Utilization Management & Authorization

9.1 Overview

Overview
Kaiser Permanente 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 (RN) perform concurrent review of members’ admission to both participating and non-participating hospitals and facilities. RNs also review or process outpatient referrals, requests for durable medical equipment, and home care services. RNs coordinate 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, physical and occupational therapies.

9.2 Attestation Regarding Decision-Making and Compensation

Utilization Management Affirmation Statement
MAPMG physicians and Health Plan staff 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.

9.3 Utilization Management Approved 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 (RUMC) as delegated by the Regional Quality Improvement Committee (RQIC). 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.

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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 Approved Criteria Sets and Guidelines**

**A. Commercial Products: District of Columbia, Maryland, Federal and Virginia Jurisdictions**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>UM Approved Criteria Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Rehabilitation</td>
<td>✔ MCG formerly called Milliman Care Guidelines®</td>
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<tr>
<td>Ambulance Services</td>
<td>✔ KPMAS Medical Coverage Policy</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>✔ MCG</td>
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<tr>
<td>Durable Medicare Equipment</td>
<td>✔ Medicare National/Local Coverage Determination Policies</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>✔ MCG</td>
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<tr>
<td>Inpatient Services</td>
<td>✔ MCG</td>
</tr>
<tr>
<td>Neonatal Care</td>
<td>✔ KP Revised Milliman Care Guidelines® NICU Levels</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>✔ KPMAS Medical Coverage Policies</td>
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<tr>
<td></td>
<td>✔ MCG</td>
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<tr>
<td>PT/OT/Speech</td>
<td>✔ MCG</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>✔ MCG</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>✔ National Transplant Network Services Patient Selection Criteria</td>
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<td>✔ InterQual® Criteria – Transplant and Hematology/Oncology</td>
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**B. Medicare Cost**

The CMS National and Local Determination Policies are the primary sources for guidelines/criteria utilized in UM review of Medicare Cost members as applicable.

<table>
<thead>
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<th>Service Type</th>
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</tr>
</thead>
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<tr>
<td>Acute Rehabilitation</td>
<td>✔ Medicare Medical Coverage Determination Policies</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>✔ Medicare Benefit Policy Manual Chapter 10 - Ambulance Services</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>✔ Medicare Benefit Policy Manual Chapter 2 - Inpatient Psychiatric Hospital Services</td>
</tr>
<tr>
<td></td>
<td>✔ Medicare National Coverage Determinations Manual Chapter 1, Part 2 Sections 130 - Mental Health</td>
</tr>
<tr>
<td></td>
<td>✔ Medicare Benefit Policy Manual Chapter 6 - Section 70 - Outpatient Hospital Psychiatric Services</td>
</tr>
<tr>
<td></td>
<td>✔ MCG if there are no existing Medicare policies available</td>
</tr>
<tr>
<td>Durable Medicare Equipment</td>
<td>✔ Medicare National/Local Coverage Determination Policies</td>
</tr>
<tr>
<td>Home Health Services</td>
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<td>Inpatient Services</td>
<td>✔ MCG</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>✔ Medicare National/Local Coverage Determination</td>
</tr>
<tr>
<td></td>
<td>✔ KPMAS Medical Coverage Determination Policies – if there are no existing Medicare policies available</td>
</tr>
<tr>
<td>PT/OT/Speech</td>
<td>✔ Medicare National/Local Coverage Determination Policies</td>
</tr>
</tbody>
</table>

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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 free of charge by calling the Utilization Management Operations Center (UMOC) at (800) 810-4766, and select 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) collaborates with the Kaiser Permanente Interregional New Technologies Committee (INTC) and Medical Technology Assessment Unit to assist physicians and patients 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.

### 9.4 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. The table below provides the UM hours of operations and responsibilities:

<table>
<thead>
<tr>
<th>UM Department Section</th>
<th>Hours of Operation</th>
<th>Core Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Management Operations Center (UMOC), Emergency Care Management</td>
<td>24 hours/day, 7 days/week, including holidays</td>
<td>• Process transfer requests for members who need to be moved to a different level of care including emergency rooms, inpatient facilities, and Kaiser Permanente Medical office Buildings&lt;br&gt;• Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities</td>
</tr>
<tr>
<td>UM Department Section</td>
<td>Hours of Operation</td>
<td>Core Responsibilities</td>
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<td>-----------------------------------------------------------</td>
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</tr>
<tr>
<td>Utilization Management Operations Center (UMOC): Outpatient, Speciality Referrals, Clinical Research Trials</td>
<td>Monday through Friday 8:00 A.M. to 4:30 P.M.</td>
<td>• Support all levels of transfers from Hospital to Hospital</td>
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<td></td>
<td>Weekend and Holidays: 11A.M. to 1 P.M. for Urgent and emergent referrals only</td>
<td>• Conduct pre-service review of outpatient or inpatient services to include Clinical Research Trials</td>
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<tr>
<td></td>
<td></td>
<td>• Weekends and holidays pre-service review of urgent/emergent referrals except Clinical Research Trials</td>
</tr>
<tr>
<td>Utilization Management Operations Center: Durable Medical Equipment (DME), Home Care, Rehabilitative Therapy: Physical Therapy, Occupational Therapy and Speech Therapy</td>
<td>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</td>
<td>• Conduct pre-service and concurrent review of Home Care, Durable Medical Equipment, Physical Therapy, Occupational Therapy and Speech Therapy, and post-service review</td>
</tr>
<tr>
<td>Patient Care Coordinators Medical /Surgical Cases</td>
<td>Monday to Friday Weekends and Holidays 8:00 A.M. to 4:30 P.M.</td>
<td>• Conduct concurrent inpatient review and transition care management</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) and Acute Rehabilitation Facility</td>
<td>Monday through Friday 8:00 A.M. to 4:30 P.M. Excluding holidays</td>
<td>• Conduct concurrent review and transition care management for members in the acute rehab and SNF settings</td>
</tr>
<tr>
<td>UM Hospital Services – Behavioral Health</td>
<td>Monday to Friday: 8:00 A.M. to 4:30 P.M. Excluding holidays</td>
<td>• Conduct concurrent inpatient review and transition care management services of behavioral health service</td>
</tr>
<tr>
<td>UM Outpatient Services – Behavioral Health</td>
<td>Monday to Friday: 8:30 A.M. to 5:00 P.M. Excluding holidays</td>
<td>• Conduct Pre-service and concurrent review of behavioral health outpatient services</td>
</tr>
<tr>
<td>CareConnect/ Complex Case Management Renal Case Management</td>
<td>Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding holidays</td>
<td>• Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease (ESRD) Members</td>
</tr>
</tbody>
</table>

