

Utilization Management & Authorization

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9.1 Overview

Utilization Management (UM) within Kaiser Permanente Mid-Atlantic States (KPMAS) is a collaborative partnership between Mid-Atlantic Permanente Medical Group (MAPMG) practitioners and UM staff to ensure appropriate treatment plans and resources is utilized in the management of member's health care needs throughout the care continuum.

The UM Department is organized around three Service Areas (Baltimore, District of Columbia/ Suburban Maryland (DC/SM), and Northern Virginia (NOVA)) and the Utilization Management Operations Center (UMOC). The UM activities within each service area include inpatient and ambulatory case management (ACM), hospital utilization management and SNF utilization management. Collectively, these areas implement the UM Program for medical, surgical, and behavioral health care rendered to KPMAS members. Registered Nurses and Referral Management Assistants at the Utilization Management Operations Center (UMOC) process outpatient and durable medical equipment referrals, set up home care services, coordinate emergency department visits and non core and out of area facility admissions. Physical Therapy Resource Specialist (PTRS) review clinical appropriateness of members requiring functional and mobility needs for durable medical equipment, physical, occupational, and speech therapies.

9.2 Attestation Regarding Decision-Making and Compensation

Utilization Management Affirmation Statement

Kaiser Permanente practitioners and health care professionals make medical decisions based on the appropriateness of care, service and existence of coverage for members' medical needs.

Kaiser Permanente does not compensate anyone for denying coverage or service and does not use financial incentives to encourage denials. In order to maintain and improve the health of our members, all practitioners and health professionals should be especially diligent in identifying any potential underutilization of care or service.

9.3 Utilization Management Approved Medical Coverage Policies and Guidelines

KPMAS UM utilizes and adopts nationally and regionally developed medical policies, and commercially recognized criteria sets. Additionally, expert medical opinion of subject matter experts certified in the specific field of medical practice are sought in guideline development process.

UM criteria are not designed to be the final determinate of the need for care, but are based upon local practice patterns and are applied based upon the needs and stability of the individual patient. In the absence of applicable guidelines the UM staff refers the case for review of appropriateness to a licensed, board-certified practitioner in the same specialty as the requested service. The reviewing practitioners base their

determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, on the needs of individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system.

KPMAS adheres to Medicare rules and regulations for medical necessity determinations for applicable services such as skilled nursing facility (SNF), acute rehabilitation, home health, hospice, DME, prosthetics and orthotics, ambulance transportation for all Medicare beneficiaries.

Adopting Emerging Technology for UM Referral Management

The Kaiser Permanente Interregional New Technologies Committee (INTC) performs the formal assessment of emerging technologies. The membership of this national committee includes board certified physicians, ethicists, and medical-legal experts. Committee members base their assessment of new technology on evidence published in peer reviewed medical journal, recommendations from federal health and regulatory agencies, clinical experts both internal and external to the Permanente Medical Groups. The Region’s Technology Review and Implementation Committee (TRIC) evaluate and implement the decisions of the INTC. The membership of this committee includes board certified physicians, nurses and KP operations leaders knowledgeable regarding benefits and contract administration. Informing practitioners and health plan benefits administrators of the medically appropriate use of a new medical technology is the primary mission of the Region’s Technology Review and Implementation Committee.

The Technology Review and Implementation Committee (TRIC) subgroup is co-chaired by the UM Physician Director of Referrals and Medical Policies in partnership with the Director of UM are responsible for overseeing the implementation of emerging technology adopted by the Region. This subgroup consists of various functional disciplines within the organization. Each member plays a vital role in the implementation stage of the adopted technology.

<ul style="list-style-type: none"> ▪ Utilization Management ▪ Diamond Configuration ▪ Pharmacy ▪ Claims Administration ▪ Credentialing 	<ul style="list-style-type: none"> ▪ Contract ▪ Legal and Compliance ▪ Products and Benefits ▪ KP HealthConnect Applications ▪ Delivery System
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UM Approved Criteria Sets and Specialty Referral Guidelines

(As of June 7, 2011)

Service Type	UM Approved Criteria Sets
Acute Rehabilitation	<ul style="list-style-type: none"> ☑ Medicare Benefit Policy Manual Chapter 1: Inpatient Hospital Services Covered Under Part A. Section 110 - Inpatient Rehabilitation Facility (IRF) Services ☑ Milliman Guidelines TM
Durable Medicare Equipment	<ul style="list-style-type: none"> ☑ Medicare National/Local Coverage Determination Policies
Home Health Services	<ul style="list-style-type: none"> ☑ Medicare Benefit Policy Manual Chapter 7: Home Health Services ☑ Milliman Guidelines TM

Service Type	UM Approved Criteria Sets
Inpatient Services	<input checked="" type="checkbox"/> Milliman Guidelines TM
Neonatal Care	<input checked="" type="checkbox"/> KP Revised Milliman Guidelines TM NICU Levels
Outpatient Services	<input checked="" type="checkbox"/> KPMAS Medical Coverage Policies <input checked="" type="checkbox"/> Milliman Guidelines TM <input checked="" type="checkbox"/> Medicare National/Local Coverage Determination Policies
PT/OT/Speech Therapy	<input checked="" type="checkbox"/> Guide to Physical Therapist Practice <input checked="" type="checkbox"/> Medicare National/Local Coverage Determination Policies <input checked="" type="checkbox"/> Milliman Guidelines TM
Skilled Nursing Facility	<input checked="" type="checkbox"/> Medicare Benefit Policy Manual Chapter 8: Coverage of Extended Care (SNF) Services <input checked="" type="checkbox"/> Milliman Guidelines TM
Transplant Services <ul style="list-style-type: none"> • Solid organs • Bone marrow • Stem cell 	<input checked="" type="checkbox"/> Interqual/ISP Criteria – Transplant and Hematology/Oncology <input checked="" type="checkbox"/> National Transplant Network Services Member Selection Criteria

Medical Coverage Policies (As of June 9, 2011)

- Acupuncture
- Ambulance Transportation
- Autologous Stem Cell Cardiomyoplasty
- Benign Skin Lesion Treatment Version II
- Biofeedback
- Blepharoplasty
- Botulinum Toxin Type A and B
- Breast Reduction Surgery
- Capsule Endoscopy
- Cardiac Rehabilitation
- Circumcision (Non-newborn)
- Compression Garment for Upper and Lower Extremities
- Continuous Passive Motion (CPM)
- Cranial Remodeling Bands and Helmets
- Foot and Ankle Orthotics
- Genetic Testing
- Hyperbaric Oxygen
- Infertility Procedures and Services
- Intensity Modulated Radiation Therapy (IMRT) for Prostate Cancer
- Interspinous Process Decompression System (X STOP)
- Intradiscal Electrothermal Therapy (IDET) For Discogenic Pain
- Morbid Obesity/Bariatric Surgery for DC, VA, Federal
- Morbid Obesity/Bariatric Surgery for Maryland
- Oncotype DX Assay
- Panniculectomy
- Pulmonary Rehabilitation
- Spinal Cord Stimulation for Pain Management
- Surgery for Pectus Excavatum
- Treatment of Vitiligo
- Varicose Veins
- Virtual Colonoscopy - D.C, Federal, Virginia
- Virtual Colonoscopy - Maryland

There are several ways to access the UM criteria sets, national guidelines and referral specialty guidelines.

