term care facility are not considered an interruption of Kaiser Permanente's coverage of thirty (30) continuous days in a long-term care facility as long as the member is discharged from the hospital back to the long-term care facility.

An individual with serious mental illness, or mental retardation or a related condition may not be admitted to a nursing facility (NF) unless the State determines that nursing facility services are appropriate. For each member seeking nursing facility admission, a Pre-admission Screening and Resident Review (PASRR) ID Screen must be completed. The first section of the ID Screen exempts a member if NF admission is directly from a hospital for the condition treated in the hospital and the attending physician certifies prior to admission to the NF that the recipient is likely to require less than thirty (30) days of NF services.

If a member is not exempted, complete the ID Screen to identify whether the member screens positive for mental illness or mental retardation. If the member screens negative, refer to Adult Evaluation and Review Services (AERS) located in the local health department for a STEPS assessment to help identify alternative services to NF placement.

A member admitted to an Intermediate Care Facility - Mental Retardation (ICF-MR) is disenrolled from Kaiser Permanente immediately upon admission to the facility and we retain no responsibility for the member's care.

If we place a member in a licensed nursing facility that is not a Maryland Medical Assistance Program provider, Medicaid cannot pay the facility for services. Upon MCO disenrollment, the member may transfer to a nursing home that accepts Medicaid payment.

If a member under age 21 is admitted into an ICF-A, we are responsible for medically necessary treatment for as many days as required.

We will reserve nursing facility beds for recipients hospitalized for an acute condition within the first three (3) days not to exceed fifteen (15) days per single acute visit.

Outpatient Hospital Services

Medically necessary outpatient hospital services are covered.

Oxygen and Related Respiratory Equipment

Oxygen and related respiratory equipment are covered.

Pharmacy Services

We will expand our drug formulary to include new products approved by the Food and Drug Administration (COMAR 10.09.67.04D(3)) in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, new brand name drug rated as P (priority) by the FDA will be added to the formulary. Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided in a timely manner so as not to adversely affect the member's health and within two (2) business days of receipt of necessary clinical information but not later than seven (7) calendar days from the date of the initial request. If the service is denied, Kaiser Permanente will notify the prescriber and the member in writing of the denial (COMAR 10.09.71.04).

When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests (COMAR 10.09.67.04F(2)(a)). The State expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

Pharmaceutical services and counseling ordered by an in-plan provider, by a provider to whom the member has legitimately self-referred (if provided on-site), or by an emergency medical provider are covered, including:

- Legend (prescription) drugs;
- Insulin;
- Contraceptives;
- Latex condoms (to be provided without any requirement for a provider's order);
- Non-legend ergocalciferol liquid (Vitamin D)
- Hypodermic needles and syringes;
- Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, jejunostomy, or gastrostomy tube;
- Enteric coated aspirin prescribed for treatment of arthritic conditions;
- Nonlegend ferrous sulfate oral preparations;

- Nonlegend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for members under age 12;
- Formulas for genetic abnormalities;
- Medical supplies for compounding prescriptions for home intravenous therapy;
- Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider;
- Most mental health drugs are on SMHS formulary and are to be paid by SMHS; and
- Most HIV/AIDS drugs are paid directly by the State.

Kaiser Permanente drug utilization review program is subject to review and approval by DHMH and is coordinated with the drug utilization review program of the Specialty Mental Health Service delivery system.

Limitations: neither the State nor the MCO cover the following:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight; and
- Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition.

Physician and Advanced Practice Nurse Specialty Care Services

Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when services are medically necessary and are outside of the PCP's customary scope of practice.

Specialty care services covered under this section also include:

- Services performed by non-physician, non-APN practitioners, within their scope of practice, employed by a physician to assist in the provision of specialty care services, and working under the physician's direct supervision;
- Services provided in a clinic by or under the direction of a physician or dentist; and
- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians.

Kaiser Permanente shall clearly define and specify referral requirements to all providers.

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary.

PCPs must follow our special referral protocol for children with special healthcare needs who suffer from a moderate to severe chronic health condition which:

- Has significant potential or actual impact on health and ability to function;
- Requires special health care services; and

- Is expected to last longer than six (6) months.

A child who is functioning one third or more below chronological age in any developmental area must be referred for specialty care services intended to improve or preserve the child's continuing health and quality of life, regardless of the services ability to affect a permanent cure.

Podiatry Services

Kaiser Permanente provides its members medically necessary podiatry services as follows:

- For members younger than 21 years old
- Diabetes care services specified in COMAR 10.09.67.24
- Routine foot care for members 21 years old or older with vascular disease affecting the lower extremities

Primary Care Services

Primary care is generally received through a member's PCP, who acts as a coordinator of care, and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits for which a member is eligible. In some cases, members will opt to access certain primary care services by self-referral to providers other than their PCPs, for example, school-based health centers. Primary care services include:

- Addressing the member's general health needs;
- Coordination of the member's health care;
- Disease prevention and promotion and maintenance of health;
- Treatment of illness;
- Maintenance of the members' health records; and
- Referral for specialty care.

For female members, if the member's PCP is not a women's health specialist she may see a women's health specialist within Kaiser Permanente, without a referral, for covered services necessary to provide women's routine and preventive health care services.

Primary Mental Health Services

We cover primary mental health services required by members, including clinical evaluation and assessment, provision of primary mental health services, and/or referral for additional services, as appropriate.

The PCP of a member requiring mental health services may elect to treat the member if the treatment falls within the scope of the PCP's practice, training, and expertise. Neither the PCP nor Kaiser Permanente may bill the Public Mental Health System (PMHS) for the provision of such services because these services are included in the Maryland HealthChoice capitation rates.

When, in the PCP's judgment, an member's need for mental health treatment cannot be adequately addressed by primary mental health services provided by the PCP, the PCP should, after determining the member's eligibility (based on probable diagnosis), refer the

member to the SMHS for specialty mental health services. (This process is described in Section IV.)

Rehabilitative Services

Rehabilitative services including medically necessary physical therapy, speech therapy, and occupational therapy for adults are covered. For members under 21, rehabilitative services are covered by Kaiser Permanente only if part of a home health visit or inpatient hospital stay. All other rehabilitative services for members under 21 should be billed fee-for-service to the Department.

Authorization for physical, occupational, speech therapies and rehabilitative services are based upon medical necessity for both acute and non-acute conditions.

To refer a member for PT/OT/ST, please fax a URF to UMOC at ☎ (301) 388-1633.

Re-authorization for DME, Home Care, PT, OT, and ST

Requests for reauthorizations should be faxed to the following department fax numbers:

Home Care: Fax ☎ (301) 388-1632

PT, OT, ST: Fax ☎ (301) 388-1633

DME: Fax ☎ (301) 388-1632

Second Opinions

If a member requests one, we will provide for a second opinion from a qualified health care professional within our network. If necessary, we will arrange for the member to obtain one outside of our network.

If a second opinion is indicated, the member's PCP should initiate a new referral request by completing a URF and fax it to the UMOC at ☎ (800) 660-2019.

