KAISER PERMANENTE®

To: HOMECENTRIS HOME HEALTH II LLC@ OWINGS MILLS
Company:
Fax: 410-494-4918
Phone:

From:
Fax:
Phone:
Company:
Other:

Subject:

KAISER PERMANENTE®

Date and time of transmission: Monday, May 18, 2026 6:25:50 AM
Number of pages including this cover sheet: 08

Referred To Provider:
HOMECENTRIS HOME HEALTH II LLC
10 CROSSROADS DR, STE 102
OWINGS MILLS, MD 21117-5459

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

Health or wellness or prevention information

May 18, 2026
Member Name: Zoraida V Dunn
Member Address:
2305 Sidney Ave
Baltimore MD 21230
Member Phone Numbers:
Home Phone 443-955-5533
Work Phone 443-955-5533
Mobile 410-800-8612
Gender: female
Member Date of Birth: 02/26/1960
KP Mid-Atlantic States Member Medical Record Number: 55176515
Member Medicare Number: 7JF2GR5YG70

Referral ID: 1720894010-1
Referral Status: Authorized
Referral Priority: Routine
Referral Type: Home Health Care
Referral Start Date: 05/18/2026
Referral Expiration Date: 11/14/2026
Visits Requested: 2
Visits Authorized: 2

Referred By:
Provider: HUANG, JAMES LEE (M.D.)
Address:
1701 TWIN SPRINGS RD
HALETHORPE, MD 21227-3553
Phone: 410-737-5000
NPI: 1154567709

Referred To Provider: HOMECENTRIS HOME HEALTH II LLC
Address:

10 CROSSROADS DR, STE 102
OWINGS MILLS, MD 21117-5459
Phone: 410-321-8448
Fax: 410-494-4918
Referred To Provider Specialty: z Home Health Agency

Member Diagnosis:
Diagnoses:
M16.12 (ICD-10-CM) - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT HIP

Pertinent History:
Recorded Per Joint Replacement Spreadsheet

Facility: OR-ASC-SO BALT

☐ **Right** Total Knee Replacement ☐ **Left** Total Knee Replacement
☐ **Right** Total Hip Replacement ☒ **Left** Total Hip Replacement

Date of Surgery: 6.8.2026

Summary: Anticipated home assessment date; to be determined by HHA and completed prior to surgery date. Functional mobility; to be determined upon discharge.

Anticipated Discharge Date: 6.9.2026
Anticipated Start of Care Date: 6.10.2026

Anticipated Medical Orders:
Home Physical Therapy Safety Eval /Assessment
☐ Home Physical Therapy:
Teach Joint Protection Technique, Therapeutic Exercises to include; Strength, ROM of Affected Joint, Endurance, Balance and Gait Training.
☒ Skilled RN:
Medical Clearance and Post – Operative Pain Control

Coverage:
Primacy:
☐ Kaiser Permanente
☐ Medicare Part A - Only
☐ Medicare Part A and B
☒ Medicare Advantage
☐ Medicaid
HICN / MBI Number: 7JF2GR5YG70

PCP: ABIGAIL MANDELAH HAMILTON MD, M.D.
Reauthorization Contact:
Kaiser Permanente Physical Therapy Reviewer – Fax: 855-414-1698
Kaiser Permanente Skilled RN Reviewer – Fax: 855-414-1695

Completed by: Catina Parker, Referral Management Assistant - Utilization Management Operations Center (1-800-810-4766 opt. 4) May 18, 2026, 9:23 AM

Procedures/Services:

Code	Procedure Name	Approved Quantity
S9123	NURSING CARE THE HOME; REGISTERED NURSE PER HOUR	1

Signed by: JAMES LEE HUANG MD **Date:** 05/18/2026 **NPI:** 1154567709

Physician Order Addendum Notes and or Referral Comments

Only the services listed in this referral are authorized and such authorization is subject to Kaiser Permanente's right to review it retrospectively. Any additional services not listed in this referral must be authorized separately. Please note that subject to applicable law, payment for authorized services will be subject to Member's eligibility and benefits coverage, and cost-sharing (including deductibles, copayments and coinsurance amounts) being met (if applicable) on the date that the Covered Service is rendered and subject to all of the terms and conditions of the Member's Evidence of Coverage or other documents describing the member's coverage. Payment for Covered Services authorized prior to the date on which they are rendered is subject to confirmation that services furnished were consistent with this authorization.

