Provider Manual

- Section 4: Utilization Management
### KAISER PERMANENTE OF OHIO

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Section 4: Utilization Management

4.1 Decision Making for Medical Service Requests

Appropriate utilization management contributes to the success of Kaiser Permanente and its Members. The ultimate goal of utilization management is to achieve optimum results by determining what resources are Medically Necessary and appropriate for an individual patient, and to provide those Services to the patient in an appropriate setting in a timely manner. Decisions about what is Medically Necessary and appropriate are based on evidence-based criteria and professional Practitioner’s judgment as well as assessing the individual Member’s medical condition.

Effective utilization management is NOT withholding necessary Services that may result in less than optimum outcomes. Each Practitioner uses his/her clinical expertise to evaluate the care needs of the individual using evidence-based criteria and arranging for those Services in the appropriate setting.

Kaiser Permanente does not offer incentives or additional compensation to Plan Providers or other individuals conducting utilization management activities in return for denial of care.

4.2 Concurrent Review Process

Kaiser Permanente Referrals Management and Clinical Review Department performs Concurrent Review of all hospital and/or Facility admissions. This also includes observation stays, home health care requests and outpatient therapies. Onsite hospital reviews as well as telephonic reviews may be performed on a case-by-case basis. The participating hospital and/or Facility’s utilization review department is responsible for providing clinical information to Kaiser Permanente daily or as requested by telephone and/or electronic means. Kaiser Permanente staff may contact the utilization review department as well as the attending physician if further clarification of the Member’s clinical status and treatment plan is necessary. This may include a peer to peer discussion.

The Kaiser Permanente nurse uses approved criteria to determine Medical Necessity for acute hospital care. If the clinical information meets Kaiser Permanente’s Medical Necessity criteria, a specified number of days/Services will be approved. If the clinical information does not meet Medical Necessity criteria, the case will be referred to the Physician Advisor/Reviewer. Once the Kaiser Permanente Physician Advisor/Reviewer reviews the case, the staff nurse will notify the attending Physician and the Facility the results of the review. The attending Physician may request an expedited Appeal of any Adverse Benefit Determination (see Section 4.12 of this Manual).

Failure to provide clinical information for Authorized days/Services by the next assigned review date can result in a denial of all days/Services beyond the initial Authorization period, due to untimely clinical review.
4.3 Medical Appropriateness Criteria

All Services Authorized by the Kaiser Permanente Referrals Management and Clinical Review Department will be evaluated to determine medical appropriateness based on the following evidence-based criteria and guidelines:

<table>
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<tr>
<th>Criteria</th>
<th>Explanation of Application</th>
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| • InterQual Intensity of Service/Severity of Illness (ISD) Acute Criteria (Adults and Pediatrics) | Hospitals/Acute Care Coordination (Med/Surg & BHS)  
• Pre-admissions Screening  
• Continued Stay Reviews  
• Discharge Planning |
| • Milliman USA Optimal Recovery Guidelines | Outpatient Care Coordination  
• Surgical Procedures / Treatments  
• Inpatient Care Coordination  
  • Length of Stay Efficiency (Benchmark)  
  • Med/Surg & BHS  
  • Clinical Pathways: (e.g., CHF, COPD, and Community Acquired Pneumonia) |
| • Medicare Regulations (DMERC, Palmetto GBA, Medicare Explained), as required by the Centers for Medicare and Medicaid Services (CMS) | Inpatient Care Coordination  
• SNF, Inpatient Rehabilitation  
Outpatient Care Coordination  
• DME, SNF, Home Health Care, IV Drugs, Other Drugs/Treatment |
| • Kaiser Permanente Ohio: CDU Manual / P&P: Introduction to Protocols | Kaiser Permanente’s Observation level of care (Clinical Decision Unit – CDU) |
| • American Society of Addiction Medicine (ASAM) Patient Placement Criteria (required by the Ohio Department of Alcohol and Drug Addiction Services [ODADAS]) | Level II Adult Admission Criteria |
| • Kaiser Permanente National Transplant Network | Patient selection and Site selection transplant criteria |

These criteria are available for review by contacting Kaiser Permanente’s Referrals Management and Clinical Review Department at 1-866-433-1333 (toll free). Denials of requests for Service are determined by a board certified Physician. Each Adverse Benefit Determination letter issued to Plan Providers contains the reason for the denial and explains the right to appeal the decision. The patient, or his/her authorized representative, receives a similar notice.

4.4 Case Management

The case management process includes arranging care in the appropriate setting for acutely ill, chronically ill, or injured Members on a case-by-case basis that supports the achievement of realistic treatment goals. Nurses and Social Workers work with the Member, the Member’s Primary Care Physician (PCP), the Specialist responsible for follow up care, Kaiser Permanente staff and Plan Providers to develop and implement...
plans of care to optimize the Member’s level of independence and quality of life. They proactively assess, identify, coordinate, monitor and evaluate medical problems and service needs of the Member’s condition. The PCP is responsible for approving the plan of care and reviewing it with the Case Manager at regular intervals.

4.4.1 Inpatient Case Management
Inpatient case management may involve Kaiser Permanente nurses, case managers and social workers who are working in real time to coordinate a safe discharge plan which may include transitioning a patient from one level of care to another level, and may involve both inpatient and outpatient case management staff.

4.5 Disease Management
Kaiser Permanente is dedicated to helping support clinical practices and providing quality care to all Members. As part of this effort, Kaiser Permanente of Ohio offers a variety of comprehensive disease management programs to Members, many components of which are available to Plan Providers. Our most well-developed disease management programs are directed toward the following chronic conditions:

- Adult Asthma.
- Coronary Artery Disease.
- Depression.
- Diabetes.
- Elder Care.
- Heart Failure.
- Hypertension.
- Weight Management.

A major focus has been the advancement of care for people with diabetes, including treatment medications, blood sugar and lipid control, blood pressure control, and a greater participation of Members in their care.

Through the use of information technology systems and sophisticated data registries, Kaiser Permanente can identify Members needing medical or nursing interventions. Centralized Patient Care Coordinators support Primary Care Physicians by reaching out to these Members and ensuring that necessary interventions are performed.

In order to confront the growing health concern of heart failure, Kaiser Permanente of Ohio developed a Heart Failure Care Management Program designed to improve the quality of life for our Members living with heart failure through education, self-management, nutrition counseling, medication management, treatment, and follow-up care. Our multidisciplinary team performs initial evaluations, ongoing follow-up care, education, and communication.

Disease management has always been built into the way Kaiser Permanente delivers care. Addressing co-morbidities (when one person has two or more chronic conditions) is more efficient in a care delivery system designed to manage the total health of each
KAISER PERMANENTE OF OHIO

Member. Because we deliver the care our Members need, all of our Practitioners are able to consider every aspect of an individual’s health.

At the heart of our efforts to help Members manage chronic conditions through our Complete Care program is the highly respected Care Management Institute (CMI). Created in 1997 to help us improve quality of care and health outcomes for our Members, CMI is one of the first organizations in America to earn disease management certification in program design from the National Committee for Quality Assurance (NCQA). Members benefit from innovative, personalized, population-based care provided by Practitioners who follow CMI clinical practice guidelines. These guidelines come from our own clinical experience, research, and data, with input from research centers worldwide.

Following our Care Management Institute (CMI) clinical practice guidelines, our Complete Care programs employ a proactive approach, which includes the following elements, to deliver coordinated, integrated care to our Members with chronic conditions:

- Use of population-based information systems and innovative technology (e.g., disease-specific registries such as Permanente Online Interactive Technologies (POINT), tracking systems, Interactive Voice Recognition (IVR’s) to support outreach and other automated systems to support clinical functions and risk-stratified case finding.
- Extensive decision-support systems for Practitioners (e.g., clinical practice guidelines, KP HealthConnect [Kaiser Permanente’s electronic medical record system]) which provide automated reminders/prompts, standing orders, which embed evidence-based practice into Kaiser Permanente care processes.
- Specifically designed delivery systems to support health and disease management through the use of outreach efforts for clinical and preventive care gaps, care managers and centralized improvement specialists when appropriate, group appointments when more effective, etc.
- Unmatched resources available for Member self-management and engagement, including educational content, health classes, health tools, and Total Health Assessments as well as online healthy lifestyle programs and support.
- Measurements of clinical effectiveness through continual monitoring and reporting upon our clinical performance.

Kaiser Permanente Members with specific chronic medical conditions—such as diabetes, adult asthma, hypertension, cardiovascular disease, and heart failure—do not need to actively enroll in our programs. Members are automatically identified and added to our programs using disease-specific case identification protocols, triggered by information in Kaiser Permanente’s pharmacy, laboratory, outpatient, and hospital discharge data systems.

The following Sections review critical components of Kaiser Permanente’s disease management programs available to Plan Providers and Members.
4.5.1 Distribution of Preventive Care and Clinical Practice Guidelines to Plan Providers
Preventive Care and Clinical Practice Guidelines are based on sound scientific evidence and designed to promote quality care. They have been developed for screening, immunization, education, prenatal care and condition/disease management. Preventive Care and Clinical Practice Guidelines are available on our Kaiser Permanente’s Community Providers website at providers.kaiserpermanente.org/oh. See Section 8.10 of this Manual for more information regarding Preventive Care and Clinical Practice Guidelines.

4.5.2 Informing and Educating Practitioners
Plan Practitioners are informed of Kaiser Permanente disease management programs and how to access them via the Provider Manual, under “News and Announcements” on the Kaiser Permanente Community Providers website at providers.kaiserpermanente.org/oh, and the Provider Connection newsletter.

4.5.3 Outreach Activities for Members
Kaiser Permanente sends letters monthly to Members newly diagnosed with heart failure, asthma and diabetes, describing our disease management programs and how to access them. We also send letters quarterly to Members with these conditions that have not seen their Primary Care Physician in 1 year, reminding the Members to make appointments for follow-up.

4.5.4 Healthy Lifestyles for Families
Healthy Lifestyles for Families was developed to address the issue of childhood obesity. This program is a two week healthy lifestyle program aimed at children and pre-teens ages 5 through 12 and includes their parents or guardians. The parents attend the first session and learn how they can support their families in living healthier. Parents and children attend the second session. The two-session classes focus on ways families can stay healthy by balancing nutritious foods with active living. The classes are interactive and help children understand why it is important to take care of their bodies and maintain their health. Parents can teach their children healthy habits that will last a lifetime. For more information about Healthy Lifestyles for Families, call the Member Health Education Line at 216-524-5948.

4.5.5 My Health Manager
Members who receive their care at a Kaiser Permanente medical Facility have the ability to manage their health and the health of their family online through My Health Manager at kaiserpermanente.org. My Health Manager provides Members with instant access to secure health care information online from wherever they have Internet access.

Some of these time-saving features include:
- Emailing an Ohio Permanente Medical Group Physician.
- Managing prescriptions.
• Viewing lab results.
• Acting for a family member.
• Viewing past office visit information.
• Viewing Eligibility and Covered Benefits.
• Tracking documented allergies.
• Scheduling or canceling future appointments.
• Viewing immunization records.
• Requesting updates to medical records.

4.5.6 Kaiser Permanente Total Health Assessment
Total health assessment (THA) is a health risk assessment tool that Kaiser Permanente offers to our Members. Kaiser Permanente's THA program is provided by HealthMedia Inc. and is called HealthMedia® Succeed™. With this program, Members can get an in-depth look at their current total health and obtain a customized plan to help them look better, feel better, and improve their well-being. THA allows Members to assess their health as a whole and prioritize what kinds of health changes they want to make based on their risk of developing certain health conditions and on their confidence and readiness to make a change. In addition, Members may receive recommendations for customized action, which may include tips on healthy eating, exercise, stress management, or information about other healthy lifestyle programs offered by Kaiser Permanente.

Members can choose to make their THA a part of their electronic medical record and share that information with their Kaiser Permanente health care Practitioner via My Health Manager. Only the Member's doctor and other appropriate Kaiser Permanente health staff are able to access the information.

4.6 Referrals

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan Specialists.

A Referral is a prospective, written recommendation by a Plan Provider for Specialty medical care, procedures, testing, therapies and equipment and/or supplies. A Referral is not approved until it is Authorized by Kaiser Permanente. See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product. See Appendices B, C, D and E of this Manual for a list of procedures, tests and injections that can be ordered and performed by Plan Providers in conjunction with an Authorized Referral, without additional Referrals or Precertifications.

Plan Specialists are expected to provide timely feedback to referring Physicians regarding the outcome of consultations, plans of care, and need for further testing and
follow up. Kaiser Permanente is able to provide diagnostic, imaging and laboratory testing for Members at Kaiser Permanente Medical Facilities. For a current list of Plan Facilities, see the Ancillary Directory on Kaiser Permanente’s Community Providers website at providers.kaiserpermanente.org/oh, or call either your Network Associate or the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to request a Kaiser Permanente Ancillary Directory.

Plan Providers may submit Referral requests via KP Online-Affiliate (see Section 6.17.2 of this Manual) or on a written Referrals Management and Clinical Review Referral Form (see Section 4.6.4 of this Manual). A Referral from a Member’s Primary Care Physician (PCP) is necessary for all specialty care office visits, except outpatient Behavioral Health, Ob/Gyn, and Optometry. The Referral form serves to assist in coordination of care and communication with the Specialist. To ensure routine Referrals are handled efficiently and timely, complete all areas of the form and include as much clinical information as necessary for appropriate Authorization.

Review and Authorization of routine Referral requests are usually completed within 3 to 5 business days.

