SECTION 11

REFERRALS/AUTHORIZATIONS

11.1 INTRODUCTION

The term, “authorization” refers to the prior approval for the provision of any services to members by a designated provider. Except as specifically set forth in this Provider Manual, an authorization is required for all durable medical equipment and prosthetic and orthotic supplies and services.

Kaiser Permanente’s Service Area Durable Medical Equipment (DME) department personnel, or regionally-applicable department personnel may authorize supplies and services during normal business hours. The hours are as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado Region</td>
<td>8:30 a.m. – 4:30 p.m.</td>
</tr>
<tr>
<td>Georgia Region</td>
<td>8:00 a.m. – 5:00 p.m.</td>
</tr>
<tr>
<td>Hawaii Region</td>
<td>8:30 a.m. – 5:00 p.m.</td>
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<tr>
<td>Mid-Atlantic Region</td>
<td>8:30 a.m. – 5:00 p.m.</td>
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<tr>
<td>Northern California Region</td>
<td>8:30 a.m. – 5:00 p.m.</td>
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<tr>
<td>Northwest Region</td>
<td>8:30 a.m. – 5:00 p.m.</td>
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<tr>
<td>Ohio Region</td>
<td>8:30 a.m. – 5:00 p.m.</td>
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<tr>
<td>Southern California Region</td>
<td>8:30 a.m. – 5:00 p.m.</td>
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</table>

Kaiser Permanente clinical personnel from Kaiser Permanente and Kaiser Permanente contracted facilities (e.g. RN, MD, PA, NP, etc.) may authorize the supply or service(s) after normal business hours.

The provider must receive a Kaiser Permanente authorization prior to rendering any service or supply. If a member contacts the provider for any product or service and the provider has not received a Kaiser Permanente authorization, the provider should direct the member to the local Kaiser Permanente DME department, or regionally-applicable department for further direction. The local telephone numbers are listed in the “Key Contact” section of this Provider Manual.

11.2 REFERRAL/AUTHORIZATION PROCESS

“Covered Services” generally refer to those health care services a member is entitled to receive as a benefit under the Membership Agreement, as determined by the applicable payer.
The authorization will include the following (may vary by region):

- Member name and demographic information
- Medical Record Number (MRN)
- Prescribing Physician
- Diagnosis
- HCPCS code
- Rental/purchase designator
- Authorization period/length of need
- Delivery timeframe or requested delivery date/time
- Estimated member Cost Share
- Payer type
- Any special delivery instruction

Specific regional processes are as follows:

**Colorado:**

- **Denver/Boulder**
  - The provider is required to contact the Kaiser Permanente Central Referral Center by faxing the authorization request for approval before a specific service is rendered.
  - The authorization is provided with the use of the Referral Approval Form which is generated from either Kaiser Permanente’s claims systems. For a sample contact the Claims department at the telephone number listed in the “Key Contacts” section of this Provider Manual.
  - The completed Referral Approval Form is sent to the provider via Affiliate Link, faxed or mailed to the provider. All information related to pre-authorization of services is coordinated through the Central Referral Center. Telephone/fax telephone numbers are listed in the “Key Contacts” section of this Provider Manual.
  - Authorizations are valid for 6 months.

- **Southern Colorado Region**
  - The provider is required to contact the Resource Stewardship department at the telephone number listed in the “Key Contacts” section of this Provider Manual.
  - Authorizations are valid for 6 months.

**Georgia:**

- The provider must verify eligibility and benefits via KP Online-Affiliate.
- The provider must request an authorization via KP Online-Affiliate.
- The Quality Resource Management department will review and generate authorization if approved.
- The authorization will be forwarded to the provider electronically via KP Online-Affiliate.
When a request for authorization is entered via KP Online-Affiliate, the authorization number is visible prior to the request being approved. Possession of an authorization number is not an approval. The provider must check the status of the authorization to determine if the request has been approved, pended, denied, canceled or closed. Claims will only be paid on those services for which an approved authorization is present in the system.

If you are unable to access KP Online-Affiliate, you can call Customer Service to verify eligibility and benefits and to the Quality Resource Management department to request an authorization. These telephone numbers are listed in the “Key Contacts” section of this Provider Manual.