FOR CONTRACTED PROVIDERS

If **PROVIDER** is under a current contract with Kaiser Permanente, that contract will apply.

FOR NON-CONTRACTED PROVIDERS

Service Rendering:

PROVIDER will provide the Authorized Services outline above to the Member on the

same basis in the same manner and with the same personnel and facilities as **PROVIDER** provides to its other patients who are not Members. **PROVIDER** shall obtain prior authorization from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Health Plan") for all other medical conditions, except emergency services which are medically necessary as determined by Kaiser Permanente, not specifically described herein.

Reimbursement

All such Authorized Services shall be rendered in compliance with the terms and conditions set forth in (i) the Member's coverage document which describes the terms and conditions applicable to his/her health care benefit plan administered, sponsored or underwritten by Health Plan and (ii) this authorizing letter.

Reimbursement Rate for Medicare Advantage Members

In providing the above Authorized Services, **PROVIDER** agrees to accept as payment in full, the lesser of one hundred percent (100%) of billed charges or one hundred percent (100%) of the then current CMS Fee Schedules, based upon specialty, for the applicable service area (e.g., DC/MD/VA Suburbs, Baltimore/Surrounding Counties, the Rest of Maryland, Virginia) subject to all applicable modifiers and coding guidelines, upon receipt of timely filed Clean Claim, less any copayment and/or deductibles owed by Member pursuant to the applicable Membership Agreement. **PROVIDER** will submit a CMS-1500 claim form (or its equivalent successor) for services rendered.

Reimbursement Rate for Maryland Medicaid Members

In providing the above Authorized Services, **PROVIDER** agrees to accept as payment in full, the lesser of one hundred percent (100%) of billed charges or one hundred percent (100%) the Maryland Program Payment System, based upon specialty, subject to all applicable modifiers and coding guidelines, upon receipt of timely filed Clean Claim, less any co-payment and/or deductibles owed by Member pursuant to the applicable Membership Agreement. **PROVIDER** will submit a CMS-1500 claim form (or its equivalent successor) for services rendered.

Reimbursement Rate for Virginia Medicaid Members

In providing the above Authorized Services, **PROVIDER** agrees to accept as payment in full, the lesser of one hundred percent (100%) of billed charges or one hundred percent (100%) of the then current allowable under the Virginia Medicaid Program payment system, based upon specialty, at the time of service, subject to all applicable modifiers and coding guidelines, upon receipt of timely filed Clean Claim (as defined below), less any co-payment and/or deductibles owed by Member pursuant to the applicable Membership Agreement. **PROVIDER** will submit a CMS-1500 claim form (or its equivalent successor) for services rendered.

Reimbursement Rate for Maryland Hospitals

If the **PROVIDER** is a Maryland Hospital with services regulated by the Maryland

Health Services Cost Review Commission (HSCRC), then reimbursement will be made in accordance with the Maryland Medicare Advantage reimbursement rates and guidelines established and/or approved by the HSCRC, upon timely filed Clean Claim.

Any additional medically necessary services required for the continuing treatment of this Member shall be subject to **PROVIDER** obtaining a subsequent authorization(s) for such additional covered services.

"Clean Claim" means a claim that (a) has no material defect or impropriety, including any lack of any reasonably required substantiation documentation such as an Authorization number, which substantially prevents timely payment from being made on the claim or (b) Health Plan, as the designated payment agent of KFH has failed timely to notify Hospital of any defect or impropriety in accordance with the terms of this Agreement and/or applicable law. In the event that applicable law defines "Clean Claim" differently, then any claim to be paid pursuant to such applicable law shall be a Clean Claim only if it complies with all of the requirements of the applicable law.