Incomplete Referral forms submitted to the Kaiser Permanente Referrals Management and Clinical Review Department for Kaiser Permanente HMO Members will be returned to the referring Physician with notations explaining what additional information is needed. If the requested information is not received within 45 calendar days of the original request date, the Referral request will be sent to the Physician Advisor to render a Medical Necessity determination on the information that is available. The referring Plan Physician and the Member are notified of the Authorization or Benefit Determination in writing.

Incomplete Referral forms submitted to the Referrals Management and Clinical Review Department for Kaiser Permanente Added Choice® Point-of-Service (POS) Tier One Members will be returned to the referring Physician with notations explaining what additional information is needed. If the requested information is not received within 45 calendar days of the original request date, a Benefit Determination letter is sent to the referring Plan Physician and the Member.

If there is a clinical need for an urgent/emergent Referral request, either call the Kaiser Permanente Referrals Management and Clinical Review Department at 1-866-433-1333 (toll free) or write “Urgent” at the top of a Referral form and fax to 1-866-422-5940. Review and Authorization of urgent/emergent Referrals will be completed within 72 hours.

Kaiser Permanente will only pay for Covered healthcare Services when Kaiser Permanente Referral and Authorization requirements are met. This policy includes those instances when Kaiser Permanente is the secondary Payor for Kaiser
Permanente HMO and Added Choice® Point-of-Service (POS) Members and Plan Sponsors are the secondary Payor for Self-Funded Members.

**Note:** Retroactive Referral requests are not accepted.

The Referral form allows the Primary Care Physician (PCP) to do the following:
- Authorize treatment for the Member.
- Identify the Services the Member requires.
- Communicate pertinent clinical information to the Specialist or Provider.
- Provide Member billing information.

If a Referral request is approved, Referrals for Specialists consults are valid for 6 months, unless otherwise indicated. Up to two visits per referral are Authorized, unless otherwise indicated. Each Referral is assigned a unique Authorization number.

In order for an Authorization to be valid:
- Plan Providers must have a completed, written Referral form from Kaiser Permanente.
- The Member must be eligible on the date of Service.
- Services must be rendered between the assigned start date and expiration date of the Authorization to the Specialist or Provider.
- The number of visits made to the Specialist or Provider must not exceed the number of Authorized visits between the corresponding Referral start and expiration date.
- The procedure or treatment must be medically appropriate for the patient’s diagnosis.
- The procedure or treatment must be performed in an Authorized Plan Provider’s office, or at a Plan Facility.
- The Member must have Covered Benefits which cover the stated condition.

### 4.6.1 Secondary Referrals

**Note:** Kaiser Permanente Referral policies and procedures apply to:
- **A.** Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
- **B.** Self-Funded Exclusive Provider Organization (EPO) Members.

Medicare Plus Members DO NOT need Referrals to Plan Specialists.

The term secondary Referral is used to describe an outpatient Referral from one Plan Specialist to another. Kaiser Permanente of Ohio does not permit secondary Referrals, except when initiated by a Plan Ob/Gyn Provider to an Ob/Gyn sub-specialist (see Section 4.6.6.2.1 of this Manual). All Specialty care Referrals for Kaiser Permanente Members must be initiated by the Members’ Primary Care Physicians.
4.6.2 Standing Referral Requirements

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan Specialists.

Some Members have complex medical needs that require on-going specialty care. Standing Referrals for specialty care are usually generated by the Primary Care Physician, who in conjunction with the appropriate Specialist, develops a treatment plan that includes number of outpatient visits, specified start and expiration dates and ongoing communication between the Member, Primary Care Physician and Specialist. These types of Referrals will be Authorized on a case-by-case basis to include multiple visits, tests, and/or procedures.

4.6.3 Outpatient Referrals for Procedures, Testing and Injectables

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan Specialists.

The following guidelines are to be used in conjunction with the Appendices located in the back of this Manual:
- Appendix B: Auto Auth List.
- Appendix C: Auto Auth List for Therapies.
- Appendix D: Auto Auth List for Dermatology Services.
- Appendix E: Auto Pay List.

Note: Outpatient procedures, testing and injectables that are not on either the Auto Auth or the Auto Pay Lists must be Precertified. For more information, see Section 4.7 and/or Appendix A (Precertification Guidelines) of this Manual.

4.6.3.1 Referral Guidelines for Plan Primary Care Physicians

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan Specialists.

The Services listed in Appendices B (Auto Auth List), D (Auto Auth List for Dermatology Services) and E (Auto Pay List) of this Manual may be performed in your office without
completion of a Referral form. Reimbursement for these Services will be made in accordance with the terms of your Agreement.

If you are ordering Services in Appendices B (Auto Auth List), C (Auto Auth List for Therapies) and D (Auto Auth List for Dermatology Services) of this Manual to be performed by a Plan Specialist or at a Kaiser Permanente Plan Facility on an outpatient basis, you MUST submit a Referral form (see Section 4.6.4 of this Manual) to the Kaiser Permanente Referrals Management and Clinical Review Department in advance of the date of Service to request a Referral.

4.6.3.2 Referral Guidelines for Plan Dermatologists

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan Specialists.

You may perform the Services listed in Appendices D (Auto Auth List for Dermatology Services) and E (Auto Pay List) of this Manual in your office or at a Kaiser Permanente Plan Facility on an outpatient basis IF you have a current, valid Authorization number from a Kaiser Permanente Plan Physician to see the Member. Payment will be issued with a valid Authorization number whether or not these Current Procedural Terminology (CPT) codes appear on your completed Authorization form. Reimbursement for these Services will be made in accordance with the terms of your Agreement.

If you are ordering Services that are listed in Appendices B (Auto Auth List) or C (Auto Auth List for Therapies) of this Manual, you MUST submit a Referral form (see Section 4.6.4 of this Manual) to the Kaiser Permanente Referrals Management and Clinical Review Department in advance of the date of Service to request Authorization.

4.6.3.3 Referral Guidelines for Plan Behavioral Health and Ob/Gyn Specialists

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan Specialists.

Kaiser Permanente Members may self-refer to Plan Behavioral Health and Ob/Gyn Providers.

You may perform the Services listed in Appendix E (Auto Pay List) of this Manual in your office or at a Kaiser Permanente Plan Facility on an outpatient basis without completion of a Referral form. Reimbursement for these Services will be made in accordance with the terms of your Agreement.
You may perform the Services listed in Appendices B (Auto Auth List), C (Auto Auth List for Therapies) or D (Auto Auth List for Dermatology Services) of this Manual in your office without completion of a Referral form. Reimbursement for these Services will be made in accordance with the terms of your Agreement.

If you are ordering Services that are listed in Appendices B (Auto Auth List), C (Auto Auth List for Therapies) or D (Auto Auth List for Dermatology Services) of this Manual to be performed at a Kaiser Permanente Plan Facility other than your office, you MUST submit a Referral form (see Section 4.6.4 of this Manual) to the Kaiser Permanente Referrals Management and Clinical Review Department in advance of the date of Service to request Authorization.

See Sections 4.6.6.1—4.6.6.1.4.2 of this Manual for more information regarding Behavioral Health Services. See Sections 4.6.6.2—4.6.6.2.6 of this Manual for more information regarding Ob/Gyn Services.

4.6.3.4 Referral Guidelines for All Other Medical Specialists

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan Specialists.

You may perform the Services listed in Appendices B (Auto Auth List), D (Auto Auth List for Dermatology Services) and E (Auto Pay List) of this Manual in your office or at a Kaiser Permanente Plan Facility on an outpatient basis IF you have a valid Authorization number from a Kaiser Permanente Plan Physician to see the Member. Payment will be issued with a valid Authorization number whether or not these CPT codes appear on your completed Authorization form. Reimbursement for these Services will be made in accordance with the terms of your Agreement.

If you are ordering Services that are listed in Appendix C (Auto Auth List for Therapies) of this Manual, you MUST submit a Referral form (see Section 4.6.4 of this Manual) to the Kaiser Permanente Referrals Management and Clinical Review Department in advance of the date of Service to request Authorization.

4.6.3.5 Referral Guidelines for Plan Therapy Providers

Note: Kaiser Permanente Referral policies and procedures apply to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
B. Self-Funded Exclusive Provider Organization (EPO) Members.
Medicare Plus Members DO NOT need Referrals to Plan therapy Providers.

The Services listed in Appendix C (Auto Auth List for Therapies) of this Manual may be performed in your office IF you have a valid Authorization number from a Kaiser
Permanente Plan Physician. Payment will be issued with a valid Authorization number whether or not these CPT codes appear on your completed Authorization form. Reimbursement for these Services will be made in accordance with the terms of your Agreement.

See Section 4.8.3 of this Manual for more information regarding therapy Services.

### 4.6.4 Referral Form

See the following page.
### Referrals Management and Clinical Review Referral Form

**FOR ROUTINE REFERRALS:**
Please fax this completed form to Kaiser Permanente Referrals Management and Clinical Review Department at 1-866-422-5940 (toll-free)

**IF THERE IS A CLINICAL NEED FOR A SAME DAY/NEXT DAY CONSULTATION OR PROCEDURE:**
Please write “URGENT” on the top of this form and follow the same instructions as listed above for routine Referrals.

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<thead>
<tr>
<th>REFERRING PHYSICIAN'S REQUEST</th>
<th>KAISER PERMANENTE'S AUTHORIZATION OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Name:</td>
<td></td>
</tr>
<tr>
<td>Office Phone #:</td>
<td></td>
</tr>
<tr>
<td>Office Fax #:</td>
<td></td>
</tr>
<tr>
<td>Referring Physician:</td>
<td></td>
</tr>
<tr>
<td>Referring Physician's NPI:</td>
<td></td>
</tr>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>Patient M#:</td>
<td></td>
</tr>
<tr>
<td>Patient's DOB:</td>
<td>Assigned Authorization Number:</td>
</tr>
<tr>
<td>Requested Start Date:</td>
<td>Assigned Start Date:</td>
</tr>
<tr>
<td>Anticipated Expiration Date:</td>
<td>Assigned Expiration Date:</td>
</tr>
<tr>
<td>Requested Number of Visits:</td>
<td>Assigned Number of Visits:</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>ICD-9 code:</td>
<td>Assigned ICD-9 code:</td>
</tr>
<tr>
<td>Procedure:</td>
<td></td>
</tr>
<tr>
<td>CPT code:</td>
<td>Assigned CPT code:</td>
</tr>
<tr>
<td>Servicing Provider Name, Phone # and Fax #:</td>
<td>RN/ specialist:</td>
</tr>
<tr>
<td>(Preferred Specialists Name)</td>
<td>Provider specialty:</td>
</tr>
<tr>
<td>Provider specialty:</td>
<td>Date Authorized:</td>
</tr>
<tr>
<td>Requested Hospital:</td>
<td></td>
</tr>
<tr>
<td>Clinical information:</td>
<td>Please attach all pertinent medical records</td>
</tr>
<tr>
<td>Please Indicate if this Referral was:</td>
<td></td>
</tr>
<tr>
<td>☐ Member initiated or ☐ Physician initiated</td>
<td></td>
</tr>
</tbody>
</table>

Dr. Signature__________________________ (Required)

Revised: 01/13

[Image: KAISER PERMANENTE OF OHIO logo]
4.6.5 Request for Out-of-Network Authorization

**Note:** This Kaiser Permanente Referral policy and procedure applies to:

- A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice® Point-of-Service (POS) Tier One Members.
- B. Kaiser Permanente Medicare Plus Members.
- C. Self-Funded Exclusive Provider Organization (EPO) Members.

If a Plan Provider determines that it is Medically Necessary to refer a Member to a non-contracted practitioner/provider, attach clinical notes to the Referrals Management and Clinical Review Referral Form (see Section 4.6.4 of this Manual) indicating the need for that practitioner/provider. Referral requests for non-contracted practitioner/providers will be reviewed by a Referrals Management and Clinical Review Department Physician Advisor and a determination issued in approximately 3 to 5 business days.

If a Referral form for a non-contracted practitioner/provider is received without the necessary supporting documentation, the form will be returned with a Request for Out-of-Network Authorization form, requesting either clinical notes indicating Medical Necessity for said practitioner/provider or an alternate (contracted Practitioner/Provider). If no response is received within 45 calendar days, a denial will be issued to the Member and the referring Practitioner/Provider.

4.6.5.1 Request for Out-of-Network Authorization Form

See the following page.
REQUEST FOR OUT-OF-NETWORK AUTHORIZATION

Kaiser Permanente
Referrals Management and Clinical Review Department

Kaiser Foundation Health Plan of Ohio
P.O. Box 5316
Cleveland, Ohio 44101
Phone: 1-866-433-1333 (toll-free)
Fax: 1-866-422-5940

To
From

Fax #: Phone #:

Pages (including cover):

Phone #: Date:

Re: CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply

☐ Clinical notes are required to process/extend this Referral
Please provide: Clinical notes to indicate medical necessity

☐ The requested provider/facility is not contracted with Kaiser Permanente or is not in this
Member’s network

Please provide: An alternate in plan/in network provider or:
Clinical notes to indicate medical necessity for this provider

Please respond within 7 working days in order that we may remain in compliance with regulatory
timeframes for processing Referrals. If no response received within that timeframe, a formal
denial will be issued to the Member and requesting provider.
4.6.6 Self-referrals
The term self-referral refers to the following Specialty Services which all Kaiser Permanente of Ohio Fully-Insured and Self-Funded Members may access from Plan Providers on an outpatient basis without written Referrals from their Primary Care Physicians:

- Behavioral Health Services.
- Ob/Gyn.
- Optometry.