### 9.5 Utilization Management Operations Center (UMOC)

The Utilization Management Operations Center (UMOC) is a centralized 24-hour operation telephonic Utilization Management (UM) and Referral Management Service Center designed to assist Mid-Atlantic Permanente Medical Group (MAPMG) practitioners, community-based practitioners, affiliate providers, and KPMAS staff in
coordinating health care services for KPMAS members. The following services are coordinated through UMOC:

- Medical, surgical, or behavioral health care admissions to acute care facilities
- Ambulance transports
- Emergency care management
- Home care
- Durable medical equipment
- Specialty referrals (including radiology and laboratory) inside and outside KPMAS centers

**Communication Services to Members with Special Needs**

Communication with deaf, hard of hearing or speech-impaired members is handled through Telecommunications Device for the Deaf (TDD) or teletypewriter (TTY) services. TDD/TTY is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. UMOC staff has a speed dial button on their phones to facilitate sending and receiving messages with the deaf, hard or hearing or speech impaired through the Maryland Relay System. Additionally, a separate TDD/TTY line for deaf, hard of hearing, or speech impaired KPMAS member is available through Member Services. Members are informed of the access to TDD/TTY through the Member’s ID card, the Member’s Evidence of Coverage handbook, and the Annual Subscriber’s Notice. Non English speaking members may discuss UM related issues, requests and concerns through the KPMAS language assistance program offered by an interpreter, bilingual staff, or the language assistance line. UMOC staff has the Language Line programmed into their phones to enhance timely communication with non English speaking members. Upon member’s request, denial notices are provided in a culturally and linguistically appropriate manner in compliance with the July 2010 Public Health Service Act section 2719 of the Patient Protection and Affordable Care Act (PPACA). Language assistance services are provided to members free of charge.

You can reach (UMOC) at 1-800-810-4766 and follow the prompts to speak with a staff member. The (UMOC) staff can assist you with the following:

- Provide information regarding utilization management processes
- Check the status of referral or an authorization
- Provide copies of criteria/guidelines utilized for decision making free of charge
- Answer questions regarding a benefit denial decision
- Speak to a UM Physician on any adverse medical necessity denial decision (select the appropriate prompt)

**9.6 Behavioral Health Services**

For information on referrals and case management for behavioral health services, please see Section 14.

**9.7 Flexible Choice Plan**

For information on referrals, authorizations, and medical management procedures for Flexible Choice members, please see Section 15.

**9.8 Specialty Care Physician Responsibilities**

Participating Specialists receive referrals from both MAPMG Providers and KPMAS Participating Network Primary Care Physicians (PCPs) i.e. community primary care physicians who contract with Kaiser Permanente. Every member receiving services from

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a Participating Specialist must have an approved referral for that visit. Referral forms authorizing services will be faxed to the referred by and the referred to provider (unless otherwise requested by the referring provider) at the time the referral is authorized. The member may request a copy of the approved referral from the referring provider. It is the responsibility of the specialist’s office to ensure that Kaiser Permanente has the demographic and contact phone/fax numbers of the specialist office on file to ensure accurate and timely communication of referral information.

Referrals are valid for ninety (90) days, except:
- Obstetrics: valid for 270 days.
- DME (Durable Medical Equipment): Referral will specify valid time period based on rental or purchase of the DME item
- Chemotherapy: valid for 180 days
- Radiation Therapy: valid for 180 days
- Dialysis: valid for 365 days/1 year.

Most Kaiser Permanente members (e.g. those in our Kaiser Permanente Signature and Kaiser Permanente Select plans) receiving services from a Participating Specialist must have an authorized initial consultation from their Primary Care Physician. Exceptions to this requirement may include members:
- enrolled in Kaiser Permanente Flexible Choice when utilizing their Option 2 or 3 point of service benefit
- seeking annual Well Womens Health-Gynecology (GYN) preventative service exams
- seeking Behavioral Health Services
- seeking optometry exams/vision services
- enrolled in the Kaiser Permanente Flexible Choice product when utilizing their Option 2 or 3 point of service benefit

Each referral has a unique referral number. This referral number must be reflected on the claim/bill for appropriate processing and payment. Each approved referral is valid only until the identified expiration date is noted on the Kaiser Permanente Referral Summary Report. Only one (1) visit is approved per referral, unless otherwise indicated on the Kaiser Permanente Referral Summary form. We encourage our referring providers to use their clinical judgment and discretion in anticipating a reasonable number of visits that might be required for a particular consultation.

During the initial office visit, a specialist may perform whatever services are medically indicated (even if they are not specified on the referral form) provided the services:
- Are performed in your office and not in another facility or location
- Are performed on the same day as the initial office visit
- Are regarded as covered benefits under the member’s health plan
- Do not appear on the list of services that require separate pre-authorization.

Providers are encouraged to order Radiology and Laboratory tests for members using the Kaiser Permanente Imaging and Laboratory facilities.

