2014

RESOURCE STEWARDSHIP-UTILIZATION MANAGEMENT
PROGRAM DESCRIPTION

KAISER PERMANENTE – HAWAII REGION
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### KAISER PERMANENTE – HAWAII REGION

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I. Introduction

A. Kaiser Permanente Hawaii (KPHI) is a medical care program composed of three closely aligned organizations. These organizations are Kaiser Foundation Health Plan, Inc. ("KFHP"), Kaiser Foundation Hospital ("KFH"), and the Hawaii Permanente Medical Group (HPMG). These three entities together serve over 220,000 Health Plan members. Throughout this document, these entities are collectively referred to as "the Program".

B. Kaiser Foundation Health Plan, Inc. ("KFHP") is a non-profit, public benefit corporation that contracts with individuals and groups to provide or arrange comprehensive prepaid health care benefits. KFHP is a federally qualified health maintenance organization, and a Hawaii Medicaid (QUEST) health care service plan.

C. KFHP contracts with Kaiser Foundation Hospital ("KFH"), a non-profit, public benefit corporation that owns and operates a community hospital to provide or arrange hospital services for health plan members.

D. KFHP contracts with Hawaii Permanente Medical Group ("HPMG"), a multi-specialty physician partnership, to provide or arrange medical and other health care services for KFHP members.

E. This Program Description describes the Resource Stewardship-Utilization Management ("RS-UM") program and processes in Hawaii.

II. Scope of KPHI Services

A. KPHI offers a comprehensive health care delivery system, including ambulatory care, preventive services, hospital care, behavioral health, home health care, rehabilitation services and skilled nursing services.

B. Health care services are provided for all islands in the Hawaii Region. These areas are managed by KP senior managers and physicians collectively.

C. There are over 420 physicians in HPMG. KPHI owns and operates one acute care hospital, which is accredited as a general acute care hospital by The Joint Commission ("TJC"). There are over 15 KPHI owned and/or operated free-standing medical office buildings and two home health agencies. KPHI has been granted accreditation from TJC for the hospital and sites where anesthesia is provided in the outpatient setting.

D. Majority of care and services offered by KFHP is provided directly by HPMG practitioners in KPHI managed facilities. However, KPHI does contract with outside providers for hospital services, skilled nursing facility (SNF) care, some home health care and other ambulatory health services as required to provide medical care to our members. If medically
indicated services are not available within HPMG or KFH, contracted community practitioners (Contract Practitioners) are used to ensure availability of medical care and services in accordance with KFHP benefit agreements.

E. KPHI’s Regional Quality Program covers care and ancillary services provided to members and patients across the continuum of care. Although KFHP, Inc. is ultimately accountable for the quality of care and service provided as the licensee, quality management and oversight is a shared responsibility among KFHP, KFH and HPMG. These three entities are in partnership to provide and coordinate high quality and effective medical management for Health Plan members while striving continuously to improve the care and service provided. Please see the Regional Quality Program Description for additional information.

F. Utilization Management is a shared responsibility of KFHP, KFH and HPMG. These three entities are in partnership to provide and coordinate high quality and effective medical management for Health Plan members, while striving continuously to achieve appropriate and efficient utilization of resources. All activities related to Utilization Management are reported to the Hawaii Quality Committee and to the KFH/HP Board of Directors.

III. Approach

A. For care delivered by HPMG and Kaiser Foundation Hospital-Moanalua staff, Utilization Management is based on an approach of advisory Utilization Management. HPMG physicians work collaboratively with their peers to ensure appropriate treatment plans and utilization of resources. In most cases, the final decision regarding a member’s treatment plan rests with the HPMG attending physician. Utilization Management / Continuing Care staff is available to support physicians in the management of member’s health care needs throughout the care continuum and provide a variety of services, such as discharge planning, utilization review, care management and ensuring compliance with internal and external regulatory requirements related to Utilization Management.

B. For a few selected services, such as external (Out-of Plan) referrals, solid organ transplants, Durable Medical Equipment (DME) / Prosthetics and Orthotics (P&O) / Soft Goods, Chiropractic Care, Continuous Home Care, Radiation Therapy, and Bariatric Surgery, there is an authorization UM review process to determine medical necessity.

C. For care delivered by Contract Providers and Practitioners, the approach to Utilization Management includes an authorization process. For services not available within the HPMG / KFH system, procedures are developed for referrals to Contract Providers to ensure that referrals are appropriate. Contract Providers are expected to comply with the
Utilization Management procedures, to continue treatment plans, and to ensure appropriateness of care and resource management. In cases where Contracted Providers do not comply with HPMG / KFH procedures, reimbursement for services may be at risk.

D. Kaiser Permanente and affiliated physicians and health care professionals make medical decisions based on the appropriateness of care and services at which point the existence of coverage for Members’ medical needs is determined. Kaiser Permanente does not compensate anyone for denying coverage or service, and Kaiser Permanente does not use financial incentives to encourage denials or decisions that result in under-utilization. In order to maintain and improve the health of Members, all practitioners should be especially vigilant in identifying any potential under-utilization of care or service.

E. Kaiser Permanente allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care with the member.

F. Kaiser Permanente ensures that patient safety is an integral part of all aspects of the UM / Continuing Care Program.

G. KPHI believes that the following core elements are key principles associated with high quality Utilization Management practices:

1. An integrated/collaborative approach by KFH / KFHP and HPMG to utilization/resource management, inclusive of all physicians, administrators and multidisciplinary staff, is critical in order to achieve desired clinical outcomes and to ensure wise use of our members’ resources. The commitment of Organizational and Regional Senior Management to the UM process is critical for effective utilization management across the continuum of care. Recognition of the valuable contributions of physicians, managers and staff is essential to achieve and sustain ongoing improvement efforts.

2. A two-tiered admission process is in place in the emergency department and includes the following components:
   a. Emergency Department Physicians do not admit patients, but refer potential admissions to another physician for assessment.
   b. Only HPMG partner and associate physicians should make admission decisions.
   c. HPMG partner and associate physicians are available on every shift in the Emergency Department.
d. Understanding the reality of current practice if per diems are used, they must be oriented to the organization’s policies and practices. They should be scheduled routinely in order to become familiar with our operations. They must be supervised, and their admission decisions should be monitored on an ongoing basis by the UM department.

e. A mechanism must exist for regular / ongoing education and communication with per diem physician staff.

f. There must be a proactive, well-managed clinical program for all patients admitted to observation status, and a plan to ensure high priority access to consultation and diagnostic services. This is necessary to ensure admission for those patients whose medical condition warrants admission.

3. Key components include:

   a. Vigilance by medical staff to round as often as necessary on observation patients.

   b. Well-defined admission and discharge guidelines.

   c. Well-defined role of Nursing and UM staff.

   d. Priority access to support and diagnostic services – radiology, laboratory, consults, cardiac diagnostic studies (e.g., treadmills, echocardiograms).

H. A highly functioning UM Department includes the following:

1. Emergency Department (ED) coverage by Continuing Care Coordinators/Case Managers.

2. Seven (7) day per week coverage, including on-call coverage with appropriate numbers of UM staff to match demand.

3. Coverage for all areas, including Critical Care, Observation, Medical Surgical, Telemetry, Obstetrics (OB), Pediatrics.

4. Consistent use of InterQual and Medicare guidelines to review admissions, assess alternative levels of care and monitor against discharge criteria.

5. Consistent use of InterQual to track barriers and identify system and clinical improvement opportunities.

6. Clerical support to handle routine UM duties and tasks.(e.g., preparation and assisting with Notice of Non Coverage (NONC) letters, etc. that do not require the expertise of the UM staff).

7. Analytical support to facilitate data analysis, trending, and reporting.
8. A utilization review focus, in addition to a discharge planning and case management role.

9. Core processes that need to be present in the ED to fully support utilization management efforts include:
   a. Ability for ED staff to arrange follow-up visits with primary care for patients and ability to transfer patients directly to skilled nursing facilities and arrange home care visits.
   b. Support services and staffing that match ED peak demands (radiology technicians, laboratory, consultants, UM staff, etc.).
   c. Priority queues for ED for consults, diagnostic and support services.

10. Routine Social Work coverage is critical in the support of a successful UM program and includes the following elements:
   a. On-call coverage for crisis intervention in ED.
   b. Social Worker coverage in the ED to proactively assist with non-member and social issues including placement opportunities, etc.
   c. Routine daily presence in Critical Care and Medical/Surgical units, with knowledge of end of life discussions, palliative care, social issues, and family interactions.

11. The use and ongoing review of order sets in HealthConnect is strongly encouraged for selected high volume, high acuity, and high risk diagnostic-related groups (DRGs). In addition, it is essential to:
   a. Monitor and update order sets on an ongoing basis for appropriateness and effectiveness.
   b. Share feedback with physicians, UM staff and other providers.
   c. Take appropriate actions and make revisions when issues are identified.

12. Continuing Care / UM focused physician daily rounds to review the plan of care, assess potential alternative levels of care and assist with appropriate discharge planning--to be conducted on all medical, surgical, telemetry, and critical care units in order to maximize utilization management opportunities.

   Physician-led rounds should review appropriateness of admission and/or continued stay and include the following components:
a. All patient populations must be included [e.g., Observation Status, Obstetrics (OB) and Pediatrics (Peds)].
b. Dialogue with UM staff and others.
c. Identify delays and barriers and intervene as necessary.
d. Educate and interact with rounding physicians.
e. Participants to include but not be limited to: Nursing, UM, Physical Therapy (PT) / Occupational Therapy (OT), case finding liaison staff (e.g., SNF, Home Health / Hospice).