- The Utilization Management Operations Center (UMOC) can be reached during regular business hours, to request copies of the criteria sets, national guidelines and referral specialty guidelines
- Medicare based national medical policies applicable for Medicare members, and DME for commercial members are accessible through the Centers for Medicare and Medicaid Services (CMS) website, in the Medicare national database for national and local determinations. This includes outpatient and DME services.

- For MAPMG and KPMAS physicians and staff, access to the Kaiser Permanente e-Clinical Library on the KPMAS Intranet
- Community based or network providers have access to the Kaiser Permanente referral guidelines through the MAPMG website portal:
<http://providers.kp.org/mas/index.html> - go to the authorization folder and look for the specialty referral guidelines

9.4 **Accessibility of Utilization Management**

The Kaiser Permanente Utilization Management Department ensures that all members and providers have access to UM staff, physicians and managers 24 hours a day, seven days a week. The table below describes the hours of operations.

Specific UM Area	Hours of Operation	Responsibilities
Utilization Management Operations Center (UMOC) - Telephonic Admission and Concurrent Review Team (TACT)	Monday to Friday 8.30 A.M. to 5 P.M.	<ul style="list-style-type: none"> • Perform concurrent review for members in non-core and out of area facilities. • Support non-core facilities with transition management care needs
Utilization Management Operations Center (UMOC)– Emergency Care Management (ECM)	24 hours/day, weekends and holidays	<ul style="list-style-type: none"> • Process requests for emergency services for members at non core and/or out of area facilities. • Process transfer requests for members who need to be moved to different level of care including emergency rooms, inpatient facilities, and Kaiser Permanente Medical Centers. • Enter referrals for all in-patient admissions received from core and non-core facilities. • Process transfer requests for members needing behavior health admissions. • Support all cardiac transfers for level of care needed. <p>Note: Patients receiving emergency services (ER) at the core facilities are managed by the Mid Atlantic Permanente Medical Group (MAPMG) Hospitalists. Core facilities include: Holy Cross Hospital, Washington Hospital Center, Greater Baltimore Medical center, and</p>

Specific UM Area	Hours of Operation	Responsibilities
		Fairfax Inova Hospital
Utilization Management Operations Center (UMOC) - Outpatient, and Clinical Trial	Regular business hours Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> • Conduct Pre-service review, concurrent review of outpatient services, and post-service review of non-emergency services
Utilization Management Operations Center (UMOC) - Durable Medical Equipment (DME), Home Care	Regular business hours Monday through Friday 8:30 A.M. to 5:00 P.M. Saturday, Sunday and holidays 11:00 A.M. to 3:00 P.M.	<ul style="list-style-type: none"> • Conduct Pre-service review, concurrent review of Home Care and DME
UM Core Hospital Services – Non Behavioral Health	Monday to Friday: 8:30 A.M. to 5:00 P.M. Weekends and Holidays: 8:00 A.M. to 4:30 P.M.	<ul style="list-style-type: none"> • Conduct concurrent review and transition care management
UM Hospital: Services: Skilled Nursing Facility (SNF) and Rehabilitation services	Regular business hours Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> • Conduct concurrent review and transition care management
UM Hospital Services – Behavioral Health	Monday to Friday: 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> • Conduct concurrent review and transition care management services of behavioral health members
UM Outpatient Services – Behavioral Health	Monday to Friday: 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> • Conduct Pre-service review and concurrent review of members requiring outpatient services
Ambulatory Case Management (ACM) Program	Regular business hours Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> • Conduct outpatient medical case management and care coordination

9.5 Utilization Management Operations Center (UMOC)

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

- Authorization services for planned inpatient, outpatient or office care are available Monday-Friday (excluding holidays) from 8:30 A.M. to 5:00 P.M.
- Emergency Department visits can be phoned to 1-800-810-4766 or faxed to 301-879-6192 or entered on Affiliate Link 24 hours a day/7 days a week.
- Emergency Care Management located at the Utilization Management Operations Center (UMOC) is available 24-hours/day on weekends and holidays. It is designed to manage Kaiser Permanente members who have been admitted to non-core and/or out of area admissions to facilities around the country.

Registered Nurses at the Utilization Management Operations Center (UMOC) work collaboratively with licensed, board-certified UM Physician Managers and practitioner in managing the patient's medical, surgical, or behavioral health care through telephonic utilization review of requested services and equipment, and by coordinating care across the continuum.

The following services are coordinated through the Utilization Management Operations Center (UMOC):

<ul style="list-style-type: none"> ▪ Medical, surgical, or behavioral health care admissions to acute care facilities; ▪ Medical, post-surgical, or behavioral health care admissions to sub-acute care facilities; ▪ Concurrent review of out-of-area medical, surgical, or behavioral health care inpatient hospitalizations ▪ Retrospective review of inpatient acute care that was not pre-authorized ▪ Ambulance transports ▪ Urgent care 	<ul style="list-style-type: none"> ▪ Emergency Room visits ▪ Home care ▪ Durable medical equipment ▪ Follow-up primary care practitioner or behavioral health care practitioner visits ▪ Specialty referrals (including radiology and laboratory) outside KPMAS centers ▪ Repatriation from non-core to core facilities ▪ Provider call- in line for member information and triage
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Pre-service review is required for selected procedures and services. This process is administered at the Utilization Management Operations Center (UMOC). RNs (Referral and Durable Medical Equipment and Home Health nurses) and UM ancillary staff manage the referrals following KPMAS UM policies and procedures. Referrals requiring medical necessity review are forwarded to Board Certified UM Medical Directors. All UM Physicians are Certified Medical Directors by the State of Maryland.

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

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

9.6 Behavioral Health Services

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

9.7 Flexible Choice Plan

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

9.8 Specialty Care Physician Responsibilities

Participating Specialists receive referrals from both MAPMG Providers and KPMAS Participating Network Primary Care Physicians (PCPs) i.e. community primary care physicians who contract with Kaiser Permanente. Every member receiving services from a Participating Specialist must have an approved referral for that visit. Referral forms authorizing services will be faxed to the referred by and the referred to provider (unless otherwise requested by the referring provider) prior to the member's scheduled appointment. The member may request a copy of the approved referral from the referring provider. It is the responsibility of the specialist's office to ensure that Kaiser Permanente has the demographic and contact phone/fax numbers of the specialist office on file to ensure accurate and timely communication of referral information.