Additional Visits, Care or Consultations
Following the initial authorized consultation, should the patient require additional visits, care and/or consultation with you or another provider, the Participating Specialist may initiate an extension to the initial referral and/or submit a new referral/authorization request directly by:

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• Calling the Utilization Management Operations Center (UMOC) at 1-800-810-4766 (follow the prompts) to request additional visits and/or an extension to an existing referral.
• Following the initial approved consultation, should the patient require a referral to another provider, facility and/or a service requiring pre-authorization, the Participating Specialist may initiate a referral/authorization request directly by:
• Completing a Uniform Referral Form (URF) and fax it to the Utilization Management Operations Center (UMOC) at Fax 1-800-660-2019.

In all instances, after a participating specialist has received an approved referral and has determined that additional services are required, it is not necessary to contact the referring PCP for approval. Rather, the point of contact should always be directed to the Utilization Management Operations Center (UMOC) as noted above by phone, fax or internet communication.

If a member visits your office for care, but does not have a referral, please, call the Utilization Management Operations Center (UMOC) at 1 (800) 810-4766 to determine if the care is authorized and if so, obtain a referral number, which should be noted on the claim/bill for these services.

Basic diagnostic testing does not require a referral form or authorization. Routine laboratory services may be rendered and billed directly to the Kaiser Permanente Mid-Atlantic States Claims Department.

9.9 Self-Referred Services

Kaiser Permanente members are entitled to direct access to the following services through Participating Providers without securing a referral from their Primary Care Physicians:

• Routine and preventative gynecological care (except OB care)
• All Behavioral health/chemical dependency services
  o For detailed information on Behavioral Health, please see Section 14
• Primary Care: Members may self-refer for any service performed by their Participating PCPs.
• Optometry/vision care services: Members may self-refer to an optometrist only

9.10 Referral Management Procedures

Please review the steps below for the following referral types:
A. Specialist Care (No authorization required)
B. Specialist Care (Authorization required)
C. Standing Referrals
D. Referring Members for Radiology Services
E. Radiology and Imaging Referral Verification Process
F. Referring Members for Laboratory Services

A. How to request a referral for Specialist Care (No Authorization Required)

Step 1: VERIFY that the referral specialist is a Participating Provider
**Step 2:** VERIFY that the requested procedure DOES NOT REQUIRE AUTHORIZATION

**Step 3:** FAX
Fax a copy of the Maryland Uniform Referral or the KPMAS Referral request to the Utilization Management Operations Center (UMOC) via Fax ☎️ 1 (800) 660-2019

**OR**

**MAIL**
Mail a copy of the Maryland Uniform Referral or the KPMAS Referral request to:

**Utilization Management Operations Center**
**11900-A Bournefield Way**
**Silver Spring, Maryland 20904**

**Step 4**
Give a copy of the referral form to the member to take to the appointment with the Participating Specialist

**B. How to request referrals for Specialist Care (Authorization Required)**

**Step 1** - Verify that the procedure/service requires authorization

**Step 2** - Determine if the specialist is a Participating Provider

**Step 3** - Complete the referral form and fax to the Utilization Management Operations Center (UMOC) at Fax ☎️1 (800) 660-2019

**Step 4** - Ensure that any required clinical documentation accompanies the referral request

**Step 5** - Complete the referral form and attach appropriate lab, x-ray results, or medical records. Incomplete referrals will be faxed back to the Participating PCP or Participating Specialist office with request to include required information. Be sure to include fax numbers on the request.

**Combined Referral Requirements:**

1. **Urgent Referrals:** Determinations will be made within 24 hours of receipt of the request for urgent referrals submitted with appropriate documentation.
   - Questions on urgent referrals call ☎️ 1 (800) 810-4766, follow the prompts.

2. **Standard Referrals:** Standard referral requests will be handled within two (2) working days of receipt of the information necessary to make the determination.

3. Once processed and approved, the referral form with the authorization number will be returned by fax to the Participating PCP and to the Participating Specialist. It is the responsibility of the Primary Care Physician office and Participating Specialist office to ensure that Kaiser Permanente has accurate fax numbers on file to ensure timely and efficient communication of referral information.

4. Participating Specialists must send a written report of their findings to the Participating PCP, and should call the Participating PCP, if their findings are urgent.

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5. All consulting specialists' reports must be reviewed, initialed, and dated by the referring physician and maintained in the member's chart.

6. After an initial consult, if the Participating Specialist believes the member will require continued treatment, the Participating Specialist must submit a referral request to the Utilization Management Operations Center (UMOC).

7. For laboratory or radiology services, members should be directed to Participating laboratory or radiology providers, or to a Kaiser Permanente Medical Center.

C. Standing Referral Requirements (Authorization Required)

Standing Referral is an authorization to a specialty practitioner to provide consultative, diagnostic and therapeutic services to the member without additional referral from the PCP. Standing Referrals may not exceed the life of the referral (designated by requesting practitioner), the extent of the member's contract year, or deviate from the treatment plan developed in collaboration with the member, the PCP, and the member's specialist.

The Participating PCP may request a “Standing Referral” to a Participating Specialist for care which will most appropriately be coordinated by the Participating Specialist for such condition. A Participating Specialist is a physician who is part of the Health Plan's provider panel.

Standing referral to a specialist is provided if:
1. The primary care physician of the member determines, in consultation with the specialist, that the member needs continuing care from the specialist
2. The member has a condition or disease that
   - is life threatening, degenerative, chronic, or disabling; and
   - requires specialized medical care, and
3. The specialist
   - has expertise in treating the life threatening, degenerative, chronic, or disabling disease or condition; and
   - is part of the Health Plan's provider panel

Written Treatment Plan
Standing referral shall be made in accordance with a written treatment plan for a covered service developed by: (1) the primary care physician; (2) the specialist; and (3) the member.