13. Other physician-based processes to support the UM program:

a. Rounding or pairing model to include a core group of physicians who round on a routinely scheduled basis (i.e., monthly).
b. The transition day between rounding teams should be limited to Tuesday, Wednesday or Thursday in order to ensure continuity of care before and after weekends.
c. Proactive identification of appropriate patients for placement in Skilled Nursing Facilities (SNFs), Home Care, Care Management, Palliative Care, Hospice, etc. should be an integral part of this process.

14. Critical Care Units must have a qualified and dedicated physician medical director who is responsible for the oversight of administrative, clinical and resource management of all patients in critical care units.

a. The physician leader should be supported in his / her efforts by qualified UM staff and nursing manager.
b. Physician-led concurrent rounds in Critical Care conducted.
c. Critical Care Admission / Discharge Guidelines should be widely published, followed, and monitored.
d. A systematic process to monitor patient outcomes and appropriate resource consumption must be an integral part of the Quality Management Program for these units. These monitoring programs should be used to assist in day-to-day clinical management decisions and to assess quality management improvement projects, such as movement of surgical patients to lower levels of care.
e. Social Worker support, particularly to address end of life issues, palliative care, social issues, and family interactions.
15. All Hospital operations must move towards providing necessary acute hospital services to our members/patients seven (7) days per week that match peak demands and ensure quality care to maximize utilization management opportunities (e.g., UM, laboratory, radiology, pharmacy and other diagnostic services).
   a. Routine services must be available within reason 24 hours per day, seven (7) days per week.
   b. Radiology technician on-call backup.
   c. Priority queues for ED and Observation status patients.
   d. Innovative approaches such as teleradiology, telehealth and after-hours should be considered to ensure timely intervention to provide more timely care, facilitate disposition and efficiency of operations.

16. Physician / Advanced Practice Provider (APP) rounding at SNFs must be a component of utilization management program.
   a. Rounds may be performed by a physician or by an APP, such as a Registered Nurse Practitioner (RNP).
   b. Proactive identification of appropriate patients for placement in SNFs, Home Care, Care Management, Palliative Care, Hospice, etc. should be an integral part of this process to identify patients who would benefit from an alternative level of care.
   c. Utilization of a monitoring tool to evaluate specialty services (e.g., physical therapy, setting expectations, functional improvement assessment).

17. The coordination and integration of all Care Management Programs and linkages with the Outside Utilization and UM across the continuum must continue to be developed with a focus on:
   a. Appropriate and proactive outpatient clinical management of chronic conditions and frequent utilizers.
   b. Establishing a collaborative and cooperative relationship to support UM efforts.
   c. Improving linkages with KFH, non-KFH, and SNF patients including proactive identification of frequent utilizers; complex chronic conditions, and one (1) to two (2) day length of stays, etc.
   d. Incorporate data from frequent utilizers to help future planning for population care management programs.
   e. Timely and appropriate referrals to other disciplines such
as social work, dietary, rehab and pharmacy, etc. to assist in management of the patient.

f. Heightened emphasis on coordination of care for members identified with asthma, congestive heart failure (CHF) and diabetes across the continuum of care (i.e. Patient Centered Medical Home).

g. Palliative Care Management such as Advance Illness Care Coordination, SNF Palliative Care Program and Outpatient Palliative Care.

IV. Responsibility and Authority

The following is a description of the Resource-Stewardship-Utilization Management program and its related responsibility and authority for the Hawaii Region.

A. Responsibility

1. Outside Medical Services-Authorizations and Referrals Management (“ARM”), including all annual review, approval and modification for Patient Selection Criteria in the following areas: Organ Transplants; Speech / Occupational / Physical Therapy, Acupuncture; Procedures / Imaging / Specialty Referrals; DSM Behavioral Health guidelines for non-plan mental health and chemical dependency admissions.

2. Establishment of strategies to address complex case management.

3. Dialysis Referral Management

4. QUEST Case Management

5. Emergency Prospective Review


7. New Technology Assessment

8. Claims Administration (review of non-plan emergency room encounters)

9. Behavioral Health Help Line (Call Center)

10. Systematic monitoring of utilization of care and services, including over- and under-utilization.

11. Drug Utilization Review.

12. Oversight of Specialty Providers, such as chiropractic services.


14. Outside Utilization: Coordination of in-area and out-of-state
inpatient admissions, including the issuance of Notices of Non-Coverage (NONCs).


17. Transportation (arranging medically necessary transport) by UM, Travel and/or Nursing Departments.


23. Evaluation of practitioner and member satisfaction with the UM processes at a regional level.

24. Monitoring and ensuring compliance with internal and external regulatory requirements and standards.

25. Providing UM communication services to practitioners and members.

B. Additional, KPHI is responsible for developing Regional and hospital UM targets and goals.

C. The Hospital is responsible for the following local UM functions:

1. Internal and selected external referrals management (i.e., HPMG Primary Care to Specialty Care / Primary & Specialty Care to Out-of-Plan Care).

2. Hospital admission and concurrent review, including non-contracted, non-KFH facilities and Contract Facilities.

3. Skilled nursing facility admission and concurrent review.

4. Case / Care Management, including home health / hospice, selected complex cases and DME referrals.

6. Issuance of Notices of Non-Coverage (NONCs) for both KFH and non-KFH Inpatient Utilization.

7. Local pharmacy / radiology / laboratory utilization review.

8. Local systematic monitoring and analysis of utilization of care and
services, including over- and under-utilization.


10. Evaluation of practitioner and member satisfaction with the UM processes at the medical center.

V. Levels of Authority

There are three major levels of authority, accountability and responsibility for the quality of care, and service in the KPHI quality and utilization management programs: Governing Body / National, Regional / Shared Services and Hospital.

A. Governing Body / National

The Kaiser Foundation Health Plan/Hospitals Boards of Directors (Oakland, California) have the ultimate accountability and responsibility for the quality of care and service provided to Kaiser Permanente members. KFH and KFHP each have a separate Board, however, the same individuals serve on both Boards. The same KFHP / KFH Boards of Directors govern each of Kaiser Permanente’s geographic Divisions / Regions.

The Boards’ quality oversight committee is known as the Quality and Health Improvement Committee (QHIC).

At the national and program-wide level, the Senior Vice-President of Hospital, Quality and Care Delivery Excellence employed by KFH/KFHP partners with Permanente Medical Groups and Kaiser Foundation Hospitals, regional and national leaders to oversee Kaiser Permanente’s national quality, utilization and resource stewardship agenda, ensuring members and patients receive affordable, high quality care and service. This position reports to the KFH/KFHP Board of Directors for clinical quality and hospital performance.

Case-by-case decisions regarding medical necessity are managed within Hawaii Region by physicians and staff involved in utilization decisions with local oversight by the RS-UM Committee. Issues of particular concern regarding Medicare beneficiaries will be elevated to the Medical Director for Medicare Advantage, Cost and Part D Plans. The Health Plan UM Physician Advisor will engage the Medical Director for Medicare Advantage, Cost and Part D Plans in written or telephonic communication as expeditiously as required to resolve the issue or mitigate risk to KP Medicare beneficiary or to KP.

Issues for concern that may be suitable for escalation include, but are not limited to:

a. Awareness of a situation or event that has potential for KFHP, Inc. operation-wide concern, i.e. one that may impact all Medicare Advantage Plans, Cost Plans, and
Prescription Drug Plans.

b. UM or quality related occurrence or event which has the potential to put the organization or member at risk.

c. Opportunity to request consultative advice or opinion from medical director, such as review of a challenging case.

d. Notify the medical director of a decision on appeal from an Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC).

B. Hawaii Region

1. The Boards hold the Hawaii KFH / KFHP Region President (“President”) and the HPMG Executive Medical Director (“Executive Medical Director”) accountable and responsible for the quality of care and service provided in Hawaii. The President and the Executive Medical Director:

a. Establish Hawaii’s Regional Quality and Utilization Management Programs and a Quality and Utilization Management structure of committees and groups that provide effective oversight and review.

b. Hold KFHP, KFH and HPMG physicians, managers and staff responsible for specific functions of quality assessment and improvement, patient safety, credentialing, risk management, utilization management, continuing care, monitoring and resolution of member complaints and appeals, assessment of provider/member satisfaction, medical records review, regulatory and accreditation compliance, coordination, consultation, facilitation, and review.

c. Establish annual quality goals.

d. Establish annual utilization targets.

e. Direct action as necessary to improve care and service.

2. The President and Executive Medical Director provide leadership by establishing Hawaii strategic quality goals and objectives, care and service expectations and standards, and priorities. They establish quality performance targets for the Region and Hospital. They receive and review regular, written regional quality reports, and make inquiries and take action as appropriate.

C. Resource Stewardship-Utilization Management Structure

1. HPMG Executive Committee
The HPMG Executive Committee, chaired by the Executive Medical Director of HPMG, is composed of appointed Associate Medical Directors, Chief of Staff of KFH, and selected other senior Medical Group leaders. The Committee, acting as a whole or through a designee, serves as the final arbiter of medical necessity determinations and referrals for care/services outside of the Medical Group, including referrals for services directed to mainland facilities.

2. Hospital Executive Committee (HEC)

The HEC provides oversight of KFH’s services, activities and functions, and implements Professional Staff policies. It receives and acts upon reports and recommendations from departments, committees, and other groups performing services as defined by the Board of Directors of KFH as requested. The HEC is responsible for the quality, utilization and safety activities of the professional staff as well as the mechanisms to implement, evaluate and improve such activities.