Substance Use Disorder Treatment Services

Substance abuse treatment services are covered. (See Page 26)

Transplants

Medically necessary transplants are covered.

Vision Care Services

Medically necessary vision care services are covered. Kaiser Permanente is responsible to provide at a minimum:

- One eye examination every two (2) years for members age 21 or older*
- For members under 21, at least one (1) eye examination every year in addition to EPSDT screening, one (1) pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate, and contact lenses, if eyeglasses are not medically appropriate for the condition.

Refer to "Optional Services Provided by Kaiser Permanente" for additional vision benefits.

Benefit Limitations

The following are not covered under Maryland HealthChoice:

- Services that are not medically necessary.
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state).
- Services that are beyond the scope of practice of the health care practitioner performing the service.
- Abortions. (Available under limited circumstances through Medicaid fee-for-service.)
- Autopsies.
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities.
- Services provided outside the U.S.
- Dental services for adults, unless pregnant. Refer to “Optional Services Provided by Kaiser Permanente” for additional dental benefits.
- Diet and exercise programs for weight loss except when medically necessary.
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial as specified in COMAR 10.09.67.26-1.
- Immunizations for travel outside the U.S.
- In-vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- Lifestyle improvements (physical fitness programs, nutrition counseling, smoking cessation) unless specifically included as a covered service.
- Medication for the treatment of sexual dysfunction.
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is younger than 12 years old.
- Non-legend drugs other than insulin and enteric-coated aspirin for arthritis.

- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- Orthodontia except when the member is under 21 and scores at least fifteen (15) points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction.
- Ovulation stimulants.
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis.
- Private duty nursing for adults 21 years old and older.
- Private hospital room unless medically necessary or no other room available.
- Purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, other than for members younger than 21 years old.
- Reversal of voluntary sterilization procedure.
- Services performed before the effective date of the member's coverage.
- Transportation services that are provided through LHDs. Kaiser Permanente will assist members to secure non-emergency transportation through their LHD. Additionally, we provide non-emergency transportation to access a covered service if we choose to provide the service at a location that is outside of the closest county in which the service is available. The following is a list of the transportation contact numbers for each county:

<u>County</u>	<u>Telephone number to Call</u>
Alleghany	Van Trans Inc. – 301-722-2770 Alleghany Ambulance – 301-689-1113
Anne Arundel	AAA Transport – 1-800-442-2858
Baltimore City	New Clients – 410-396-7007 Established Clients – 410-396-6422 (Facilities only) – 410-396-6665
Baltimore County	Veolia Transportation – 410-783-2465 410-887-2828
Calvert	AAA Transport – 800-577-1050
Caroline	Bay Area Transportation – 800-987-9088 Best Care Ambulance – 410-476-3688

Carroll	Butler Medical Transport – 888-602-4007 410-602-4007
Cecil	410-996-5171
Charles	301-6097917
Dorchester	410-901-2426
Frederick	301-600-1725
Garrett	Garrett Community Action – 301-334-9431
Harford	410-638-1671
Howard	AAA Transport – 800-577-1050
Kent	410-778-7025
Montgomery	Montgomery Co Dept. of Public Works & Transit – 240-777-5899
Prince George's	301-856-9555
Queen Anne's	QA Co Dept. of Aging – 410-758-2357
St. Mary's	301-475-4296
Somerset	Shore Transit – 443-260-2300 Lifestar – 410-546-0809
Talbot	Bay Area Transportation – 800-987-9008 Best Care ambulance – 410-476-3688
Washington	240-313-3264
Wicomico	Shore Transit – 443-260-2300 Lifestar -- 410-546-0809
Worcester	410-632-0092 or 0093

- Therapeutic footwear other than for a member who qualifies for diabetes care services or for a member who is younger than 21 years old.

MEDICAID COVERED SERVICES THAT ARE NOT THE RESPONSIBILITY OF KAISER PERMANENTE

The following services are not the responsibility of the MCO and are paid by the State on a fee-for-service basis:

- Dental services for children and pregnant women of any age.
- Occupational therapy, Physical therapy, Speech therapy or Audiology services for children under the age of 21 years old.
- Intermediate care facilities - mental retardation services are available through State facilities.
- Medical day care services are available through direct provider reimbursement by the State on a fee-for-service basis.
- Personal care services are available through direct provider reimbursement by the State on a fee-for-service basis.
- Viral load testing, genotypic, phenotypic or HIV/AIDS drug resistance testing, and enfuvirtide used in treatment of HIV/AIDS are reimbursed directly by the Department if the service is rendered by a Department approved provider and medically necessary.
- Specialty mental health services. (See Section IV.)
- All services to individuals enrolled in the Rare and Expensive Case Management Program. (See Section V.)
- Service provided after the thirtieth day of a member's admission in a chronic hospital, rehabilitation hospital, skilled nursing facility, intermediate care facility or Institution for Mental Disease. The thirty (30) day limit is subject to Kaiser Permanente receiving the Departments approval for disenrollment from our MCO.
- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Family Service Plan or Individualized Education Plan and provided in the schools or by community-based children's medical services providers.
- Special support services for individuals covered under the Developmental Disabilities waiver.
- Antiretroviral drugs in American Hospital Formulary Service therapeutic class 8:18:08 used in the treatment of HIV/AIDS.
- Speech augmenting devices.

- Cochlear implant devices.

SELF-REFERRAL SERVICES

Members can elect to receive certain covered services from out-of-plan providers. Kaiser Permanente will cover these pursuant to COMAR 10.09.67.28. The services that a member has the right to access on a self-referral basis include:

- Certain family planning services including office visits, diaphragm fitting, IUD insertion and removal, special contraceptive supplies, Depo-Provera-FP, latex condoms, and PAP smear.
- Certain school-based healthcare services including diagnosis and treatment of illness or injury that can be effectively managed in a primary care setting, well child care and the family planning services listed above.
- Initial medical examination for a child in State-supervised care.
- Unless Kaiser Permanente provides for the service before a newborn is discharged from the hospital, the initial examination of a newborn before discharge, if performed by an out-of-network on-call hospital provider.
- Annual Diagnostic and Evaluation Service (DES) visit for a member diagnosed with HIV or AIDS.
- Continued obstetric care with her pre-established provider for a new pregnant member.
- Renal dialysis services.
- Pharmaceutical and laboratory services, when provided in connection with a legitimately self-referred service, provided on-site by the same out-of-plan provider at the same location as the self-referred service.
- A newly enrolled child with a special health care needs may continue to receive medical services directly related to the child's medical condition under a plan of care that was active at the time of the child's initial enrollment, if the child's out-of-plan provider submits the plan of care to Kaiser Permanente for review and approval within thirty (30) .days of enrollment (For additional information, see Page 9).
- Emergency services as described in COMAR 10.09.66.08 B.
- Substance use disorder services such as individual and group counseling, detoxification and inpatient care when provided by and ADAA certified provider and ASAM criteria is met.
- Services performed at a birthing center, including an out-of-state center.