- Referrals received on Uniform Referral Requests are valid for ninety (90) days, except:
 - Obstetrics: valid for 270 days.
 - DME (Durable Medical Equipment): Referral will specify valid time period
 - Allergy: valid for 180 days
 - Chemotherapy: valid for 180 days
 - Radiation Therapy: valid for 180 days
 - Dialysis: valid for 365 days/1 year.
 - Dermatology: valid for 180 days
- Most Kaiser Permanente members (e.g. those in our Kaiser Permanente Signature and Kaiser Permanente Select plans) receiving services from a Participating Specialist must have an authorized initial consultation from their Primary Care Physician. Exceptions to this requirement may include members enrolled in Kaiser Permanente Flexible Choice when utilizing their Option 2 or 3 point of service benefit.
- Each referral has a unique referral number. This referral number must be reflected on the claim/bill for appropriate processing and payment.

- During the initial office visit, a specialist may perform whatever services are medically indicated (even if they are not specified on the referral form) provided the services:
 1. Are performed in your office and not in another facility or location
 2. Are performed on the same day as the initial office visit
 3. Are regarded as covered benefits under the member's health plan
 4. Do not appear on the list of services that require separate pre-authorization.
- Only one (1) visit is approved per referral, unless otherwise indicated on the referral form. We encourage our referring providers to use their clinical judgment and discretion in anticipating a reasonable number of visits that might be required for a particular consultation.
- Each approved referral is valid only until the identified expiration date is noted on the Kaiser Permanente Referral Summary Report.

Additional Visits, Care or Consultations

Following the initial authorized consultation, should the patient require additional visits, care and/or consultation with you or another provider, the Participating Specialist may initiate an extension to the initial referral and/or submit a new referral/authorization request directly by using one of the following options:

Option 1: Call the Utilization Management Operations Center (UMOC) at 1-800-810-4766 (follow the prompts) to request additional visits and/or an extension to an existing referral.

-OR-

Option 2: Participating Specialists with secure internet access to our "KP HealthConnect Online Affiliate" service may enter a referral message directly to the Utilization Management Operations Center (UMOC) to request *additional* visits on an existing referral or simply create a *new* referral request directly via the web (www.providers.kp.org/mas)

Following the initial approved consultation, should the patient require a referral to another provider, facility and/or a service requiring pre-authorization, the Participating Specialist may initiate a referral/authorization request directly by using one of the following options:

Option 1: Complete a Uniform Referral Form (URF) and fax it to the Utilization Management Operations Center (UMOC) at Fax 1-800-660-2019.

-OR-

Option 2: A Participating Specialist with secure access to "KP HealthConnect Online Affiliate" may enter a referral or authorization request directly via the web. (www.providers.kp.org/mas).

In all instances, after a participating specialist has received an approved referral and has determined that additional services are required, it is not necessary to contact the referring PCP for approval. Rather, the point of contact should always be directed to the

Utilization Management Operations Center (UMOC) as noted above by phone, fax or internet communication.

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

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

9.9 Self-Referred Services

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

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

9.10 Referral Management Procedures

Please review the steps below for three referral types:

- A. Specialist Care (No authorization required)
- B. Specialist Care (Authorization required)
- C. Standing Referrals
- D. Referring Members for Radiology Services

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

Step 1: VERIFY that the referral specialist is a Participating Provider

Step 2: VERIFY that the requested procedure DOES NOT REQUIRE AUTHORIZATION

Step 3: FAX

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

-OR-

A Primary Care Physician or Participating Specialist with secure access to “KP HealthConnect Online Affiliate” may enter a referral or authorization request directly via the web. (www.providers.kp.org/mas).

-OR-

A Primary Care Physician or Participating Specialists with secure internet access to our “KP HealthConnect Online Affiliate” service may enter a referral message directly

to the Utilization Management Operations Center (UMOC) to request *additional* visits on an existing referral or simply create a *new* referral request directly via the web (www.providers.kp.org/mas)

-OR-

MAIL

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

Provider Service Center
11921-B Bournefield Way Suite B
Silver Spring, Maryland 20904

Step 4

Give a copy of the referral form to the member to take to his appointment with the Participating Specialist

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

Step 1 - Verify that the procedure/service requires authorization

Step 2 - Determine if the specialist is a Participating Provider

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

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

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

Combined Referral Requirements:

1. Urgent Referrals: Determinations will be made within 24 hours of receipt of the request for **urgent referrals** submitted with appropriate documentation.
 - Questions on urgent referrals call ☎ 1 (800) 810-4766, follow the prompts.
2. Standard Referrals: **Standard referral requests** will be handled within two (2) working days of receipt of the information necessary to make the determination.
3. Once processed and approved, the referral form **with the authorization number** will be returned by fax to the Participating PCP and to the Participating Specialist. It is the responsibility of the Primary Care Physician office and Participating Specialist office to ensure that Kaiser Permanente has accurate fax numbers on file to ensure timely and efficient communication of referral information.
4. Participating Specialists must send a written report of their findings to the Participating PCP, and should call the Participating PCP, if their findings are **urgent**.

5. All consulting specialists' reports must be reviewed, initialed, and dated by the referring physician and maintained in the member's chart.
6. After an initial consult, if the Participating Specialist believes the member will require continued treatment, the Participating Specialist must submit a referral request to the Utilization Management Operations Center (UMOC)
7. For laboratory or radiology services, members should be directed to Participating laboratory or radiology providers, or to a Kaiser Permanente Medical Center.

C. Standing Referral Requirements (Authorization Required)

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

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

Standing referral to a specialist is provided if:

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

Written Treatment Plan

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

A treatment plan may:

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

Standing Referral for Pregnant Members

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

Referral to a Non-Participating Specialist

A member, primary care practitioner, or specialist may request a referral to a specialist who is not part of the Health Plan's provider panel (Non-Participating Specialist). Referrals to non-participating specialist must be provided if the member is diagnosed with a condition or disease that requires specialized medical care; **and**

1. The Health Plan does not have in its panel a specialist with the professional training and expertise to treat the condition or disease; **or**
2. The Health Plan cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel

D. Referring Members for Radiology Services

Kaiser Permanente provides Members with access to radiology and imaging services at our Medical Office Buildings, Imaging Centers, and through community-based providers within our Participating Provider Network.

Following patient consultation, Participating Providers should follow the procedures below when referring a Member for radiology services:

1. Provide the Member with a script for the necessary radiological/imaging service.
2. Instruct the Member to contact Kaiser Permanente to secure a radiology/imaging appointment.