Note: The Plan Providers of the above Services are required to follow Kaiser Permanente Referrals Management and Clinical Review Department guidelines for all Services that require Authorization. See Appendix A (Precertification Guidelines) for a list of inpatient and outpatient Services which require Precertification, by product.

4.6.6.1 Behavioral Health Services (Mental Health and Chemical Dependency)
The following guidelines are for Plan Behavioral Health Services Providers.

4.6.6.1.1 Access to Services
Kaiser Permanente Fully-Insured and Self-Funded Members may self-refer to any Plan Provider for Behavioral Health Services. However, the following parameters apply:

- Direct Access does not exempt Plan Behavioral Health Providers from the usual and customary Authorization policies of Kaiser Permanente including, but not limited to, inpatient and emergent admissions and ambulatory procedures performed at a Plan Facility. Authorization of procedures is a requirement of each Plan Provider’s Agreement and a necessary step for appropriate Claim adjudication and payment. See Appendix A (Precertification Guidelines) for a list of Services, admissions, tests and procedures which require Precertification, by product. See Appendix E (Auto Pay List) of this Manual for a list of laboratory and imaging tests and procedures that can be done in a Plan Provider’s office or at a Plan Facility without Authorization.

- If a Plan Behavioral Health Provider needs to refer a Member to another clinical specialty, the Member should be directed back to their Primary Care Physician (PCP) to obtain the Referral. See Section 4.6 of this Manual for a list of products which require Referrals for Specialty care Services.

- Inpatient and outpatient hospital Services, including laboratory, imaging and other studies, must be provided at a Kaiser Permanente medical Facility or at a Plan Facility. Services rendered by a non-contracted provider or facility without prior Authorization will be the Member’s financial responsibility. See Appendix A (Precertification Guidelines) for a list of Services, admissions, tests and procedures which require Precertification, by product. See Appendix E (Auto Pay List) of this Manual for a list of laboratory and imaging tests and procedures that can be done in a Plan Provider’s office or at a Plan Facility without Authorization.
Members may call any Plan Behavioral Health Provider office location listed in the Kaiser Permanente Provider directory during normal operating hours and speak with a triage clinician. Plan Behavioral Health Providers must be available after hours, 24 hours per day, 7 days per week for assessment, Referral and intervention Services.

4.6.6.1.2 Covered Services and Exclusions for Fully-Insured Members
The following Sections of this Manual summarize basic Covered Services and exclusions for Behavioral Health Services. Covered Services may vary by product, employer and/or benefit design.

4.6.6.1.2.1 Covered Mental Health Benefits for Fully-Insured Members
For biologically based mental health illnesses, such as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, Kaiser Permanente covers diagnostic and treatment Services. There is no limit on covered inpatient hospital days or outpatient Services.

For mental health illnesses that are not biologically based, Kaiser Permanente covers evaluations and crisis intervention and treatment. Covered Benefits include outpatient individual therapy visits for diagnostic evaluation and psychiatric treatment; group therapy visits, and visits for the purpose of monitoring drug therapy. There is no limit on covered inpatient hospital days or outpatient Services. However, certain employer groups have limitations based on contract renewal dates.

Exclusions for mental health illnesses include the following:

- Recreational, music, diversional, and play therapy as part of either inpatient or outpatient mental health treatment.
- Testing for ability, aptitude, intelligence or interest.
- Cognitive therapy.
- Care, as a condition of probation, parole, or any other third party or court order, unless a Plan Provider determines such Services to be Medically Necessary and appropriate.
- Inpatient/residential rehabilitation, including specialized behavioral modification programs in a residential facility.
- Long-term rehabilitative Services.

For Fully-Insured Members, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

For Self-Funded Members, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.
4.6.6.1.2.2 **Covered Chemical Dependency Benefits for Fully-Insured Members:**

Covered Services include the following:

- Inpatient and outpatient detoxification for the medical management of withdrawal symptoms. Medical management of withdrawal symptoms in a specialized chemical dependency treatment Facility or program is covered in a Facility designated by Kaiser Permanente.
- Outpatient individual and group therapy sessions. Limitations may apply.

Exclusions for chemical dependency Services include the following:

- Inpatient/residential rehabilitation.
- Methadone maintenance.

**For Fully-Insured Members,** call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

**For Self-Funded Members,** call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

4.6.6.1.3 **Quality Standards**

Kaiser Permanente has established appointment accessibility standards that each Plan Behavioral Health and Chemical Dependency Provider must meet. See Section 8.9 of this Manual for the Kaiser Permanente appointment accessibility standards.

Kaiser Permanente is required by the National Committee for Quality Assurance (NCQA) and HEDIS® (Health Plan Employer Data Information Set) to periodically monitor Plan Behavioral Health Providers to ensure Kaiser Permanente accessibility standards are met. The Behavioral Health Department Telephone Access Survey (see the following Section of this Manual) is one tool Kaiser Permanente utilizes to monitor the access to care available for Members seeking behavioral health Services from Plan Providers. This survey is conducted semi-annually by the Kaiser Permanente Network Development and Performance Department for all Plan Provider offices that Members may directly access for care. Each Plan Mental Health or Chemical Dependency Provider will be asked several questions relative to the following:

- The level of clinical competence of staff members assigned to triage incoming Member calls (must be at a minimum of a Registered Nurse or a licensed counselor).
- The appointment availability of all Plan Providers to assess and treat Members with emergent, urgent, routine and follow up needs.
- The availability of the Plan Providers for Members who need assessment and care outside of normal office hours.
Each survey question score is tallied, compared and shared with the Plan Provider. Plan Providers scoring less than 50 percent on any one measure, or less than 90 percent overall, will receive individual follow up from Kaiser Permanente and reassessment.

Patient safety and the reduction of medical errors are important topics that have emerged as major concerns about today’s health care delivery system. The potential for errors is perhaps greater when multiple practitioners/providers provide care for an individual patient without adequate communication regarding findings and therapeutic interventions. For this reason, Kaiser Permanente encourages real time exchange of information among Plan Providers treating the same patient and periodically monitors to assess whether effective communication is occurring.

It is the policy and expectation of Kaiser Permanente that all Plan Behavioral Health Providers will communicate with the Member’s Primary Care Physician (PCP) via mail, email, fax or telephone regarding a new episode of care and obtain written authorization to release information to the PCP when indicated.

In keeping with the patient safety and quality standards of Kaiser Permanente, we may request retrospective utilization review or quality data concerning Plan Providers and/or Facilities.

4.6.6.1.3.1 Behavioral Health Department Access Survey Form

See the following page.
**Group Name:** ________________________________________________________________________________

**Practitioner:** __________________________________________________  **Network:** __________

**Date of Review:** _______________  **Office Location:** ________________________________

**Reviewer:** ___________________________  **Office Contact:** ________________________________

<table>
<thead>
<tr>
<th>Criteria Assessed</th>
<th>Standard</th>
<th>Office Practice/Practitioner Availability</th>
<th>Standard Met?</th>
<th>Goal</th>
<th>Goal Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls answered within 30 seconds.</td>
<td>Phone must be answered by a live person (i.e. non-recorded voice) within 30 seconds of first ring.</td>
<td>Current Time: Time phone answered:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triage of patient requests for appointments involving clinical judgment of urgency.</td>
<td>Staff triaging patients should be, at a minimum, either an RN, or a Master's prepared counselor.</td>
<td>Calls are triaged by the Triage staff on duty.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment availability for patients calling with an immediate emergent need, such as suicidal ideation.</td>
<td>Patients with immediate emergent needs will be seen immediately/sent to Emergency Department/hospital.</td>
<td>Current Time: Next Available Emergent Appt:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment availability for patients calling with a non-life threatening emergent need.</td>
<td>Patients with a non-life threatening emergent need will be given an appointment within 6 hours or less from the time of contact with the patient.</td>
<td>Current Time: Next Available Emergent Appt:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment availability for patients calling with an urgent need, such as delusional behavior or (for ACD) withdrawal symptoms.</td>
<td>Patients with urgent needs will be given an appointment within 48 hrs. from the time of contact with the patient.</td>
<td>Current Time: Next Available Urgent Appt:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment availability for patients calling with a routine need, such as stress or depression, or need for ACD screening.</td>
<td>Patients with routine needs (non-urgent) will be given an appointment within 10 working days from the time of contact with the patient.</td>
<td>Current Time: Next Available Routine Appt:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After-hours access to care.</td>
<td>Practitioners will be available to patients 24 hours/day for assessment, Referral, and intervention. Access is provided via emergency telephone advice in collaboration with the psychiatrist on-call and via emergency room visit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Practitioner/Group Score:** __/___

The above answers are reflective for all providers at this location. Practitioners are:
4.6.6.1.4 Postpartum Depression Screening
Postpartum depression is common in one of seven new mothers. Postpartum onset is defined as occurring in the first 12 weeks after birth. Maternal depression can interfere with mother-infant bonding and have negative effects on the child. Screening for symptoms of depression can lead to earlier recognition and Medically Necessary treatment.

Postpartum depression screening is an important health initiative at Kaiser Permanente. Primary Care Physicians and Plan Ob/Gyn providers are asked to screen new mothers for postpartum depression within 8 weeks of delivery. A sample screening form, the Patient Health Questionnaire (PHQ 9), and the PHQ 9 Scoring Card for Severity Determination are located in the following Sections of this Manual.

Plan Practitioners are responsible for evaluating their patients and making clinically appropriate treatment recommendations. If Plan Providers do not already have a screening tool to use, the PHQ 9 and the Scoring Card can help Practitioners develop an appropriate treatment plan for each patient.

4.6.6.1.4.1 Postpartum Depression Screening Questionnaire

See the following page.
## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**  __________________________________________________

**DATE:**   _________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**add columns:**

**Total:**

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any* problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not difficult at all</td>
</tr>
<tr>
<td>Somewhat difficult</td>
</tr>
<tr>
<td>Very difficult</td>
</tr>
<tr>
<td>Extremely difficult</td>
</tr>
</tbody>
</table>

---

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4.6.6.1.4.2  Postpartum Depression Scoring Card

**PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION**

*for healthcare professional use only*

Scoring – add up all checked boxes on PHQ-9

For every ☑:  Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

**Interpretation of Total Score**

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20 – 27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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4.6.6.2 Ob/Gyn
The following guidelines are for Plan Ob/Gyn Providers.

4.6.6.2.1 Access to Services
Kaiser Permanente Fully-Insured and Self-Funded Members may self-refer to any Plan Provider for Ob/Gyn Services. However, the following parameters apply:

- Direct Access does not exempt Plan Ob/Gyn Providers from the usual and customary Authorization policies of Kaiser Permanente including, but not limited to, inpatient and emergent admissions and ambulatory procedures performed at a Plan Facility. Authorization of procedures is a requirement of each Plan Provider's Agreement and a necessary step for appropriate Claim adjudication and payment. See Appendix A (Precertification Guidelines) for a list of Services, admissions, tests and procedures which require Precertification, by product. See Appendix E (Auto Pay List) of this Manual for a list of laboratory, imaging and Ob/Gyn tests and procedures that can be done in your office or at a Plan Facility without Authorization.

- Plan Ob/Gyn Providers must obtain Authorization for Referrals for Ob/Gyn subspecialties, such as reproductive endocrinology, gynecological oncology, high risk obstetrical Specialists and others. If a Plan Ob/Gyn Provider needs to refer a Member to another clinical specialty, other than the Ob/Gyn subspecialties listed above, the Member should be directed back to their Primary Care Physician to obtain the Referral. See Section 4.6 of this Manual for a list of products which require Referrals for Specialty care Services.

- Inpatient and outpatient hospital Services, including laboratory, imaging and other studies, must be provided at a Kaiser Permanente medical Facility or at a Plan Facility. Services rendered by a non-contracted provider or Facility without prior Authorization will be the Member’s financial responsibility. See Appendix A (Precertification Guidelines) for a list of Services, admissions, tests and procedures which require Precertification, by product. See Appendix E (Auto Pay List) of this Manual for a list of laboratory, imaging and Ob/Gyn tests and procedures that can be done in your office or at a Plan Facility without Authorization.

4.6.6.2.2 Infertility Services Referral Protocol
If a Member has tried to conceive after 12 months of regular intercourse (6 months if a woman is over 35), without the use of contraceptives, the Member may need special medical Services to evaluate or treat infertility. Services to determine if infertility exists are not part of the infertility benefit, i.e.: sperm count, evaluation of fallopian tubes for patency. Once infertility is diagnosed however, the treatment of such is infertility Services. This evaluation, if done prior to a Referral to an infertility Specialist, would be considered regular gynecology Service. Once the diagnosis is made and the Referral to an infertility Specialist is made, twelve visits for 6 months are Authorized.

To initiate a Referral to an infertility Specialist for Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice Point-of-Service Tier One and Self-Funded Exclusive Provider Organization (EPO) Members, complete the following
Infertility Checklist and fax it along with a Referrals Management and Clinical Review Referral Form (see Section 4.6.4 of this Manual) to 1-866-422-5940. Questions regarding the infertility Referral process may be directed to the Referrals Management and Clinical Review Department at 1-866-433-1333 (toll free).

