9.0 Utilization Management & Authorization

9.1 Overview

Kaiser Permanente utilization management (UM) activities include emergency care management, complex case management, skilled nursing facility case management, renal case management, facility-based utilization management, outpatient specialty referral management, home care including advanced care at home, durable medical equipment, and rehabilitative therapy referral management. Collectively, these areas implement the UM Program for medical, surgical, pediatric, maternal health, geriatric, and behavioral health care.

Kaiser Permanente UM is supported by board certified UM physician reviewers who hold a current license to practice without restrictions. These licensed physicians oversee UM decisions to ensure consistent and appropriate medical necessity determinations. Registered nurses (RN) perform concurrent review of members' admission to both participating and non-participating hospitals and other facilities. RNs also review or process outpatient referrals, requests for durable medical equipment, and home care services. RNs coordinate emergency care and out-of-area admissions. Rehabilitative Therapy Utilization Coordinators (RTUC) are licensed physical therapists responsible for reviewing clinical appropriateness for members with functional and mobility needs who may require durable medical equipment, physical and occupational therapies.

9.2 Attestation Regarding Decision-Making and Compensation

Utilization Management Affirmative Statement
Kaiser Permanente practitioners and health care professionals make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of care and service, and existence of health plan coverage.

Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. The health plan does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or benefits or care.

No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and services or result in underutilization. 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

Measurable, evidence-based, and objective decision-making criteria ensure that decisions are fair, impartial, and consistent. Kaiser Permanente utilizes and adopts nationally recognized UM criteria and internally developed medical coverage policies (MCP). Additionally, subject matter experts currently certified in the specific field of medical practice are actively engaged in the guideline development process.

All criteria sets are reviewed and revised annually, then approved by the Regional Utilization Management Committee (RUMC) as delegated by the Regional Quality Improvement Committee (RQIC). Our UM criteria are not designed to be the final determinate of the need for care but has been developed in alignment with local practice patterns and are applied based upon the needs and stability of the individual patient. In the absence of applicable criteria or MCPs, the UM staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determination on their training, experience, the current standards of practice in the community, published peer -reviewed literature, 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.

UM Approved Criteria Sets and Guidelines

A. Behavioral Health UM Criteria
   - Nationally Recognized UM Criteria
     - Milliman Care Guidelines (MCG) 27th Edition
     - American Society of Addiction Medicine (ASAM) Criteria for Substance-Use Disorder (SUD)
   - Internally Developed UM Criteria
     - Medical Coverage Policies (MCP)

B. Non-Behavioral Health UM Criteria and Guidelines
   - Nationally Recognized UM Criteria
     - MCG 27th Edition
     - Adult and Pediatric CMS Coverage Database for National (NCD) and Local Coverage Determination (LCD) for DME and Supplies
     - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines
     - 2023 InterQual Level of Care Criteria for Transplant-related Services
   - Internally Developed UM Criteria
     - MCP
     - National Transplant Services (NTS) Transplant Referral Guidelines

BEHAVIORAL HEALTH
2023 Utilization Management Criteria

Referral Service Type Approved criteria sets are used in order of hierarchy.	**Commercial & Exchange Jurisdiction**
Behavioral Health: Substance Use Disorder (SUD) specifically *All Levels, i.e., IP, OP, RTC, PHP, IOP	MCG/ASAM
Behavioral Health: Inpatient	MCG
Behavioral Health: Outpatient *Excludes SUD	MCP MCG
Behavioral Health: Partial Hospitalization *Excludes SUD	MCG
Behavioral Health: MHS Covered Services	Not Applicable

NON-BEHAVIORAL HEALTH
2023 Utilization Management Criteria
Note: Commercial and Exchange includes District of Columbia, Maryland, and Virginia jurisdictions