A treatment plan may:
A. limit the number of visits to the specialist
B. limit the period of time in which visits to the specialists are authorized
C. require the specialist to communicate regularly with the primary care physician regarding the treatment and health status of the member

Standing Referral for Pregnant Members
1. A member who is pregnant shall receive a standing referral to an obstetric practitioner
2. The Obstetric practitioner is responsible for the primary management of the member's pregnancy, including the issuance of referrals through the postpartum period

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Referral to a Non-Participating Specialist
A member, primary care practitioner, or specialist may request a referral to a specialist who is not part of the Health Plan’s provider panel (Non-Participating Specialist). Referrals to non-participating specialist must be provided if the member is diagnosed with a condition or disease that requires specialized medical care; and
1. The Health Plan does not have in its panel a specialist with the professional training and expertise to treat the condition or disease; or
2. The Health Plan cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel

D. Referring Members for Radiology Services

Kaiser Permanente provides Members with access to radiology and imaging services at our Medical Office Buildings, 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:

1. Provide the Member with a script for the necessary radiological/imaging service.

2. 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 Office Building or Imaging Center directly, or call the Medical Advice/Appointment Line at 1-800-777-7904 to secure an appointment with a representative. If the radiology/imaging service requested is not available at a Kaiser Permanente Medical Office Building or Imaging Center, an external referral request may be provided to a community-based group or facility within our Participating Provider Network. Kaiser Permanente Select Members may elect a referral to a community-based provider with our Participating Provider Network.

E. Radiology and Imaging Referral Verification Process

When a Kaiser Permanente Member presents to your office with a script for radiology or imaging services, you must confirm that an approved KP External Referral Summary Report has been issued to your practice or facility prior to rendering the services.

- KP External Referral Summary Reports are issued electronically to providers with access to KP HealthConnect AffiliateLink.
  o If you receive Kaiser Permanente referrals electronically, you may view and print your approved referral by logging-on to KP HealthConnect AffiliateLink at www.providers.kp.org/mas.
  o If you do not receive referrals electronically from Kaiser Permanente, the referral will be sent to your office via fax upon approval by our Utilization Management and Operations Center.

In the event a Member presents to your office for radiology or imaging services without an approved KP External Referral Summary Report, you must contact our Utilization Department.

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Management and Operations Center at 1-800-810-4766 to confirm the status of the referral, or direct the Member to contact their Referring Provider.

F. Referring Members for Laboratory Services

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

Kaiser Permanente Select™ Members have access to a delivery system that includes Mid-Atlantic Permanente Medical Group (MAPMG) physicians, health care services provided at Kaiser Permanente Medical Centers, and a wider range of community-based providers within our Participating Provider Network. Members enrolled in this plan may be directed to a Kaiser Permanente Medical Center for laboratory services or may choose to utilize a Participating Provider location for laboratory services.

Laboratory procedures covered under a current CLIA Certificate of Waiver or a current CLIA Certificate of Provider-Performed Microscopy Procedures may be performed in your office laboratory.

Members should be given an order or signed script to present to the Kaiser Permanente 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 or ICD-10 codes

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.

9.11 Services Requiring Authorization

List of Services Which Require Kaiser Permanente Review

Please note that this is periodically updated and may not be an all inclusive list. Questions should be directed to the Utilization Management Operations Center (UMOC) at 1-800-810-4766, follow the prompts.

A. Acute Inpatient Services
1. Inpatient Admissions (elective and emergent)
2. Short Stay Admissions
3. Observation Services
4. Acute Rehabilitation
5. Sub-acute Rehabilitation services in Skilled Nursing Facility (SNF)
6. Inpatient Hospice Admissions
7. Inpatient Behavioral Health Admissions

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8. Outpatient Behavioral Health Admissions
* Partial Hospitalization

B. Elective Services
1. Abortions, Elective/Therapeutic
2. Acupuncture
3. Anesthesia for Oral Surgery/Dental
4. Any Services Outside Washington Baltimore Metro Areas
5. Behavioral Health Services
6. Biofeedback
7. Blepharoplasty
8. Breast Surgery for any reason
9. Chiropractic Care
10. Clinical Trials
11. Cosmetic and Reconstructive or Plastic Surgery
12. CT – Scans (Computerized Tomography)
13. Dental Services Covered Under Medical Benefit
14. Durable Medical Equipment (DME)
   14.1. Assistive Technologies
15. Gastric Bypass Surgery, Gastroplasty
16. Home Health Care Services (Including Hospice)
17. Infertility Assessment and Treatment
18. Infusion Therapy and Injectables (Home IV, Excluding Allergy Injections)
19. Intensity Modulated Radiation Therapy (IMRT) – Modulated Therapy
20. Interventional Radiology
21. Investigational/ Experimental Services
22. Magnetic Resonance Imaging (MRI)
23. Narrow Beam Radiation Therapy Modalities
   23.1. Cyberknife
   23.2. Gamma Knife
   23.3. Stereotactic Radiosurgery
24. Nasal Surgery (Rhinoplasty or Septoplasty)
25. Non-Participating Provider Requests
26. Nuclear Medicine
27. Obstructive Sleep Apnea Treatment including Sleep Studies
28. Oral Surgery
29. Orthognatic Surgery
30. Outpatient Surgery –All Hospital Settings/Ambulatory Surgery Centers
31. Pain Management Services
32. Penile Implants
33. Positron Emission Tomography (PET) Scan
34. Podiatry Services
35. Post Traumatic (Accidental) Dental Services
36. Prosthetics/Braces/Orthotics/Appliances
37. Prostate Biopsies - Ambulatory Surgery Center or Outpatient Hospital Surgery Setting
38. Radiation Oncology
39. Radiology Services (all radiology and imaging services, including diagnostic plain films)
40. Rehabilitation Therapies
   40.1. Cardiac Rehabilitation
   40.2. Occupational Therapy
   40.3. Physical Therapy

Publication Date: 12/20/2007
Last Review and Revised Date: June 2013
40.4. Pulmonary Rehabilitation Therapy  
40.5. Speech Therapy  
40.6. Vestibular Rehabilitation  
41. Scar Revision  
42. Sclerotherapy and Vein Stripping Procedures  
43. Screening Colonoscopy – Consultations  
44. Uvulopalatopharyngoplasty (UPPP)  
45. Social Work Services  
46. Temporo Mandibular Joint Evaluation and Treatment  
47. Transplant Services – Solid Organ and Bone Marrow

9.12 **Authorization Documentation Requirements**

All requests must be initiated by either the Participating PCP or Participating Specialists. Please submit all materials that would be pertinent to allow the referral to be authorized.