**Fully-Insured Members** should call the Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).

**Self-Funded Members** should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY).

4.6.6.2.2.1 Infertility Checklist Form

See the following page.
Kaiser Permanente
Criteria and Tests Prior to Referral for Infertility

Patient Name: _______________________

Medical Record Number: _____________

Referring Physician ________________ Phone Number: ____________

Date Completed: __________

<table>
<thead>
<tr>
<th></th>
<th>Test Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Semen Analysis</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HSG</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>GC/Chlamydia</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>PAP</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Rubella</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Progesterone Cycle Day 21</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>FSH Cycle Day 3 (if indicated)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Clomid Challenge Test - for patients over 35 (if indicated)</td>
<td></td>
</tr>
</tbody>
</table>

**All results of the tests listed above should be forwarded to the Plan Physician that will be providing the infertility services.**
4.6.6.2.3 Infertility Services Benefits for Fully-Insured Members

Kaiser Permanente pays a percentage of the cost of Covered Services for infertility treatment.

The following Services are not covered by Kaiser Permanente. The Member will have 100 percent financial responsibility for these Services and should be made aware of their financial liability prior to rendering Service.

- Services to reverse voluntary, surgically induced infertility.
- The cost of semen, including purchase, storage and cryopreservation.
- Donor eggs and Services related to the procurement and storage of donor eggs.
- Services, other than artificial insemination, for conception by artificial means, including, but not limited to, In-vitro Fertilization, Gamete Intra Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), and ovum transplants.
- Infertility Services for a partner who is not a Kaiser Permanente Member.
- Services related to a surrogacy arrangement, including, but not limited to, conception, pregnancy or delivery are not covered as a means to correct a Member's infertility. A surrogacy arrangement is one in which a woman agrees to become pregnant and surrender the baby to another person or persons who intend to raise the child.
- If the Member has no drug benefit, the Member will pay the full cost of prescription drugs.

**Fully-Insured Members** should call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free), to verify Covered Benefits for infertility Services and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY). Information regarding Covered Benefits also appears in the Kaiser Permanente Evidence of Coverage which is mailed to the Member's home on an annual basis.

See Section 4.6.6.2.3.1 of this Manual for a sample Patient Acknowledgement Form for Fully-Insured Members which may be used to inform the Member of his/her financial responsibility for infertility Services.

**Self-Funded Members** should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free) to verify Covered Benefits for infertility Services and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY). Information regarding Covered Benefits also appears in the Summary Plan Description which is mailed to the Member's home on an annual basis.

4.6.6.2.3.1 Patient Acknowledgment Form for Fully-Insured Members

See the following page.
PATIENT ACKNOWLEDGEMENT FORM

I understand and acknowledge that Kaiser Permanente pays a percentage of the cost of covered infertility Services. I also understand that I will be billed for the balance of all covered infertility Services, and that there is no guarantee that pregnancy will occur.

I understand that the following infertility Services are not covered by Kaiser Permanente, and that I am responsible for paying 100 percent of the cost if I choose to use them.

- Services to reverse voluntary, surgically induced infertility.
- The cost of semen, including purchase and storage.
- Donor eggs and services related to the procurement and storage of donor eggs.
- Services, other than artificial insemination, for conception by artificial means, including, but not limited to, In-vitro Fertilization, Gamete Intra Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), and ovum transplants.
- Infertility Services for a partner who is not a Kaiser Permanente Member.
- Services related to a surrogacy arrangement, including, but not limited to, conception, pregnancy or delivery are not covered as a means to correct a Member’s infertility.
- If my Kaiser Permanente health plan has no drug benefit, then I will pay the full cost of prescription drugs.

_______________________ ______________________________
Patient Signature   Date

Fully-Insured Members: Refer to your Kaiser Permanente Evidence of Coverage for specific information regarding infertility benefits. If you have questions about your benefits, contact the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free). The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).
4.6.6.2.4 Requests for Termination of Pregnancy
Note: Not all Kaiser Permanente Members have coverage for pregnancy terminations.

For Fully-Insured Members, Plan Providers should call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility and Covered Benefits prior to the date of the procedure.

Fully-Insured Members should call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free) to verify Covered Benefits. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).

For Self-Funded Members, Plan Providers and Members should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility and Covered Benefits prior to the date of the procedure. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY).

A Kaiser Permanente identification (ID) card and a picture ID are required when the Members present for the procedure.

Plan Providers for termination of pregnancy include:
- **Cuyahoga County:**
  - Cleveland Surgicenter: 216-295-3330
  - Pregnancy terminations up to 24 weeks gestation.
  - MetroHealth System: 216-778-7624
  - Planned Parenthood of Greater Cleveland: 440-232-5040
- **Summit County:**
  - Pregnancy terminations up to 24 weeks gestation.

Claims for pregnancy terminations for Fully-Insured Members should be submitted to the Kaiser Permanente Claims Department (see Section 5 of this Manual for more information). Kaiser Permanente will issue payment without an Authorization or a Referral form as long as the Member meets Eligibility requirements and the Service is a Covered Benefit.

Claims for pregnancy terminations for Self-Funded Members should be submitted to the Kaiser Permanente Insurance Company (KPIC) Self-Funded Claims Administrator, Harrington Health (see Section 11.5 of this Manual for more information). Plan Sponsors will issue payment without an Authorization or a Referral form as long as the Member meets Eligibility requirements and the Service is a Covered Benefit.
4.6.6.2.5 Contraception

Contraception is an exclusion under a Member’s base medical benefit plan. Oral and injectable contraceptives and contraceptive devices may be covered under prescription drug riders. Not all Members have a prescription drug benefit as part of their coverage.

For Fully-Insured Members, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

For Self-Funded Members, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

4.6.6.2.5.1 IUD

Contraception is an exclusion under a Member’s base medical benefit plan. Oral and injectable contraceptives and contraceptive devices may be covered under prescription drug riders. Not all Members have a prescription drug benefit as part of their coverage.

Prescriptions for Mirena or Paraguard IUD’s should be brought to a Kaiser Permanente Plan Pharmacy. Members should allow 1-2 days for the prescription to be filled. Cost of the IUD will vary depending on the Member’s drug benefit. In general, the cost is $200.00.

For Fully-Insured Members, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

For Self-Funded Members, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

4.6.6.2.5.2 DEPO PROVERA

Contraception is an exclusion under a Member’s base medical benefit plan. Oral and injectable contraceptives and contraceptive devices may be covered under prescription drug riders. Not all Members have a prescription drug benefit as part of their coverage.

Kaiser Permanente Members can receive Depo Provera one of two ways as follows:

- At the Nurse Clinic in a Kaiser Permanente medical Facility. (Members who select a MetroHealth System Primary Care Physician will need to stay within the MetroHealth System).
- At a Plan Primary Care or Ob/Gyn Provider’s office.
For Depo Provera injections given at a Kaiser Permanente Nurse Clinic:

- Give the Member a prescription for the Depo Provera and an order for the injection. The prescription is turned into the Plan Pharmacy and the order is given to the nurse at the time of the first injection (without the order, the medication cannot be given). The Member should be instructed to call refills in to a Plan Pharmacy 1-2 days in advance of the injection, to allow adequate time to have the Depo Provera available. A 3 month Copayment will be collected at the time the Depo Provera is dispensed.
- Orders for the injection may be faxed into the Kaiser Permanente Nurse Clinic at the following numbers:
  
  - Avon: 440-937-2345
  - Bedford: 440-735-6472
  - Chapel Hill: 330-630-4275
  - Cleveland Heights: 216-297-2582
  - Fairlawn: 330-873-4823
  - Parma: 216-362-2779
  - Rocky River: 440-895-3957
  - Strongsville: 440-846-2810
  - Twinsburg: 330-486-2805
  - Willoughby: 440-975-4657

- Members will need to make an appointment for the injection to be given at the Kaiser Permanente Nurse Clinic. They can call the Kaiser Permanente Member Service Center at 1-800-524-7377 (toll free) to schedule their appointments.

For Depo Provera injections given at a Plan Primary Care or Ob/Gyn Provider’s office:

- Give the Member a prescription for the Depo Provera.
- The Member must fill the prescription at a Plan Pharmacy prior to the first appointment for the injection. A three month Copayment will be collected at the time the Depo Provera is dispensed.
- Schedule the Member for her injection.
- The Member brings the Depo Provera to her first appointment.

For Fully-Insured Members, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

For Self-Funded Members, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

### 4.6.6.2.6 Postpartum Depression

See Section 4.6.6.1.4 of this Manual.
4.6.6.3 Optometry

Optometry Services for Kaiser Permanente Fully-Insured and Self-Funded Members are provided by VSP® Vision Care, a leader in the business of eye health. The VSP® Advantage network includes over 200 independent Optometrists within the Kaiser Permanente of Ohio Service Area. Members may be seen by a VSP® Advantage provider without a Referral from their Primary Care Physician.

Members may select a VSP® Advantage Optometrist by calling the VSP® Customer Service Department at 1-800-877-7195 (toll free) or by accessing the VSP® website at vsp.com/advantage. The hearing/speech-impaired may call 1-800-428-4833 (toll free TTY).

Routine eye exams are a Covered Benefit for all Members, except those enrolled in a Fully-Insured Health Maintenance Organization (HMO) High Deductible Health Plan (see Section 3.5.1.3 of this Manual) or a Self-Funded Exclusive Provider Organization (EPO) High Deductible Health Plan (see Section 11.3.1 of this Manual). There is no annual limit on routine eye exams for Fully-Insured Members who have an eye exam benefit. The number and frequency of allowed exams for Self-Funded Members may vary by Plan Sponsor.

Medical treatment of the eye must be provided by a Plan Ophthalmologist under contract with Kaiser Permanente of Ohio. See Sections 4.6 and 4.7 of this Manual for detailed descriptions of Authorization policies and procedures for Ophthalmology services.

In addition to routine eye care, some employer groups cover a hardware rider which provides a dollar allowance for frames, lenses and contact lenses. Kaiser Permanente Members may use their hardware rider at any authorized VSP® Advantage location. VSP® also offers a discount on frames, lenses and contact lenses to all Kaiser Permanente Members with or without coverage for hardware.

**Fully-Insured Members** should call the Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).

**Self-Funded Members** should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY).
4.7 Precertification

Note: See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product. For Kaiser Permanente Medicare Plus Members, notification is requested for certain services, as specified throughout the Manual.

Precertification is a determination by Kaiser Permanente that an admission, extension of stay or other health care Service has been reviewed, and based on the information provided, meets the clinical requirements for Medical Necessity, appropriateness, level of care and/or effectiveness and meets clinical criteria under the auspices of the Member’s applicable health benefit plan. See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product. To precertify, call 1-866-433-1333 (toll free) or fax to 1-866-422-5940.

4.7.1 Emergency Hospital Admissions

Note: This Kaiser Permanente Precertification policy and procedure applies to:

A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.
C. For Kaiser Permanente Medicare Plus Members, notification is requested as soon as possible, but no later than 48 hours.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.

In the event that an emergent inpatient admission is needed, including emergent or urgent admits directly from a physician’s office, follow the procedures below in order to expedite reimbursement and facilitate case management:

1. Direct the Member to a Kaiser Permanente Plan Facility where you have privileges or to the nearest emergency room.
2. Precertification of Emergency admissions is expected prior to admission for Kaiser Permanente Fully-Insured HMO, Added Choice® Point of Service (POS), Out-of-Area (PPO) Members and Self-Funded EPO and Out-of-Area (PPO) Members. Call 1-866-433-1333 (toll free) to precertify or fax to 1-866-422-5940. For Kaiser Permanente Medicare Plus Members, notification is requested as soon as possible, but no later than 48 hours.
3. Provide the Precertification staff with the following information:
   - Member name.
   - Member Medical Record Number.
   - Name of the Member’s Primary Care Physician (PCP.)
   - Name of the admitting Physician.
   - Admitting hospital or Facility name.
   - Date of admission.
• Admitting diagnosis.
• Proposed treatment and length of stay.

Plan Facilities are also responsible for calling the Kaiser Permanente Precertification Line for all inpatient Emergency admissions. Precertification of Emergency admissions is expected prior to admission for Kaiser Permanente HMO, Added Choice® Point-of-Service (POS), Out-of-Area (PPO) Members and Self-Funded EPO and Out-of-Area (PPO) Members. For Kaiser Permanente Medicare Plus Members, notification is requested as soon as possible, but no later than 48 hours.

**Failure to call and secure Authorization prior to admission, after emergency evaluation and stabilization of the patient, can result in denial of payment of the admission.**

Following Precertification for Medical Necessity, an Authorization notice with the Authorization number will be returned by fax to the admitting Physician. A copy will also be sent to the admitting Plan Facility. Kaiser Permanente will only pay for Covered healthcare Services when Kaiser Permanente Referral and Authorization requirements are met. **This policy includes those instances when Kaiser Permanente is the secondary Payor for Kaiser Permanente HMO, Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members and Plan Sponsors are the secondary Payor for Self-Funded EPO and Out-of-Area (PPO) Members.**

Note: Only one hospital Deductible is paid per benefit period for Kaiser Permanente Medicare Plus Members. If a Medicare Plus Member is transferred from one hospital to another, Kaiser Permanente must pay the Deductible for a covered stay, minus any applicable Member Copayment, to the first hospital. Case management is provided to Kaiser Permanente Medicare Plus Members while in an inpatient setting. Continued stay review in Plan hospitals is required.

4.7.1.1 Hospital Discharge and Repatriation Policy
The centralized Kaiser Permanente Repatriation team (Ohio Permanente Medical Group [OPMG] Physicians, HUB Coordinator and staff) review Emergency Department and inpatient cases at hospitals for quality and resource stewardship. Kaiser Permanente may transfer stable patients, when appropriate, to Plan Facilities where our Inpatient Care Managers and OPMG Physicians are on staff and medical records are electronically accessible. Physicians and staff at any facilities are able to talk directly with an OPMG Physician on the centralized Repatriation team 24 hours a day, seven days a week at 1-877-676-6270 (toll free) or 216-524-5333 to facilitate a safe transfer. If there are any issues around approvals/denials, the facility and Member will be notified.
4.7.2 Non-Emergent and Elective Inpatient Hospital Admissions and Services

Note: This Kaiser Permanente Precertification policy and procedure applies to:

A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.
C. For Kaiser Permanente Medicare Plus Members, notification is requested.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.

