Provider Manual

- Utilization Management
- Care Management

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This section of the Manual was created to help guide you and your staff in working with Kaiser Permanente’s Resource Stewardship and Utilization Management (RS/UM) Program policies and procedures. It provides a quick and easy resource with contact phone numbers, important websites and detailed processes for UM services.

If, at any time, you have a question or concern about the information in this Manual, you can reach our Provider Relations Department by calling 503-813-3376.
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Section 4: Utilization Management

4.1 Overview of UM Program
The Kaiser Permanente Resource Stewardship and Utilization Management (RS/UM) Program has been designed to ensure the following:

1. Services are medically necessary, consistent with the patient’s diagnosis, and delivered at appropriate levels of care.
2. Authorized care matches the member’s benefit.
3. Services are provided by NWP or its contracted providers unless otherwise authorized.
4. Guidelines, standards, and criteria set by regulatory and accrediting agencies are adhered to as is appropriate to health plan product and specific population (e.g. Commercial, Medicare, Medicaid):
   - KPNW uses written, current versions of criteria based on sound clinical evidence to make RS/UM decisions (e.g., Milliman Care Guidelines, InterQual, and those developed by NWP) taking into account the local delivery system and members’ individual circumstances.
5. The UM team of physicians, licensed staff, and unlicensed staff are trained and qualified to assess clinical information used to make UM decisions. Appropriately licensed health professionals supervise all review decisions.
6. A written RS/UM Work Plan and Program evaluation are approved annually by the Regional Operations Quality Group (ROQG).

Utilization Review decision-making is based only on appropriateness or medical necessity of services and the existence of coverage. Kaiser Permanente does not specifically reward practitioners or other individuals for issuing denials or coverage or service care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

4.2 Medical Appropriateness
All Utilization Review (UR) medical necessity criteria (MNC) purchased or developed are based on medical evidence; on a consensus of relevant health professionals; and/or, are imposed by a funding source. UR MNC used are adopted with input/oversight of application by NWP MDs with clinical expertise in the area of service for which the MN criteria apply. All UR MN Criteria have an associated policy, UR Criteria (UR 1), describing how to apply the criteria. UR MN Criteria developed within KPNW have documentation of objective medical evidence which is noted in the bibliography section of each UR Criteria document.

While written MN criteria direct UR decisions, physicians involved in making medical necessity determinations utilize clinical expertise, knowledge of availability of resources/services in the local system, and supporting clinical information that may include consultation with a board-certified specialist in making coverage decisions. As outlined in the Regional UR Medical Necessity Policy (UR 4) and in all UR Department
policies, staff and physicians involved in review processes review appropriate clinical information sent with the request for service, access the patient’s electronic or paper medical record, and/or consult with the ordering clinician.

Staff and physicians involved in approval or denial processes will review appropriate clinical information for the individual patient involved, both from clinical information sent with the request, and/or by accessing the patient’s electronic record, and/or by consultation with the ordering clinician. Information may include but is not limited to lab results, consultations, history and physical examination reports, medication history and imaging reports. Physicians involved in medical necessity determinations will utilize clinical expertise, knowledge of availability of resources/services in the local delivery system, and supporting clinical information related to the patient’s individual needs and safety (age, co-morbidity, complications, and progress of treatment, psychosocial and home environment, as applicable). Clinical considerations may include consultation with a board-certified specialist. Clinical criteria are available to practitioners and members upon request.

Appropriate reviewing personnel include:

Approve: Medical Necessity reviews maybe approved by a designated pharmacist, pharmacy technician, Physician Assistant, Nurse Practitioner, Registered Nurse, Medical Assistant, Social Worker, PhD or any other properly trained licensed or unlicensed staff.

Denial: Medical Necessity denials are completed by a physician whose education, training or professional experience is appropriate, and who is practicing with an unrestricted license (see additional requirements below). Denials for Oregon members may only be made by an Oregon licensed MD or DO. Chiropractic determinations for the Washington Commercial mandated chiropractic benefit and Medicare chiropractic medical necessity denial determinations may be performed by a chiropractic practitioner.