9.13 **Denials & Appeals**

The UM Department has policies and procedures in place to ensure that timely notifications are rendered for adverse determinations. These policies require discussion with the requesting practitioner, review by the UM physician, or review by a board-certified practitioner/specialist if necessary, as well as provisions for verbal and written notifications of the denial decision based on timeliness requirements by local, Federal, Medicare, Patient Protection and Affordable Care Act (PPACA), and NCQA rules.

**Timeliness of Decision and Notification**

**Guide to Referral Processing Turn-Around Time by Product Line**

**Commercial**: DC, Federal, Maryland and Virginia

<table>
<thead>
<tr>
<th>Priority of Request</th>
<th>Determination Timeframe</th>
<th>Verbal/Electronic Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Request</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Concurrent</td>
<td>Within one (1) calendar day of receipt of request</td>
<td>Within 24 hours of receipt of request</td>
<td>Within one (1) calendar day of receipt of request</td>
</tr>
<tr>
<td>• Pre-service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Urgent Request (Routine)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Pre-Service       | Within two (2) business days after receipt of all necessary information | Within one business day after decision is made | • State of Maryland: Within five (5) business days after decision is made  
| • Concurrent: Referrals with prior authorization | | | • State of Virginia: Within two (2) business days after decision is made |
| **Post service**    | Within 30 calendar days of receipt of request | Not Applicable | Within 30 working days of receipt of request |

---

1 Commercial Lines of Business includes Federal, Maryland, D.C and Virginia. Timeliness guideline is based the State of Maryland requirement. Maryland Insurance Article Section 15-10B-06

2 NCQA UM 5: Timeliness of UM Decisions: post service decisions

Publication Date: 12/20/2007  
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Medicare<sup>3</sup> Line of Business

<table>
<thead>
<tr>
<th>Priority of Request</th>
<th>Determination Timeframe</th>
<th>Verbal/Electronic Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent or Expedited Referrals</td>
<td>Within 72 hours of receipt of the request for adverse determinations and approvals</td>
<td>Within 72 hours of receipt of the request</td>
<td>Within 3 calendar days after providing oral notification</td>
</tr>
<tr>
<td>Routine or Standard Referrals</td>
<td>Within fourteen (14) calendar days of receipt of request</td>
<td>Within fourteen (14) calendar days of receipt of request</td>
<td>Within fourteen (14) calendar days of receipt of request</td>
</tr>
</tbody>
</table>

- Participating Providers requesting reconsideration of a service denial on behalf of the KPMAS member may call ☎️ 1-888-989-1144, and request to speak with the UM physician on-call within 24 hours of the verbal notification of the adverse decision.

Grievance and Appeals Process
Any member and/or his/her authorized representative, the attending practitioner or health care provider on behalf of the member may file a grievance or appeal a denial decision.

Expeditied grievance and appeals are available for urgent medical, surgical, or behavioral health situations, including adverse determinations for acute care services. An expedited appeal process is available for grievances and appeals where anticipated services are related to the treatment of a condition that, if left untreated, will endanger the life or well-being of the member.

To request an expedited appeal a member or provider should contact our member Services Department at: ☎️ (800) 777-7904 toll-free; ☎️ (866) 513-0008, TTY or by fax ☎️ (301) 816-6192.

Member Services will notify the member or Participating Provider as expeditiously as the medical condition requires, but no more than 72 hours after receipt of the request. Written confirmation of the disposition of the expedited appeal is sent within three (3) calendar days after the decision has been verbally communicated.

Reconsideration or Appeal
A reconsideration request or appeal should include the following information:

- Name and identification number of the member involved
- Name of member’s Participating PCP
- Service that was denied authorization
- Name of initial Kaiser Permanente reviewing physician, if known

A nurse and/or physician who were not involved in the initial review and denial of the service will review the appeal. If it is determined that additional information is required to perform a thorough review, a staff member or the reviewing physician may contact you to request the information or to discuss the clinical issue. Once the necessary

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<sup>3</sup> Medicare Members based on Medicare Managed Care Manual Chapter 13: Medicare Managed Care Beneficiary Grievances, Organization Determinations and Appeals

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information has been received, the case will be reviewed and the Participating Provider will be notified verbally and in writing of the disposition of the appeal.

9.14 Emergency & Urgent Care

Emergency Services are health care services that are provided by a Plan or non-Plan Provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

a) Placing the patient's health in serious jeopardy;
b) Serious impairment to bodily functions;
c) Serious dysfunction of any bodily organ or part; or
d) In the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus.

Participating PCPs are responsible for providing evaluation, triage, and telephone services 24 hours a day, 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 a Participating PCP or coverage/on-call physician is unavailable, members may call Kaiser Permanente's Medical Advice Nurse by calling 1 (703) 359-7878 or 1 (800) 777-7904.

If, due to the nature of the problem, the member must be directed to a Hospital Emergency Department (ED), the Participating PCP should instruct the member to go to the Emergency Department 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 done by simply using the UMOC ED Visit Notification Form. The form can be faxed to (301) 388-1639. Additionally, notification can be made by calling (800) 810-4766 Option 1 (Please reference Attachment B at end of Utilization Management section of this manual for the UMOC ED Visit Notification Form).