Submit Claims and a copy of this letter to:

Mid-Atlantic Claims Administration
Kaiser Permanente
PO Box 371860
Denver, CO 80237-9998

Kaiser Permanente shall compensate **PROVIDER** according to the terms of above upon the submission of a Clean Claim (as determined by Kaiser Permanente) in compliance with all applicable state and federal law for all hospital and medical services for which Kaiser Permanente has financial liability pursuant to the Member's health care benefit plan. In no event, will Kaiser Permanente be financially responsible for Authorized Services in which the Member was not, or no longer eligible to receive under the Member's health care benefit plan.

PROVIDER shall bill Kaiser Permanente for the Authorized Services rendered in compliance with this arrangement and applicable law. Unless applicable law requires that a longer period be allowed, **PROVIDER** agrees to submit Clean Claims to Kaiser Permanente or its payment designee within **90** days from the date of service. **PROVIDER** shall submit all Clean Claims using appropriate form UB-04, or CMS-1500 form or such other successor forms which Kaiser Permanente may adopt from time to time.

Kaiser Permanente will be responsible for the processing and payment of claims to professional providers; utilization management, including but not limited to interpretation and accrual of benefits for benefit limitation purposes; quality assurance activities; discharge planning services; and regulatory and accreditation compliance.

PROVIDER shall provide Kaiser Permanente utilization management, quality assurance and discharge planning staff with access to the Member and to his/her medical record.

Held Harmless and Not Balanced Billed:
The Member will be held harmless and not balanced billed for any service(s) included in this arrangement.

PROVIDER agrees that in no event, including but not limited to nonpayment by Kaiser Permanente, its insolvency, shall **PROVIDER** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against the Member or any person acting on his/her behalf other than Kaiser Permanente for Authorized Services provided. As set forth in applicable statute, **PROVIDER** shall look to the Member for the payment of any copayments, coinsurance, deductibles and/or amounts for non-Authorized Services for which Member has assumed financial liability prior to the rendering of such non-Authorized Services. **PROVIDER** agrees that this provision shall survive the termination of this arrangement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Member and that this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between **PROVIDER** and the Member or any person acting on the Member's behalf.

Compliance and Understanding
PROVIDER warrants that it is, and at all time during this arrangement shall remain in compliance with all applicable local, state and federal laws, rules and regulations including, but not limited to, those regarding licensure, certification and accreditation of **PROVIDER's** facility and related services, those necessary for participation in the Medicare and Medicaid programs and those regulating the operations and safety in **PROVIDER's** facility (including all laws, rules and regulations regarding hazardous substances).

This arrangement shall not be interpreted, directly or indirectly, to create any formal provider contracting relationship except for the one specifically identified herein. Furthermore, the parties shall not interpret this arrangement as conferring any right on **PROVIDER** to be considered as a "participating provider" in Kaiser Permanente's network of contracted health care providers. Each party hereto shall be an independent contractor of the other and shall have no authority to bind any other entity other than itself.

It is our understanding that this arrangement and the provisions herein will only apply to the Member named herein.

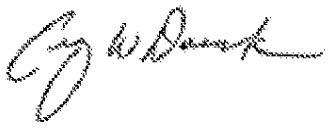
Unless otherwise agreed in writing by the parties hereto, the term of this authorization shall terminate on **End Authorization Date** 11/14/2026 or prior discharge whichever occurs first.

We thank you for your ability to accommodate our needs with regard to this Member in such a timely manner.

Non-Behavior Health (Medical, Surgical): If there are questions related to Non-Behavior Health Services, please contact **1-800-810-4766**

Behavior Health: If there are questions related to Behavior Health, please contact: **301-552-1212;** Select the prompt for Providers

Sincerely,



Craig Domeck, Chief Financial Officer
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Farzaneh Sabi, M.D.

Farzaneh Sabi, MD, Associate Medical Director
Mid-Atlantic Permanente Medical Group

MA NCP COMBINED LOB APPROVAL NOTICE TO REF TO PROVIDER 8.2025