4.3 “Referral” and “Authorization”

Referral: When a provider wishes to send a Member for a specific service, the Provider issues a referral.

Authorization: The Company, Kaiser Permanente, must authorize all referrals requiring pre-authorization or prospective review and must authorize all referrals being made to providers outside of Kaiser Permanente.

All requests for medical services to be provided outside of Kaiser Permanente are processed through Regional Referral Services. Referral requests are generated electronically through the HealthConnect electronic medical record. Members are notified in writing of the decision to approve or deny a request for referral to medical services outside of the Kaiser Permanente program.
4.4 Referral Policy and Procedure
Requests for referral for medically necessary services may be initiated by the Kaiser Permanente clinician or the community clinician providing medical services through an authorized referral. Most medical and diagnostic services are available within the Kaiser Permanente program or our network of preferred providers. Members are referred to the preferred provider network or community resources when the medically necessary services are not available within the Kaiser Permanente program.

4.4.1 Admission to Skilled Nursing Facility (SNF)
Authorization for SNF admission must be obtained through the SNF placement coordinator at 503-499-5438.

4.4.2 Home Health/Hospice Services
Authorization for Home Health and Hospice Services must be obtained through the Continuing Care Services Utilization Manager at 503-499-5253.

4.4.3 Durable Medical Equipment (DME)
All DME and prosthetics & orthotics require preauthorization by the DME department. An authorization is created by the DME department after an order is received from a Kaiser Permanente Northwest Clinician and it has been determined that the member meets the medical criteria for the specific DME item.

Authorization letters are sent directly to the member or to the DME provider. If additional items are needed or any change is needed in the authorization, approval must be obtained by the DME provider prior to dispensing the item. DME providers can address any questions they have to the DME department by calling 503-813-4550.

4.5 Provider Receiving Authorization
Upon receipt of an approved Authorization Form, you should:

1. Place the copy of the Authorization Form in the Member’s chart
2. Forward all work-up results to the referring Provider with any other pertinent clinical information pertaining to the consultation, and call the referring Provider, if your findings are urgent.
3. If you believe the Member will require continued treatment or additional care beyond what is authorized, you must submit a new Referral Request to the Referral Department at 503-813-4560.

4.6 Concurrent Review Process
Concurrent review occurs when a member is in the process of receiving care and an evaluation for the continuation of care is conducted. Concurrent reviews generally occur when a member is receiving inpatient care or ongoing ambulatory care which
required prior authorization initially or post stabilization care after an emergency. Often an extension of services is being requested. Clinical staff within the respective departments (i.e. nurse reviewers/UM coordinators in Mental Health for inpatient services, DME staff for DME requests, referral center staff and nurses for referral extensions to non KPNW practitioners) review and involve designated physician reviewers as require. Any services that are denied must be reviewed by the designated physician reviewer prior to issuing the denial.

4.7 Appeals
Members or the member’s representative may file an appeal to have a complaint or adverse determination reviewed again by sending their appeal to Member Relations, or may contact Membership Services at 503-813-2000 (Portland area) or 1-800-813-2000 (all other areas) for information on how to initiate an appeal. Members are also notified of the complaint, grievance and appeal processes in their evidence of coverage distributed annually.

Denials:
When a medical necessity denial is made using approved UM criteria or the UM decision is made by a practitioner in a UM Advisor role, written notification to the referring clinician specifies the title and credentials of the reviewer, complete applicable criteria used in reaching the decision, applicable contractual provisions and policy upon which the decision was based, specific appeals rights, and regulatory and group specific required language. The notification also includes information on how to contact the reviewer who made the decision so that if you want to discuss the case you may do so.

Practitioner appeals
If the physician or practitioner does not agree with a care or service decision, he or she may appeal the decision. Instructions for how to appeal are provided in the letter you receive, or you may contact Membership Services for information on how to initiate an appeal.

Expedited reviews
Initial requests, grievances, and appeals are expedited according to the clinical urgency of the situation. Requests will also be expedited if a physician states a need based on the member’s medical condition.