OPTIONAL SERVICES PROVIDED BY KAISER PERMANENTE

The following are optional services provided by Kaiser Permanente for Maryland HealthChoice members:

Adult Dental

Kaiser Permanente offers preventive dental benefits to our adult members who are not pregnant (pregnant members already have coverage for dental services). Dental services are provided by DentaQuest. You can call DentaQuest at 1-855-208-6316. Dental services do not require a referral from your PCP. The preventive services we cover include:

- Dental exams two (2) times/year (one (1) every six (6) months)
- Dental cleaning two (2) times/year (one (1) every six (6) months)
- Limited X-rays once a year
- Limited fillings for cavities
- Limited non-surgical extractions

Adult Vision

Kaiser Permanente also offers Maryland HealthChoice members ages 21 and over with one (1) eye exam/year and one (1) pair of eyeglasses every two (2) years. Contact lenses are covered only when medically necessary. For a complete listing of Kaiser Permanente locations with vision centers, please visit our online facility directory on our Community Provider Website at www.providers.kp.org or contact Provider Relations at 1-877-806-7470.

Transportation

Transportation is offered as medically necessary and appropriate on a case-by-case basis as deemed by Case Manager.

Section IV

SPECIALTY MENTAL HEALTH SERVICES

Introduction

Under the Maryland HealthChoice program we are responsible for a comprehensive package of services, with limited exceptions detailed in Section III. The Maryland HealthChoice program, however, has two significant program areas where eligible recipient's services are not the responsibility of the MCO. These 'carve outs' are distinct in that one carves out a service, specialty mental health care, and the other carves out a population, individuals who qualify for the Rare and Expensive Case Management (REM) program.

SPECIALTY MENTAL HEALTH SERVICES (SMHS)

www.dhmfh.maryland.gov/mha

Description

In the State of Maryland, the system responsible for the delivering of specialty mental health services to Medicaid recipients is the Public Mental Health System (PMHS). The PMHS will deliver all specialty mental health services to members in Maryland HealthChoice. The Mental Hygiene Administration (MHA), in collaboration with Core Service Agencies (CSA) operates the PMHS. The MHA contracts with an Administrative Service Organization (ASO) to provide administrative management functions for all the PMHS, statewide.

Local Access to SMHS – Role of the Core Services Agencies (CSAs)

www.dhmfh.maryland.gov/mha/sitepages/csa.aspx

Twenty (20) CSAs serve as the local entities in charge of the mental health service delivery system in their jurisdictions. Working in conjunction with the MHA, CSAs:

- Plan, establish, coordinate and manage publicly funded mental health services in their respective jurisdictions. CSAs will promote the full participation of mental health recipients, family members, caregivers, local human service and healthcare agencies, as well as other appropriate stakeholders in developing and evaluating these services.
- Determine type and capacity need of providers to offer a comprehensive array of publicly funded mental health services for their communities.
- Assure recipient access to services.
- Measure the quality of the services rendered.
- Handle grievances and appeals, in accordance with COMAR.

Role of the Administrative Service Organization (ASO):

- Verifies the eligibility of recipients.
- Authorizes services that are determined to be medically necessary according to criteria set by the MHA.

- Refers individuals to qualified providers of public mental health services
- Performs service utilization review to assess quality, appropriateness and effectiveness of care for the MHA in collaboration with the CSAs.
- Processes billing claims and remits payments.
- Maintains 24-hour, toll-free telephone access seven (7) days a week for recipients at 1-800-888-1965. Access for providers is maintained from 8:00 A.M. – 6:00 P.M. Monday through Friday at 1-800-888-1965.
- Conducts annual provider and recipient satisfaction surveys and submits results to the MHA and the CSAs.

Access to Specialty Mental Health Services

- Specialty mental health services (i.e., any mental health services other than primary mental health services) are not subject to capitation and are not our responsibility. Even so, Kaiser Permanente or our Participating PCPs do have the responsibility to refer eligible members to the PMHS when specialty mental health services are needed.
- A member with a probable diagnosis of a mental disorder is eligible for referral to the SMHS by the PCP or Kaiser Permanente if the following conditions are met:
 - The member's probable diagnosis of a mental disorder was established in accordance with the current American Psychiatric Association Diagnostic and Statistical Manual recognized by DHMH;
 - The probable diagnosis is not a sole diagnosis of substance abuse or dependence, dementia, or mental retardation or one of the diagnoses listed at the end of this section; and
 - The PCP or Kaiser Permanente determines that primary mental health services provided by the PCP are insufficient to address the member's mental health treatment needs.
- A mental health professional functioning as the SMHS utilization review (UR) agent will accept preauthorization requests to determine the medical necessity for mental health assessment or treatment. The SMHS UR agent will preauthorize medically necessary services of a type, frequency, and duration that are consistent with expected results and are cost-effective.
- If the SMHS UR agent determines that there is medical necessity for specialty mental health services, the member will be linked with the appropriate services.
- If the SMHS UR agent determines that specialty mental health services are not medically necessary, the SMHS UR will, as appropriate, promptly consult the referral source for assistance in developing a plan for the member, to determine whether an

alternative service or a service of alternate duration is appropriate.

- If the SMHS UR agent denies services, the member and the provider are notified in writing, specifying the clinical rationale for the denial, and outlining procedures for appealing the denial.
- With the recipient's permission, the treating mental health provider communicates directly with the PCP, to coordinate mental health and somatic care.
- The SMHS UR agent may not deny services without arranging an appropriate alternative service if the denial of services would abruptly change the member's living situation or cause severe disruption to a member with serious and persistent mental illness or serious emotional disturbance.

Referring a Member to the SMHS through a Toll-Free Help Line: 1-800-888-1965

The ASO's toll-free number is available 24 hours a day, 7 days a week and is staffed by qualified mental health professional called Care Managers.

Members are able to access the ASO directly or through assistance from Kaiser Permanente, their PCP, a mental health provider, family member or caregiver. Staff is trained to handle those who are non-English speaking or hearing impaired. Back up physician advisors will be available at all times.

Once a call is received, Care Managers assess requests for service using the following definitions of need:

- Acute Crisis - A situation in which an individual is threatening imminent harm to them self or others. The member or the person making the call may state or imply that the recipient is not in control of these impulses. Help will be dispatched immediately, while keeping the caller on the line with a clinician.
- Emergency - A situation involving a member or the person making the call who states or implies that the recipient may do harm to them self or others if help is not received soon. The caller states or implies the recipient's need for help, but may be able to maintain impulse control for several hours until help can be arranged. The Care Manager's assessment of the situation presented is that acute crisis services would not be needed. In these cases, the PMHS protocols require that authorizations be made within one (1) hour and face-to-face emergency services must be provided within four (4) hours.
- Urgent - A situation in which the recipient is experiencing a decrease in self-control and increasing frustration over life events. The Care Manager's assessment is that neither acute crisis nor emergency services are needed. As a result, the member plans or engages in avoidance activities, such as running away, rather than threatening harm to self or others. The PMHS protocols require that an urgent situation be handled through face-to-face services within 24 hours.
- Scheduled - A situation in which the member or caller feels that the member is in no immediate harm, but requires an assessment and probably mental health services. The

PMHS protocols require that recipients be seen by a provider within ten (10) working days.