If a patient requires inpatient admission after an ED visit, please be sure to notify UMOC of the admission within 24 hours of the admission. Failure to notify Kaiser Permanente within this time frame may result in the denial of authorization and payment of services. The provider cannot hold the member financially responsible for lack of authorization or late notification.

Ambulance Transport
If the member is in your office at the time of the emergency, and you would like the Utilization Management Operations Center (UMOC) to arrange ambulance transportation other than 911, please call our Utilization Management Operations Center (UMOC) at 1 (800) 810-4766 and listen for the appropriate prompt selection. Please provide the following information to the UMOC representative:

- Your name and phone name
- Member's name and Kaiser ID number
- Member's specific location
- Member's diagnosis

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Type of ambulance requested: Basic Life Support, Advanced Life Support
Medical necessity of ambulance transport. Please refer to the KPMAS Ambulance Transportation guideline accessible through the KP Provider website: http://providers.kp.org/mas/utilizationguidelines.html or through the KPMAS Clinical Library for KPMAS physicians and staff
Specific patient needs for transport purposes, example: medications requiring monitoring, equipment (oxygen etc.), and specify patient's weight

9.15 Durable Medical Equipment and Home Health Care

At the time of hospital discharge, a Hospital Case Manager makes the initial arrangements for any medically necessary durable medical equipment and/or home health care. The Participating PCP should initiate a referral request for additional home health care and/or durable medical equipment when the need for these services is identified. Referrals for Home Health Care and Durable Medical Equipment are reviewed by the Utilization Management Operations Center (UMOC) Home Health and Durable Medical Equipment professional staff to determine the member's level of benefit coverage and medical necessity. KPMAS adopts Medicare Medical Policy for most durable medical equipment. This can be accessed through Medicare national and local coverage database available through the Medicare website: http://www.cms.hhs.gov. Home Health criteria for commercial members are based on Milliman Care Guide criteria, while Medicare members follow Medicare medical and benefit policies.

The Home Health and Durable Medical Equipment staff coordinates these services with a participating provider and/or vendor. Medical necessity determinations for denials are made by the Utilization Management Medical Directors. The Participating PCP member are notified once a determination has been made.

To request a referral for DME, prosthetics, orthotics, and supplies:

1. Complete the Uniform Consultation Referral form; include correct CPT and ICD codes.
2. Send the completed Uniform Consultation Referral form along with all required clinical documentation such as notes and treatment plans to the UMOC via fax to 301-388-1632. Please do not specify a particular vendor when requesting referrals, the Kaiser Permanente Utilization staff will refer to the appropriate vendor.

Once your request is received and processed by the UMOC, a KP External Referral Summary Report will be faxed to the Medicare approved vendor.

9.16 Hospital & Facility Admissions

All urgent and emergent admissions require notification within 24 hours of the admission or the next business day to the Utilization Management Operations Center (UMOC) by the Participating PCP, his/her agent, or the participating hospital/facility at ☏ 1 (800) 810-4766.

The Participating Hospital and/or Facility are responsible for notifying KP for all inpatient emergency admissions. Calls, voice mail, or faxes must be received within 24 hours of the admission or the next business day. Failure to notify Kaiser Permanente within this time frame may result in the denial of authorization and payment of services. The
participating provider cannot hold the member financially responsible for lack of authorization or late notification.

All non-emergent and elective admissions require preauthorization. The Participating PCP should initiate the Referral form for authorization, or contact the Utilization Management Operations Center (UMOC) at ☏ 1 (800) 810-4766. An authorization number will be generated for all approved admissions. The Participating Hospital or Facility is responsible for notifying KP for all non-urgent and elective admissions within 24 hours of the admission or on the next business day.

Non-Emergency & Elective Admissions
All non-emergent and elective admissions require preauthorization. The Participating PCP should initiate the referral form for authorization, or contact the Utilization Management Operations Center (UMOC) at ☏ 1 (800) 810-4766. An authorization number will be generated for all approved admissions

Pre-Admission Notification Requirements
The participating hospital and/or facility are responsible for initiating all calls and requests for authorization for an admission. Kaiser Permanente must receive all calls and requests at least five (5) business days prior to the admission for all elective admissions. An exception to this policy is applied when it is not medically feasible to delay treatment due to the member’s medical condition. Failure to notify Kaiser Permanente within this time frame may result in the denial of authorization and payment for services. The Participating Hospital and/or Facility cannot hold the member financially liable for the denial of services.

Emergency Admissions
In order to expedite reimbursement and facilitate concurrent review, please follow these procedures:

Step 1: Direct the member to a Kaiser Permanente participating facility where you have privileges, or to the nearest emergency room. (See Section 2 for listing)

Step 2: Contact the Utilization Management Operations Center (UMOC) at ☏ 1 (800) 810-4766 and select the appropriate prompt, to immediately report the admission, 24-hours a day, and 7-days a week via voice mail or fax.

Step 3: Provide the following information in your call or fax:
- Member Name
- Member Identification Number
- Name of the Referring Physician
- Admitting Hospital or Facility
- Admitting Diagnosis
- Proposed Treatment and Length Of Service
- Date of Admission

Emergency Department Visits
In order to expedite reimbursement, please follow these procedures:

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Referring Members to the Emergency Room

**Step 1:** Direct the member to a Kaiser Permanente Participating Facility where you have privileges, or to the nearest emergency room. (See Section 2 for listing)

**Step 2:** Contact the Utilization Management Operation Center (UMOC) at 1 (800) 810-4766 and select the appropriate prompt, to immediately report the ED visit, 24-hours a day, and 7-days a week via voice mail or fax.