3. Quality Committee (QC)

The HPMG AMD for Quality Improvement and the KFHP VP for Quality and COO, Care Delivery co-chair the Region’s Quality Committee, which provides direction, oversight, coordination, and communication of the Hawaii Region Quality, Patient Safety and Service priorities, activities and performance. The QC provides direction, oversight, coordination and communication of the Hawaii Region Quality, Patient Safety and Service priorities. The role of its members is to ensure quality objectives are accomplished and strategic quality goals are achieved. The QC sponsors local quality improvement initiatives through the Performance Improvement Teams.

4. Hospital Quality Improvement Committee (QUIC)

The Hospital Quality Improvement Committee develops and implements a hospital wide quality, utilization, and patient safety program to ensure the provision of safe, effective patient care and service through ongoing monitoring, evaluation and improvement processes. The QUIC facilitates preparation of a quarterly report of the hospital’s assessment and improvement activities submitted to the Board of Directors through the HEC.

5. Resource Stewardship-Utilization Management Committee
The QHIC and HPMG Board of Directors hold the Hawaii Region President and the HPMG Executive Medical Director accountable for the Hawaii Region Resource Stewardship-Utilization Management (RS-UM) Program. RS-UM is a shared responsibility among KFHP, KFH, and HPMG. These entities partner to provide and coordinate high quality and effective medical management for Health Plan members while striving continuously to improve the quality, safety and service provided. The Hawaii Region President and the HPMG Executive Medical Director assigned leadership of the RS-UM Program to the Assistant Medical Director of Outside Services and Network Management and the Senior Director of Continuing Care who Co-Chair and has overall accountability for the Resource Stewardship-Utilization Management Committee. The Assistant Medical Director of Outside Services and Senior Director’s role involves oversight, implementation and evaluation of the UM program. This also involves oversight and coordination of UM processes and activities assigned to other key physicians responsible for UM in the hospital, clinic, outside services and behavioral health services. The RS-UM Committee will meet a minimum of four to six times per year.

6. Regional Appeals Committee

The Regional Appeals Committee is a multidisciplinary group, which provides the final level of internal reconsideration of Member appeals. The Committee’s activities are aligned with State, Federal and accreditation requirements.

7. Behavioral Health Services

The Hawaii Region provides Behavioral Health Services (BHS) for Oahu, Maui County and Hawaii and contracts for Behavioral Health Services on Kauai. Protocols used by triage staff are reviewed and/or revised every two years. The physician Chair of BHS leads the group of four BHS Physician Advisors for UM. The Physician Advisors for Behavioral Health perform utilization review, providing final medical necessity determinations. Established policies, procedures, and protocols address the urgency of the patient’s clinical circumstances and define the appropriate care setting and treatment resources for behavioral health and substance abuse.

D. Committee / Group Structure
1. Resource Stewardship-Utilization Management Committee (RS-UM Committee)
   a. This committee provides oversight of Utilization Management activities and performance across the continuum of care at KPHI. The objectives include:
      1) To ensure that the KPHI Utilization Management / Resource Stewardship programs, initiatives and strategies are aligned with the Program’s quality agenda.
      2) To address utilization issues, monitor utilization performance (Average Length of Stay (ALOS), Utilization Rates, Discharge Rates), follow-up on utilization performance improvement opportunities across the continuum of care.
      3) To provide linkage with Hawaii Quality Committee (QC) to ensure that quality and utilization goal and activities are aligned in KPHI.
      4) To request and review service area utilization management initiatives, action plans and outcomes.
      5) To develop and approve annual utilization goals / targets.
      6) To sponsor utilization projects and initiatives across the continuum of care that also improves quality of care and clinical outcomes.
      7) To review and approve policy decisions related to utilization management.
      8) To address regulatory / accreditation issues related to utilization management.
      9) To provide leadership and support for Kaiser Permanente Hawaii as we strive for improved quality and appropriate utilization.
     10) To ensure the integration of quality, utilization management and finance to better understand the costs and benefits of any utilization initiative, while maintaining or improving the quality of care delivered to our members.
     11) To monitor for potential areas of over and under utilization and initiate appropriate actions as indicated.
12) To ensure that the needs of the individual member and available hospital and community resources are taken into consideration during all processes related to the medical plan of care and utilization management efforts.

b. RS-UM Committee Membership includes:

**Co-Chairs:**
- Associate Medical Director (AMD), Outside Services & Network Management
- Senior Director, Continuing Care

**Members:**

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<td>AMD, Hospital Specialties / UM</td>
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<td>AMD, Ancillary Specialties</td>
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<td>AMD, Primary Care Specialties and Clinics – ad hoc</td>
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<td>AMD, Neighbor Islands – ad hoc</td>
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<td>AMD, Surgical Specialties – ad hoc</td>
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<td>AMD, Medical Specialties – ad hoc</td>
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<td>AMD, Professional Chief of Staff</td>
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<td>MD, New Ventures – ad hoc</td>
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<tr>
<td>Chief, Continuing Care</td>
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<tr>
<td>Chief, Diagnostic Imaging – ad hoc</td>
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<tr>
<td>PIC, Maui Area</td>
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<tr>
<td>Chief, Behavioral Health Services – ad hoc</td>
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<tr>
<td>Chief, Government Programs – ad hoc</td>
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<tr>
<td>MD, Emergency Services</td>
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<tr>
<td>Senior Director, Pharmaceutical Services – ad hoc</td>
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<tr>
<td>Administrator, Clinical Operations &amp; Finance – ad hoc</td>
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<tr>
<td>VP, Quality and COO, Care Delivery – ad hoc</td>
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<td>Administrator, Hospital</td>
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<tr>
<td>Director, PCR, DME, ARM</td>
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<td>CNO, Nursing Administration</td>
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<tr>
<td>Director, Clinic Operations, Moanalua – ad hoc</td>
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<td>CFO &amp; VP of Business Operations or designee, Finance</td>
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<td>Director, Performance Assessment – ad hoc</td>
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<td>HPMG/Finance Manager – ad hoc</td>
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The RS-UM Committee provides oversight of utilization performance across the ambulatory, acute and post-acute settings and for day-to-day operational issues pertaining to successful Utilization Management practices, utilization targets and/or barriers to successes across the care continuum.

c. RS-UM Committee serves as the review and approval body for utilization / resource management policies, procedures, utilization targets, UM guidelines and criteria, goals and improvement activities, across the continuum of care, including behavioral health in KPHI. It ensures regulatory compliance with all external and internal regulatory bodies and agencies, monitors performance for areas of potential over and under utilization and monitors utilization performance at the medical center level. RS-UM Committee holds the Hospital responsible for day-to-day operations and performance related to Utilization / Resource Management. A report on behalf of the RS-UM Committee is provided twice a year to QC.

d. RS-UM Committee meets monthly. The Regional UM and Continuing Care / Resource Management Department supports RS-UM Committee.
e. RS-UM Committee evaluates the total spectrum of utilization across the continuum of care: inpatient, emergency, ambulatory care, population-based care management, home health, hospice, SNF, rehabilitation, mental health care, and transplants, which include KFH, non-KFH, claims, and referrals. Monitoring aspects include data analysis of patterns and trends, identification and transfer of "successful practices" and monitoring for potential areas of under-utilization and over-utilization. RS-UM Committee is also responsible for the annual development of utilization targets, goals and establishing regional priorities.

f. KPHI recognizes that its resources are finite and improvement projects are selected that would have the greatest positive impact on the health of its members. RS-UM Committee is responsible for reviewing and prioritizing the utilization management opportunities identified by various committees and groups. Projects are established based on the priority of the project in relationship to organizational mission, goals, organizational strategies, potential for added benefit to KP customers, and the resources required to complete the project.

2. Regional Laboratory, Radiology and Drug Action Teams (Re-LUAT / Re-RUAT / Re-DUAT)

These action teams meet to look at focused quality and utilization opportunities related to outpatient laboratory, radiology, and drug utilization and clinical practice patterns. These teams report to RS-UM Committee.

3. The Regional Pharmacy and Therapeutics Committee is responsible for developing P&T standards, formulary development and compliance and drug utilization review.

VI. Scope of Utilization Management

The scope of the Utilization Management Program encompasses the care continuum, which includes the following medical services:

A. Ambulatory Medical Services, including: primary care, specialty care, out-of-plan referrals, drug utilization, laboratory, pharmacy, imaging and diagnostic services, nuclear medicine and rehabilitation.

B. Acute Inpatient Hospital Care (KFH and Contracted Facilities)

C. Outside Utilization Review

D. Outpatient Surgeries
E. Skilled Nursing Facilities
F. Acute Rehabilitative Services
G. Hospice Care
H. Home Health Services
I. Behavioral Health
J. Addiction Medicine
K. Durable Medical Equipment / Prosthetics and Orthotics / Soft Goods
L. Medical Transportation
M. Benefit Interpretation
N. Claims Management/Review of Non-Plan Emergency Room Encounters
O. Total Panel Management
P. Complex Case Management
Q. Transition to Other Care When Member’s Health Plan Coverage Ends
R. Provision of UM Communication Services for Practitioners and Members
S. Provision of Language Assistance Services for Members

The Hawaii region provides services at its own medical clinics: four on Big Island (Hawaii), four on Maui and 12 on Oahu. Majority of services are provided internally by KFH and HPMG providers and staff. If medically indicated services are not available within HPMG and/or KFH, outside community providers are contracted or arranged to ensure availability of medical care and services in accordance with KFHP benefit agreements.

VII. Program Goals

A. To ensure continuity of quality medical care and effective resource management for services provided to our members.
B. To ensure that our members’ rights are recognized and protected.
C. To incorporate the quality improvement philosophy and methodologies into the Utilization Management activities in order to accomplish the Kaiser Permanente Quality Agenda, Strategic Quality Goals and KP Promise.
D. To achieve the organization’s strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently at the right time at the right place.
E. To achieve consistency in program-wide policies and guidelines.
F. To ensure compliance with all regulatory requirements and accreditation standards.
G. To monitor for potential areas of under-utilization and over-utilization and to initiate appropriate action(s) as indicated.