Follow the procedures below in order to expedite reimbursement and facilitate case management.

1. For Kaiser Permanente Fully-Insured HMO, Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members and Self-Funded EPO and Out-of-Area (PPO) Members, call 1-866-433-1333 (toll free) or fax to 1-866-422-5940 to precertify the admission. For Kaiser Permanente Medicare Plus Members, notification is requested.

2. Provide the Precertification staff with the following information:
   - Member name.
   - Member Medical Record Number.
   - Name of the Member’s Primary Care Physician (PCP.)
   - Name of the admitting Physician.
   - Admitting Plan Hospital or Facility name (location of Service.)
   - Date of Service.
   - Type of Service requested (for example, inpatient surgery.)
   - Procedure code.
   - Patient’s diagnosis.
   - Diagnosis code.
   - Significant patient history (attach Physician notes if indicated.)
   - Attach copies of supporting laboratory or imaging test results.
   - Plan of care.

Routine Precertification requests will be handled within 3 to 5 days of receipt of the information necessary to make the determination. Determination for urgent Precertification requests will be made within 24 hours of receipt with appropriate documentation. If additional information is needed, it will be requested within the first 24 hours of notification, with up to 48 hours given for submission of requested information.

Upon receipt of a Precertification request, Kaiser Permanente will do the following:
   - Verify Member Eligibility.
   - Verify that the requested Service is a Covered Benefit.
   - Determine if the admitting practitioner is a Plan Provider.
   - Apply clinical criteria (Medically Necessary and appropriate.)
   - Determine that the Services will be rendered in the correct setting and within the appropriate timeframe.
Once processed and approved, an Authorization notice with the Authorization number will be returned by fax to the admitting Physician. A copy will also be sent to the admitting Plan Facility.

Note: Only one hospital Deductible is paid per benefit period for Kaiser Permanente Medicare Plus Members. If a Medicare Plus Member is transferred from one hospital to another, Kaiser Permanente must pay the Deductible for a covered stay, minus any applicable Member Copayment, to the first hospital. Case management is provided to Kaiser Permanente Medicare Plus Members while in an inpatient setting. Continued stay review in Plan hospitals is required.

### 4.7.3 Skilled Nursing Facility (SNF) Admissions

Note: This Kaiser Permanente Precertification policy and procedure applies to:
- A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members.
- B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.
- C. For Kaiser Permanente Medicare Plus Members, notification is requested.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.

For Kaiser Permanente Fully-Insured HMO, Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members and Self-Funded EPO and Out-of-Area (PPO) Members, call 1-866-433-1333 (toll free) or fax to 1-866-422-5940 to precertify the admission. For Kaiser Permanente Medicare Plus Members, notification is requested.

Note: If the Kaiser Permanente Medicare Plus Member **does not have a 3 day qualifying acute care inpatient stay** preceding the admission, or within the preceding 30 days of the admission, and Kaiser Permanente has Authorized the SNF admission for the Member, Kaiser Permanente will assume financial responsibility for the cost of the Part A stay at each Plan Provider’s Agreement rate. The SNF can obtain payment from Medicare for Part B Covered Services and Kaiser Permanente will pay any applicable Coinsurance for approved care.

If the Kaiser Permanente Medicare Plus Member **does have a 3 day qualifying acute care inpatient stay** preceding the admission, or within the preceding 30 days of the admission, and Kaiser Permanente is managing or approved the SNF admission for the Member, Medicare will be the primary Payor of all Part A Services for days 1 to 20. Kaiser Permanente will assume financial responsibility for the Member’s Coinsurance (or a portion thereof) for days 21 to 100 per benefit period for Part A Covered Services, provided the Member continues to meet skilled care criteria. Kaiser Permanente will also pay any applicable Coinsurance for Part B Covered Services.
4.7.4 Ambulance Transfers

Note: This Kaiser Permanente Precertification policy and procedure applies to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.

Kaiser Permanente will only pay for Covered healthcare Services when Kaiser Permanente Precertification requirements are met. This policy includes those instances when Kaiser Permanente is the secondary Payor for Kaiser Permanente HMO, Added Choice® Point-of-Service (POS), and Out-of-Area (PPO) Members and Plan Sponsors are the secondary Payor for Self-Funded EPO and Out-of-Area (PPO) Members. Failure to secure Authorization prior to a scheduled transport can result in a denial of payment for the transport.

All ambulance transfers, including air ambulance, will be reviewed against Centers for Medicare and Medicaid Services (CMS) ambulance criteria as described in Chapter 10, Ambulance Services, Paragraph 4 of the Medicare Benefit Policy Manual posted on the CMS website at cms.gov/manuals/Downloads/bp102c10.pdf.

Transportation by wheelchair van is not a Covered Benefit. The Member is financially responsible for wheelchair transportation and the service should be arranged by the transferring facility.

4.7.4.1 Non-Emergent Facility to Facility Ambulance Transfers

To precertify non-emergent ambulance transfers from facility to facility for Kaiser Permanente HMO, Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members and Self-Funded EPO and Out-of-Area (PPO) Members, call the Emergency Case Management HUB at 1-877-676-6270 (toll free) or 216-524-5333.

4.7.4.2 Ambulance Transfers of Stable Patients

For Kaiser Permanente Fully-Insured HMO, Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members and Self-Funded EPO and Out-of-Area (PPO) Members, all ambulance transfers of stable patients, even if the patients have received Emergency Services, are to be arranged through the Emergency Case Management HUB at 1-877-676-6270 (toll free) or 216-524-5333.
4.7.5 Home Health Care

Note: This Kaiser Permanente Precertification policy and procedure applies to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO),
   Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO)
   Members.
See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient
and outpatient Services which require Precertification, by product.

To precertify home health care for Kaiser Permanente Fully-Insured HMO, Added
Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members and Self-Funded
EPO and Out-of-Area (PPO) Members, call the Kaiser Permanente Precertification Line
at 1-866-433-1333 (toll free) or fax the completed Home Care, Home Rehab and
Hospice Services Precertification form (see Section 4.7.5.2 of this Manual) to
1-866-422-5940. The Precertification form must be signed by a Plan Physician.

Note: Since Medicare pays for home health care at 100 percent, no Coinsurance is
payable by either Kaiser Permanente or the Kaiser Permanente Medicare Plus Member
for these Services.

4.7.5.1 Frequently Asked Questions about the Appropriate Use of Home Health Care
Services

4.7.5.1.1 Which Members Qualify For Kaiser Permanente Home Health Care
Services?
To qualify for Covered home health care Benefits, a Member must meet the following
requirements:
• The Member must be confined to the home. (While a Member does not have to
  be bedridden to be considered confined to home, there should exist
circumstances whereby leaving home requires a considerable and taxing effort
and absences from home are infrequent or of relatively short duration.)
• The Member is under a Plan Physician’s care.
• The Member is receiving Services under a plan of care established and
  periodically reviewed by a Plan Physician.
• The Member must be in need of skilled nursing care on an intermittent basis, or
  home occupational, physical or speech therapy.

Custodial care and/or assistance with activities of daily living are not Covered Benefits.

4.7.5.1.2 What Are Skilled Needs?
Skilled needs are medically appropriate intermittent skilled Services, provided by a
licensed professional (RN, LPN, PT, OT, LISW, and Home Health Aide) under the
direction of a Plan Physician. Members must meet medical criteria for this level of care
and be manageable in the home setting. This includes direct orders from the office,
Emergency Department or Clinical Decision Unit, as well as discharges from the hospital or nursing home.

4.7.5.1.3 How Do I Precertify Home Health Care Services?
Precertification is required for home health care Services for all Kaiser Permanente Fully-Insured HMO, Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members, and Self-Funded EPO and Out-of-Area (PPO) Members. To precertify, call the Kaiser Permanente Precertification Line at 1-866-433-1333 (toll free) or fax the completed Home Care, Home Rehab and Hospice Services Precertification form in Section 4.7.5.2 of this Manual to the Home Health Care Department at 1-866-422-5940. Be sure to complete the form as accurately as possible. The Precertification form must be signed by a Plan Physician. Direct any questions about Precertification to the Precertification Line at 1-866-433-1333 (toll free).

For clinical updates and questions about ongoing care, call the Home Health Care Department at 216-749-8383. After 5:00 p.m., weekends and holidays, call the Emergency Hub at 1-877-676-6270 (toll free) or 216-524-5333.

If a Member needs home IV Therapy, first fax the completed Home Care, Home Rehab and Hospice Services Precertification Form to the Kaiser Permanente Pharmacy at 216-265-6856. Next, call 1-800-524-7372 (toll free) and ask the operator to page the Home Infusion Pharmacist for medication orders.

Note: Since Medicare pays for home health care at 100%, no Coinsurance is payable by either Kaiser Permanente or a Kaiser Permanente Medicare Plus Member for these Services.

4.7.5.1.4 Who Should I Contact If I Need To Provide Or Receive Additional Information On A Home Health Care Patient?
Call the Kaiser Permanente Home Health Care Department at 216-749-8383. Home Health Care staff can provide the name, number, and contact person of the home health care agency assigned to each Kaiser Permanente patient. Providers can then contact the assigned agency to review patient concerns.

4.7.5.2 Home Care, Home Rehab and Hospice Precertification Form
See the following page.
Kaiser Permanente – Ohio Region

HOME CARE/HOME REHAB/HOSPICE REFERRAL REQUEST

Type Of Service Ordered: ☐ Home Care ☐ Home Rehab ☐ Home Infusion ☐ Hospice
FAX TO: Home Care/Hospice 1-866-422-5940 Phone: 1-866-433-1333
FAX TO: Home Infusion 216-265-6856 Phone: 877-265-6855

Instructions: Complete and return all three pages of this form. Physician signature is required for ALL orders.

PATIENT INFORMATION NEEDED TO SCHEDULE APPOINTMENT
(Please print legibly)
Pt. Name: ___________________________ D/C Date: ______________
Admit Date: ________________________ Kaiser Permanente MRN: ______________
D/C Address: ________________________
Date of Birth: ______________________ SSN: __________________ D/C Phone: ______________
Diagnosis:
1. ________________________________ Family/Friend Phone: __________________
2. ________________________________ Primary Caregiver: __________________
3. ________________________________ Facility Physician: __________________
4. ________________________________ Primary Physician: __________________
Allergies: __________________________
Surgeon: ___________________________ Surg Date: ______________
Mentation/Cognition: __________________
Social Concerns: ____________________

_____________________________ ________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________

REFERRING FACILITY INFORMATION

Facility Name: __________________________ Contact Person: __________________
Phone: _______________________________ NPI #: __________________

Revised: 01/13
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# Kaiser Permanente – Ohio Region

## HOME CARE/HOME REHAB/HOSPICE REFERRAL REQUEST

### SKILLED HOME CARE SERVICES

(Check all that apply and provide details)

**Nursing Care**
- [] Wound Care (specify treatment):
- [ ] Other tube or ostomy (specify):
- [ ] Home Evaluation:
- [ ] IV Therapy Site: Type: Gauge: Insertion Date:
- [ ] Other Nursing Care:

### HOME REHAB THERAPIES

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<th>WBAT</th>
<th>PWB</th>
<th>Evaluate &amp; Treat</th>
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HOSPICE SERVICES
Hospice care may be provided in an inpatient setting (e.g., hospital, freestanding hospice, nursing home) or in the patient’s home. Hospice services may include nursing care, physicians’ services, nurse practitioner services, medical social services, or short-term inpatient care. Generally, inpatient care is to provide pain control and symptom management or to provide respite care for relief of the patient’s caregivers (symptom, and pain management). In some cases, a brief period of inpatient hospice care may follow an acute hospital stay while preparation is being made for the patient to receive home hospice care.

Diagnosis: 
Estimated length of life: 
Preferred Hospice Provider: 
Hospice Provider Contact Information: 

REQUIRED
Physician Signature: ________________________ Beeper #: ______________ Date: ________________

HOME CARE CASE MANAGER’S CONFIRMATION
Case Manager: ______________________________
S.O.C. Code: ______________________________

REHAB SERVICES RECEIPT CONFIRMATION

Revised: 01/13
KC100
4.7.6 Hospice Services

Note: This Kaiser Permanente Precertification policy and procedure applies to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO),
   Added Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO)
   Members.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient
and outpatient Services which require Precertification, by product.

To precertify hospice Services for Kaiser Permanente Fully-Insured HMO, Added
Choice® Point-of-Service (POS) and Out-of-Area (PPO) Members and Self-Funded
EPO and Out-of-Area (PPO) Members, call the Kaiser Permanente Precertification Line
at 1-866-433-1333 (toll free), or fax the completed Home Care, Home Rehab and
Hospice Services Precertification form (see Section 4.7.5.2 of this Manual) to
1-866-422-5940.

Note: If Members are eligible for Part A of Medicare, they can receive hospice Services
from any Medicare-certified hospice provider, in or out of the Kaiser Permanente of
Ohio Service Area. Since Medicare pays for hospice Services at 100 percent, no
Coinsurance is payable by either Kaiser Permanente or the Kaiser Permanente
Medicare Plus Member for these Services.