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

9.11 Services Requiring Authorization

List of Services Which Require Kaiser Permanente Review

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

A. Acute Inpatient Services

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

* *Partial Hospitalization*

B. Elective Services

1. Abortions, Elective/Therapeutic
2. Acupuncture
3. Anesthesia for Oral Surgery/Dental
4. Any Services Outside Washington Baltimore Metro Areas
5. Assistive Technologies
6. Behavioral Health Services
7. Biofeedback
8. Blepharoplasty
9. Breast Surgery for any reason
10. Chiropractic Care
11. Clinical Trials
12. Cosmetic and Reconstructive or Plastic Surgery
13. CT – Scans (Computerized Tomography)
14. Dental Services Covered Under Medical Benefit
15. Durable Medical Equipment (DME)
16. Gastric Bypass Surgery, Gastroplasty
17. Home Health Care Services (Including Hospice)
18. Infertility Assessment and Treatment
19. Infusion Therapy and Injectables (Home IV, Excluding Allergy Injections)
20. Intensity Modulated Radiation Therapy (IMRT) – Modulated Therapy
21. Interventional Radiology
22. Investigational/ Experimental Services
23. Magnetic Resonance Imaging (MRI)
24. Narrow Beam Radiation Therapy Modalities
 - 24.1. Cyberknife
 - 24.2. Gamma Knife
 - 24.3. Stereotactic Radiosurgery
25. Nasal Surgery (Rhinoplasty or Septoplasty)
26. Non-Participating Provider Requests
27. Nuclear Medicine
28. Obstructive Sleep Apnea Treatment including Sleep Studies

29. Oral Surgery
30. Orthognatic Surgery
31. Outpatient Surgery –All Hospital Settings/Ambulatory Surgery Centers
32. Pain Management Services
33. Penile Implants
34. Positron Emission Tomography (PET) Scan
35. Podiatry Services
36. Post Traumatic (Accidental) Dental Services
37. Prosthetics/Braces/Orthotics/Appliances
38. Prostate Biopsies - Ambulatory Surgery Center or Outpatient Hospital Surgery Setting
39. Radiation Oncology
40. Rehabilitation Therapies
 - 40.1. Cardiac Rehabilitation
 - 40.2. Occupational Therapy
 - 40.3. Physical Therapy
 - 40.4. Pulmonary Rehabilitation Therapy
 - 40.5. Speech Therapy
 - 40.6. Vestibular Rehabilitation
41. Scar Revision
42. Sclerotherapy and Vein Stripping Procedures
43. Screening Colonoscopy – Consultations
44. Uvulopalatopharyngoplasty (UPPP)
45. Social Work Services
46. Temporo Mandibular Joint Evaluation and Treatment
47. Transplant Services – Solid Organ and Bone Marrow


9.12 Authorization Documentation Requirements






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


Refer to the table on Timeliness Guidelines for Decision Making and Notification of Decisions under section 9.13.



Documentation requirements

Note: Applicable CPT or HCPCS codes must be documented in the referral.

<i>Procedure</i>	<i>KPMAS Specialty Referral Guidelines</i>	<i>Documentation Required</i>
Acupuncture		PCP progress notes for initial referrals including descriptions of other types of treatments attempted; acupuncturist records may be requested for referrals requesting continuation of acupuncture treatment.

Procedure	KPMAS Specialty Referral Guidelines	Documentation Required
Biofeedback		PCP progress notes, including descriptions of other types of treatments attempted. Biofeedback records may be requested for referrals requesting continuation of biofeedback treatment.
Blepharoplasty		Visual field testing with and without the upper eyelids taped to relieve visual obstruction.
Breast Reconstruction		History of breast cancer and any previous surgery, actual expected date of surgery, facility where surgery will be performed.
Breast Surgery, not related to cancer		PCP notes, consultant notes, all pertinent clinical information.
Breast Mastectomy for Benign Conditions		Pathology reports, age at onset (for gynecomastia) and results of hormonal evaluation, actual or expected date of surgery, facility where surgery will be performed.
Breast, Reduction Mammoplasty		Patient age, height, weight, and frame size, estimate of grams of tissue to be removed from each breast, description of any medical problems related to size of breasts, history of any previous breast surgery, actual or expected date of surgery, facility where surgery will be performed.
Chiropractic services		X-Ray/MRI reports, PCP's notes documenting conservative medical treatment attempted, PT, medications.
Cosmetic/Plastic Surgery		Photographs of area to be operated, description of any functional impairment, history of injury or previous surgery, expected date/facility of surgery.
Durable Medical Equipment		<u>Medicare DME guidelines are to be followed as applicable.</u> Provider's name and tax ID number, expected date equipment will be delivered, description of equipment, physician notes or letter describing the member's condition and reason the equipment is required. HCPCS code(s) and charges for the equipment are also required.
Gastric Bypass Surgery, Gastroplasty	 Use applicable guideline by jurisdiction and	Member height and weight, body frame size, duration of obesity, history or weight loss methods that have been tried, behavioral health clearance for weight reduction surgery, complicating medical conditions, actual expected date of surgery, facility where surgery will be performed.

Procedure	KPMAS Specialty Referral Guidelines	Documentation Required
	Medicare	
Home Care and Hospice		PCP notes, treatment plan. For hospice – provide diagnosis that is expected to result in death in 6 or less months.
Infertility		Primary gynecology notes, ultrasound results, lab results.
MRI Substitutes for Angiography (any body part)		PCP notes, specialist progress notes, x-ray and laboratory reports.
MRI (Magnetic Resonance Imaging) (any body part)	MRI, Breast guideline available	PCP notes, specialist progress notes, x-ray and laboratory reports.
Nasal Surgery, Rhinoplasty		Date and type of nasal injury or trauma, history of breathing difficulties or problems, letter of medical necessity from attending physician, previous conservative medical treatment including medications and duration treated, actual or expected date of surgery, facility where surgery will be performed.
Nasal Surgery, Septoplasty		History of difficulty breathing through nose with types and dates of treatment, physician findings with estimate of airway obstruction for each side, history of ear, sinus or throat infections with types and dates of treatment, reports of any sinus x-ray or CT scans, expected date of treatment and facility where surgery will be performed.
Oral Surgery, TMJ Surgery		PCP notes, Specialist progress notes, x-rays and laboratory reports, arthrograms, CT scan reports.
Orthognathic Surgery		Narrative of member's impairment of speech and/or nutritional function, photographs, cephalometric x-rays, posterior-anterior view if asymmetry is identified, computer analysis may substitute for models, photos and x-rays (analysis must allow measurement of the SNA and SNB angles), actual or expected date of surgery, facility where surgery will be performed
Out of Area Service		PCP notes, Specialist notes, ER notes, x-ray and laboratory reports and Advice Call documentation.
Pain Clinic		Physician and Specialist progress notes including documentation of medication and therapeutic interventions, PT and OT record, x-