H. To ensure the integration of patient safety into all aspects of the UM / Continuing Care Program.

I. To ensure qualified interpreter and translation services are available to members in keeping with state regulations.

VIII. Program Objectives

A. To foster KPHI sharing of state-of-the-art Utilization Management practices and strategies.

B. To promote physician leadership in Utilization Management.

C. To set the direction and scope of Utilization Management in Hawaii.

D. To promote Member/Provider satisfaction and include Member / Provider feedback for continuous program improvement.

E. To ensure that Members are informed of their grievance and appeal rights.

F. To focus utilization monitoring on high-cost and high-volume services, as well as in the areas of over- and under-utilization.

G. To have a systematic process to measure, track and analyze data related to monitoring of potential areas of over and under-utilization and to initiate appropriate action.

H. To analyze and utilize emerging new technology appropriately, effectively, and efficiently.

I. To use available medical services within KPHI in order to avoid costly outside contracted services and to better coordinate and manage the care of our members.

J. To achieve consistency in program-wide policies, procedures and guidelines.

K. To comply with all regulatory requirements and accreditation standards, while providing quality of care to our members.

IX. Methodology

A. CLINICAL CRITERIA FOR UM DECISIONS

At Kaiser Permanente, the primary care physician has authority in planning and directing the care of patients, in collaboration with the UM staff. Board certified physicians from appropriate specialty areas assist in making medical determinations as appropriate. This includes medical
review across the care continuum (i.e. inpatient care, SNF, Home Health, Hospice).

Utilization decisions are made in a timely manner to accommodate the clinical urgency of the situation using relevant clinical information, as specified in policy #6425-502 regarding utilization decisions. Relevant clinical information is collected and documented for every decision. Applicable UM criteria are based on clinical information, and service setting as summarized below and described in procedure #6425-500-B Utilization Management: Use of Review Criteria.

<table>
<thead>
<tr>
<th>Reason for use</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital care</td>
<td>InterQual ISD-AC (Indications for Acute and Critical Care, Adults and Pediatrics).</td>
</tr>
<tr>
<td>SNF, Home Health, Rehabilitation</td>
<td>Medicare Criteria (Medicare Explained)</td>
</tr>
<tr>
<td>Behavioral Health and Chemical Dependency Services</td>
<td>InterQual ISD-AC American Society of Addiction Medicine (ASAM)</td>
</tr>
<tr>
<td></td>
<td>Global Assessment of Function (GAF)</td>
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<tr>
<td></td>
<td>Diagnostic and Statistical Manual by the American Psychiatric Association (DSM IV)</td>
</tr>
<tr>
<td>Pharmaceutical management</td>
<td>Closed formulary</td>
</tr>
<tr>
<td>Referred services</td>
<td>Referral Authorization Guideline</td>
</tr>
<tr>
<td>Emergency claims</td>
<td>George Washington University Department of Emergency Medicine Triage Classifications (as adopted by the Region)</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>DME Formulary Durable Medical Equipment Regional Carrier (DMERC)</td>
</tr>
</tbody>
</table>

Consideration is also given to the local delivery system: These considerations may be used in addition to the UM criteria and address:

- Availability (and benefit coverage) of skilled nursing facilities, or home health in the service area
- Local hospital ability to provide all recommended services with the estimated length of stay
- Availability of ancillary providers and clinical specialty services needed to provide or support inpatient or outpatient care
- Ability of local providers/practitioners to provide the appropriate level of clinical services, per the Use of Review Criteria Policy #6425-500-B.
For out of plan referrals, guidelines are developed, reviewed and approved annually with the Clinical Chiefs, and appropriate clinical delivery service staff. Following development, the guidelines are presented to RS-UM Committee for approval per the Out of Plan Referrals Policy #5054-01A. Guidelines must include requirements for approval and clinical criteria if indicated and are made available to all Practitioners and members upon request.

InterQual Level of Care Criteria for Acute Care is purchased and approved annually by the following process:
- The practitioners in the departments review and may recommend modifications based on current evidence and submit the criteria for endorsement to the RS-UM Committee
- The RS-UM reviews and approves updated/revised criteria
- An annual update is communicated to clinical service providers, including affiliated practitioners, and UM staff

Behavioral Health—Criteria for behavioral health services are based on clinical evidence and currently accepted industry practice as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. Criteria address a full range of services and levels of care including: inpatient, continued inpatient stay, residential or day treatment, and outpatient services. The Behavioral Health criteria are annually reviewed by the Chief of Behavioral Health prior to review and endorsement by the HRS-UM. (All other criteria for Behavioral Health Services are annually reviewed by the appropriate medical department before review and approval by the HRS-UM).

In addition, an attachment to policy #6425-500-B identifies staff by name and a contact telephone number where individuals can obtain copies of the criteria (e.g., hospital, emergency, DME, etc), if desired.

Kaiser Permanente physicians, affiliated care practitioners and all UM staff have access to and utilize approved evidence-based criteria to guide utilization decisions. The criteria are available from the RS-UM Committee and the Kaiser Foundation Hospital UM Department and the Authorization and Referrals Management Department. New physicians and UM staff are provided with and educated on the use of the criteria and guidelines during orientation.

Information sources used to determine medical appropriateness include:
- Demographics
- Diagnosis
- Co-morbidities
• Complications
• Progress of treatment
• Severity of illness and intensity of services from the patient’s inpatient and / or outpatient chart
• Feedback from the physician care team
• Eligibility
• Prior history/hospitalization(s)
• Signs and symptoms
• Tests and procedure results
• Functional ability related to activities of daily living and other related issues
• Cognitive skills

Supplemental information from the patient and / or family is used, in adjunct to the clinical information obtained, to plan for and arrange necessary medical care, post-discharge needs and ensure continuity of care. Additional information may include, but is not limited to:

• Medication, wound care, nutrition, etc.
• Advanced Directives/Code Status
• Medical equipment and supplies, including DME benefit/type, and anticipated DME needs
• In home support systems, including caregiver, meals, transportation, utilities and other related issues
• Financial resources, including Medicaid eligibility, etc.
• Anticipated discharge needs (subject to physician diagnosis, treatment, and care plan) including Home Health and type of care giver/services needed (RN, PT, OT, Speech, HHA, etc.), SNF, Acute Rehab, Care Home, Home IV Care, Hospice, community resources, etc.
• Follow-up care needs, (i.e., return to see Primary Care Physician, Ambulatory Treatment Center, etc).
• Psycho-social situation
• Home environment
• Patient safety

Consideration is also given to resources available in the local delivery system and may be used in addition to the utilization management criteria in making decisions:

• Availability and benefit coverage of skilled nursing facilities, sub-acute care facilities, or home health in the service area
• Local hospital ability to provide all recommended services with the estimated length of stay

Inter-Rater Reliability Process
Pursuant to the Procedure for Inter-Rater Reliability Policy #6424-701, inter-rater reliability reviews are conducted at least annually to ensure criteria are applied correctly and consistently by staff responsible for service determination. Case studies are provided to staff and the responses are tabulated to assess consistency among staff regarding application of UM criteria. If discrepancies exist, the criteria are reviewed to determine whether criteria need correction or staff require further education. The following lists the staff annually surveyed for the IRR Process:

- Physicians
- Nurses
  - Oahu hospitals and skilled nursing facilities,
  - UM staff from neighbor island hospitals and skilled nursing facilities,
  - Authorizations and Referrals Management
- Behavioral Health physicians and staff

B. COMMUNICATION SERVICES

KP Hawaii provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. The Communication Services Policy #6425-03-011 outlines the mechanism for ensuring staff accessibility to practitioners and members to discuss UM issues. The procedure for ensuring communication of information is outlined as followed:

1. Staff identify themselves by name, title and organizational name when initiating or returning UM related calls

2. UM Staff are available at least eight hours a day during normal business days for inbound and outbound communication regarding UM issues including:
   - Continuing Care Coordinators
   - Extended Care Coordinators
   - Authorization and Referral Management Staff
   - Behavioral Health UM

3. Availability of staff after normal business hours:
   - A published toll-free number is located on back of membership cards, linked to a voice mail box to accommodate inbound communication after business hours
   - UM staff retrieve, triage or respond to all voice mail messages no later than the next working business day.
   - Specific questions about UM are referred/directed to appropriate UM or Customer Services department
4. UM Staff communicate with members via several methods that may include fax, telephone, letter, email or voicemail.

5. Other departments involved with UM decisions have been assigned as a key contact with title, telephone, and fax numbers listed in policy #6425-03-011 and include:
   - Authorizations & Referrals Management
   - Authorizations & Referrals Management for Behavioral Health Services
   - Outside Services/Hospital Operations Center
   - MOA Hospital UM
   - Neighbor Island Community Based Programs including Home Health, SNF and Hospice
   - Oahu SNF
   - DME
   - Neighbor Island Quest Coordinator
   - Oahu Quest
   - Oahu Home Health Services
   - Community & Medical Services
   - Claims Processing, Wailuku
   - Appeals

C. TIMELINESS OF UM DECISIONS

UM is committed to making decisions in a timely manner that accommodate the clinical urgency of each situation. The following types of approvals or denials are made for all areas, including Behavioral Health, as documented in policy #6425-502:

- Non-urgent pre-service (within 14 days)
- Urgent pre-service (within 72 hours)
- Urgent concurrent (within 24 hours)
- Post service (within 30 calendar days)

1. Pre-Service Authorization is required for all care and supplies provided by non-KP practitioners or providers using pre-established criteria:

   Referral requests are reviewed and authorized by the appropriate department:
   - Authorization and Referrals Management
   - Durable Medical Equipment

   Additional support is provided in the following ways:
   - Designated HPMG physicians are consulted as needed
• Pre-admission and admission reviews are conducted, as indicated, for admissions to the Kaiser Foundation Hospital and all community skilled nursing facilities
• Denial letters are provided to the member as appropriate. The notice informs the patient of his/her financial liability and the right to appeal the decision.