**Step 3:** Provide the following information:
- Member Name
- Member Identification Number
- Name of the Referring Physician
- Admitting Hospital or Facility
- Complaint/Diagnosis
- Transportation method used to bring member to the ED
- Date of Service

**Participating Hospitals and Facilities**
Kaiser Permanente Members may be directed and/or self-direct to a Participating 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.

There are two (2) quick and convenient options for providing notification to Kaiser Permanente:

**Option 1:** Fax Option: Complete the Emergency Department Visit Notification Form and fax to the Utilization Management Operations Center at (301) 388-1639. A copy of the Emergency Department Visit Notification Form can be located at the end of this section.

**Option 2:** Contact the Utilization Management Operations Center (UMOC) at (301) 879-6143, or 1-800-810-4766. Select Option 1 and follow the prompts to report the Emergency Department Visit.

All emergency room 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

**Concurrent Review Process**
The Kaiser Permanente Utilization Management Department performs concurrent review of all hospital and/or facility admissions. The participating hospital and/or facility’s Utilization Review department is responsible for providing clinical information to Kaiser Permanente Utilization Management nurses by telephone. **Failure to provide the clinical information within the required timeframe may result in an administrative denial due to lack of information.** The participating hospital cannot hold the member

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financially responsible for the denial. The Utilization Management nurse may contact the
attending physician if further clarification of the member’s clinical status and treatment
plan is necessary. The Utilization Management nurse uses Kaiser Permanente
approved criteria to determine medical necessity for acute hospital care. If the clinical
information meets Kaiser Permanente’s medical necessity criteria, the days/service will
be approved. If the clinical information does not meet medical necessity criteria, the
case will be referred to the Utilization Management physician. Once the Utilization
Management Physician reviews the case, the Utilization Management nurse will notify
the attending physician and the facility of the outcome of the review. The attending
physician may request an appeal of any adverse decision. The participating hospital
cannot hold the member financially responsible on day(s) that are not deemed medically
necessary.

Managing our members in Participating Hospitals/Facilities
The Kaiser Permanente Utilization Management Department performs concurrent review
for all hospital and/or facility admissions.
- The Participating Hospital and/or Facility’s Utilization Review department is
  responsible for providing clinical information to Kaiser Permanente Utilization
  Management nurses by telephone or onsite review. Failure to provide the clinical
  information within the required timeframe may result in an administrative denial due
to a lack of clinical information by which to make an approval decision.
- The Utilization Management nurse may contact the attending physician if further
  clarification of the member’s clinical status and treatment plan is necessary.
- The Utilization Management nurse applies Kaiser Permanente approved criteria to
determine Medical Necessity for acute hospital care.
  - If the clinical information meets Kaiser Permanente’s Medical Necessity criteria,
    the days/service will be approved.
  - If the clinical information does not meet Medical Necessity criteria, the case will
    be referred to the Utilization Management physician.
  - Once the Utilization Management Physician reviews the case, the Utilization
    Management nurse will notify the attending physician and the facility of the
    outcome of the review.
  - The attending physician may request an appeal of any adverse decision.
- The participating hospital cannot hold the member financially responsible for day(s)
  that are not deemed to be medically necessary.

Administrative Denials

Kaiser Permanente Mid-Atlantic States may issue administrative denials for non-
compliance to contractual obligations. Administrative denials do not include denials due
to lack of medical necessity or lack of coverage. They include the following:

Lack of information denial: An administrative denial rendered because the
provider/facility failed to provide KPMAS with clinical information regarding an inpatient
admission or continued stay within 24 hours following KPMAS’s request for such
information, provided that KPMAS communicated the deadline and consequences to the
provider/facility.

Lack of notification denial/Late notification denial: An administrative denial
rendered for failure of a provider/facility, member or authorized representative to notify
Kaiser Permanente of the admission of a KPMAS member within the timeframes
required by contract, communicated to the provider/facility, or set forth on the member’s
coverage documents.

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**Delay in service denial:** An administrative denial rendered when a service ordered in a facility was delayed; the delay was avoidable (i.e. not the result of a change in the member’s condition or for other clinical reasons); and the delay resulted in a longer length of stay than expected if the delay did not occur (avoidable day or days). This also includes denials where a provider failed to follow an approved course of treatment.

The tables below outline specific examples of common delays in service/procedure by hospital, SNF or physician category. This table lists hospital and SNF services that hospitals and SNFs, respectively, are expected to be able to deliver seven days a week, provided that such services are within the scope of the provider/facility’s services. Note: This is not an exclusive list.

### I. Hospital Delays

<table>
<thead>
<tr>
<th>Diagnostic Testing/Procedures</th>
<th>Operating Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI CT scans (test performed/read/results available)</td>
<td>CABG delays</td>
</tr>
<tr>
<td>Other Radiology delays (test performed/read/results available)</td>
<td>No OR time</td>
</tr>
<tr>
<td>Laboratory tests (test performed/read/results available)</td>
<td>Physician delay (i.e. lack of availability)</td>
</tr>
<tr>
<td>Cardiac catheterization delays (including weekends and holidays)</td>
<td></td>
</tr>
<tr>
<td>PICC Line placement</td>
<td></td>
</tr>
<tr>
<td>Echocardiograms</td>
<td></td>
</tr>
<tr>
<td>GI Diagnostic procedures (EGD, Colonoscopy, ERCP, etc.)</td>
<td></td>
</tr>
<tr>
<td>Stress tests</td>
<td></td>
</tr>
<tr>
<td>Technical delays (i.e. machine broken or machine is not appropriate for patient, causing delay)</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td>Transfusions</td>
<td></td>
</tr>
<tr>
<td>AFBs</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ancillary Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT/OT/Speech evaluation</td>
</tr>
<tr>
<td>Social Work/Discharge Planning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in carrying out or omission of physician orders</td>
</tr>
<tr>
<td>Medications not administered</td>
</tr>
<tr>
<td>NPO order not acknowledged</td>
</tr>
<tr>
<td>Kaiser Utilization Management not notified that the patient refuses to leave when discharged</td>
</tr>
</tbody>
</table>