- The PMHS will arrange for medically appropriate psychiatric consultations for any condition.

Specialty Mental Health Diagnoses Covered by the PMHS

295.00 – 298.9
299.9
300.00 – 301.6
301.81 – 302.6
302.81 – 302.9
307.1
307.3
307.5 – 307.89
308.0 – 308.9
309.0 – 309.9
311
312.0 – 312.9
313.0 – 313.82
313.89 – 314.9
332.1
333.1
333.82
333.90
333.92
333.99
648.4
648.40 – 648.44

Section V

RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

Overview

The Department of Health and Mental Hygiene (DHMH) administers a Rare and Expensive Case Management (REM) program to address the special needs of waiver-eligible individuals diagnosed with rare and expensive medical conditions. The REM program, a part of the Maryland HealthChoice Program, was developed to ensure that individuals who meet specific criteria receive high quality, medically necessary and timely access to health services.

Qualifying diagnoses for inclusion in the REM program must meet the following criteria:

- Occurrence is generally fewer than 300 individuals per year;
- Cost is generally more than \$10,000 on average per year;
- Need is for highly specialized and/or multiple providers/delivery system;
- Chronic condition;
- Increased need for continuity of care; and
- Complex medical, habilitative and rehabilitative needs.

Medicaid Services and Benefits

To qualify for the REM program, a recipient must have one or more of the diagnoses specified in the Rare and Expensive Disease List at the end of this section. The recipients may elect to enroll in the REM Program or to remain in Kaiser Permanente if the Department agrees that it is medically appropriate. REM participants are eligible for fee-for-service benefits currently offered to Medicaid-eligible recipients not enrolled in MCOs as well as additional, optional services, which are described in COMAR 10.09.69. All certified Medicaid providers other than HMOs, MCOs, ICF-MRs and IMDs are available to REM participants in accordance with the individual's plan of care.

Case Management Services

In addition to the standard and optional Medicaid services, REM participants have a case manager assigned to them. The case manager's responsibilities include:

- Gathering all relevant information needed to complete a comprehensive needs assessment;
- Assisting the participant with selecting an appropriate PCP, if needed;
- Consulting with a multi-disciplinary team that includes providers, participants, and family/caregivers to develop the participant's plan of care;
- Implementing the plan of care, monitoring service delivery, and making modifications to the plan as warranted by changes in the participant's condition;
- Documenting findings and maintaining clear and concise records;
- Assisting in the participant's transfer out of the REM program, when and if appropriate.

Care Coordination

REM case managers are also expected to coordinate care and services from other programs and/or agencies to ensure a comprehensive approach to REM case management services. Examples of these agencies and programs are:

- Developmental Disability Administration - coordinate services for those also in the Home

- and Community-based Services Waiver;
- DHMH - Maternal Child Health Division on EPSDT - guidelines and benchmarks and other special needs children's issues;
 - AIDS Administration - consult on pediatric AIDS;
 - DHR - coordinate Medical Assistance eligibility issues; coordinate/consult with Child Protective Services and Adult Protective Services; coordinate with foster care programs;
 - Department of Education - coordination with the service coordinators of Infants and Toddlers Program and other special education programs;
 - Mental Hygiene Administration - referral for mental health services to the Specialty Mental Health System, as appropriate, and coordination of these services with somatic care.

Referral and Enrollment Process

Candidates for REM are generally referred from Maryland HealthChoice MCOs, providers, or other community sources. Self-referral or family-referral is also acceptable. Referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information in order to determine the recipient's eligibility for REM. If the Intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the recipient and referral source.

If the Intake nurse determines that the recipient has a REM-qualifying diagnosis, the nurse approves the recipient for enrollment. However, before actual enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services in the fee-for service environment. If not, the case is referred to a case manager to arrange a PCP in consultation with the recipient. If the PCP will continue providing services, the Intake Unit then calls the recipient to notify of the enrollment approval, briefly explain the program, and give the recipient an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. At the time of recipient notification, the Intake Unit also ascertains if the recipient is receiving services in the home, e.g., home nursing, therapies, supplies, equipment, etc. If so, the case is referred to a case manager for service coordination. We are responsible for providing the recipient's care until the recipient is actually enrolled in the REM program. If the recipient does not meet the REM criteria, the recipient will remain enrolled in Kaiser Permanente.

For questions or to request a REM Referral Form, please call telephone number 800-565-8190. Referrals may be faxed to the REM Intake Unit at 410-333-5426 or mailed to the following address:

REM Program Intake Unit
Maryland Department of Health and Mental Hygiene
Office of Health Services
201 W. Preston Street, Room 210
Baltimore, MD 21201-2399

Table of Rare and Expensive Disease List as of January 2013

ICD-9	Disease	Age Group
042	Symptomatic HIV disease/AIDS (pediatric)	0-20
V08	Asymptomatic HIV status (pediatric)	0-20
795.71	Infant with inconclusive HIV result	0-12 mos.
270.0	Disturbances of amino-acid transport: <ul style="list-style-type: none"> • Cystinosis • Cystinuria • Hartnup disease 	0-20
270.1	Phenylketonuria – PKU	0-20
270.0	Other disturbances of aromatic-acid metabolism	0-20
270.3	Disturbances of branched-chain amino-acid metabolism	0-20
270.4	Disturbances of sulphur-bearing amino-acid metabolism	0-20
270.5	Disturbances of histidine metabolism: <ul style="list-style-type: none"> • Carnosinemia • Histidinemia • Hyperhistidinemia • Imidazole aminoaciduria 	0-20
270.6	Disorders of urea cycle metabolism	0-20
270.7	Other disturbances of straight-chain amino-acid: <ul style="list-style-type: none"> • Glucoglycinuria • Clycaemia (with methylmalonic academia) • Hyperglycinemia, Hyperlysinemia • Pipecolic academia • Saccharopinuria • Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine 	0-20
270.8	Other specified disorders of amino-acid metabolism: <ul style="list-style-type: none"> • Alaninemia • Ethanolominuria • Glycoprolinuria • Hydroxyprolinemia • Hyperprolinemia • Iminoacidopathy • Prolinemia • Prolinuria • Sarcosinemia 	0-20
271.0	Glycogenosis	0-20
271.1	Galactosemia	0-20
271.2	Hereditary fructose intolerance	0-20
272.7	Lipidoses	0-20
277.00	Cystic fibrosis without ileus	0-64
277.01	Cystic fibrosis with ileus	0-64
277.02	Cystic fibrosis with pulmonary manifestations	0-64
277.03	Cystic fibrosis with gastrointestinal	0-64
277.09	Cystic fibrosis with other manifestations	0-64