2. Concurrent Review
Appropriate staff and physician advisors perform concurrent review functions and protocols in the acute care and long term care settings. Concurrent review is conducted periodically for patients requiring continued hospitalization, depending on the patient’s condition.

Review will include communication with the attending physician and/or UM Physician Advisor to obtain, share and/or reinforce information necessary to justify hospitalization and level of care, as needed.

Reviews are done consistently for all patients regardless of the payer source (i.e., Medicare, Health Plan, Medicaid, Kaiser QUEST and third party payers) using the standard criteria. All specific regulatory guidelines are followed.

3. Post Service Review
Urgent/emergent care that has not been authorized and disputed claims cases will be reviewed retrospectively using approved criteria by the Authorization and Referrals Management Department. The Medical Director of Outside Services, or designated physicians, determines medical necessity. A payment decision or notification of denial is made within established time frames. Members and practitioners are notified in writing of denials.

a. Referral Management
   1) Authorization and Referrals Management (ARM)

The ARM Department manages Member referrals to affiliated practitioners or providers within the Hawaii Region and the mainland for medically necessary services unavailable within the Hawaii Region. The Medical Director of Outside Services (HPMG physician) and the Director of Provider Contracting and Relations, Authorizations and Referrals Management/Durable Medical Equipment are responsible for oversight of this program.
a) Referrals to the KFHP’s affiliated Licensed Independent Practitioners (LIP) or Health Delivery Organizations (HDO) for medically necessary care or service may be initiated when the HPMG capacity is exceeded or capability is unavailable within HPMG and/or KFH. Provisions are made for urgent and emergency referrals.

b) If a referral does not meet established medical necessity criteria, the Medical Director of Outside Services, or designee, will make the denial decision within the established time frames. Board certified physicians from appropriate specialty areas will be used in making determinations of medical appropriateness on an as needed basis. If the request is denied, the requesting physician and member will be notified of the decision and provided appeals rights information within established time frames.

c) The ARM Staff will make health plan benefit coverage decisions within established time frame.

d) Medical appropriateness of referral requests to non-contracted, non-participating practitioners and mainland services must be reviewed by the Executive Committee of the HPMG or designee. Recommendations are then made to the Medical Director of Outside Services for consideration of approval.

e) Emergency admissions by non-affiliated practitioners to in-area non-plan acute care facilities are tracked by the Outside Services Continuing Care Coordinators. Repatriations are made when the member is stable for transfer. Members who refuse repatriation are advised of their financial responsibility and are notified in writing of the denial of continued stay. Notifications are issued within established timeframes.

b. Alternative Treatment Plans

In certain circumstances, Alternative Treatment Plans (ATP) may be offered to Kaiser Permanente Health Plan Members in lieu of traditional treatment. Provision of an Alternative Treatment Plan does not obligate Health Plan to provide or pay for the same or similar alternative treatment(s) in future situations to the same or another Member, and Kaiser Permanente and Member must both agree to and sign the Alternative Treatment Plan Agreement for the individualized plan. Under the terms of the agreement, Kaiser Permanente
will pay for services or supplies not otherwise covered under the Member’s Service Agreement, only to the extent specifically described in the Alternative Treatment Plan.

All of the following conditions must be met for an ATP:

1) The ATP is medically safe and appropriate for the patient’s condition;
2) The Member’s medical condition requires costly, long-term, or extensive care; and
3) The Alternative Treatment Plan is a cost-efficient means for Kaiser Permanente to provide treatment in comparison to traditional treatment.

c. Transition to Other Care

If services are no longer covered and the member still needs care, Kaiser Hawaii Region educates the member about other alternatives for continuing care and informs the member of ways to obtain that care.

D. DENIAL NOTICES

The KP HI Region complies with regulatory/accreditation standards regarding the issuance of denials or Notices of Non-Coverage (NONC) for Medicare members. These include:

- The Important Message from Medicare letter to all Medicare Plan members from the Kaiser Foundation Hospital upon change of level of care or when a member disputes discharge from an acute care hospital
- Notice of Denial of Medical Coverage (NDMC) letters to all Senior Advantage and Medicare Cost Plan members when the member does not meet appropriate admission criteria upon entry into the acute hospital or Skilled Nursing Facilities
- Hospital-Issued Notice of Non-Coverage (HINN) to patients with Original Medicare (Fee-for-Service) in Kaiser Foundation Hospital or Malama Ohana Nursing and Rehab Center (MONARC) when the patient no longer meets appropriate criteria
- Notice of Medicare Non-Coverage (NMNC) letters to all Senior Advantage and Medicare Cost Plan members, in SNFs and those receiving Home Health services, at least 2 days (or 2 visits) prior to service termination
- Detailed Explanation of Non-Coverage (DENC) letter to all Senior Advantage and Medicare Cost Plan members, in SNFs and those receiving Home Health services after the member appeals to the Quality Improvement Organization
If a Health Plan Member remains in the acute care setting at a skilled level of care, they will receive a notice informing them that their SNF benefit will begin.

All other denials issued by the Health Plan will include the appropriate appeal language and time frames. These may include but are not limited to:

- Emergency services
- Hospital admission and continued stay
- SNF admission and continued stay
- DME
- Referred services
- Home Health
- Rehabilitation
- Behavioral Health
- Pharmacy

Staff review cases and may approve care based on medically approved criteria. Only physicians will make denial decisions based on medical necessity.

The Assistant Medical Director of Outside Services and Network Management designates physician advisors to make decisions regarding medical necessity. A denial may occur during pre-service, concurrent or post-service review. If the reviewing physician determines that a second opinion consultation is necessary, a participating board certified physician/specialist will make the determination. The treating practitioner may contact a physician advisor to discuss denial decisions. Member and practitioner notifications of denials include the specific utilization criteria or benefits provision applied and information on how to appeal the decision.

All denials, except Kaiser Foundation Hospital’s Medicare Fee-for-Service denials, are entered into the Denial Letter Assistant (DLA) System for tracking, monitoring timeliness of decision making and issuance of written notification and appeal rights to practitioners and members. Appropriate language related to the denial, appeals, expedited appeals and external review appear in the notices of denial and/or non-coverage. Monitoring reports are prepared and reported monthly to assure timeliness requirements. Appropriate time frames for response, both verbal and written for all denials (i.e. Medicare Modernization Act (MMA) Part-D can be found in the Utilization Decision Policy # 6425-502.

Policy #6425-03-011 ensures that both members and practitioners have multiple methods to inquire about UM decisions during regular business and after hours, through a local and toll free number or voice mail. UM staff may also communicate with members and practitioners via email, fax or letter.
E. POLICIES FOR APPEALS

All members and practitioners have the right to appeal decisions regarding medical necessity, benefit determinations, claims and other issues pertaining to health plan coverage. The regional Appeals Department processes all internal levels of appeal and prepares cases for external review. Designated physician advisors review and determine standard first level appeals, while the Regional Appeals Committee reviews and determines second level appeals, those appeals subject to only one internal level. The organization appoints a staff/physician not involved in the prior adverse decision to review the appeal. Reviews are completed and written determinations are sent to appellants in accordance with regional standards. Policies and procedures are in place for processing pre-service and urgent appeals on an expedited basis. The following policies address the timely resolution of member concerns/grievances and appeals of complaints/grievances and denial determinations:

- Policy # 5054-03-A: Management of Post-Service Appeals (Medicare Managed Care Members)
- Policy # 5054-04-A: Management of Post-Service Appeals (Non-Medicare Members)
- Policy # 5054-05-A: Management of Pre-Service and Expedited Appeals (Medicare Managed Care Members)
- Policy # 5054-06-A: Management of Pre-Service and Expedited Appeals (Non-Medicare Members)

External Appeals

All Kaiser Foundation Health Plan Members have the right to request reconsideration of the Health Plan’s adverse final decisions involving medical necessity determinations to an external review organization. The applicable independent review organization (IRO) to perform the external review is determined by the member’s Health Plan coverage. Kaiser Foundation Health Plan actively advises Members of their IRO appeal rights, and facilitates the timely submission of the appeal file and other pertinent information to the IRO. Final internal decisions may be reviewed by an external Quality Improvement Organization in accordance with the regulatory guidelines established by the membership category and documented Policy #5054-20-A regarding Independent Review Organization Appeals.

F. INTERNAL REFERRALS MANAGEMENT FOR HPMG

1. Members are encouraged to select a Kaiser Permanente primary care physician (PCP) to be their personal physician to coordinate
and provide medical care. Primary care physicians can be Family Practice, Internal Medicine, or Pediatrics.

2. In non-urgent circumstances, Members contact their primary care physician for medical care. In urgent situations, another primary care physician may manage a Member’s medical needs.

3. Primary care physicians can make referrals, verbally or in writing, to specialty services within the Kaiser Permanente system. Pre-authorization is not required in most cases. Some self-referral by Member is permitted, such as OB/GYN and Behavioral Health.