4.7.7 Bariatric Surgery

Note: This Kaiser Permanente Precertification policy and procedure applies to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO),
   Added Choice® Point-of-Service (POS) Tier One and Out-of-Area (PPO)
   Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO)
   Members.
C. For Kaiser Permanente Medicare Plus Members, notification is requested.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient
and outpatient Services which require Precertification, by product.

Kaiser Permanente covers bariatric surgery for Members that meet specific medical
criteria. A multi-disciplinary team at Kaiser Permanente, which includes an RN case
manager, bariatric surgeon, nutritionist, and representatives from Behavioral Health and
Internal Medicine Departments, reviews each case prior to surgical consultation.

To refer any Kaiser Permanente Fully-Insured HMO, Medicare Plus, Added Choice®
Point-of-Service (POS) Tier One or Out-of-Area (PPO) Member, or a Self-Funded EPO
or Out-of-Area (PPO) Member to Kaiser Permanente for evaluation, submit a completed
Referrals Management and Clinical Review Referral form (see Section 4.6.4 of this
Manual) to the Referrals Management and Clinical Review Department. The Bariatric
Case Manager will contact the Member to discuss the pre-approval assessment and
management program. This program is a mandatory step before any consideration is given for bariatric surgical interventions.

Entry criteria includes the following:
- Documentation of previous failed attempts at weight loss.
- Patients with a BMI at time of assessment of greater than 35, but less than 40, must have at least two or more co-morbidities. Patients with a BMI, at time of assessment, of at least 40, require no co-morbidities. See the Clinical Guideline for Bariatric Surgery for more information. Clinical Guidelines are available on Kaiser Permanente’s Community Providers website at providers.kaiserpermanente.org/oh.
- Patients must be at least 18 years old.

For Kaiser Permanente Fully-Insured Added Choice® Point-of-Service (POS) Members: Only a Tier One Primary Care Physician or a Tier One Specialist who is Authorized to treat the Member may request a Referral for a bariatric surgery evaluation. Kaiser Permanente Added Choice® Point-of-Service (POS) Members do not have benefits for bariatric surgery at the Tier Two or Tier Three levels of their plan. Covered Benefits for bariatric surgery are only available through the Tier One HMO Referral process. If you are not sure if you are seeing the Member as a Tier One Primary Care Physician or Authorized Specialist, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at toll-free 1-800-441-9742, option 1, prior to submitting a bariatric surgery Referral request.

For Fully-Insured Members, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

For Self-Funded Members, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

4.7.8 Transplants

Note: This Kaiser Permanente Precertification policy and procedure applies to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) Tier One and Out-of-Area (PPO) Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.
C. For Kaiser Permanente Medicare Plus Members, notification is requested. See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.
Kaiser Permanente has developed a National Transplant Network that consists of 29 Centers of Excellence (see Section 4.7.8.2 of this Manual) across the nation offering 70 transplant programs including: Heart, Lung, Simultaneous Pancreas/Kidney, Pancreas, Pancreas after Kidney, Small Bowel, Small Bowel/Liver, Liver, Heart/Lung, and Bone Marrow (Autologous and Allogenic). The goals of the Kaiser Permanente Transplant Network include offering Members greater choice and access to transplant Services and contracting with Facilities that have experienced quality programs, successful outcome management, and the ability to measure and manage optimal outcomes.

All Centers of Excellence must pass a rigorous credentialing process including a site visit. During the site visit, Kaiser Permanente representatives review data and clinical information, tour inpatient, outpatient, and housing Facilities to ensure appropriateness for Kaiser Permanente Members, discuss pre-transplant and post-transplant patient flow, and provide education on Kaiser Permanente's expectations of a working relationship.

4.7.8.1 Transplant Evaluation Referral Requests

If any Kaiser Permanente Fully-Insured HMO, Medicare Plus, Added Choice® Point-of-Service (POS) Tier One or Out-of-Area (PPO) Member, or Self-Funded EPO or Out-of-Area (PPO) Member is identified as a candidate for transplantation, call the Kaiser Permanente Transplant Manager at 440-786-3856. Complete a Kaiser Permanente Referrals Management and Clinical Review Referral Form (see Section 4.6.4 of this Manual) for the transplant candidate. See the National Transplant Network Centers of Excellence Chart in the following Section of this Manual to select the Plan Facility of choice for the Member's evaluation.

Include a brief summary of care that has already been provided to the Member. Note the indications for the transplant and any known contraindications. Fax any pertinent labs and/or test results that have been completed. All of this information is needed to process the Referral request.

The Member’s Referral must be signed off by a Kaiser Permanente Specialty Department Chief before the transplant evaluation can be started. Kaiser Permanente Medicare Plus Members do not need Authorization but notification is requested for transplant evaluation. The Transplant Department will help facilitate testing and appointments at the contracted Center of Excellence. If you need to check on the status of a Referral, call the Utilization Review Transplant Coordinator at 1-440-975-4655.

For Kaiser Permanente Fully-Insured Added Choice® Point-of-Service (POS) Members: Only a Tier One Primary Care Physician or a Tier One Specialist who is Authorized to treat the Member may request a Referral for a transplant evaluation. Kaiser Permanente Added Choice® Point of Service (POS) Members do not have benefits for transplant Services at the Tier Two or Tier Three levels of their plan. Covered Benefits for transplant Services are available only through the Tier One HMO Referral process. If you are not sure if you are seeing the Member as a Tier One Primary Care Physician
or Authorized Specialist, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, prior to submitting a transplant Referral request.

**For Fully-Insured Members**, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

**For Self-Funded Members**, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

4.7.8.2 National Transplant Network Centers of Excellence Chart

See the following page.
# Center of Excellence Facilities Chart

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**Key to Symbols**

- A = Adult
- ABO = ABO Incompatible
- AIO = ABO Incompatible
- Auto = Autologous
- BMT = Bone Marrow Transplant/Stem Cell Rescue
- C = Contract On File - Active
- I = Inactive
- L = General Letter of Agreement - Active
- N = Letter of Agreement Required & Contract in
- P = Pediatric
- PAK = Pancreas After Kidney
- PTA = Pancreas Transplant Alone
- SPK = Simultaneous Pancreas Kidney Transplant

1. Boston Medical Center
   General Letter of Agreement signed for Bone Marrow/Stem Cell Rescue
2. VAD, Insertion, & Related Care
   VAD services included per the terms of the Agreement
3. SOEs Accepting Self Funded Members
   Self Funded language or amendment included

**Note on "N"**
Contact National Provider Contracting (510)

Revised: 3/29/10
4.7.9 Durable Medical Equipment (DME), External Prosthetics Devices and Orthotic Appliances

Note: This Kaiser Permanente Precertification policy and procedure applies to:
A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO),
   Added Choice® Point-of-Service (POS) Tier One and Out-of-Area (PPO)
   Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO)
   Members.
See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient
and outpatient Services which require Precertification, by product.

Fax a Physician signed Statement of Medical Necessity or the Kaiser Permanente DME
Precertification form (see the following Section of this Manual) to 1-866-422-5940.
The form must be signed by the ordering Physician. If the item is needed on a same-
day basis, or within 24 hours, write “Urgent” at the top of the Precertification form. To
ensure Authorizations are handled efficiently and timely, complete all areas of the form
and attach as much clinical information as necessary.

Upon receipt of a completed DME Precertification form, Kaiser Permanente Referrals
Management and Clinical Review Department staff will do the following:
- Verify Member Eligibility.
- Verify that the requested device is a Covered Benefit.
- Verify that the ordering practitioner is a Plan Provider.
- Apply Centers for Medicare & Medicaid Services’ (CMS) criteria.

Kaiser Permanente has Agreements with a variety of Providers to fulfill DME, external
prosthetics devices and orthotic appliances orders. If the Member meets CMS criteria
for Covered Services, Authorization will be faxed to a designated Plan Provider for
fulfillment. The Authorized Plan Provider will notify Kaiser Permanente of delivery
confirmation, service date and billed HCPC codes. Plan Practitioners will only be given
Authorization to dispense DME in their medical offices if there is clinical urgency.

If the Member does not meet CMS criteria for Covered Services and/or Eligibility, and/or
Kaiser Permanente Eligibility requirements, Referrals Management and Clinical Review
Department staff will review the request with the Physician Advisor and notify the
prescribing Physician and issue a Benefit Determination in writing to both the Member
and the Physician. Examples of exclusions include:
- Dental appliances, arch supports, foot orthotics, corrective shoes, non-rigid
  appliances and supplies such as elastic stockings and garter belts.
- Experimental or research devices and appliances.
- Replacement or repair necessitated by misuse or loss that is covered under any
  insurance policy or by any governmental program.
- Educational training in the use of prosthetic devices and orthotic appliances.
• Deluxe equipment, except when such deluxe features are necessary for the effective treatment of a Member’s condition and required in order for the Member to operate the equipment.
• Equipment usually used for comfort or convenience that is not primarily medical in nature (e.g., bed boards, telephone arms, or portable versus stationary equipment.)
• Exercise and hygienic equipment.
• Self-help devices not primarily medical in nature (e.g., sauna bath, elevators.)

DME, external prosthetics devices and orthotic appliances Providers should contact the Kaiser Permanente Referrals Management and Clinical Review Department at 1-866-433-1333 (toll free) for any re-orders of supplies, extensions or renewed Authorizations. Requests may also be faxed to 1-866-422-5940.

For Fully-Insured Members, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

For Self-Funded Members, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

4.7.9.1 Durable Medical Equipment (DME) Precertification Form

See the following page.
Kaiser Permanente – Ohio Region

Request for DME Referral

To precertify durable medical equipment, external prosthetics and orthotics, call 1-866-433-1333 or FAX this completed form to Kaiser Permanente’s DME Specialist at 1-866-422-5940

Date of Referral: ___________________________ Auth #: ___________________________

Kaiser Permanente MRN: __________________________________________________________

Patient Name: _________________________________________________________________

Patient Height: ________________________________________________________________

Patient Weight: ________________________________________________________________

Person to contact to arrange delivery: _____________________________________________

Phone: (day) ___________________________ Phone: (eve) _____________________________

Address for delivery: ___________________________________________________________

____________________________________________________________________________

Diagnosis: _____________________________________________________________________

____________________________________________________________________________

Equipment Required: _____________________________________________________________________________

____________________________________________________________________________

Length of time equipment is needed: (i.e. 3 weeks, 6 months, lifetime, etc) ______________

If urgent when required: Date/Time: _______________________________________________________

If O2, CPAP* or Apnea Monitor

LPM: ____________________________________________________________________________

PO2: _____________________________________________________________________________

Sat: _____________________________________________________________________________

Date: _____________________________________________________________________________

*Attach sleep study results

Date of Discharge from SNF/Hospital: ________________________________________________

Physician Signature: ___________________________ Date: _____________________________

Print Physician Name: ____________________________________________________________

Person submitting this request: ___________________________ Phone: ______________________

Revised: 01/13

#00784
4.8 Ancillary Services
The following Sections of this Manual summarize guidelines for laboratory, imaging and therapy Services.

4.8.1 Laboratory Services

Note: For laboratory Services which require Precertification, this Kaiser Permanente Precertification policy and procedure applies to:

A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) Tier One and Out-of-Area (PPO) Members.
B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.

All outpatient laboratory Services are provided by Kaiser Permanente laboratories, or the Plan Facilities identified on the Kaiser Permanente Ancillary Provider directory. Be sure to include an ICD-9 code and Plan Physician signature on all laboratory orders. If this information is not supplied to a Kaiser Permanente laboratory, a staff member will contact the requesting Plan Physician to ask for the missing information. Orders will be returned via fax to the Plan Physician’s office for completion. Once the completed order is received the laboratory will process the samples for testing. Testing may be delayed and/or cancelled if the information is not received the following business day.

See Appendix A (Precertification Guidelines) for a list of laboratory Services that require Precertification. See Appendix E (Auto Pay List) of this Manual for a list of routine diagnostic laboratory Services that do not require Authorization if ordered by a Plan Provider and provided at either a Kaiser Permanente medical Facility or a Plan Facility.

Kaiser Permanente expects your office to submit any laboratory specimens taken in the office to a Plan Facility. Otherwise, your office will be held financially responsible for payment of Services provided by non-contracted laboratories and the Member must be held harmless.

Plan Providers must comply with Kaiser Permanente’s Utilization Review requirements.

For a current list of Plan Facilities, see the Ancillary directory on Kaiser Permanente’s Community Providers website at providers.kaiserpermanente.org/oh or contact either your Network Associate or call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to request a Kaiser Permanente Ancillary Provider directory.
**Fully-Insured Members** should call the Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).

**Self-Funded Members** should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY).

### 4.8.2 Imaging (Radiology) Services

Note: For imaging (radiology) Services which require Precertification, this Kaiser Permanente Precertification policy and procedure applies to:

- **A. Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) Tier One and Out-of-Area (PPO) Members.**
- **B. Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.**

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.

All outpatient imaging Services are provided by Kaiser Permanente medical Facilities, or at Plan Facilities as identified on the Kaiser Permanente Ancillary Provider directory. The written imaging order must include an ICD-9 code and the Plan Physician’s signature. If this information is not supplied to a Kaiser Permanente Imaging Department, a staff member will contact the requesting Plan Physician to request the missing information. A completed order can then be faxed to the Imaging Department. An imaging procedure cannot be scheduled or performed without a written order, signed by the requesting Plan Physician.

See Appendix A (Precertification Guidelines) for a list of imaging Services that require Precertification. See Appendix E (Auto Pay List) of this Manual for a list of routine diagnostic imaging Services that do not require Authorization if ordered by a Plan Provider and provided at either a Kaiser Permanente medical Facility or a Plan Facility.