Hawaii:

- Upon receipt of a physician’s signed written order, the DME department will review the prescription, member’s coverage and eligibility and criteria.
- If the member meets all criteria, the DME Coordinator will fax the preauthorization to the vendor and to the Claims department.
- When the provider receives the order they then fax a confirmation to the DME department that it has been received. The fax telephone number is listed in the “Key Contacts” section of this Provider Manual.
- Provider must contact the member to coordinate the appointment.
- Provider must collect all co-payments, deductible or coinsurance as applicable.
- If the member does not meet coverage and eligibility requirements, the DME department will notify the prescribing physician, process a denial as per Kaiser Permanente policy and contact the member. Should the member like to obtain the product directly from the provider, the DME department will conduct a courtesy request to the vendor as a private pay agreement between the provider and the member.

Mid-Atlantic:

- Authorizations are coordinated through the Provider Service Center.
- Approved authorizations will be faxed directly to the provider.
- A copy of the Maryland Uniform Referral or the KPMAS Referral form must be faxed to the Provider Service Center at the number listed in the Key Contacts Section of this Provider Manual. For a sample of the above-mention forms contact the Claims department at the telephone number listed in the “Key Contacts” section of this Provider Manual.
- Always ensure that any required clinical documentation accompanies the referral request.
Northern/Southern California:

Prosthetics & Orthotics (P&O)

Member Evaluation:

- The DME department upon receipt of an electronic (eDME in Northern California, HealthConnect in Southern California) or signed, written physician prescription for anew or repair/modification of a prosthetic or orthotic device, verifies the member’s coverage and eligibility for P&O benefits.

- If the member meets coverage and eligibility requirements, the DME department will create an order to the most appropriate vendor for an evaluation. The DME department will send an authorization to the vendor that will include “VEVAL” user codes and include a description of the type (new, repair or modification) of evaluation required. The authorization will be faxed to the vendor.

*Note: This authorization allows the vendor to initiate an evaluation to determine the member’s individual prosthetic or orthotic device needs and/or the appropriate and safe operation of a previously approved device. This authorization does NOT provide approval of payment for any devices or services. Evaluations are NOT subject to a member co-payment.*

- The vendor must contact the Kaiser Permanente DME department to confirm receipt of the request for evaluation (VEVAL).

- The vendor, no later than the next business day, must call the member or caregiver to confirm the receipt of the request for evaluation to set up an appointment.

- The member’s evaluation appointment with the vendor must be made within 7 business days.

- No later than the next business day after the evaluation, the vendor needs to fax the evaluation with necessary evaluation detail findings and recommendations (quote) to the authorizing DME department for approval. Fax telephone numbers are listed in the “Key Contact” section of this Provider Manual.

- If there are questions/concerns with the vendor’s quote submitted, the local DME department will contact the vendor for clarification or correction request or a request to contact the local Kaiser Permanente clinician for further discussion and direction.

- If the member is at the vendor’s facility the vendor must contact the local Kaiser Permanente DME department for an authorization. If the member telephones the vendor the vendor must instruct the member/caregiver to contact the local Kaiser Permanente DME department for an authorization and/or further direction.
Service/Device Authorization:

- Within 5 business days after receipt of the provider evaluation the DME department will fax the DME Ordering and Tracking System (DOTS) authorization to the designated provider. For a sample of a DOTS authorization form see the Appendix, Item # 2.
- Upon receipt of the Kaiser Permanente authorization the provider is responsible for initiating contact with the member to schedule an appointment. The call should be made within 48 hours (2 business days) for a routine appointment (for a complete description of a “routine appointment” and the specific timing guidelines, please contact your local DME department) should be scheduled within 2 weeks unless the member requests an appointment at a later date. For requests outside of the routine 2-week period, the provider will notify the local Kaiser Permanente DME department of such a request. For urgent orders the appointment should be scheduled as soon as possible. Urgency of the request will be noted on the Kaiser Permanente authorization in the “Notes” section.