277.2	Other disorders of purine and pyrimidine metabolism	0-64
277.5	Mucopolysaccharidosis	0-64
277.81	Primary Carnitine deficiency	0-64
277.82	Carnitine deficiency due to inborn errors of metabolism	0-64
277.89	Other specified disorders of metabolism	0-64
284.01	Constitutional red blood cell aplasia	0-20
284.09	Other constitutional aplastic anemia	0-20
286.0	Congenital factor VIII disorder	0-64
286.1	Congenital factor IX disorder	0-64
286.2	Congenital factor XI deficiency	0-64
286.3	Congenital deficiency of other clotting factors	0-64
286.4	von Willebrand's disease	0-64
330.0	Leukodystrophy	0-20
330.1	Cerebral lipidoses	0-20
330.2	Cerebral degenerations in generalized lipidoses	0-20
330.3	Cerebral degeneration of childhood in other diseases classified elsewhere	0-20
330.8	Other specified cerebral degeneration in childhood	0-20
330.9	Unspecified cerebral degeneration in childhood	0-20
331.3	Communicating hydrocephalus	0-20
331.4	Obstructive hydrocephalus	0-20
333.2	Myoclonus	0-5
333.6	Idiopathic torsion dystonia	0-64
333.7	Symptomatic torsion dystonia	0-64
333.90	Unspecified extrapyramidal disease and abnormal movement disorder	0-20
334.0	Friedreich's ataxia	0-20
334.1	Hereditary spastic paraplegia	0-20
334.2	Primary cerebellar degeneration	0-20
334.3	Cerebellar ataxia NOS	0-20
334.4	Cerebellar ataxia in other diseases	0-20
334.8	Other spinocerebellar diseases NEC	0-20
334.9	Spinocerebellar disease NOS	0-20
335.0	Werdnig-Hoffmann disease	0-20
335.10	Spinal muscular atrophy unspecified	0-20
335.11	Kugelberg-Welander disease	0-20
335.19	Spinal muscular atrophy NEC	0-20
335.20	Amyotrophic lateral sclerosis	0-20
335.21	Progressive muscular atrophy	0-20
335.22	Progressive bulbar palsy	0-20
335.23	Pseudobulbar palsy	0-20
335.24	Primary lateral sclerosis	0-20
335.29	Motor neuron disease NEC	0-20
335.8	Anterior horn disease NEC	0-20
335.9	Anterior horn disease NOS	0-20
341.1	Schilder's disease	0-64
343.0	Diplegic infantile cerebral palsy	0-20

343.2	Quadriplegic infantile cerebral palsy	0-64
344.00	Quadriplegia, unspecified	0-64
344.01	Quadriplegia, C1-C4, complete	0-64
344.02	Quadriplegia, C1-C4, incomplete	0-64
344.03	Quadriplegia, C5-C7, complete	0-64
344.04	Quadriplegia, C5-C7, incomplete	0-64
344.09	Quadriplegia, Other	0-64
359.0	Congenital hereditary muscular dystrophy	0-64
359.1	Hereditary progressive muscular dystrophy	0-64
359.21	Congenital myotonic dystrophy (Steinert's only)	0-64
437.5	Moyamoya disease	0-64
579.3	Short gut syndrome	0-20
582.0	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis	0-20
582.1	Chronic glomerulonephritis with lesion of membranous glomerulonephritis	0-20
582.2	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis	0-20
582.4	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis	0-20
582.81	Chronic glomerulonephritis in diseases classified elsewhere	0-20
582.89	Other: Chronic glomerulonephritis with lesion of exudative nephritis interstitial (diffuse) (focal) nephritis	0-20
582.9	Chronic glomerulonephritis with unspecified pathological lesion in kidney Nephritis specified as chronic Nephropathy specified as chronic NOS glomerulonephritis specified as chronic Hemorrhagic glomerulonephritis specified as chronic	0-20
585.1	Chronic kidney disease, Stage I	0-20
585.2	Chronic kidney disease, Stage II (mild)	0-20
585.3	Chronic kidney disease, Stage III (moderate)	0-20
585.4	Chronic kidney disease, Stage IV (severe)	0-20
585.5	Chronic kidney disease, Stage V	0-20
585.6	End stage renal disease	0-20
585.9	Chronic kidney disease, unspecified	21-64
585.6, V45.11	Chronic renal failure with dialysis	21-64
741.00	Spina bifida with hydrocephalus NOS	0-64
741.01	Spina bifida with hydrocephalus cervical region	0-64
741.02	Spina bifida with hydrocephalus dorsal region	0-64
741.03	Spina bifida with hydrocephalus lumbar region	0-64
741.90	Spina bifida unspecified región	0-64
741.91	Spina bifida cervical región	0-64
741.92	Spina bifida dorsal región	0-64
741.93	Spina bifida lumbar región	0-64
742.0	Encephalocele:	0-20

	<ul style="list-style-type: none"> • Encephalocystocele • Encephalomyelocele • Hydroencephalocele • Hydromeningocele, cranial • Meningocele, cerebral • Menigoencephalocele 	
742.1	Microcephalus: <ul style="list-style-type: none"> • Hydromicrocephaly 	0-20
742.3	Congenital hydrocephalus	0-20
742.4	Other specified anomalies of brain	0-20
742.51	Other specified anomalies of the spinal cord Diastematomyelia	0-64
742.53	Other specified anomalies of the spinal cord: Hydromyelia	0-64
742.59	Other specified anomalies of spinal cord: <ul style="list-style-type: none"> • Amyelia • Congenital anomaly of spinal meninges • Myelodysplasia • Hypoplasia of spinal cord 	0-64
748.1	Nose anomaly - cleft or absent	0-5
748.2	Web of larynx	0-20
748.3	Laryngotracheal anomaly NEC- Atresia or agenesis of larynx, bronchus, trachea, only	0-20
748.4	Congenital cystic lung	0-20
748.5	Agenesis, hypoplasia and dysplasia of lung	0-20
749.00	Cleft palate NOS	0-20
749.01	Unilateral cleft palate complete	0-20
749.02	Unilateral cleft palate incomplete	0-20
749.03	Bilateral cleft palate complete	0-20
749.04	Bilateral cleft palate incomplete	0-20
749.20	Cleft palate and cleft lip NOS	0-20
749.21	Unilateral cleft palate with cleft lip complete	0-20
749.22	Unilateral cleft palate with cleft lip incomplete	0-20
749.23	Bilateral cleft palate with cleft lip complete	0-20
749.24	Bilateral cleft palate with cleft lip incomplete	0-20
749.25	Cleft palate with cleft lip NEC	0-20
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis	0-3
751.2	Atresia large intestine	0-5
751.3	Hirschsprung's disease	0-15
751.61	Biliary atresia	0-20
751.62	Congenital cystic liver disease	0-20
751.7	Pancreas anomalies	0-5
751.8	Other specified anomalies of digestive system NOS	0-10
753.0	Renal agenesis and dysgenesis, bilateral only: <ul style="list-style-type: none"> • Atrophy of kidney congenital and infantile • Congenital absence of kidney(s) 	0-20