### II. SNF Delays

<table>
<thead>
<tr>
<th>Diagnostic Testing/Procedures</th>
<th>Ancillary Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory tests (test performed/read/results available)</td>
<td>Social Work/Discharge Planning</td>
</tr>
<tr>
<td>PICC line placement</td>
<td>Delay in initiation of therapy services (PT/OT/Speech)</td>
</tr>
<tr>
<td>Radiology delays(test performed/read/results available)</td>
<td>Lack of weekend therapy services</td>
</tr>
<tr>
<td></td>
<td>Delay in initiation of respiratory services</td>
</tr>
<tr>
<td></td>
<td>Delay in Pharmacy services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment delays due to transportation issues</td>
</tr>
<tr>
<td>Delay in initiation of nursing</td>
</tr>
</tbody>
</table>

*SNF*

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Physician delays in facilities that do not have Kaiser Permanente on-site reviewers

III. Physician Delays

Hospital
- Delays in Specialty consultations
- Delay in discharge order for alternative placement
- Member not seen by attending physician or not seen in a timely manner

9.17 Case Management Programs

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 (666) 223-2347. This confidential self-referral line is available 24 hours/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.

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Transplant Services
Health Plan contracts with local and national centers of excellence for transplant services. Referring participating providers are 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 Coordination. Please call the National Transplant Services Department at (301) 625-6201 to refer a member for an evaluation for a transplant or to receive additional information about the NTS.

Pre-Natal and Infant Program Overview
At Kaiser Permanente we provide a comprehensive prenatal and postnatal program to support positive outcomes for mothers and babies. Our program is designed to support maximum health of mothers to help reduce infant mortality and morbidity. To support mothers throughout pregnancy and after the birth of their babies we focus on all their needs including medical and non-medical that impact their well-being and that of their babies.

Special Needs
For Moms who have special needs during pregnancy KP has the Special Care Perinatal Nurse Case Management Program. Special Care is designed to provide case management support to women experiencing high risk pregnancies due to medical and/or psychosocial issues. Based on the initial and on-going assessments, OB providers can refer a woman to the program at any time during pregnancy. Special Care nurse case manager will work with the member to develop a care plan to maximize her chances of having a healthy baby. Nurse case managers coordinate needed medical and non-medical assistance and provide on-going follow-up to women in the program.

High –Risk Case Management
Our commitment to the health and well-being of Moms and their babies continues after a baby is born. For babies or Moms who need extra assistance to make the transition home from the hospital can be referred to our Pediatric Case Management Department for follow-up.
## Uniform Consultation Referral Form

### Date of Referral:

### Patient Information:

<table>
<thead>
<tr>
<th>Name: (Last, First, MI)</th>
<th>Date of Birth: (MM/DD/YY)</th>
<th>Phone: ( )</th>
</tr>
</thead>
</table>

### Member #:

<table>
<thead>
<tr>
<th>Site #:</th>
</tr>
</thead>
</table>

### Carrier Information:

<table>
<thead>
<tr>
<th>Name: Kaiser Permanente</th>
<th>Phone Number: 1-(800)-810-4766</th>
</tr>
</thead>
</table>

| Facsimile/Data #: 1-(800)-660-2019 |

### Primary or Requesting Provider:

<table>
<thead>
<tr>
<th>Name: (Last, First, MI)</th>
<th>Specialty:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Institution/Group:</th>
<th>Provider ID#: 1</th>
<th>Provider ID#: 2 (If Required)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address: (Street #, City, State, Zip)</th>
<th>Phone Number:</th>
</tr>
</thead>
</table>

### Consultant/Facility Provider

<table>
<thead>
<tr>
<th>Name: (Last, First, MI)</th>
<th>Specialty:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Institution/Group:</th>
<th>Provider ID#: 1</th>
<th>Provider ID#: 2 (If Required)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address: (Street #, City, State, Zip)</th>
<th>Facsimile/ Data Number:</th>
</tr>
</thead>
</table>

### Referral Information:

#### Reason for Referral:

#### Brief History, Diagnosis, Test Results:

#### Services Desired: Provide Care as Indicated:

- Initial Consultation Only:
- Diagnostic Test: (specify)
- Consultation With Specific Procedures: (specify) __________

#### Specific Treatment:

- Global OB Care & Delivery
- Other: (Explain)

#### Place of Service:

- Office
- Outpatient
- Medical/Surgical Center *
- Radiology
- Laboratory
- Inpatient Hospital *
- Extended Care Facility *
- Other: (Explain) * (Specific Facility Must be Named.)

#### Number of Visits:

<table>
<thead>
<tr>
<th>If Blank, 1 Visit is assumed.</th>
</tr>
</thead>
</table>

#### Authorization #:

<table>
<thead>
<tr>
<th>(If Required)</th>
</tr>
</thead>
</table>

#### Referral is Valid Until:

(See Carrier Instruction)

#### Signature:

<table>
<thead>
<tr>
<th>(Individual Completing This Form)</th>
</tr>
</thead>
</table>

#### 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.

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Last Review and Revised Date: June 2013
**Attachment B**

*Utilization Management Operations Center*

**Contracted Facility**

*Emergency Department Visit Notification Form*

Fax Number: (301) 388-1639  
Name/Department__________________________

Telephone Number: (301) 879-6143 or (800) 810-4766  
Date ______________ Fax Number _______________________

Telephone Number____________________________________

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**To Be Completed by KPMAS ECM Staff**

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<th>Message sent to health care team? (Y or N)</th>
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**To Be Completed by Kaiser Permanente**

Date Received ____________ECM Rep___________________________

**If Visit or Message was not completed above, please explain below**

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