DME – Non-Custom Items

- The DME department, upon receipt of an electronic (eDME in Northern California and HealthConnect in Southern California) or signed, written physician prescription for a DME item will verify the member’s coverage and eligibility for DME benefits.
- If the member meets coverage and eligibility requirements, the DME department will create an order to the most appropriate vendor. The vendor will be sent an authorization that includes the MCPCS code and a description of the item required and any member co-insurance amounts. The authorization will be faxed to the vendor.
- The vendor, within one business day of receipt of the authorization will either mail the item to the member or arrange for the delivery of the item to the member’s home.
- The vendor is required to collect any co-insurance amount that is due at the time of delivery/service.

Northwest:

- DME letters are sent directly to the member or to the provider.
- If additional items are needed or any change is needed in the authorization, approval must be obtained by the provider prior to dispensing the item. The contact telephone number can be found in the “Key Contacts” section of this Provider Manual.
- If the provider believes the member will require continued treatment or additional care beyond what is authorized a new Referral Request (contact the Claims department for a sample) to the referral department at the telephone number found in the “Key Contacts” section of this Provider Manual.
Ohio:

- Upon receipt of a referral from a Kaiser Permanente Plan Provider, the Referrals Management and Clinical Review department will issue an authorization based on the member meeting the eligibility requirements and medical criteria for the specific DME or P&O item.
- Providers need to fax the Request for DME Referral form (contact the Claims department for a sample form) the telephone numbers listed in the ‘Key Contacts’ section of this Provider Manual.
- The provider, member and referring provider will receive written notification of an approved authorization.

### 11.3 PRODUCT UPGRADES

**Member Requested:**

Kaiser Permanente is responsible to provide the standard product(s) that meets the member’s medical needs. If the member desires a product(s) that is above the authorized standard item, they have the option to pay additional costs above the authorized amount to obtain the product(s). A notice of financial responsibility must be presented to the member by the provider.

For any product(s) upgrade situation, any and all cost differences with any future re-order requests will also be the member’s financial responsibility.

For all mastectomy only upgrades the provider must complete an Advanced Beneficiary Notice form. This form is designed to make clear to the member that he/she is financially responsible for the cost difference. A copy of the completed Advanced Beneficiary Notice form must be forwarded to Kaiser Permanente for all upgrades. Please see the Appendix, item #3 for a sample of this form. Note: This section does not apply to the Mid-Atlantic region. For further information regarding this, please contact the Provider Relations department at the telephone number listed in the ‘Key Contacts’ section of this Provider Manual.

**Kaiser Permanente Authorized:**

Occasionally there may be a situation in which a Kaiser Permanente clinician believes that a specific product that is above the normal Kaiser Permanente standard is medically necessary. In these situations, there will be a Kaiser Permanente review and authorization as appropriate and Kaiser Permanente will be financially responsible for payment (excluding any applicable member co-insurance). In both California regions Kaiser Permanente DME will indicate approval in the “Notes” section of the Kaiser Permanente DOTS authorization form. This information will also be indicated on the applicable authorization form the all other Kaiser Permanente regions. **Note:** This section does not apply to the Mid – Atlantic States region. For further information regarding this, please contact the Provider Relations department at the telephone number listed in the ‘Key Contacts’ section of this Provider Manual.
11.4 RE-AUTHORIZATION GUIDELINES

Members should contact their local Kaiser Permanente regionally-designated department for any re-orders of products/services to obtain a Kaiser Permanente authorization. Providers cannot issue any re-order supplies without a Kaiser Permanente authorization for the specific supplies.

Quantities and frequency of re-orders/re-authorizations are at the discretion of Kaiser Permanente and are determined based on the member’s benefits and established formulary clinical guidelines. The provider will refer members to their local Kaiser Permanente authorizing department for specific questions and/or additional information related to re-orders that do not have an accompanying Kaiser Permanente authorization.

11.5 PRODUCT/SERVICE CHANGES TO KAISER PERMANENTE AUTHORIZATION

The provider must promptly notify the Kaiser Permanente authorizing department for any change for products/services other than what is listed on the Kaiser Permanente authorization (e.g., changes for additional quantity or a need for a custom item). A new Kaiser Permanente authorization is required for these types of situations.