Referral Service Type Approved criteria sets are used in order of hierarchy	**Commercial & Exchange Jurisdiction**
Acute Rehabilitation (Inpatient)	MCG
Ambulance Services	KP-MAS MCP
Durable Medical Equipment (DME) and Supplies	KP-MAS MCP MCG NCD-LCD
Orthotics and Prosthetics	KP-MAS MCP MCG NCD-LCD
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	Not Applicable
Home Health Services	MCG
Inpatient Services	MCG
Neonatal Care	MCG
Outpatient Services	KP-MAS MCP MCG
PT/OT/Speech	KP-MAS MCP MCG
Skilled Nursing Facility	MCG
Transplant Services	National Transplant Services (NTS) Referral Guidelines InterQual® Criteria Transplant and Hematology/Oncology

*Use Approved Criteria Sets in order of hierarchy. Example – Criteria 1 must be applied first. In the absence of applicable criteria from number 1, then use criteria 2, and finally criteria 3.

Hard copies of UM criteria or guidelines used in UM review are available free of charge by calling the Utilization Management Operations Center (UMOC) at ☎ 800- 810-4766 and selecting the appropriate prompt. Behavioral health inquiries may be called to ☎ 301- 625-5565. Updates to medical coverage policies, UM criteria and new technology reports are featured in “Network News”, our quarterly participating provider newsletter. You can also access current and past editions of “Network News” on our provider website by visiting online at:
https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/provider-info#newsletters.

Adopting Emerging Technology for UM Referral Management
Medical research identifies new drugs, procedures, and devices that can prevent, diagnose, treat and cure diseases. The Kaiser Permanente Technology Review and Implementation Committee (TRIC) collaborates with Kaiser Permanente’s national technology review committee, i.e., the Interregional New Technologies Committee (INTC) and Medical Technology Assessment Unit to assist physicians and patients in determining whether a new or emerging procedure, treatment, or device is medically necessary and appropriate. TRIC provides recommendation to the Health Plan of the potential adoption or exclusion of a

new or emerging technology as a covered benefit based on indications for use, safety, effectiveness, and relevance of the technology for the health care delivery system.

If compelling scientific evidence is found indicating a new or emerging technology has exceeded or is comparable to the safety and effectiveness of currently available drugs, procedures, or devices, the committee will recommend the new technology be implemented internally by Kaiser Permanente and/or authorize for coverage from external sources of care for its indication for use. This technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

9.4 Accessibility of Utilization Management (UM)

Accessibility is important to our members and providers. The Kaiser Permanente UM Department ensures that all members and providers have access to UM staff, physicians, and managers 24 hours a day, 7 days a week. Staff will identify themselves by name, title, and organization name when they initiate or return calls regarding UM issues. UM staff are available eight hours a day during normal business hours for inbound collect or toll-free calls to ☎ 800-810-4766 (follow the prompts). The following table provides the specific UM hours of operations and main responsibilities:

2024 UTILIZATION MANAGEMENT HOURS OF OPERATION

UM Department Section	Hours of Operation	Core Responsibilities
Emergency Care Management (ECM) – Clinical Call Center Department	24 hours/day, 7 days/week including holidays	• Process transfer and admission requests for Members who need to be moved to a different level of care including emergency rooms, inpatient facilities, and Kaiser Permanente Medical Office Buildings • Assist with repatriation from hospital to hospital • Support all cardiac transfers for level of care needed
Utilization Management Operations Center: Outpatient, Specialty Referrals, and Clinical Research Trials	Monday through Friday, except clinical trials: 8:30 A.M. to 5:00 P.M. Clinical Trials: 8:00 A.M. to 4:30 P.M. Weekends and Holidays, except clinical trials: 8:30 A.M. to 5:00 P.M. for Urgent and emergent referrals and care coordination referrals	• Conduct pre-service review of specialty referrals (outpatient and inpatient) to include external clinical trial requests • Weekends and holidays pre-service review of urgent/emergent referrals except clinical research trials
Utilization Management Operations Center: • Durable Medical Equipment (DME) • Home Care	Monday through Friday: 8:30 A.M. to 5:00 P.M. Weekends and Holidays:	• Conduct pre-service and concurrent review of Home Care, Durable Medical Equipment, Physical Therapy, Occupational