4. The Chiefs of the specialty services or their designees may review referrals and prioritize them for Member appointments based on their clinical judgment of urgency, and guidelines developed by the specialty departments. The specialty physician may contact the referring physician if more information or clarification is needed. If after consultation with the specialist, the referring physician determines that a better alternative exists in place of the specialty referral, this care is then arranged. This is not an authorization process, but rather a potential first step in the specialty consultation to assure appropriate and timely care. If a Member at any time disagrees with the physician’s medical plan of care, the Member can exercise their rights to grieve the medical decision to Customer Services Department.

5. A PCP may request a standing referral with an internal specialist without the PCP having to provide a specific referral request for each visit.

G. BENEFITS MANAGEMENT

Benefits are based on a member's individual benefit package. Each member's benefit package is described in their specific Evidence of Coverage. The Evidence of Coverage is the agreement between a purchaser (Medicare, Med-QUEST, an employer group or individual) and Kaiser Permanente to provide health care and covered products and services. Evidences of Coverage are available for reference and mailed to members by the member's employer group or Kaiser Permanente when appropriate. Evidences of Coverage are also available upon request to any member and are made available to healthcare providers. Kaiser Permanente has a variety of tools to assist in the proper adjudication and management of benefits consistent with the member's benefit package.

The following mechanisms are used to assist KPHI in making coverage determinations:
1. **Common Membership/Mainframe and KPHC** -- Kaiser Permanente’s information management system developed for health plan administration. It is a source for maintaining members’ benefit information. This system is used for a variety of reasons, which include medical record look up, membership history, benefit eligibility, purchaser information and more.

Claims/Benefits systems, along with other downstream information systems, work to properly adjudicate member benefits. Downstream systems include HealthConnect, Pharmacy Information and Durable Medical Equipment (DME) Ordering and Tracking Systems.

2. The **DME Formulary Guidelines** are utilized to inform benefit and coverage determinations. KP DME Formulary Guidelines allow members to obtain non-formulary DME items (those not listed on the formulary) if they would otherwise be covered by the Health Plan and if the Medical Group determines that they are Medically Necessary. All Medicare beneficiaries have a DME benefit, which is administered, covered and supplied in compliance with Medicare regulations. The general information on benefits is found in the members Evidence of Coverage (EOC).

KP DME Formulary, which is a list of durable medical equipment that has been approved by Kaiser Permanente’s DME Formulary Review Committee. The DME formulary was developed by a multidisciplinary clinical and operational workgroup with review and input from Plan Physicians and medical professionals with DME expertise. The formulary is periodically updated to keep pace with changes in medical technology and clinical practice.

3. **Pharmacy Formulary Guidelines** inform members of benefit and coverage information. The Pharmacy Formulary Guidelines allow members to obtain non-formulary prescription drugs (those not listed on the KP drug formulary for the member’s condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary.

**Pharmacy Formulary** includes the list of drugs that have been approved by KP’s Pharmacy and Therapeutics Committee for its Members. The Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature.

4. **Federal, State laws.** Laws and regulations set a baseline for what the Plan must cover and / or offer purchasers. The Plan organizes the benefits into two broad categories -- base and supplemental. Medical necessity (as determined by a Plan
physician) is almost always prerequisite to coverage when a member has coverage for a particular benefit. When a member feels that he has been denied rightful coverage, the member has appeal rights based on whether the denial is due to medical necessity versus not having the benefit. The appeal rights are defined in law and regulations.

5. **Benefits and regulatory experts** in Health Plan Service and Administration Division are also used as a resource for benefit determinations and regulatory understanding, as needed.

6. **Member Relations / Customer Services / Member Services Call Center** is also used as a resource for benefit determinations as needed.

H. **Management of Non-Plan Emergency Room Encounters**

For members who receive urgent / emergent care outside of a KP Plan facility and have not contacted KP to assist in the transition of care, a claim is submitted to the Claims Administration Department for adjudication. Emergency medical condition definition is used to evaluate out-of-plan claim(s) for emergency care. The claim with all necessary clinical information is forwarded to the ARM Department. The Registered Nurse / designee in the ARM Department reviews all submitted claims. The Registered Nurse / designee makes the determination to either pay the claim, or submit the claim for review to the Physician Advisor. The Physician Advisor makes the final determination to approve or deny the claim based on the emergency medical condition definition and medical appropriateness. The Physician Advisor (in the ARM Department) makes retrospective medical emergency or medical necessity decisions upon review of claims (bills) submitted based on medical documentation. The Physicians make clinical determination, not coverage decisions, when reviewing the non-Plan emergency room claim. Payment decisions are based on:

1. Documentation or records provided by the non-plan provider with consideration to member's presenting symptoms as well as diagnosis.
2. Emergency medical condition definition.
3. Medical and clinical expertise and community medical standards.
4. Consultations with treating physicians and other specialists, as appropriate.

Time frames, as determined by Centers for Medicare and Medicaid Services (CMS), the Department of Health (DOH), and the National Committee for Quality Assurance (NCQA), are followed in the review process for out-of-Plan emergency room encounters.
I. Transition to Other Care

1. The Utilization Management Department and other departments such as Social Services and Members Relations / Services are responsible for ensuring that when a Member's Health Plan coverage ends and the Member still needs care, the Member is assisted in obtaining other care. This includes the following types of coverage:

a. Specific benefit exhaustion, such as acute rehab, SNF, hospice, home health, DME, inpatient or outpatient behavioral health care.

b. Voluntary or involuntary dis-enrollment.

c. Non-payment of membership dues.

d. Other specific situations where coverage ends.

2. Provisions that may be offered / considered include:

a. Provide information regarding the Consolidated Omnibus Budget Reconciliation Act (COBRA), Medicare, Med-QUEST, Single Coverage options, and community-based organizations/clinics.

b. Offer conversion to Direct Pay coverage for active Members who lose their group coverage and do not select COBRA, or whose COBRA coverage has expired.

c. Referral to Social Work to explore and arrange community-based care, as appropriate, to assist with the Member's social and financial circumstances.

d. Local service delivery availability for site and level of care options, are considered when plans of care for individual Members are developed.

J. Inpatient Utilization Management / Case Management

1. The department of Utilization Management / Continuing Care Services of the Hospital manages hospital resource utilization. Utilization Management / Continuing Care Services personnel responsible for or involved in ongoing review and management activities may include:

a. Utilization Management / Continuing Care Director

b. Utilization Management Physician Director / Advisor

c. Physician Advisors of general and specialty services
2. Various strategies are employed to manage resource utilization in the hospital. These strategies are outlined as follows:

a. Combined the functions of utilization review and discharge planning in order to better manage and coordinate patient care in the hospital and care continuum. In addition, Case Managers / Care Coordinators have been placed in the Emergency Department to facilitate appropriate admissions as well as to coordinate appropriate level of care for the members.

b. Case Managers / Care Coordinators perform concurrent reviews for appropriateness of admissions and continued stay in the hospital and non-plan facilities. Concurrent reviews are done on-site with multidisciplinary rounding teams or by telephone to determine whether the needed care or services can be rendered in an alternative setting. Case Managers / Care Coordinators / Discharge Planners evaluate patients during the concurrent review process for appropriate levels of care and discharge planning needs and coordinate discharge activities with health care providers, patients and family members as appropriate. Every effort is made to proactively prepare the hospitalized patient and his/her family for post-hospital continuing care needs and plans.

c. Case Managers / Care Coordinators refer cases that do not appear to require an acute level of care, or a continued stay in the hospital to the assigned HPMG Physician Advisor(s) for review and consultation with the attending physician, as appropriate.

d. Types of clinical information that may be collected and used by the Physician, Case Manager / Care Coordinator, and other members of the Health Care Team to assist in determining the medical plan of care and appropriate interventions include, but are not limited to:

   1) Demographics
   2) Diagnosis
   3) Eligibility
   4) Prior history/hospitalization(s)
5) Issues related to mobility, activities of daily living (ADLs), mentation, and other related issues.

6) Functional ability and knowledge skills.

7) Therapeutic modalities (intravenous therapy, wound care, physical therapy, etc.)

8) Advance Health Care Directives (AHCD)/Physician Orders for Life Sustaining Treatment (POLST)

9) Medical equipment and supplies. Assessment of DME benefits and needs.

10) In home support systems, including caregiver needs, meals, transportation, and environmental factors.

11) Assessment of financial resources and need for assistance.

12) Anticipated discharge needs (subject to physician treatment, diagnosis and plan of care) including Home Health and type of caregiver / services needed (Registered Nurse (RN), Physical Therapy (PT), Occupational Therapy (OT), Radiation Therapy (RT), Speech, Home Health Aide (HHA), etc.), SNF, Acute Rehab, Alternative Living Arrangements, Home IV Program, Hospice Program, Community Resources and other.

13) Follow-up care needs; appointment arrangement.

14) In addition to the above, the following additional information is used, in adjunct to the clinical information obtained, to plan for and arrange the necessary medical care, post-discharge needs and to ensure continuity of care:

   a) Age
   b) Co-morbidities
   c) Complications
   d) Progress of treatment
   e) Psycho-social situation
   f) Home environment
   g) Patient safety
   h) Results of tests and procedures
i) Local service delivery availability for site and level of care options, are considered when plans of care for individual Members are developed.

j) Language assistance needs.

3. Designated coordinators perform continuing care reviews and coordination for cases in the following settings:
   a. Skilled Nursing Facilities
   b. Rehabilitation Services
   c. Home Health Services
   d. Hospice / Palliative Care

Care Coordinators may include Extended Care Coordinators and Home Health Case Managers.