	<ul style="list-style-type: none"> • Hypoplasia of kidney(s) 	
753.10	Cystic kidney disease, bilateral only	0-20
753.12	Polycystic kidney, unspecified type, bilateral only	0-20
753.13	Polycystic kidney, autosomal dominant, bilateral only	0-20
753.14	Polycystic kidney, autosomal recessive, bilateral only	0-20
753.15	Renal dysplasia, bilateral only	0-20
753.16	Medullary cystic kidney, bilateral only	0-20
753.17	Medullary sponge kidney, bilateral only	0-20
753.5	Exstrophy of urinary bladder	0-20
756.0	Musculoskeletal--skull and face bones: <ul style="list-style-type: none"> • Absence of skull bones • Acrocephaly • Congenital deformity of forehead • Craniosynostosis • Crouzon's disease • Hypertelorism • Imperfect fusion of skull • Oxycephaly • Platybasia • Premature closure of cranial sutures • Tower skull • Trigonocephaly 	0-20
756.4	Chondrodystrophy	0-1
756.50	Osteodystrophy NOS	0-1
756.51	Osteogenesis imperfecta	0-20
756.52	Osteopetrosis	0-1
756.53	Osteopoikilosis	0-1
756.54	Polyostotic fibrous dysplasia of bone	0-1
756.55	Chondroectodermal dysplasia	0-1
756.56	Multiple epiphyseal dysplasia	0-1
756.59	Osteodystrophy NEC	0-1
756.6	Anomalies of diaphragm	0-1
756.70	Anomaly of abdominal wall	0-1
756.71	Prune belly syndrome	0-1
756.72	Omphalocele	0-1
756.73	Gastrochesis	0-1
756.79	Other congenital anomalies of abdominal wall	0-1
759.7	Multiple congenital anomalies NOS	0-10
V46.1	Dependence on respirator	1-64

Section VI

DHMH QUALITY IMPROVEMENT AND MCO OVERSIGHT ACTIVITIES

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

Well child exam only (see attached physical exam form)

SBHC Name & Address: SBHC Provider Number: Contact Name: Telephone: Fax:		MCO Name & Address: Contact Name: Telephone: Fax: Date Faxed:	
Student Name: DOB: MA Number: SS Number:		Date of Visit:	ICD-9 Codes
Provider Name/Title: (Please Print)		Type of Visit: <input type="checkbox"/> Acute/Urgent <input type="checkbox"/> Follow Up <input type="checkbox"/> Health Maintenance	CPT Codes
T: _____ Hgt: _____ Rapid Strep test: + - P: _____ Wgt: _____ Hgb: _____ RR: _____ BMI: _____ BGL: _____ BP: _____ U/A: _____ PF: _____ PaO2: _____		Drug Allergy: _____ <input type="checkbox"/> NKDA	Immunization review: <input type="checkbox"/> UTD Given today: _____ Needs: _____

Chief Complaint: _____ **Age:** _____

HPI:

Past Medical History: Unremarkable See health history Pertinent: _____

Physical Findings:

General: Alert/NAD

Pertinent:

Head: Normal

Pertinent:

Ears: TMs: pearly, + landmarks, + light reflex

Cerumen removed curette/lavage

Pertinent:

Eyes: PERRLA, sclera clear, no discharge/crusting

Pertinent:

Nose: Turbinates: pink, without swelling

Pertinent:

Mouth: Pharynx without erythema, swelling, or exudate

Normal dentition without caries

Pertinent:

Neck: Full ROM. No tenderness

Pertinent:

Lymph Nodes: No lymphadenopathy

Pertinent:

Cardiac: RRR, normal S1 S2, no murmur

Pertinent:

Lungs: CTA bilaterally, no retractions, wheezes, rales, rhonchi

Pertinent:

Abdomen: Soft, non-tender, no HSM, no masses,

Bowel sounds present

Pertinent:

Genitalia: Normal female/normal male Tanner Stage ____

Pertinent:

Extremities: FROM

Pertinent:

Neurologic: Grossly intact

Pertinent:

Skin: Intact, no rashes

Pertinent:

ASSESSMENT:

PLAN:

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

For MCO formulary info, find MCO website at:

<http://dhmh.state.md.us/mma/healthchoice/>

Provider Signature: _____
DHMH 7-10-2009/ch

PCP F/U Required:

Yes No

QUALITY ASSURANCE MONITORING PLAN

The quality assurance monitoring plan for the Maryland HealthChoice program is based upon the philosophy that the delivery of health care services, both clinical and administrative, is a process that can be continuously improved. The State of Maryland's quality assurance plan structure and function supports efforts to deal efficiently and effectively with any identified quality issue. On a daily basis and through a systematic process of annual audit of MCO operations and health care delivery, the Department identifies both positive and negative trends in service delivery. Quality monitoring and evaluation and education through member and provider feedback is an integral part of the managed care process and helps to ensure that cost containment activities do not adversely affect the quality of care provided to members.

The Department's quality assurance monitoring plan is a multifaceted strategy for assuring that the care provided to Maryland HealthChoice members is high quality, complies with regulatory requirements, and is rendered in an environment that stresses continuous quality improvement. Components of the Department's quality improvement strategy include: establishing quality assurance standards for MCOs; developing quality assurance monitoring methodologies; and developing, implementing and evaluating quality indicators, outcomes measures and data reporting activities.

The Department has adopted a variety of methods and data reporting activities to assess MCO service quality to Medicaid members. These areas include:

- Health Risk Assessment screening conducted by the enrollment broker at the time the recipient selects an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs.
- A complaint process administered by Department staff.
- A complaint process administered by Kaiser Permanente
- A review of each MCO's quality improvement processes and clinical care through an annual systems performance review performed by an External Quality Review Organization (EQRO) selected by the Department. The audit assesses the structure, process, and outcome of each MCO's internal quality assurance program.
- The annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures designed by the National Committee for Quality Assurance. The measures are audited by an independent entity and results are reported to DHMH.
- The annual collection and evaluation of a set of performance measures identified by the Department.
- An annual member satisfaction survey using the Consumer Assessment of Health Plans Survey (CAHPS)

- Monitoring of preventive health, access and quality of care outcome measures based on encounter data.
- Development and implementation of Maryland HealthChoice outreach plan.
- A review of services to children to determine our compliance with federally required EPSDT standards of care.
- The annual production of a Consumer Report Card.

Quarterly Complaint Reporting

We are responsible for gathering and reporting to the State information about member's appeals and grievances and our interventions and resolution to these appeals and grievances. The reports contain data on appeals and grievances in a standardized format and are submitted on a quarterly basis. To accomplish this, we are required to operate a Consumer Services Hotline and Internal complaint process.

Member Services

Kaiser Permanente maintains a member services unit that operates a member services hotline Monday through Friday, 7:30 a.m. to 5:30 p.m. Kaiser Permanente member services can be reached at 1-855-249-5019. This unit handles and resolves or properly refers members' inquiries or complaints to other agencies. Additionally, we provide members with information about how to access our member services unit and consumer services hotline to obtain information and assistance.