Procedure	KPMAS Specialty Referral Guidelines	Documentation Required
		rays and laboratory reports.
Penile Implants		History of disease process causing impotence, history or past and present alcohol or substance abuse, history of past or present psychiatric conditions and treatments, date and type of inquiry causing impotence, length of time member has been impotent, serum testosterone level, results of penile tumescence studies or rigiscan, documentation of failed medical treatment or contraindication to medical treatment, actual or expected date of surgery
Prosthetics, Braces, Orthotics, Appliances		PCP notes, consultant progress notes, x-ray and laboratory reports.
Rehabilitation Services		<u>Note:</u> Use applicable guideline for pediatric rehabilitation, habilitation, early intervention, cardiac or pulmonary rehabilitation (Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac, Pulmonary, Vestibular) PCP or Specialist notes to include history of medical condition which caused deficit, anticipated duration and frequency of treatment. Evaluation by licensed speech therapist (for speech therapy).
Scar Revision		Photographs of the scar and any impairment to be corrected, history relating to cause of scar and date of injury, complicating medical conditions and attempted treatment, actual or expected date of surgery, facility where surgery will be performed, description of any functional impairment caused by the scar.
Varicose Veins		Treatments – PCP and Specialist progress notes, x-rays and laboratory reports, doppler ultrasound study.
Sleep Lab Services		CPAP, UPPP, Laser UPPP – Clinical history and physical exams (including member's height, weight, pharyngeal exam, and treatment for obesity, if present), x-ray and laboratory reports, description of any surgical procedure proposed, CPT code(s), sleep lab report (including measurements), history of alcohol use, results of trial of abstinence from alcohol, facility and expected date of surgery, member response to trial of CPAP or BiPAP.

9.13 Denials & Appeals

Medical Appropriateness Determinations

Medically appropriate care is defined as care that is necessary for the diagnosis, treatment, and/or management of a medical, surgical, or behavioral health condition; within accepted standards of medical, surgical, or behavioral health care; and performed in a capable setting at the precise timing required to treat the patient.

For continued inpatient stays, the UM nurse (Patient Care Coordinator) evaluates the patient using approved UM criteria sets. Discharge plan is initiated on admission and regularly revisited based on the clinical status and needs of the patient. The attending physician, the health care team and the appropriate hospital staff are engaged in the discharge planning decision processes throughout the member's hospitalization stay. Most importantly, the member and/or the authorized representative are included in decision making.

Notification and Timeliness of Coverage Determination

The UM Department has policies and procedures to ensure that timely notifications are rendered for adverse decisions when care is determined to be not medically appropriate.

Notification is made through the following:

- Verbal notification is given to the member or authorized representative and the requesting provider after decision is rendered
 - Electronic or verbal notification includes information on how to contact a UM reviewer or UM physician, and how to obtain a copy of the UM criteria applied to make the decision
- Written notification is generated after the verbal notification is given
 - Written notification includes information on how to contact Member Services to file an expedited or standard appeal
 - Instructions where to obtain a copy of the UM criteria applied to make the decision
- Written notifications are hand-delivered (for inpatient or SNF onsite review) or mailed on the same day that the verbal notifications are made for Medicare members, or no later than the next day for commercial members

Timeliness of Decision and Notification

KPMAS is required to adhere to regulatory timeline requirements in decision making, verbal notification, and written notification according to the member's jurisdiction or lines of business. The processing of coverage determinations may differ for KPMAS members due to differences in regulations in Maryland, the District of Columbia and Virginia. In addition, Medicare and Federal jurisdiction members must follow their specific timeliness mandates. Processing of coverage determination also depend on the urgency of request, and to the type of review conducted: pre-service, concurrent, or post service review. The table below summarizes the timeliness requirements for all lines of business and jurisdictions.

Timeliness Guidelines for Urgent Concurrent Review and Notification

Jurisdiction	Determination Timeframe	Verbal, Telephonic or Electronic Notification	Written Notification
Maryland	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of receipt of request
Medicare	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of receipt of request
Federal, DC, VA	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of receipt of request

Timeliness Guidelines for Urgent Pre-Service Review and Notification

Jurisdiction	Determination Timeframe	Verbal, Telephonic or Electronic Notification	Written Notification
Maryland	Within 24 hours of request	Within 24 hours of request	1 day after verbal, telephonic or electronic notification is communicated to the member or health care provider
Medicare	Within seventy two (72) hours of receipt of request	Within seventy two (72) hours of receipt of request	Within seventy two (72) hours of receipt of request
Federal, DC, VA	Within seventy two (72) hours of receipt of request	Within seventy two (72) hours of receipt of request	Within seventy two (72) hours of receipt of request

Timeliness Guidelines for Non-Urgent (Routine) Pre-Service Review and Notification

Jurisdiction	Determination Timeframe	Verbal, Telephonic or Electronic Notification	Written Notification
Maryland	Within 2 business days of receiving all information necessary to make the determination	Within 1 business day of determination	Within 5 business days of determination
Medicare	14 calendar days of receipt of request	Within 1 business day of determination	14 calendar days of receipt of request
Federal,	15 calendar days	15 calendar days of	15 calendar days of receipt of

DC, VA	of receipt of request	receipt of request	request
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Timeliness Guidelines for Post-Service Review and Notification

Jurisdiction	Determination Timeframe	Verbal, Telephonic or Electronic Notification
All	Within 30 calendar days of receipt of request	Within 30 working days of receipt of request

- Participating Providers requesting reconsideration of a service denial on behalf of the KPMAS member may call ☎ 1-888-989-1144, and request to speak with the UM physician on-call within 24 hours of the verbal notification of the adverse decision.
- If more than 24 hours has elapsed, the Participating Provider or the member must file a formal grievance in order to obtain further review.

Grievance and Appeals Process

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

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

For non-Medicare Plus members, an expedited appeal may be initiated by following the timeframes below.

During normal business hours (7:30 a.m. to 5:30 p.m. Monday through Friday): Member Services	☎ (301) 468-6000 ☎ 1 (800) 777-7902 (toll free outside the local calling area) ☎ TTY (301) 816-6380 (available for hearing impaired)
Outside normal business hours (Evenings, Weekends, and Holidays): Appointments / Advice	☎ (703) 359-7878 ☎ 1 (800) 777-7904 (toll free outside the local calling area) ☎ TTY (703) 359-7616 // ☎ 1 (800) 700-4901
OR by faxing from 7:30 a.m. to 5:30 p.m. Monday through Friday (except holidays) ☎ (301) 816-6192	

For Medicare Plus members, an expedited appeal may be initiated by calling

From 8:00 a.m. to 8:00 p.m. 7 days a week	☎ 1 (888) 777-5536 (toll free) ☎ TTY 1 (866) 513-0008 (toll free available for hearing impaired)
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All other hours:	<p>☎ (703) 359-7878</p> <p>☎ 1 (800) 777-7904 (toll free outside the local calling area)</p> <p>☎ TTY (703) 359-7616 //</p> <p>☎ 1 (800) 700-4901</p>
<p>OR by faxing from 7:30 a.m. to 5:30 p.m. Monday through Friday (except holidays)</p> <p>☎ (301) 816-6192</p>	

Member Services will notify the member or Participating Provider as expeditiously as the medical condition requires, but no more than 24 hours to 72 hours after receipt of the request. Written confirmation of the disposition of the expedited appeal is sent within three (3) calendar days after the decision has been verbally communicated.