K. Clinical Practice Guidelines
   1. HPMG Clinical Practice Guidelines (CPGs) are developed to support evidence-based clinical decision-making at the point of service. They are intended for those practitioners who provide medical care in medical offices and hospitals. HPMG disseminates new and revised guidelines to all physicians, physician assistants, nurse practitioners / midwives and other health care professionals in relevant specialty groups by several methods: direct mail, a CPG Handbook (published every two years), and via the CPG Intranet Web site, and HPMG symposia displays. To keep current with changing medical practices, all guidelines are reviewed and, if appropriate, revised at least every two years. Some guidelines are updated more frequently in response to the publication of important new evidence.

   2. The CPGs are designed to be flexible, and are not used to approve or deny medical care. All providers are responsible for applying recommendations to the specific clinical characteristics of each patient.

L. Behavioral Health Care
   1. The Hawaii Region provides Behavioral Health Services (BHS) on Oahu, Maui, and Hawaii and contracts for BHS on Kauai. In addition, members may receive services from the Behavioral Medicine Specialists who work collaboratively with primary care practitioners as part of the health care team in the primary care setting.
2. The Chief of Behavioral Health – who is a board certified psychiatrist with a current unrestricted license, oversees the Behavioral Health triage therapists and supervisor. Licensed practitioners make decisions regarding clinical judgment as listed in procedure #6425-03-003 Staff Involved In Utilization Decisions. Protocols used by triage staff are reviewed and/or revised every two years. Physician Advisors perform utilization review processes and make final decisions for all medical necessity determinations. The Manager of BHS works with the Chief of Behavioral Health to ensure compliance with all standards and regulations. Policies are reviewed or revised on an annual basis. Any denial of services follows policy #6425-502 Utilization Decisions. Concurrent utilization review for acute, residential, and outpatient behavioral health and chemical dependency services are provided by a licensed clinical social worker.

3. Behavioral Health Services Call Center assesses member needs, determines the appropriate level of service and connects the member to that service. The Behavioral Health Screening and Referral Policy #2545-04 describe the guidelines used by Kaiser staff to screen Kaiser members requesting behavioral health services. Procedure #6425-500-B UM: Use of Review Criteria lists the BHS clinical criteria used to determine utilization decisions. A member requesting BHS must first call the regional toll free number for assessment and referral to the appropriate level of care. Behavioral health care practitioners employed in the Call Center and others who make triage and referral decisions that require clinical judgment are appropriately qualified and licensed, as documented in procedure #6425-03-003. The Call Center Coordinator has a master’s degree in nursing with specialty in community mental health, behavioral health, psychiatric nursing and provides oversight for triage and referral decisions. Unavailable BHS within HPMG and KFH are provided through contracted community practitioners and services to ensure availability of medical care in accordance with KFHP benefit agreements.

X. Evaluation of New Technology

The Hawaii Region Benefits Committee receives information/recommendations on new health care delivery technologies (including behavioral health, drugs and equipment) from the Kaiser Permanente Interregional New Technologies Committee Hawaii Region representative. The Hawaii Region Representative reviews the scientific literature and sends it to appropriate medical departments.
New technologies can be incorporated from departmental recommendations, Pharmacy and Therapeutics Committee, decisions by Medicare intermediaries and/or carrier and national Medicare coverage decisions, and regulatory agency requirements. Considerations regarding integrating this information into the Hawaii Region benefit design is reviewed and updated by the Benefits Committee.

XI. Review Guidelines / References

A. At KPHI, except for a few selected services the physician has ultimate authority and autonomy in planning and directing the care of patients, in collaboration with the multidisciplinary staff. Board certified physicians from appropriate specialty areas will assist in making medical determinations as appropriate. This includes medical review across the care continuum (i.e., inpatient care, SNF, Home Health). KPHI uses InterQual ISD: Acute Level of Care Guidelines as an external reference to assist in determining appropriate levels of care. The guidelines are not used to approve or deny medical care or in any authorization process. These guidelines are used as a reference to review levels of care decisions and post-hospital care arrangements. RS-UM Committee reviews and approves all guidelines, references and criteria used in the UM process annually. External guidelines are only used as a resource, in conjunction with the application of professional medical judgment and specific case considerations.

B. All physicians can access UM criteria / guidelines either on-line, or by contacting the local or regional UM departments. In addition, all notices of non-coverage advise the MD that UM criteria / guidelines are available upon request and that they may speak to the MD making the UM decision if desired.

C. KPHI adheres to Medicare Rules and Regulations for medical necessity determinations for skilled, acute rehabilitation, home health, hospice, medical transportation, speech / occupational / physical therapies, podiatry, chiropractic care for both Medicare and Commercial members. Any exclusions, limitations or modifications are noted in the Evidence of Coverage (EOC).

D. Over-utilization and Under-utilization Monitoring

1. To provide the most appropriate health care to members and patients, Kaiser Permanente and its practitioners strive to continuously improve the use of resources. Appropriate care is achieved by optimizing the use of resources in providing high-quality patient care. Inappropriate care occurs when there is over-utilization, under-utilization, and/or mis-utilization. Monitoring for potential areas of over- and under-utilization is one component by
which KPHI monitors its UM program to include aspects of patient safety.

2. KPHI provides a series of routine utilization reports that display regional, service area and hospital level performance data, including behavioral health.

3. A monthly utilization management dashboard will be produced that reviews utilization and discharge rates, and examines drivers of positive or negative variance to target.

4. In addition, a Regional Readmission Report will be produced which examines the readmission rates for the Region and hospital levels. Action plans will be developed, as appropriate to reduce readmission at both the regional and hospital levels. In addition, any rapid readmission (within 24 hours) of discharge from the emergency department or hospital also prompts a quality review.

5. Other annual reports that are produced include: selected Health Plan Employer Data and Information Set (HEDIS), and use of Service measures, including inpatient behavioral health utilization.

6. Other ad hoc data, analysis and reports may be conducted based on findings and recommendations from quality management, risk management, patient safety, etc.

7. The members on the Resource Stewardship-Utilization Management Committee review utilization patterns and trends to identify potential areas of mis-utilization, including the targeted over and under utilization monitors.

8. Areas of concern are investigated to determine if a potential mis-utilization pattern exists. If an actual issue related to under utilization is discovered, corrective action plans are requested.

XII. Quality Improvement/Risk Management/Patient Safety Integration

A. At the Regional level, quality improvement / risk management / patient safety activities include review of Utilization Management data and issues. This information is shared through various mechanisms at the Region, including the Regional Quality Committee, Hospital Quality Improvement Committee and Clinical Practice Guideline Teams.

B. At the Hospital, Care Managers / Case Coordinators and Regional Utilization Management Coordinator assist in the QI / Risk Management data collection while reviewing the hospital charts for utilization purposes. For example, Possible Avoidable Days (PAD) or waitlist, are monitored in the Hospital. Data on avoidable admissions and unnecessary continued inpatient days are collected and information is reported to the Resource Stewardship-Utilization Management Committee, physician Chiefs and...
Administration in order to make continuous medical care improvements. UM staff at the Hospital serve as the front-line monitors for quality, risk and patient safety monitoring.

C. Utilization Management serves as the front-line for Risk and Quality Management within KPHI at both KFH and contracted facilities. Potential Risk Management issues identified by the Utilization Management / Continuing Care staff are reported through the local QI processes. At the regional level, Risk Management and/or Compliance office receives ad hoc reporting of UM / Continuing Care programs, practices, data and issues. Appropriate issues, patterns and trends identified by the UM / Continuing Care Departments are reported through the local QI Committees and regionally at QC and reported at the Resource Stewardship Committee.

D. KPHI participates in the Consumer Assessment of Health Plan Survey (CAHPS). Member Satisfaction Survey and utilizes these results in the assessment of Member’s satisfaction with the Utilization Management program. Analysis of grievance and appeal data related to UM areas are also monitored as a part of member satisfaction review.

E. Post-hospital member satisfaction surveys are conducted by the Region to evaluate satisfaction with discharge planning and with specialty referrals. Survey results are shared with the Hospital Utilization Management Department and Administration in order to make continuous improvements in medical care practice.

F. Provider satisfaction surveys are conducted annually with HPMG Physicians. Aggregate findings related to Utilization Management are reviewed upon receipt of the survey results and during the annual evaluation conducted by the Resource Stewardship-Utilization Management Committee.

G. Deliver culturally responsive care by implementing the Interpretive Services Program guidelines. This service also helps KP comply with legal, regulatory, and accreditation mandates. See Regional policies and procedures for translation and interpreter services.

XIII. Delegation

The KP Hawaii Region contracts with American Specialty Health Networks, Inc. (ASHN) for supplemental riders for chiropractic, acupuncture and massage therapy and as a base benefit for Medicare subluxation and delegates utilization management functions to ASHN. The Agreement of Delegation between ASHN and Kaiser Hawaii describes in detail the responsibilities of the delegated entity, as well as the remedies to Kaiser if the delegated entity does not fulfill its obligations.
ASHN performs utilization management activities through established structures, programs, resources and support systems. The RS-UM Committee provides the primary oversight of utilization management through review of:

- Clinical Services management program or UM program Description
- Annual UM Work Plan and Goals
- Semi-annual service reports
- Member satisfaction survey results (or reports on member satisfaction)
- Inter-rater reliability studies
- Program Description

RS-UM Committee makes an annual evaluation to determine if UM delegation will be continued, rescinded or modified.

ASHN obtains NCQA certification which includes utilization management functions. The new NCQA designation for ASHN will be able to be used in lieu of defined oversight requirements for the Hawaii Region. ASHN continues to maintain their NCQA certification, which includes utilization management functions.