Member Complaints

Kaiser Permanente has written complaint policies and procedures whereby a member who is dissatisfied with the MCO or its network may seek recourse verbally or in writing from the Maryland HealthChoice Member Help Line staff. Kaiser Permanente must submit its written internal complaint policy and procedures to the Department for its approval.

Kaiser Permanente internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member's native tongue if the member is a member of a substantial minority. Kaiser Permanente delivers a copy of its complaint policy and procedures to each new member at the time of initial enrollment and at any time upon a member's request.

Kaiser Permanente includes in its written internal complaint process the procedures for registering and responding to appeals and grievances in a timely fashion. These procedures include resolving emergency medically related grievances within 24 hours, non-emergency medically related grievances within 5 days and administrative grievances within 30 days. In addition, the written procedures:

- 1) Require documentation of the substance of the complaints and steps taken to resolve;
- 2) Include participation by the provider, if appropriate;
- 3) Allow participation by the ombudsman, if appropriate;

- 4) Ensure the participation of individuals within the MCO who have the authority to make decision and implement them;
- 5) Include a documented procedure for written notification on the outcome of our determination;
- 6) Include a procedure for immediate notice to the Department of all disputed denials of benefits or services in emergency medical situations;
- 7) Include a procedure for notice to the member through an Adverse Action Letter that meets the approval of the Department of all disputed denials, reductions, suspensions, or terminations of services or benefits;
- 8) Include an appeal process which provides, at its final level, an opportunity for the member to be heard by our Chief Executive Officer, or their designee;
- 9) Include a documented procedure for reporting of all complaints received by us to appropriate parties; and
- 10) Include a protocol for the aggregation and analysis of complaints and grievance data and use of the data for quality improvement.

No punitive action will be taken against the member for making a complaint against us or the Department.

Member Appeals

If the member wants to file an appeal with us, they have to file it within ninety (90) days from the date of receipt of the denial letter.

You can also file an appeal for them if the member signs a form giving you permission. Other people can also help the member to file an appeal such as a family member or a lawyer.

When the member files an appeal, or at any time during our review they should be sure to provide us with any new information that they have that will help us make our decision. When reviewing the member's appeal we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease
- Not use the same Kaiser Permanente staff to review the appeal who denied the original request for service
- Make a decision about administrative appeals within thirty (30) days

If the member's doctor or Kaiser Permanente feels that the member's appeal should be reviewed quickly due to the seriousness of the member's condition, the member will receive a decision about their appeal within three (3) business days.

The appeal process may take up to 44 days if the member asks for more time to submit information or if we need to get additional information from other sources. We will send the member a letter if we need additional information.

If the member's appeal is about a service that was already authorized and they were already receiving, they may be able to continue to receive the service while we review their appeal. The member should contact us at 1-855-249-5019 if they would like to continue receiving services while their appeal is reviewed. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

Once we complete our review, we will send the member a letter letting them know our decision. If we decide that they should not receive the denied service, that letter will tell them how to file another appeal through us or ask for a State Fair Hearing.

A member may initiate an appeal or you may initiate an appeal on behalf of a member by call 1-855-249-5019 or by submitting the appeal in writing to:

Kaiser Permanente
Attention: Member Appeals and Correspondence Unit
2101 East Jefferson Street
Rockville, Maryland 20852

Grievances

If the member's complaint is about something other than not receiving a service, this is a grievance. Examples of grievances would be, not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone who works at Kaiser Permanente or at the doctor's office.

If the member's grievance is:

About an urgent medical problem that they are having, it will be solved within 24 hours

About a medical problem but it is not urgent, it will be solved within five (5) days

Not about a medical problem, it will be solved within thirty (30) days

If a member would like a copy of our official complaint procedure or if they need help filing a complaint, they can call 1-855-249-5019.

Provider Complaints

Kaiser Permanente is committed to ensuring that any concerns submitted by a Participating Provider and/or other provider are fairly heard and properly resolved. A provider may not be penalized in any way by the Health Plan for acting on a member's behalf or filing an appeal on their own behalf. A provider initiating a complaint or appeal on behalf of a member should follow the member complaint and appeal process to ensure any complaints related to member in an active course of care are handled in the most time sensitive and expedited manner.

A Participating Provider or other provider may file a complaint on their own behalf by contacting Provider Relations at 1-877-806-7470. Provider Relations Representatives are available Monday through Friday 8:30am to 5:30pm EST. Most provider complaints can be resolved the same day initial contact is made. However, in the event of a more complex complaint case, the matter is resolved within thirty (30) days. Notifications of resolution

and/or determinations regarding a provider complaint are delivered telephonically and in writing.

Provider Appeals

Kaiser Permanente is committed to ensuring that any concerns submitted by a Participating Provider and/or other provider are fairly heard and properly resolved. A provider may not be penalized in any way by the Health Plan for acting on a member's behalf or filing an appeal on their own behalf.

A provider who disagrees with a decision made by Health Plan not to pay a claim in full or in part have the right to file an appeal or payment dispute. Payment disputes must be filed in writing within ninety (90) business days of the date of denial and/or Explanation of Payment (EOP). Upon receipt of a provider appeal or payment dispute, a formal acknowledgement letter must be sent to provider with five (5) business days. The provider appeal/dispute process applies only to clean claims as outlined under the Submitting Claims section of this manual.

- A summary of the dispute
- Claim number(s) at issue
- Specific payment and/or adjustment information
- Necessary supporting documentation to review the request
- (i.e., medical records, proof of timely filing, other insurance carrier explanation of payment, and/or Medicare Summary Notice (MSN))

A payment appeal /dispute should be submitted in writing and sent to:

Kaiser Permanente
Attention: Provider Relations – Provider Dispute Resolution Unit
2101 East Jefferson Street
Rockville, Maryland 20852

Kaiser Permanente provides a decision on all provider disputes within forty-five (45) days. Kaiser Permanente must provide a decision on all provider appeal and payment disputes, regardless of the number of appeal levels, within ninety (90) business days from the initial appeal/dispute date.

A provider may initiate a second level appeal should they disagree with a first level appeal decision made by Kaiser Permanente. Second level appeals should also be submitted in writing and labeled "Second Level Appeal Request" within fifteen (15) business days of the first level decision.

Once a second level appeal is received by the Health Plan, the case is directed to the Kaiser Permanente Appeals Committee for reconsideration or decision.

A provider may initiate a third and final level appeal following the second adverse determination within fifteen (15) business days of the second level decision.

Once a third/final appeal level is initiated the case is directed to the Health Plan President, Chief Executive Officer, or designee for final determination.

A decision to overturn a decision made by Kaiser Permanente will be processed within five (5) business days through the payment approval process outlined in the provider dispute resolution process desk level procedures. Any additional claims payments required as a result of an overturn decision are made within thirty (30) days.

DHMH QUALITY OVERSIGHT: COMPLAINT AND APPEAL PROCESSES

The Maryland HealthChoice and Acute Care Administration operate the central complaint investigation process. The Member Help Line and the Complaint Resolution and Provider Hotline Units are responsible for the tracking of both provider and member complaints and grievances called into the hotlines or sent to the Department in writing.