Reconsideration or Appeal

A reconsideration request or appeal should include the following information:

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

A nurse and/or physician who were not involved in the initial review and denial of the service will review the appeal. If it is determined that additional information is required to perform a thorough review, a staff member or the reviewing physician may contact you to request the information or to discuss the clinical issue. Once the necessary information has been received, the case will be reviewed and the Participating Provider will be notified verbally and in writing of the disposition of the appeal.

9.14 Emergency & Urgent Care

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

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

Participating PCPs are responsible for providing evaluation, triage, and telephone services 24 hours a day, 7 days a week. If the Participating PCP is unavailable, that Participating PCP's on-call back up will direct the member's care based upon medical necessity.

If a Participating PCP or coverage/on-call physician is unavailable, members may call Kaiser Permanente's Medical Advice Nurse by calling ☎ 1 (703) 359-7878 or ☎ 1 (800) 777-7904.

If, due to the nature of the problem, the member must be directed to a Hospital Emergency Department (ED), the Participating PCP should instruct the member to go to the Emergency Department of the nearest hospital. The Participating PCP should notify the ED physician that the member has been referred.

Referrals to the Emergency Department can be called or faxed to the Utilization Management Operations Center (UMOC) at ☎ 1 (800) 810-4766 or entered via KP HealthConnect AffiliateLink. The Referral Management Staff will document the referral no later than the next business day.

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

Ambulance Transport

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

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

9.15 Hospital & Facility Admissions

Admission Notification Requirements

All urgent and emergent admissions require notification within 24 hrs of the admission to the Utilization Management Operations Center (UMOC) by the Participating PCP, his/her agent, or the participating hospital/facility at ☎ 1 (800) 810-4766. Failure to notify Kaiser Permanente within this time frame may result in an administrative denial. The provider cannot hold the member financially responsible for lack of authorization or late notification. If the admitting physician is not the Participating PCP, it is the admitting physician's responsibility to contact the Participating PCP in order to authorize the admission and discuss plans for care.

Non-Emergency & Elective Admissions

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

Pre-Admission Notification Requirements

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

Emergency Admissions

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

- Step 1: Direct the member to a Kaiser Permanente participating facility where you have privileges, or to the nearest emergency room. (see Section 2 for listing)
- Step 2: Contact the Utilization Management Operations Center (UMOC) at ☎ 1 (800) 810-4766 and select the appropriate prompt, to immediately report the admission, 24-hours a day, and 7-days a week via voice mail, fax or Affiliate Link.
- Step 3: Provide the following information in your call or fax:
- Member Name
 - Member Identification Number
 - Name of the Referring Physician
 - Admitting Hospital or Facility
 - Admitting Diagnosis
 - Proposed Treatment and Length Of Service
 - Date of Admission

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

Emergency Department Visits

In order to expedite reimbursement, please follow these procedures:

Referring Members to the Emergency Room

- Step 1: Direct the member to a Kaiser Permanente Participating Facility where you have privileges, or to the nearest emergency room. (see Section 2 for listing)
- Step 2: Contact the Utilization Management Operation Center (UMOC)

_____ at ☎ 1 (800) 810-4766 and select the appropriate prompt, to immediately report the ED visit, 24-hours a day, and 7-days a week via voice mail, fax or via KP HealthConnect Affiliate Link.

Step 3: Provide the following information:

- Member Name
- Member Identification Number
- Name of the Referring Physician
- Admitting Hospital or Facility
- Complaint/Diagnosis
- Transportation method used to bring member to the ED
- Date of Service

Participating Hospitals and Facilities

Kaiser Permanente Members may be directed and/or self-direct to a Participating Facility for emergency care. While prior authorization or referral approval is not required for reimbursement of covered emergency care services provided to a Member, we request notification when a Member presents to the Emergency Department for urgent and/or emergent care services. This notification will ensure that our Members are being given the best coordination and follow-up care possible.

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

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

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

All emergency room notifications should include the following information:

- Member Name
- Member Medical Record Number (MRN)
- Name of the Referring Physician (if applicable)
- Name of Hospital or Facility
- Complaint/Diagnosis
- Date of Service

Concurrent Review Process

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

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

Concurrent Review Process

All inpatient admissions (acute and sub-acute) are reviewed by Utilization Management Registered Nurses, Inpatient Case Managers (ICM). Concurrent review for Home Health and Durable Medical Equipment (DME) is performed by Referral Coordinators located at the Utilization Management Operations Center (UMOC). These nurses review medical, surgical, and behavioral health care. Concurrent review consists of the collection of clinical information from practitioners, providers, medical records and members for review against approved criteria. The UM RN will consult with UM physicians and nurse managers as needed.

Concurrent review is performed on care delivered in acute, SNF, and ambulatory settings:

- Observation (short stay) and chest pain units
- Acute inpatient hospitals
- Skilled nursing facilities
- Inpatient hospice facilities and home-based hospice care
- Inpatient rehabilitation facilities
- Partial Hospitalization and Intensive Outpatient behavioral health services
- Home care
- Outpatient rehabilitation facilities
- Durable medical equipment

Managing our members in Participating Hospitals/Facilities

The Kaiser Permanente Utilization Management Department performs concurrent review for all hospital and/or facility admissions.

- The Participating Hospital and/or Facility's Utilization Review department is responsible for providing clinical information to Kaiser Permanente Utilization Management nurses by telephone or onsite review. *Failure to provide the clinical information within the required timeframe may result in an administrative denial due to a lack of clinical information by which to make an approval decision..*
- The Utilization Management nurse may contact the attending physician if further clarification of the member's clinical status and treatment plan is necessary.
- The Utilization Management nurse applies Kaiser Permanente approved criteria to determine Medical Necessity for acute hospital care.
 - If the clinical information meets Kaiser Permanente's Medical Necessity criteria, the days/service will be approved.
 - If the clinical information does not meet Medical Necessity criteria, the case will be referred to the Utilization Management physician.

- Once the Utilization Management Physician reviews the case, the Utilization Management nurse will notify the attending physician and the facility of the outcome of the review.
- The attending physician may request an appeal of any adverse decision.
- The participating hospital cannot hold the member financially responsible for day(s) that are not deemed to be medically necessary.