Plan Providers must comply with Kaiser Permanente’s Utilization Review requirements.

For a current list of Plan Facilities, see the Ancillary directory on Kaiser Permanente’s Community Providers website at [providers.kaiserpermanente.org/oh](http://providers.kaiserpermanente.org/oh) or call either your Network Associate or the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to request a Kaiser Permanente Ancillary Provider directory.

**Fully-Insured Members** should call the Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100.
(toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).

**Self-Funded Members** should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY).

### 4.8.3 Outpatient Physical, Occupational and Speech Therapy Services

**Note:** This Kaiser Permanente Precertification policy and procedure applies to:

- **A.** Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO), Added Choice® Point-of-Service (POS) Tier One and Out-of-Area (PPO) Members.
- **B.** Self-Funded Exclusive Provider Organization (EPO) and Out-of-Area (PPO) Members.

See Appendix A (Precertification Guidelines) of this Manual for a list of inpatient and outpatient Services which require Precertification, by product.

Once a Plan therapy Provider has been selected, fax a Referrals Management and Clinical Review Referral Form (see Section 4.6.4 of this Manual) to the Kaiser Permanente Referrals Management and Clinical Review Department at 1-866-422-5940. If you need to speak with a Referral Specialist, call 1-866-433-1333 (toll free).

The following information must appear on the Referral form or your request for therapy may be returned to your office unprocessed:

- Member name.
- Member Medical Record Number.
- Referring Physician’s name.
- Diagnosis with CPT Code.
- Onset & duration of symptoms.
- Treatment options given to the patient.
- Specify if this is work related.
- Indicate if this is related to a Motor Vehicle Accident.
- Describe the patient’s previous function.
- Explain the goals of therapy.
- Requested number of visits (1-6 usually recommended). Extensions will be granted according to Referrals Management and Clinical Review Department criteria and protocols.
- Write the location of the therapy Provider on the Referral form.

To avoid a delay in care, give the Member a copy of the Referral form to take to their first therapy appointment. Members should wait to call for their first appointment until after they receive their Authorization letter from Kaiser Permanente.
Plan therapy Providers must comply with Kaiser Permanente’s Utilization Review requirements. See Appendix C (Auto Auth List for Therapies) of this Manual for a list of therapy Services that can be done in your office with your therapy Authorization number.

For a current list of Plan therapy Providers, see the Ancillary directory on Kaiser Permanente’s Community Providers website at providers.kaiserpermanente.org/oh or call either your Network Associate or the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to request a Kaiser Permanente Ancillary Provider directory.

**Fully-Insured Members** should call the Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).

**Self-Funded Members** should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY).

### 4.9 Clinical Trials

Routine patient care associated with an “Eligible Cancer Clinical Trial” is covered for Kaiser Permanente Fully-Insured Health Maintenance Organization (HMO) and Added Choice Point-of-Service (POS) Tier One Members and Self-Funded Exclusive Provider Organization (EPO) Members when prescribed, provided, or Authorized by a Plan Physician. “Routine patient care” means all health care Services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer. This includes the type and frequency of any diagnostic modality that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial. Routine patient care does not include:

- A Service, item, or drug that is the subject of the cancer clinical trial; or,
- A Service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient; or,
- An investigational or experimental drug or device that has not been approved for market by the Food and Drug Administration; or,
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial; or,
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or,
A Service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

The Medicare payment rules for Medicare-qualified clinical trials apply to Kaiser Permanente Medicare Plus Members. If a Kaiser Permanente Medicare Plus Member wants to participate in a Medicare qualifying clinical trial, the Member does not have to ask Kaiser Permanente for permission to do so. Medicare will pay for the routine care associated with clinical trials less any Deductible or Coinsurance. In this instance, Kaiser Permanente is not responsible for payment of any Deductibles or Coinsurance. Deductibles and Coinsurance for clinical trials are the financial responsibility of the Member.

For Fully-Insured Members, call the Kaiser Permanente Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

For Self-Funded Members, call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Eligibility, Copayments, Covered Benefits and limitations.

4.10 Procedure for Authorization Notices
The referral Plan Provider, the Member, and the referring Plan Provider will receive written notification of Authorized Services within 15 days. Members are reminded to bring a copy of their approved Authorization notice to their first appointment with the referral Plan Provider.

4.10.1 Referral Plan Provider Guidelines
1. Place the copy of the Authorization notice in the Member’s chart.
2. Forward all work-up results to the referring Plan Provider with any other pertinent clinical information pertaining to the consultation. Call the referring Plan Provider if your findings are urgent.
3. If the referral Plan Provider determines that additional visits are Medically Necessary prior the end date of the Authorization, the referral Plan Provider’s office may submit a completed Referral form either by fax or KP Online-Affiliate to the Referrals Management and Clinical Review Department to request additional visits. Attach clinical notes supporting the need for additional visits.

4.10.2 Referring Plan Provider Guidelines
1. Place the copy of the Authorization notice in the Member’s chart.
2. Review all referral Plan Provider reports and test results. Initial and date all reviewed documents.
3. Place all referral Plan Provider reports and test results in the Member’s chart.
4.11 Denied Authorizations

The following could be reasons a Referral or Precertification was denied:

- Services are deemed not medically appropriate.
- The patient does not meet membership Eligibility requirements.
- The request for Services is not a Covered Benefit or the Benefit is exhausted.
- Services were performed without prior Authorization.
- Refusal to use Plan Providers.

The specific reason for the denial is stated in each notice of Adverse Benefit Determination sent to the Member and the referring Plan Provider. Adverse Benefit Determination letters will also inform the Member and the Plan Provider of their rights to have the denial reconsidered (Reconsiderations are only offered for Medical Necessity denials) and/or the right to appeal the denial.

All Appeal requests submitted by Plan Providers must be accompanied by the written permission of the Member. Criteria used for making the decision will be provided upon request. Members receive similar notices informing them of the decision and their Appeal rights.

Plan Provider requests for retroactive Referrals are not accepted by the Referrals Management and Clinical Review Department. If you feel an Adverse Benefit Determination has been issued in error, write the Appeals Unit to request an Appeal of the Adverse Benefit Determination. See Sections 4.12 and 4.13 of this Manual for more information regarding Plan Provider Appeal policies and procedures for Fully-Insured Members. For Self-Funded Members, see Sections 11.4.2 – 11.4.3 of this Manual.

4.12 Reconsiderations and Appeals

Note: For Self-Funded Members, see Sections 11.4.2 – 11.4.3 of this Manual.

Plan Providers have the right to request a Reconsideration of any Pre-Service Medical Necessity initial decision made by Kaiser Permanente. See the following Section of this Manual for details. Plan Providers are also afforded the opportunity to appeal any decision made by Kaiser Permanente to deny reimbursement for Services rendered by that Plan Provider. The following Sections review the Kaiser Permanente Plan Provider Reconsideration and Provider Appeal Guidelines and Processes. For information regarding Payment Disputes, see Section 4.14 of this Manual.

4.12.1 Reconsideration of Decisions Following Initial Determination Denial

A Plan Provider has the right to request verbally or in writing and on behalf of a Fully-Insured Member a Reconsideration of a Pre-Service or Concurrent Adverse Benefit Determination issued in response to a request for an Authorization or Referral based on Medical Necessity. Note: This process does not apply to Pre-Service benefit denials or Post-Service Claim payment denials. The Member’s written consent must be
obtained prior to pursuing Reconsideration. See Sections 4.12.2.1 and 4.12.2.2 of this Manual for the appropriate Appointment of Representative form.

Reconsiderations are conducted between the Plan Provider and the Physician Advisor who made the Adverse Benefit Determination. If the Physician Advisor cannot be available within 3 business days, the Physician Advisor may designate another Physician to review the Reconsideration. To request a Reconsideration, Plan Providers may call 1-866-433-1333 (toll free) or fax your Reconsideration and the Appointment of Representative form to 1-866-422-5940.

Decisions on the Reconsideration are made within 3 business days after the receipt of the request for Reconsideration, unless the medical condition of the Member indicates a need for a more prompt decision. If the Reconsideration does not resolve the difference of opinion, Plan Providers may file a written Appeal. See Sections 4.12.2 and 4.12.3 of this Manual for Appeal guidelines and processes.

The Member’s written consent may be required prior to pursuing an Appeal on the Member’s behalf. Contact the Kaiser Permanente Appeals Unit at 1-888-479-5333 (toll free) or 216-635-4664 with any questions. The Reconsideration process is not a prerequisite to the Appeal process.

4.12.2 Standard Appeal Process of Initial Adverse Pre-Service Benefit Determinations

Note: For Self-Funded Members, see Sections 11.4.2 – 11.4.3 of this Manual.

The following guidelines for standard Pre-Service Appeals apply to Services that are not urgent in nature:

- The requesting Plan Provider may submit a written Appeal request along with a signed Appointment of Representation (AOR) form (see Sections 4.12.2.1 of this Manual) from the Member to the Kaiser Permanente Appeals Unit at the following address:

  Kaiser Permanente
  Appeals Unit
  P.O. Box 93764
  Cleveland, OH 44101-5764

  Or fax the Appeal with the AOR to: 216-635-4673.

Note: In the event the Service requested is urgently needed, the Plan Provider may request an expedited Appeal without the Member’s prior Authorization by calling 1-888-479-5333 (toll free) or 216-635-4664.

- In the event that a signed AOR form is not received with the Appeal request, the Member will be notified in writing and will be asked to complete the necessary AOR form, which will Authorize the Plan Provider to act on the Member’s behalf.
• Appeal requests must be received within the same timeframes as those that apply to the Members. Timeframes are as follows:
  a. **Commercial Members** (per the Department of Labor [DOL] and the National Committee for Quality Assurance [NCQA]): within 180 calendar days of receipt of the initial Adverse Benefit Determination unless otherwise stipulated in your Provider Health Services Agreement Section 3.2, “Adjustments to Payments.”
  b. **Kaiser Permanente Medicare Plus Members** (per the Centers for Medicare and Medicaid Services [CMS]): within 60 calendar days of receipt of the initial Adverse Benefit Determination.
  c. **Federal Employee Members** (per the Office of Personnel Management [OPM]): within 6 months of receipt of the initial Adverse Benefit Determination.

• The Kaiser Permanente Appeals Unit staff will review the documentation and contact the appealing Plan Provider for additional information; if needed.
• The Appeal will be reviewed by either the Medical Advisory Council (MAC) for Medical Necessity denials or the Benefit Advisory Council (BAC) for benefit denials within 30 calendar days of receipt of the Appeal request. An appropriate Physician or Behavioral Health clinician makes all decisions for medical appropriateness. Physicians participating on the Medical Advisory Council shall not have been involved in the initial determination or be subordinates of a Physician involved in the initial determination.
• If the initial decision for a standard Pre-Service Appeal is overturned, the Appeals Unit staff will contact the Plan Provider and the Member in writing within 30 calendar days of the request, and will process the request per department procedures.
• If the initial decision for a standard Pre-Service Appeal is upheld, the Appeals Unit staff will contact the Plan Provider and the Member in writing within 30 calendar days of receipt of the request, and will inform you of the rationale for the decision and information on any further Appeal rights. **For Kaiser Permanente Medicare Plus Members**: If the initial decision is upheld, the case will automatically be forwarded to the Independent Review Entity used by Medicare for the final determination.

4.12.2.1 Appointment of Representative Form for Fully-Insured Members

See the following page.
APPOINTMENT OF REPRESENTATIVE – Page 1 of 3

If you wish to give authority to another party to file: (1) a complaint/grievance, (2) a claim, and/or (3) an appeal on your behalf, please complete the following information. If you wish this person to make inquiries regarding your treatment and care and receive your Protected Health Information (PHI), you must check the appropriate box(es) below and you and your representative must both sign and date this form. Please return the completed form with the request you are submitting.

PART A (For Member/Patient): I understand that Kaiser Permanente¹ will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

<table>
<thead>
<tr>
<th>Member/Patient Printed Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime Phone:</td>
<td>Alternate Phone:</td>
</tr>
<tr>
<td>Medical Record #:</td>
<td>Medicare Member: Y / N</td>
</tr>
<tr>
<td></td>
<td>Medicare # (if applicable):</td>
</tr>
</tbody>
</table>

Please select one of the following:

- □ I authorize Kaiser Permanente to disclose PHI regarding my medical condition and care and/or payment information to the individual designated in Part B. This information must be relevant to the request filed with Customer Relations or Member Service Center on (insert date of request) __________. This authorization will remain in effect for the life of the request for which it is being submitted or until written revocation (whichever occurs first).
- □ I authorize Kaiser Permanente to disclose PHI regarding my medical condition and care and/or payment information to the individual designated in Part B. This information must be relevant to any request filed (as checked below) with Customer Relations or Member Service Center for the balance of the calendar year in which this authorization was submitted. This authorization will remain in effect for the balance of the calendar year in which the request was submitted or until written revocation (whichever occurs first).
  - □ Complaint/Grievance
  - □ Appeal
  - □ Appointment Scheduling
  - □ Claims

PHI release to Appointed Representative OK to include the following Information: Please check all that apply.

- □ Medical
- □ Psychiatric
- □ Drug/Alcohol
- □ Results of an HIV blood test

I hereby authorize the individual designated in Part B to represent me regarding concerns with the quality of care or service I have received from Kaiser Permanente, or in questions regarding coverage of services or supplies I may be entitled to as a member of Kaiser Permanente. I understand that this authorization is voluntary and, if I choose to do so, I have the right to revoke it in writing to Kaiser Permanente and to my designated representative. Kaiser Permanente and my appointed representative may not use or disclose my PHI relevant to this authorization except to the extent Kaiser Permanente or my appointed representative has taken action in reliance upon this authorization.