UM Department Section	Hours of Operation	Core Responsibilities
• Rehabilitative Therapies • Physical, Occupational and Speech Therapies	8:30 A.M. to 5 P.M. (for urgent and routine discharge care coordination referrals)	Therapy, and Speech Therapy • Post-service review provided to Kaiser members outside a Kaiser medical facility
UM Hospital Services-Non-Behavioral Health (located at affiliated hospitals)	Seven days a week, including holidays: 7:00 A.M. to 5:30 P.M. Limited Evening hours (3:00 P.M. to 11:30 P.M.) at the following Premier Hospitals only: • Holy Cross Silver Spring • Washington Hospital Center • Virginia Hospital Center	Conduct concurrent review and transition care management
Skilled Nursing Facility (SNF) and, Rehabilitation Services	Monday through Friday: 8:00 A.M. to 4:30 P.M. Including weekends and holidays	Conduct concurrent review and transition care management for members in SNF
Long Term Acute Care Hospitals (LTACH)	Monday through Friday: 8:00 A.M. to 4:30 P.M. Including weekends and holidays	Conduct concurrent review and transition care management for members in Acute Rehab
UM Hospital Services – Behavioral Health	Seven days a week: 8:00 A.M. to 4:30 P.M. Including weekends and holidays	Conduct concurrent review and transition care management services of behavioral health service
UM Outpatient Services – Behavioral Health	Monday to Friday: 8:00 A.M. to 4:30 P.M. Excluding weekends and holidays	Conduct Pre-service and concurrent review of behavioral outpatient services
Outpatient Continuing Care: Complex Case Management Renal Case Management	Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding weekends and holidays VHCP: 8:00 A.M. to 12:30 A.M. Seven days per week, including Weekends and Holidays	Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members
Advanced Care At Home	24 hours/day, 7 days/ including holidays	• Offers Virtual Physician and nurse follow up for members who have been recently discharged from the hospital. • Bridges gap between hospital discharge and follow up with PCP • Admission avoidance by providing acute care in the home

Telecommunications Device for the Deaf (TDD) or teletypewriter (TTY) services are available for members who are deaf, hearing or speech impaired.

Language assistance is available for Non-English speaking members to discuss UM issues.

Communication After Business Hours
Communications received after the normal business hours, as laid out in the chart above, are addressed the next business day.

After business hours, our member's first line of contact is through the Kaiser Permanente Member Services Department at 1-800-777-7902 711 (TTY). Members are instructed to follow prompts to be directed to the call center.

After business hours, practitioners and providers may contact the Utilization Management Operations Center (UMOC) toll-free at 800-810-4766 and follow the prompts to be directed to the call center, available 24 hours a day, 7 days a week.

UM staff can receive inbound communications regarding UM issues after normal business hours via the following:

- UMOC toll-free number 800-810-4766, Option 1 (Member) or Option 2 (Provider);
- Kaiser Permanente HealthConnect® (KPHC) OnlineAffiliate;
- KPHC messaging system – available to providers linked to the KPHC system; and
- Direct email to a UM staff person

Notification of Emergency and Inpatient Admissions

Emergency Care Notification

For contracted facilities where a Kaiser Permanente MAPMG physician with medical hospital staff privileges is on site, notify the Kaiser Permanente physician on duty if the member requires inpatient admission or observation after an emergency department visit.

For other contracted and non-contracted entities, please be sure to notify ECM of the admission to obtain an in-patient/observation authorization ahead of time. Notification can be made by calling ☎ 800-810-4766 (Option 1).

You may refer the member to call our 24-hour medical advice line. Additionally, you may also refer a member to a Kaiser Permanente or participating urgent care facility. For a full list of urgent care facilities in our network, please refer to Section 2.4 of this manual or go to www.kaiserpermanente.org/facilities.

Hospital Admission Notification Requirements

The hospital is responsible to notify Kaiser Permanente at the time the member is admitted.