Administrative Denials

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

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

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

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

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

I. Hospital Delays

Diagnostic Testing/Procedures

- MRI CT scans (test performed/read/results available)
- Other Radiology delays (test performed/read/results available)
- Laboratory tests (test performed/read/results available)
- Cardiac catheterization delays (including weekends and holidays)
- PICC Line placement
- Echocardiograms
- GI Diagnostic procedures (EGD,

Operating Room

- CABG delays
- No OR time
- Physician delay (i.e. lack of availability)

Ancillary Service

- PT/OT/Speech evaluation
- Social Work/Discharge Planning

Nursing

- Delay in carrying out or omission of physician orders

- Colonoscopy, ERCP, etc.)
- Stress tests
- Technical delays (i.e. machine broken or machine is not appropriate for patient, causing delay)
- Dialysis
- Transfusions
- AFBs
- Pathology

- Medications not administered
- NPO order not acknowledged
- Kaiser Utilization Management not notified that the patient refuses to leave when discharged

II. SNF Delays

Diagnostic Testing/Procedures

- Laboratory tests (test performed/read/results available)
- PICC line placement
- Radiology delays(test performed/read/results available)

Nursing

- Appointment delays due to transportation issues
- Delay in initiation of nursing services

Ancillary Service

- Social Work/ Discharge Planning
- Delay in initiation of therapy services (PT/OT/Speech)
- Lack of weekend therapy services
- Delay in initiation of respiratory services
- Delay in Pharmacy services

III. Physician Delays

Hospital / SNF

- Delays in Specialty consults
- Delay in discharge order
- Member not seen by attending or not seen in a timely manner

Hospital & Facility Admission Notification Requirements



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

The Participating Hospital and/or Facility are responsible for notifying KP for all inpatient emergency admissions. Calls, voice mail, faxes or referral entry through Affiliate Link must be received **within 24 hours of the admission or the next business day**. *Failure to notify Kaiser Permanente within this time frame may result in the denial of*

authorization and payment of services. The participating provider cannot hold the member financially responsible for lack of authorization or late notification.

Non-Emergency & Elective Admissions



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

Pre-Admission Notification Requirements

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

9.16 Ambulatory Case Management (ACM)

Case Management is a collaborative process that utilizes all aspects of the medical system to coordinate the plan of care for a member in the outpatient setting. This is accomplished through open communication, collaboration, and continuous assessment of the member's health care needs, both physical, and psycho-social. Teams of Registered Nurses and Licensed Social Workers collaborate with primary care and behavioral health care practitioners to formulate and coordinate treatment plans that meet the full continuum of a patient's complex medical, surgical, and/or behavioral health care needs. A primary case manager is assigned to each case and is accountable to plan, assess, coordinate, and orchestrate the needs of the member in cooperation with the medical plan, and to assist the member across the continuum of care, as needed. The case manager works with the Health Care Team to facilitate effective links to the multiple programs available through this organization to assist with care and management of each case. Specialties within Ambulatory Case Management include: pediatrics, adult, geriatrics, transplant (other than renal), oncology and clinical trials.

Members are referred to the program through a variety of sources to include: their personal provider, a Specialist treating them for an episode of care, a clinical RN, or by the member him/herself. Members who would benefit from case management are those who have documented patterns of poor clinical responses, inappropriate resource utilization, are high risk for hospitalization with multiple medical problems or who meet the specific criteria for automatic admission for the specialty programs. Members must voluntarily consent to enter into ACM services before interventions are initiated. The

Ambulatory Case Management Referring and Screening Criteria serves as a guide in referring members for outpatient case management intervention.

Ambulatory Case Management Referring and Screening Criteria

1. High Utilizer of Services:

- 3 or more urgent/unscheduled hospitalizations in a rolling 6 month period
- 3 or more UC/ED visits in a rolling 6 month period

2. Coordination of Care

- Collaboration with the Hospital and Skilled Nursing Facility PCC's with hand-offs for complex cases as outlined in criteria
- Approaching and/or the exhaustion of benefits
- Need to be connected to community resources for adherence to plan of care/overall health status
- Need for identification and management of psychosocial barriers that impact adherence to the plan of care

3. Complex medical condition

- Non-adherence to plan of care
- Visits to multiple specialists
- At-risk for hospitalizations
- Need for complex referral/complicated service request

4. Populations

- High Risk Infants**-*examples of possible cases include: birth weight less than 2500 grams, hospitalized more than 30 days, babies with equipment needs, and specialty appointment coordination.*
- High Risk Children**-*examples of possible cases include: hospitalized for pediatric asthma, 2 or more refills of Beta 2 agonist meds per month, State and Federal programs such as Model Waiver, and complex medical conditions.*
- Frail Elderly**-*Patients whose age or medical condition is compromising their ability to be independent or adhere to the plan of care.*
- Top 1% of members with highest medical costs**-*per case finding mechanisms.*

Referrals to case management may be made by faxing a Uniform Referral Request form to the Utilization Management Operations Center (UMOC) at 1-(800) 660-2019 and indicating on the request, the expected outcomes desired by case management services.

9.17 *TLC High-Risk Obstetrical Program*

All KPMAS obstetrical patients are proactively screened for high-risk conditions that would benefit from professional case management. Once the member is determined to have high-risk factors, she is referred to our Tender Loving Care (TLC) high risk obstetrical program.

The TLC Perinatal Nurses manage all members at risk for preterm labor, preterm delivery, pregnancy-induced hypertension (PIH), and diabetes requiring insulin. The TLC staff offers close surveillance of these high risk members by pro-active telephone calls to the member. The TLC Perinatal Nurse also provides the member with education, and self-help measures specific to the high risk factors.

Insulin-requiring prenatal members are enrolled into the program in the first trimester for glucose follow-up. Prenatal members at risk for preterm labor and PIH are enrolled at 20 – 22 weeks or 26 – 30 weeks respectively and are case-managed until after delivery. Any member who develops acute symptoms of preterm labor may be referred directly to the fax number below. In addition to close telephone contact, all members are sent educational material and resource lists.

The member's obstetricians will be contacted prior to enrolling the member into the TLC Program in order to collaboratively produce a plan of care for the member and support physician management.

To notify the TLC staff of members who require case management, please fax the following Obstetrical Patient Screening Form to 📠 703-922-1525.