Independent medical review
If the appeal process within Kaiser Permanente has been exhausted, an appeal may be eligible for an independent review. If the independent review organization (IRO) determines that the member’s case qualifies for an independent medical review, medical experts not affiliated with Kaiser Permanente will conduct the review. There is no charge to the member for this review, and Kaiser Permanente will honor the decision made by the IRO.

Contacting Membership Services:
4.8 Case Management
Kaiser Permanente case managers work with treating Providers to develop and implement plans of care for acutely ill, chronically ill or injured Members. KP case management staff may include nurses and social workers, who assist in arranging care in the most appropriate setting and help coordinate other resources and services. The Member’s PCP is responsible for approving the plan of care and reviewing it with Kaiser Permanente case management at regular intervals.

4.9 Disease Management and Clinical Practice Guidelines
KPNW Disease Management Programs are coordinated services designed to help members and practitioners manage chronic diseases. These programs include asthma, coronary artery disease, depression, congestive heart failure, and diabetes. Interventions for each program are based on stratification, and range from education and self-care tools to comprehensive case management. The programs provide resources for condition monitoring, patient adherence to treatment plans, management of co-morbidities, and lifestyle education. Each of the programs are based on programs designed by the KP Care Management Institute (CMI), a sister organization of KP that develops and maintains evidence-based clinical practice guidelines, designs disease management models of care, and collaborates with KP health plans in the development of appropriate indicators and the provision of comparative data. CMI is certified for Disease Management Program design by the National Committee for Quality Assurance (NCQA).

Eligible members for each program are identified through various avenues including referral, diagnoses, laboratory results, pharmacy information and hospital admission. The Kaiser Permanente Data Warehouse stores information from various systems. Based on certain criteria eligible members are added to the registries of the respective programs.

It is important that you be aware of these services both to integrate them with your current clinical care and to facilitate member participation. These programs evolve each year as new medical knowledge, new services or staff, and new technology become available.
KPNW enrolls members for this program using an opt-out method. Members may be disenrolled upon their request or the request of their primary care clinician.

For information about any of the disease management programs, case management, and other population care initiatives contact Population Care Support at 503-813-2744. To refer a member to a disease management program contact Membership Services at 503-813-2000.

KPNW supports the development and use of evidence-based clinical practice guidelines and practice resources to aid practitioners, providers, and members in the selection of the best prevention, screening, diagnostic and treatment options. The best options are those that have a strong basis in evidence regarding contribution to improved clinical outcomes, quality of care, cost effectiveness, and satisfaction with care and service. These guidelines recommend the preferred course of action while recognizing the role of clinical judgment and informed decision making in determining exceptions.

For more information on clinical practice guidelines and practice resources, contact the Director of Guidelines and Evidence Based Medicine at 503-813-2744.

4.10 Drug Formulary

The KP Regional Pharmacy utilizes the formulary system and evidence-based decision making to determine which medications will be made available for practitioners to order for patients. Criteria for choosing medications to be included in the formulary are, in order of priority: safety, efficacy, and cost. Drugs are listed by the product our pharmacies dispense which may be brand or generic.

The KPNW Regional Formulary & Therapeutics Committee (RFTC) reviews and maintains the Pharmaceutical Management procedures and formulary determinations on an ongoing basis. On a monthly basis, the RFTC reviews medications for addition to or deletion from the formulary. Any practitioner may petition to have a medication added to the formulary. An exception process is in place to request the use of a non-formulary drug when deemed appropriate by the practitioner.

The RFTC Formulary is available for review on the KPNW web at kp.org which is accessible to all members, practitioners, and providers. Updates are posted to the website monthly. Individuals not having internet capability may request print copies by contacting the Pharmacy Department as noted below.

For more information about the KPNW Formulary Process or other Pharmaceutical Management Policies and Procedures, including Enhanced Criteria Based Prescribing, co-payment requirements and any other restrictions and/or limitations, or to obtain a copy of the KPNW drug formulary, contact Pharmacy Services at 503-261-7900, toll free at 1-888-572-7231 or via fax at 503-261-7978.