X Member/Patient SIGNATURE: _______________________ DATE: ___________

¹ Collectively herein “Kaiser Permanente” refers to: Kaiser Foundation Health Plan of Ohio, The Ohio Permanente Medical Group, Inc., and Kaiser Permanente Insurance Company.
### APPOINTMENT OF REPRESENTATIVE – Page 2 of 3

#### PART B (For Appointed Representative):

<table>
<thead>
<tr>
<th>Printed Name of Appointed Person:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City, State &amp; Zip:</td>
</tr>
<tr>
<td>Daytime Phone:</td>
<td>Alternate Phone:</td>
</tr>
</tbody>
</table>

**REDISCLOSURE:** I understand that as the recipient of the above member/patient’s PHI, I may not lawfully further use or disclose the PHI other than the intended purpose as stated herein unless another authorization is obtained from this member/patient or unless such use or disclosure is specifically required or permitted by law.

I hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the representative; and that I recognize that any fee in relation to my appointment may be subject to review and approval by the Secretary of the Department of Health and Human Services.

X Appointed Representative SIGNATURE: ___________________________ DATE: ___________

**WAIVER OF FEE FOR REPRESENTATION:** If the member/patient being represented is a Medicare beneficiary, the Appointed Representative must read and sign below.

I waive my right to charge and collect a fee for representing (insert the name of the member/patient being represented) _______________________________ before the Secretary of the Department of Health and Human Services.

X Appointed Representative SIGNATURE: ___________________________ DATE: ___________

#### PART C (Only for members/patients with an authorized representative):

| I am authorized to sign this authorization on behalf of the above member/patient on the basis of: |
|-----------------------------------------------|-----------------------------------------------|
| □ Legal Authority (Power of Attorney, etc.) | □ Written Designation by Member                |
| □ Parent, Guardian, or other individual acting in loco parentis. |

If this authorization is for a deceased member/patient, please provide the appropriate legal documentation of appointment.

X SIGNATURE of Authorized Representative (if applicable): ___________________________ DATE: ___________

**REVOCATION:** This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

**Member/Patient has a right to a copy of this form.**

For release of medical records, please contact Medical Correspondence, Monday-Friday, 8:30 a.m. to 5 p.m., at 216-749-8448 or 1-866-749-8448. Hearing or speech impaired members may contact Customer Relations at (TTY/TDD) (216) 635-4444 or 1-877-676-6677, Monday –Thursday, 8:15 a.m. to 5 p.m. and Friday, 9 a.m. to 5 p.m.
PART D: Waiver of Payment for Items or Services at Issue.

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

Provider/Supplier SIGNATURE: ___________________________   DATE: ___________
I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, “Petition to Obtain Representative Fee” elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Part B on page 2 of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.
4.12.3 Expedited Pre-Service Appeals

Note: For Self-Funded Members, see Sections 11.4.2 – 11.4.3 of this Manual.

An expedited Appeal process is available for initial Adverse Benefit Determinations 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.

- The requesting Plan Provider may fax a written Appeal request to the Kaiser Permanente Appeals Unit at 216-635-4673 or call 1-888-479-5333 (toll free) or 216-635-4664.
- The Kaiser Permanente Appeals Unit staff will review the documentation and contact the appealing Plan Provider for additional information if needed.
- The Appeal will be reviewed by the Medical Advisory Council (MAC) as expeditiously as possible, but not to exceed 72 hours of the Appeal request. An appropriate Physician or Behavioral Health clinician makes all decisions for medical appropriateness. Physicians participating on the Medical Advisory Council shall not have been involved in the initial determination or be subordinates of a Physician involved in the initial determination.
- If the initial decision for an expedited Pre-Service Appeal is overturned, the Appeals Unit staff will contact the Plan Provider and the Member verbally and in writing immediately following the determination.
- If the initial decision for an expedited Pre-Service Appeal is upheld, the Appeals Unit staff will contact the Plan Provider and the Member verbally and immediately following the determination. They will inform you of the rationale for the decision and provide you with information on any further Appeal rights. **For Kaiser Permanente Medicare Plus Members:** If the initial decision is upheld, the case will automatically be forwarded to the Independent Review Entity used by Medicare for the final determination.

4.13 Plan Provider Post-Service Appeals

Note: For Self-Funded Members, see Sections 11.4.2 – 11.4.3 of this Manual.

This process only applies to those claims that have been denied because of the absence of a prior Authorization where Authorization is required. Strict adherence to Authorization policies and procedures specified in Section 4 of this Manual is an expectation of all Plan Providers. Failure to follow Authorization procedures, other than under very specific circumstances, does not qualify an Appeal for retro Medical Necessity review. Per your Agreement with Kaiser Permanente, Members are to be held harmless and are not financially liable for Covered Services provided in the absence of an Authorization, unless the Member was properly informed of his/her financial responsibility prior to the delivery of Covered Services.

Plan Provider Appeal requests must be received within 180 days of the original Adverse Benefit Determination. All post-service Appeals from Plan Providers will be responded...
to within 90 calendar days from receipt. Mail a letter of Appeal detailing the extenuating circumstances which led to the failure to obtain proper Authorization in advance of the Service(s) to:

Kaiser Permanente Payment Appeals Unit
P.O. Box 93764
Cleveland, Ohio 44101-5764

Or fax to: 216-635-4673.

If the decision is to uphold the denial, the Plan Provider is notified in writing by the Kaiser Permanente Appeals Unit. The written response will detail the rationale for the decision. If the decision is to overturn the denial, the Kaiser Permanente Claims Department will reprocess the Claim(s) for payment. Payment is made within 30 days of the decision. The Explanation of Payment serves as notification of the overturned denial.

The Physician advisor or Behavioral Health clinician involved in a previous decision will not review the Appeal request at a subsequent level.

4.14 Payment Disputes

Note: See Section 11.5.41 of this Manual for Self-Funded Members.

Plan Providers should contact the Kaiser Permanente Customer Relations Department Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1, with questions or concerns about the way a particular Claim was processed by Kaiser Permanente. Many questions and issues regarding Claim payments and/or denials can be resolved quickly over the phone or via fax.

If, after contacting the Customer Relations Department, you are not in agreement with the answer or research outcome relative to your issue, you may file a formal Payment Dispute.

Following is the Kaiser Permanente Provider Payment Dispute process:

1. Submit a formal Payment Dispute using the form in Section 4.14.1 of this Manual or a document of your own choosing that contains the information necessary to investigate your issue. Payment Dispute forms must be received within the same timeframes as those that apply to the Post-Service Appeals process. These timeframes are:
   a. **Commercial Members** (per the Department of Labor [DOL] and the National Committee for Quality Assurance [NCQA]): within 180 calendar days of receipt of the initial Adverse Benefit Determination unless otherwise stipulated in your Provider Health Services Agreement Section 3.2, “Adjustments to Payments.”
b. **Kaiser Permanente Medicare Plus Members** (per the Centers for Medicare and Medicaid Services [CMS]): within 60 calendar days of receipt of the initial Adverse Benefit Determination.

c. **Federal Employee Members** (per the Office of Personnel Management [OPM]): within 6 months of receipt of the initial Adverse Benefit Determination.

Send the Payment Dispute form and any supporting documentation to:

Kaiser Permanente  
Attention: Payment Dispute Unit  
P. O. Box 5316  
Cleveland, Ohio 44101

Or fax to: 216-479-5801.

2. Your Payment Dispute will receive special handling by a dedicated research specialist. Your rationale for request will be reviewed along with any applicable enclosures. All data available internally will also be considered in our research of your Claims payment or denial.

3. If the initial decision is overturned, the research specialist will process the Claim in dispute within 60 calendar days of receipt of the Payment Dispute form. Your Provider’s Explanation of Payment (EOP) will serve to notify you that the Claim has been paid.

4. If the initial decision is upheld, the research specialist will contact you in writing within 60 calendar days of receipt of the Payment Dispute form to inform you of the rationale for the decision and offer information on any further Appeal rights.

Note: The Payment Dispute process is not intended for the purpose of filing a Pre-Service Appeal. See Sections 4.12.2 and 4.12.3 of this Manual for more information regarding Pre-Service Appeals. This process is designed to provide a review of contracted Payment Disputes, review of partially paid Claims, and denials related to multiple procedures being performed on the same date where the bill was not coded accordingly. See Section 4.13 of this Manual for more information regarding Post-Service Provider Appeals.

The Payment Dispute process is not a prerequisite to the Appeal process. The Plan Provider can initiate an Appeal, in writing and on behalf of the Member, without going through the Payment Dispute process. Member’s written consent may be required prior to pursuing an Appeal on the Member’s behalf. Contact the Kaiser Permanente Appeals Unit at 1-888-479-5333 (toll free) or 216-635-4664 to determine if a Member’s written consent is required.

### 4.14.1 Payment Dispute Form

See the following page.
# PROVIDER PAYMENT DISPUTE FORM

If your office has questions or concerns about the way a particular claim was processed by Kaiser Permanente, contact the Kaiser Permanente Customer Relations Department at 1-800-441-9742, option 1 (toll free), prior to submitting this form. Many questions and issues regarding claim payments and coding can be resolved quickly over the phone.

This form is to be used to file a formal payment dispute only after you have contacted the Network Development and Performance Department and are not in agreement with the answer or research outcome relative to your issue. Do not use this form to file a provider appeal for any of the following reasons:
- Pre-service Appeal – denial of request for preauthorization or referral based on medical necessity
- Post-service Appeal – denial of claim due to the absence of prior Authorization when Authorization is required

If you are appealing for either of the above reasons, submit a written appeal to: Kaiser Permanente Appeals Unit, P.O. Box 93764, Cleveland, OH 44101-5764, Fax: 216-635-4673

Mail this completed Provider Payment Dispute Form and enclosures to:
Kaiser Permanente
P.O. Box 5316
Cleveland, OH 44101
Attention: Payment Dispute Unit or fax information to: 216-479-5801.

## PROVIDER INFORMATION:

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<th>Details</th>
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<tbody>
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</tr>
<tr>
<td>Requestor/Contact Name</td>
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</tr>
<tr>
<td>Contact Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Nine Digit Tax ID Number</td>
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</tr>
<tr>
<td>Provider Name</td>
<td></td>
</tr>
<tr>
<td>Mailing Address, City, State, Zip</td>
<td></td>
</tr>
<tr>
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<tr>
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## PATIENT INFORMATION:

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<tr>
<td>Date of Birth</td>
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</tr>
<tr>
<td>Kaiser Permanente Claim Document Number</td>
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<td>Date of Service</td>
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<tr>
<td>Denial Reason Codes from Explanation of Payment:</td>
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## TYPE OF DENIAL:

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<td>Pricing (Further Specify Below)</td>
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<td>Timely Filing</td>
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<td>☐</td>
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<td>Global Fee Denial</td>
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<tr>
<td>☐</td>
<td>Other – Specify below</td>
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</tr>
</tbody>
</table>

Rationale for Request: __________________________________________

KP Received Date: ___________

#20463 Revised 01/13
4.15 Drug Formulary

Kaiser Permanente has developed two Formularies (Commercial and Medicare Part D) to be followed by all Plan Providers. The medications included in the Kaiser Permanente Formularies are chosen by a group of Kaiser Permanente Practitioners, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This committee meets regularly to evaluate and choose medications that are most effective, safe, and useful in caring for our Members. Using Formulary medications helps Kaiser Permanente maintain high quality of care for Kaiser Permanente Members while helping to keep the cost of prescription medications affordable.

Kaiser Permanente uses closed Formularies, which means that only those medications included in the Kaiser Permanente drug Formularies are covered under the Member’s prescription drug benefit. Members who choose to purchase a Nonformulary medication should expect to pay the full retail cost of the medications. Kaiser Permanente Members are provided with a copy of the applicable Formulary based upon the Member’s drug benefit when he/she enrolls in a Kaiser Permanente health plan. Members are encouraged to bring the Formulary when receiving health care Services from a Plan Provider. Prescription drug coverage may vary, based upon the Member’s health plan. Not all Kaiser Permanente health plans include prescription drug coverage. Additionally, some prescription drug plans may exclude certain drugs, cover drugs at varying levels based upon drug cost or limit the amount of the drug the Member can receive without a prescription Copayment.

Kaiser Permanente Formularies are designed to meet the needs of the majority of Members. However, there are times when use of a Nonformulary drug is necessary. See Section 10.4 of this Manual for information regarding Nonformulary medication orders.

The Pharmacy and Therapeutics Committee reviews and updates the Formularies throughout the year and notifies Plan Providers, pharmacists and other clinicians about any changes via Drug Therapy Advisories. Copies of Drug Therapy Advisories are available by calling your Network Associate or the Kaiser Permanente Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. toll-free at 1-800-441-9742, option 1. Drug Therapy Advisories are also available on the Kaiser Permanente Community Providers website at providers.kaiserpermanente.org/oh.

Fully-Insured Members should call the Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 1-800-686-7100 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-676-6677 (toll free TTY).

Self-Funded Members should call the Harrington Health Customer Service Department, Monday through Friday, 7 a.m. to 9 p.m., at 1-877-721-2199 (toll free), to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech-impaired may call 1-877-870-0283 (toll free TTY).
4.15.1 Requesting Coverage for Nonformulary Medications

See Section 10 of this Manual for a complete description of Formulary policies and procedures for Fully-Insured Members, including Appeals. See Section 11.3.5 of this Manual for a complete description of Formulary policies and procedures for Self-Funded Members.