**XIV. Confidentiality, Conflict of Interest and Conflict of Care**

To assure that patient and provider confidentiality is protected, the Regional and Hospital UM Departments maintain all copies of UM related data and documents in a strictly confidential manner. Access to this information is restricted on a need to know basis. Utilization Management is legally protected from discovery pursuant to §624-25.5, Hawaii Revised Statutes

The Regional Resource Stewardship and Utilization Management Department manages privileged and confidential information. Persons involved in review activities must safeguard sensitive information regarding patients and practitioners. Medical information and records related to review activities are securely maintained. Employees are required to follow the Hawaii Region confidentiality policy: (Confidentiality of Patient and Employer Information - # SP39-09). Breach of this policy may result in disciplinary action up to and including termination.

**CONFLICT OF INTEREST**

HPMG practitioners and contracted consultants do not review care they have directed. The peer review process provides a mechanism for appropriate review of any medical necessity issue.

**CONFLICT OF CARE**

If situations arise where patient care is in conflict with established criteria for utilization review, treatment and discharge decisions will be made by the attending physician, based on clinical judgment in response to the care required by the patient.
The Hawaii Region Resource Stewardship Program shall be applied equitably and in compliance with existing Kaiser Permanente governance and administrative policies. Care will be based on quality and appropriateness of care, and not be restricted based only on cost.

XV. Program Evaluation

A. The overall evaluation of the effectiveness of the RS-UM Program in KPHI is conducted annually by the Resource Stewardship-Utilization Management Committee. The UM Program is evaluated annually during the first quarter of each year to assure that the program is effective in meeting its objectives to monitor, evaluate, and improve use of the organization’s resources.

B. The UM Work Plan is evaluated and approved annually by RS-UM Committee. Recommendations are reviewed and appropriate revisions are made to the UM Program Description during the first quarter. Member and provider satisfaction with Utilization Management activities will be included in the UM Program Evaluation.

C. A RS-UM report, including evaluation of the RS-UM Program is provided twice a year to the Regional Quality Committee.
APPENDIX A

APPROPRIATE PROFESSIONALS
KP HI’s General Policy Regarding Staff Involved in Utilization Decisions (Policy #6425-03-003) identifies the key staffing requirements by role, qualification and responsibility. The following table is taken directly from the policy document:

<table>
<thead>
<tr>
<th>Role</th>
<th>Qualification</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>Director of UM Services and Physician Advisors</td>
<td>MD or DO</td>
<td>Makes all medical necessity denials. The physicians occupying this role, in collaboration with the attending physician, will review selected cases as directed by staff for appropriateness of admission, level of care, continued stay, and repatriations/referrals based on approved criteria as appropriate. These services are provided to the Hawaii Region to inpatients and outpatients.</td>
</tr>
<tr>
<td>Manager, Utilization Management, Kaiser Foundation Hospital</td>
<td>RN</td>
<td>Responsible for supervision of utilization management components (e.g., hospital review, discharge planning) and day-to-day management of the Kaiser Foundation Hospital Utilization Management staff Collaborates with the UM Physician Advisors on utilization issues</td>
</tr>
<tr>
<td>Continuing Care Coordinators</td>
<td>RN</td>
<td>Provides utilization management and discharge planning services to hospital patients, Emergency Department (ED), Ambulatory Treatment Center, Surgi-Center, PACU and Skilled Nursing Facility (SNF). Authorizes services based on approved criteria. Refers all potential medical necessity denials to a UM Advisor Physician. Communicates denials, as indicated.</td>
</tr>
<tr>
<td>Extended Care Coordinators</td>
<td>RN or LPN</td>
<td>Provides utilization review of Skilled Nursing Facility (SNF) patients in internal and external extended care facilities (ECF). Authorizes services based on approved criteria. Refers all potential medical necessity denials to a UM Advisor Physician. Communicates denials, as indicated. Coordinates transfers of inpatients and members in the community to ECF’s.</td>
</tr>
<tr>
<td>Role</td>
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<tr>
<td>Hospital Operations Center (HOC)/Outside Services UM &amp; Transfers Coordinator staff</td>
<td>RN</td>
<td>Provides case management and repatriation services to patients admitted to non-Kaiser Oahu facilities. and in addition authorizes services based on approved criteria. Communicates denials Establishes repatriation priorities and assist with repatriation to Kaiser Moanalua (MOA) hospital when appropriate, refers questionable cases to the appropriate Physician.</td>
</tr>
<tr>
<td>Authorization &amp; Referrals Management Staff</td>
<td>RN</td>
<td>Makes initial determinations for out-of-plan ER visits to non-designated hospitals and refers those for medical necessity determinations to Medical Director, Affiliated Care. Is responsible for the oversight of referral authorization process. Uses internally developed criteria to screen referrals for appropriateness.</td>
</tr>
<tr>
<td>Home Health Administrator</td>
<td>Bachelor’s Degree</td>
<td>Responsible for supervision and management of Kaiser Home Health Agency on Oahu and Maui. Collaborates with Home Health Medical Director on utilization issues.</td>
</tr>
<tr>
<td>Neighbor Islands Case Coordination</td>
<td>RN</td>
<td>Oversees acute nonKFH hospital discharge planning for neighbor island facilities. Authorizes services for Home Health, and rehabilitation for neighbor islands.</td>
</tr>
<tr>
<td>Maui Case Manager- Care Coordinator,</td>
<td>RN</td>
<td>Performs daily rounding and discharge planning at Maui Memorial Medical Center Authorizes services based on approved criteria. Refers questionable cases to the appropriate Physician. Communicates denials as indicated.</td>
</tr>
<tr>
<td>Kona Case Manager - Care Coordinator</td>
<td>RN</td>
<td>Provides discharge planning services at Kona Community Hospital Authorizes services based on approved criteria. Refers questionable cases to the appropriate Physician. Communicates denials, as indicated.</td>
</tr>
<tr>
<td>Hilo Case Manager – Care Coordinator</td>
<td>RN</td>
<td>Provides discharge planning services at Hilo Medical Center and North Hawaii Community Hospital. Authorizes services based on approved criteria. Refers questionable cases to the appropriate Physician. Communicates denials, as indicated.</td>
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<tr>
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<tr>
<td>Coordinator, DME Benefits</td>
<td>Associates Degree</td>
<td>Collects data for preauthorization and concurrent review for DME for all islands. Supervised by an RN. Approves DME based on criteria. Refers questionable cases to the appropriate clinical professional for clarification, or to the MD for denials.</td>
</tr>
<tr>
<td>Coordinator, Transportation, Meals, Lodging, Hearing Aides, Medical Supplies (QUEST)</td>
<td>High School Diploma</td>
<td>Collects data for preauthorization and concurrent review. Supervised by an RN. Approves requests based on criteria. Refers questionable cases to the appropriate clinical professional for clarification, or to the MD for denials.</td>
</tr>
<tr>
<td>Manager, Behavioral Health Services</td>
<td>LCSW</td>
<td>Responsible for supervision of Behavioral health Services utilization management components. Collaborates with the UM Physician Advisors on utilization issues. Provides oversight regarding health plan policies and benefits for Behavioral Health and Chemical Dependency to internal providers and practitioners.</td>
</tr>
<tr>
<td>Behavioral Health UM Coordinator</td>
<td>LCSW</td>
<td>Performs concurrent utilization review for outpatient mental health and chemical dependency services for internal services. Approves services based on criteria. Makes initial determinations for all levels of out-of-plan visits to non-designated hospitals/providers for BHS and chemical dependency services and refers those for medical necessity determinations to designated UM physicians. Is responsible for the oversight of referral authorization process. Uses internally developed criteria to screen referrals for appropriateness. Provides oversight regarding health plan benefits for Behavioral Health and Chemical Dependency to internal providers and outside practitioners. Refers medical necessity determinations to the Chief of Behavioral Health Services.</td>
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Kaiser Permanente – Hawaii Region

**Resource Stewardship-Utilization Management**

**Program Description**

**Kaiser Permanente – Hawaii Region**

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<tr>
<th>Role</th>
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</table>
| BHS Call Center Triage Staff | LCSW, Psychologist, CNS, MD | Performs screening and assessment primarily through telephone and/or face to face contact with the member by KP Call Center staff members, or by a Behavior Medicine Specialist located in the primary care clinic, or by an assigned staff member. Obtains and documents the following minimum information on Health Connect screening form:  
  - The presenting problem;  
  - Current symptomatology  
  - Previous psychiatric history, if any  
  - Potential for imminent harm to self or others  
  - Basic demographic information and  
  - Substance abuse history  
  Schedules an appointment with Behavioral Health, Behavioral Medicine or Chemical Dependency if it is determined that the member is eligible for services. Clinical guidance is provided by the Chief of BHS. |

In addition to these roles, the overall Utilization Management structure is supported by:

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<th>Role</th>
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<tbody>
<tr>
<td>QUEST Outreach Nurse</td>
<td>RN</td>
<td>Identifies QUEST members who require case management in the home, clinic or hospital. Assesses needs and develops plan of care in the outpatient setting in collaboration with clinical staff. Serves as a resource person for QUEST benefits and coverage issues.</td>
</tr>
<tr>
<td>Neighbor Islands QUEST Case Manager</td>
<td>LPN</td>
<td>Collaborates with the Kaiser’s Maui Case Manager, QUEST Outreach Nurse, and inpatient staff at Maui Memorial Medical Center for discharge planning. Assists with outpatient case management as directed by the QUEST Outreach Nurse. Serves as a resource person for QUEST benefits and coverage issues.</td>
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</table>
This Program Description was reviewed and approved at the Quality Committee on

Date

Karen Ching, MD
Associate Medical Director, Quality
Hawaii Permanente Medical Group, Inc.

Leanne Hunstock
Vice President for Quality and
Chief Operating Officer, Care Delivery
Kaiser Foundation Health Plan, Inc.