Obstetrical Patient Screening Form

Patient's Name _____ Obstetrician's Name _____

Kaiser Permanente Medical Record# _____ MD Phone Number _____

Home Phone _____ DATE OF 1ST VISIT _____

Work Phone _____

Please review following risk categories and check all that apply at this time. **If this patient developed other risk factors later in the pregnancy (i.e. preterm labor) please call the following number to refer the patient to the TLC High Risk Program (202) 898-5154 or 1 (800) 852-2402.**

Previous History

1. ___ Hx of PTL/PTD <37 weeks abortions
2. ___ Hx of PTL
3. ___ Previous Cervical Conization
4. ___ Hx of PROM
5. ___ Hx of Gestational Diabetes change
6. ___ Hx of Eclampsia/Pre-Eclampsia (PIH)
7. ___ Hypertension prior to pregnancy losses

Minor Risk Factors

24. ___ Greater than 2 first trimester
25. ___ ETOH > 1-2oz drink/wk
26. ___ Smoking > 1 pack/week
27. ___ Adolescent 17 years old or younger
28. ___ Uterine irritability w/o cervical
29. ___ Chronic UTI's
30. ___ Hx of 2 or more second trimester

Current Pregnancy

8. ___ Current Episode PTL
9. ___ Cervical Effacement <2.6 cm after 16 weeks
10. ___ Cervical Dilatation > 1 cm < weeks symptoms
11. ___ Multiple Gestations (Twins/Triplets, etc)
12. ___ Uterine Anomaly/Large Fibroids (5x5cm)
13. ___ Oligohydramnios
14. ___ Polyhydramnios with symptoms
15. ___ Incompetent Cervix/Cerclage
16. ___ Abdominal Surgery in pregnancy with symptoms
17. ___ Placenta Previa (total/partial) with symptoms
_____ No Risk Factors
18. ___ Bleeding after 20 weeks
19. ___ Diabetic requiring Insulin
20. ___ Current Drug use
21. ___ Positive Fetal Fibronectin
22. ___ Hyperemesis Gravidarum
23. Other Major Health Problem(s)

Form Completed by _____ Date _____

Hospital Delivery Site: _____ EDC: _____

Please fax or mail form to: TLC Perinatal Nurse Case Management Program
Office (202) 898-5154

Kaiser Permanente
Fax (703) 922-1525
9th floor, TLC
6501 Loisdale Court
Springfield, VA 22150

9.18 Regional Diabetes Management Program

KPMAS' Disease Management Programs were established to develop and implement systems to manage the care of individuals diagnosed with specific chronic conditions in a proactive fashion. Our programs include clinical practice guidelines, registries for monitoring clinical indicators, and patient and practitioner education resources.

Kaiser Permanente sends a mailing to all health plan members newly diagnosed with either asthma, diabetes, or CAD. The mailing is the first step in facilitating a partnership between the member with the condition and the health care team. The mailing consists of:

- Letter to the member
- Patient education information for the member to monitor and self-management their care
- Kaiser Permanente and community resources for additional information and support

KPMAS has also developed self-management programs that are taught at the Kaiser Permanente Medical Centers. These programs address specific skill-building activities to help patients self-manage the condition. The emphasis is on developing the technical, behavioral and psychosocial skills for self-management.

To learn more about these programs or registering for a self-management program, please call the Population Care Management Department at (301) 816-7122.

9.19 Renal Disease Management Program

The KPMAS Renal Disease Management (RDM) Program operates to favorably impact the quality and cost of internal and external services delivered to members with chronic kidney disease (CKD) and end-stage renal disease (ESRD). The program is an outcome-based, continuous quality improvement model that requires physician collaboration in order to use disease management tools, including multidisciplinary pathways and guidelines, patient outcomes data, population-based interventions, and individual case management.

Renal Case Specialists partner with MAPMG and community nephrologists on the implementation and achievement of the MAPMG Nephrology Service Delivery objectives and goals specific to renal disease management, in accordance with established clinical practice guidelines for the target populations.

Currently, case management interventions are provided for the population of known patients with a GFR < 30. The disease management continuum of care includes pre-failure, and maintenance dialysis. Renal transplant patients are managed by the KP Transplant Hub. The emphasis is on education, prevention, and self-care. Care management activities include surveillance and systems intervention for the entire

population. Patterns and trends related to cost, quality and outcomes of care are monitored in aggregate.

The Renal Program is a multi-disciplinary approach to slowing the progression of kidney disease in order to avoid or delay the need for renal replacement therapy. Renal Care Specialists support the multi-disciplinary team by ensuring that:

- ✓ Patients understand the risk associated with progressive chronic kidney disease
- ✓ Patients understand the medical treatment plan
- ✓ Specific components of the medical treatment plan are coordinated and communicated
- ✓ Barriers to the implementation of the medical treatment plan are reduced or eliminated
- ✓ Dialysis readiness and transplant candidacy are facilitated.

Renal Care Specialists are also responsible for a panel of patients grouped by dialysis unit and geographic area. They are accountable for monitoring all dialysis patients in their panel for failure to meet targeted outcomes and for developing and implementing effective care management plans with individual patients, dialysis providers, and nephrologists. Proactive identification of patients at risk for poor outcomes due to inadequacy of dialysis, compromised nutrition, anemia and vascular access complications is expected to result in the attainment of optimal outcomes.

Intensive case management is a component of the RDM Program that is targeted to those patients on dialysis whose clinical status and outcomes are compromised by factors such as psychosocial problems, advanced age, functional limitations, and cognitive deficits. These patients continue to be at risk for poor outcomes despite the presence of population-based supports. Stable patients experiencing disruptions in care receive episodic case management. Typical episodic interventions are those related to vascular access complications, transportation, and dialysis unit transfer. Episodic case management is a response to a specific problem, while intensive case management is a response to the whole patient or system.

Please call the Program Coordinator at ☎ 1 (301) 816-6588 or 1(800) 368-5784 x6588

- To notify KPMAS about new patients on dialysis
- To notify KPMAS about patients referred for renal transplant evaluation
- To refer a patient for case management
- To receive additional information about the Renal Disease Management Program

9.20 National Transplant Network

KPMAS's National Transplant Network (NTN) offers a national approach to clinical care management. The goals of the network are to improve clinical outcomes associated with transplant services by:

- Contracting with transplant centers that meet or exceed minimum outcome requirements.
- Utilizing evidenced based patient selection criteria.
- Providing quality over site
- Providing Case Management services

- Establishing an operational support structure that affiliates Kaiser Permanente Home Regions and Transplant Centers with a Hub Region. The Hub Regions are Mid-Atlantic States, Northwest, and Northern and Southern California.

The Hub Regions are responsible for facilitating care coordination and clinical case management for members referred from their associated regions. Transplant Coordinators in the National Transplant Network coordinate and communicate patient care activities between Home Regions and contracted Transplant Centers of Excellence.

The KPMAS Hub Transplant Coordinators are clinical experts in the field of transplantation. They perform clinical case management, ensure compliance with internal policies and procedures, educate members and physicians, develop and maintain working relationships with Transplant Centers and members' providers, and track and report quality issues and care outcomes.

Referring Participating Providers are responsible for contacting the Hub Transplant Coordinators when they identify a member who may be a candidate for transplantation, or requesting a referral for transplant from the PCP. Participating Providers work with the Transplant Coordinators to ensure that patient selection criteria are applied consistently. All work-up and diagnostic procedures are arranged by the Hub Transplant Coordinators.

All transplant candidates must be routed through the Hub Transplant Coordination in order to guarantee coverage.

Please call the KPMAS Transplant Services Department at ☎ 1 (301) 625-6201 to refer a patient for an evaluation for a transplant or to receive additional information about the National Transplant Network.

9.21 Durable Medical Equipment and Home Health Care

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

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