Member Help Line

The Enrollee Help Line is available Monday through Friday from 8:00 AM to 5:00 PM. The toll free telephone number is: 1-800-284-4510 or TDD at 1-800-735-2258 for the hearing impaired.

The Enrollee Help Line is typically a member's first contact with the Department. Help line staff are trained to answer questions about the Maryland HealthChoice Program. Enrollee Help Line staff will:

- Direct recipients to our member services line when needed;
- Attempt to resolve simple issues by contacting us or other parties as needed; and
- Refer medical issues to the Department's Complaint Resolution Unit for resolution.

The Enrollee Help Line has the capability to address callers in languages other than English either through bilingual staff or through the use of a language line service.

The Enrollee Help Line uses an automated system for logging and tracking member inquiries and grievances. Information is analyzed monthly and quarterly to determine if specific intervention with a particular MCO is required or changes in State policies and procedures are necessary.

Provider Hotline

The Provider Hotline provides Maryland HealthChoice providers access to DHMH staff for grievances and inquiries. Provider Hotline staff respond to general inquiries and resolves complaints from providers concerning member access and quality of care as well as educating providers about the Maryland HealthChoice Program. The telephone number for the Provider Hotline is 1-800-766-8692; TDD 1-800-735-2258. We will not take any punitive action against you for accessing the Provider Hotline.

As with the Enrollee Help Line, provider inquiries and complaints are tracked and analyzed monthly and quarterly to determine if specific intervention with particular MCOs is required or changes in State policies and procedures are necessary.

Complaint Resolution Unit

The Complaint Resolution Unit is a unit in the Outreach and Care Coordination Division of the Maryland HealthChoice and Acute Care Administration.

Roles and Responsibilities

Calls are referred by either the Member Help Line or the Provider Hotline. With a staff of nurses and a physician consultant trained to address complex issues that may require medical knowledge, the Complaint Resolution Unit serves in the following capacities:

- Advocates on the caller's behalf to obtain resolution of the issue.
- Communicates with our staff, providers, and advocacy groups to resolve the issue and/or secure possible additional community resources for the member's care when needed.
- Assists members and providers in navigating the MCO system.
- Utilizes the local health department Ombudsman Program to provide localized assistance.
- Facilitates working with us and our providers to coordinate plans of care that meet the member's needs.
- Coordinates the State appeal process relating to a denied covered benefit or service for the member.

The Complaint Resolution Unit operates Monday through Friday from 7:30 AM to 5:00 PM and has the capability to address recipients in languages other than English through the use of a language line service.

Ombudsman/Administrative Care Coordination Unit (ACCU) Program

The Department operates an Ombudsman/ACCU Program for the purpose of investigating disputes between members and managed care organizations referred by the Department's complaint unit. The ombudsman educates members about the services provided by Kaiser Permanente and their rights and responsibilities in receiving services from us. When appropriate, the ombudsman may advocate on the member's behalf including assisting the member to resolve a dispute in a timely manner, using our internal grievance and appeals procedure.

The Ombudsman/ACCU program is operated locally in each county of the State, under the direction of the Department. In most jurisdictions, local health departments carry out the local ombudsman function. A local health department that desires to serve as both the county ombudsman and as a MCO subcontractor must first secure the approval of the Secretary of the Department and of the local governing body. In addition, a local health department may not subcontract the ombudsman program.

Local ombudsman programs include staff with suitable experience and training to address complex issues that may require medical knowledge. When a complaint is referred from the Department's complaint unit, the local ombudsman may take any or all of the following steps, as appropriate:

- Attempt to resolve the dispute by educating the MCO or the member;

- Utilize mediation or other dispute resolution techniques;
- Assist the member in negotiating our internal complaint process; and
- Advocate on behalf of the member throughout grievance and appeals processes

All cases referred to the Ombudsman/ACCU, will be resolved within the timeframe specified by the Department's Complaint Resolution Unit or within thirty (30) days of the date of referral.

The local ombudsman does not have the authority to compel us to provide disputed services or benefits. If the dispute is one that cannot be resolved by the local ombudsman's intervention, the local ombudsman will refer the dispute back to the Department for resolution. A local health department may not serve as ombudsman for cases in which the dispute between the member and us involves the services of the local health department as a MCO subcontractor. The Department conducts a periodic review of the Ombudsman Program activities as part of the quarterly and annual complaint review process.

Departmental Dispute Resolution

When a member does not agree with the MCO's decision to deny, stop, or reduce a service, the member can appeal the decision. The member can contact the EHL at 1-800-284-4510 and tell the representative that they would like to appeal the MCO's decision. The appeal will be sent to a nurse in the Complaint Resolution Unit. The Complaint Resolution Unit will attempt to resolve the issue with the MCO in ten (10) business days. If it cannot be resolved in ten (10) business days, the member will be sent a notice that gives them a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review. When the Complaint Resolution Unit is finished working on the appeal, the member will be notified of their findings.

If the Department disagrees with our determination, it may order us to provide the benefit or service immediately.

If the Department agrees with our determination to deny a benefit or service, it will issue written notice within ten (10) business days to the member, stating the grounds for its decision and explaining the member's appeal rights. The member may exercise their right to an appeal by calling 1-888-767-0013 or by completing the Request for a Fair Hearing form attached to their appeal letter and sending it to:

Susan J. Tucker, Executive Director
 Attn: Dina Smoot
 Office of Health Services
 201 W. Preston Street, Room 127
 Baltimore, MD 21201

Member Appeal

A Maryland HealthChoice member may exercise their appeal rights pursuant to State Government Article, 10-201 et seq., Annotated Code of Maryland. A member may appeal a Departmental decision that: (1) agrees with our determination to deny a benefit or service; (2) denies a waiver-eligible individual's request to disenroll; or (3) denies member eligibility in the REM program.

The member may appeal a decision to the Office of Administrative Hearings. In appeals concerning the medical necessity of a denied benefit or service, a hearing that meets Department established criteria, as determined by the Department, for an expedited hearing, shall be scheduled by the Office of Administrative Hearings, and a decision shall be rendered within three (3) days of the hearing. In cases other than those that are urgent concerning the medical necessity of a denied benefit or service, the hearing shall be scheduled within thirty (30) days of receipt by the Office of Administrative Hearings of the notice of appeal and a decision shall be rendered within thirty (30) days of the hearing. The parties to an appeal to the Office of Administrative Hearings under this section will be the Department and the member, the member's representative or the estate representative of a deceased member. We may move to intervene as a party aligned with the Department.

We will provide all relevant records to the Department and provide witnesses for the Department, as required.

Following the hearing, the Office of Administrative Hearings issues a final decision. The final decision of the Office of Administrative Hearings is appealable to the Board of Review pursuant to Health-General Article, 2-201 to 2-207, Annotated Code of Maryland. The decision of the Board of Review is appealable to the Circuit Court, and is governed by the procedures specified in State Government Article, 10-201 et seq., Annotated Code of Maryland.