The prescribing physician must be notified and approve of changes to an original order. The Kaiser Permanente authorizing department will be responsible to contact and obtain direction from the prescribing physician.

Products/services for changes provided without a Kaiser Permanente authorization will not be reimbursed.

11.6 PRODUCT INVENTORY

Contracted providers must maintain minimum inventory requirements. The Kaiser Permanente DME (or regionally-specific) department must be notified for any situation in which the ordered off-the-shelf/prefabricated product cannot be provided within 1 week of the appointment visit due to inventory issues. The Kaiser Permanente applicable department will provide direction to the provider in an effort to address the situation. Repeated issues related to insufficient inventory issues will be forwarded to the National Provider Contracting and Network Management department by the Kaiser Permanente applicable department.

11.7 DELIVERY OF PRODUCT

Kaiser Permanente expects providers to deliver authorized products/services in an appropriate and timely manner.
The Kaiser Permanente applicable department must be notified as soon as possible for the following situations:

- The provider is unable to deliver the product due to manufacturer backorder or inventory availability issues
- The provider is unable to deliver the product/provide the service(s) due to the inability to contact the member
- The member is unwilling or unable to pay any required coinsurance amounts

Upon notification, the Kaiser Permanente applicable department will promptly notify the prescribing physician.

11.8 WARRANTY

The manufacturer’s normal warranties are expected to be honored for all products. In an attempt to provide the highest level of customer service, each provider is expected to individualize each situation and consider reasonable replacement as appropriate. The guidelines are as follows:

- If a product is identified to be defective and is covered under the manufacturer’s warranty, the item is expected to be replaced at no charge to Kaiser Permanente or to the member.
- The provider will notify the Kaiser Permanente applicable department of any replacements in order to document the change in the Kaiser Permanente authorization system.
- If the required replacement is not covered under or is outside of a manufacturer’s warranty period, the provider needs to inform the member and a replacement and the associated costs will be the member’s responsibility unless otherwise a covered benefit. If the member is dissatisfied with the situation, the provider should contact the local Kaiser Permanente applicable department for further direction.

11.9 PRODUCT RECALL

Product Recall in the medical sector is becoming ever more common. To be able to know and track the growing number of recalls occurring every year, National Provider Contracting and Network Management utilizes the National Product Recall Program at Kaiser Permanente.

Communication is the key to resolving any supplier recall situation. If you have a recall, market withdrawal, or medical device safety alter, notify National Provider Contracting and Network Management at the number located in the “Key Contacts” section this Provider Manual. In addition to notifying the above-noted department contact the National Product Recall Team at the information noted below. The Team will document the recall and track the progress made in resolving the recall.
The National Product Recall Team will ask several questions to understand the impact on Kaiser Permanente. They will require the following information:

- What type of recall is involved
- How many members are directly affected by the recall
- Which of Kaiser Permanente’s regions are affected
- Which specific members are impacted
- What is the resolution plan to retrieve and replace the product
- When will the recall resolution be completed
- Who is the primary contact at your organization on matters related to the recall

The National Product Recall Team can be contacted by e-mail or telephone at the following:

Sally.x.Saba@kp.org

11.10 ADVANCED BENEFICIARY NOTICE

An Advanced Beneficiary Notice is a written notice the provider gives to a Medicare beneficiary before providing items and/or services that are expected to be denied by Medicare based on one of the following statutory exclusions:

- Lack of medical necessity
- Prohibited, unsolicited telephone contacts
- No provider Medicare number
- Denial of Advanced Determination of Medicare Coverage request

The Advanced Beneficiary Notice is designed for use with Medicare beneficiaries only (including those who are dually-eligible for both Medicare and Medicaid (Medi-Cal in California). The primary purpose of the Advanced Beneficiary Notice is to inform a Medicare beneficiary, before he or she receives specified items and/or services that otherwise might be paid for, that Medicare probably will not pay for them on that particular occasion. The Advanced Beneficiary Notice also allows the member to make an informed consumer decision on whether or not to receive the item and/or services for which the member may be required to pay.

For a sample of the Advanced Beneficiary Notice see the Appendix, Item #3.