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.

Participating hospitals are responsible for notifying Kaiser Permanente of all inpatient emergency admissions within 24 hours of the admission. Notification must be made to the UM

department via phone: ☎ 800-810-4766 or fax: ☎ 855-414-1704. Specifically, in the event that a member requires emergency care and is then transitioned to “inpatient status”, Kaiser Permanente must be notified of the admission to inpatient status within 24 hours of the admission. Upon notification, Kaiser Permanente reserves the sole discretion to provide authorization for continuation of care. Kaiser Permanente also maintains the right to transfer the member to another facility. Failure to notify Kaiser Permanente may result in a denial of payment of claims. The participating hospital may not hold the member financially responsible for lack of authorization or late notification.

Managing Our Members in Participating Hospitals/Facilities
Once a member has been admitted and Kaiser Permanente has been notified of the admission, the Participating Hospital must provide daily notification (seven days a week) of a member’s continued stay. Daily notification will be accepted via a daily census and submission of the necessary and meaningful clinical medical records, including any peer-to-peer interactions, to determine the member’s stability and continued need for additional hospitalization. Failure to provide daily clinical records may result in partial denial of the authorization.

9.5 Communication Services to Members with Special Needs

Communication with deaf, hard of hearing or speech-impaired members is handled through TDD or TTY services. TDD/TTY is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. UMOC staff has a speed dial button on their phones to facilitate sending and receiving messages with the deaf, hard or hearing or speech impaired through the Maryland Relay System. Additionally, a separate TDD/TTY line for deaf, hard of hearing, or speech impaired KPMAS members is available through Member Services. Members are informed of the access to TDD/TTY through the Member’s ID card, the Member’s Evidence of Coverage handbook, and the Annual Subscriber’s Notice. Non- English speaking members may discuss UM related issues, requests and concerns through the KPMAS language assistance program offered by an interpreter, bilingual staff, or the language assistance line. UMOC staff has the Language Line programmed into their phones to enhance timely communication with non- English speaking members. Upon member’s request, denial notices are provided in a culturally and linguistically appropriate manner in compliance with the July 2010 Public Health Service Act Section 2719 of the Patient Protection and Affordable Care Act (PPACA). Language assistance services are provided to members free of charge.

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) at the time the referral is authorized.

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 are valid for ninety (90) days, except:

- Obstetrics: valid for 270 days,
- DME: Referral will specify valid time period based on rental or purchase of the DME item,
- Chemotherapy: valid for 180 days,
- Radiation Therapy: valid for 180 days,
- Dialysis: valid for 365 days/1 year.

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 PCP. Exceptions to this requirement may include members:

- seeking annual Well Womens Health-Gynecology (GYN) preventative service exams,
- seeking Behavioral Health Services,
- seeking optometry exams/vision services,
- enrolled in the Kaiser Permanente Flexible Choice product 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. Each approved referral is valid only until the identified expiration date is noted on the Kaiser Permanente Referral Summary Report. Only one (1) visit is approved per referral, unless otherwise indicated on the Kaiser Permanente Referral Summary 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.

During the initial office visit, a specialist may perform Services listed on the authorized referral.

Providers are encouraged to order radiology and laboratory tests for members using the Kaiser Permanente imaging and laboratory facilities.

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:

- Calling the UMOC at ☎ 800-810-4766 (follow the prompts) to request additional visits and/or an extension to an existing referral.
- 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:

- Completing a Uniform Referral Form (URF) and fax it to the UMOC at 1-800-660-2019.

For Behavioral Health: see provider manual chapter 14

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 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 UMOC at ☎ 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 does 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 the following referral types:

A. Specialist Care (No authorization required)
B. Specialist Care (Authorization required)
C. Standing referrals
D. Referring members for radiology services
E. Radiology and imaging referral verification process
F. Referring members for laboratory 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 URF or the KPMAS Referral request to the UMOC via fax ☎ 1-800-660-2019.

-OR-

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

Kaiser Permanente New Carrollton Administrative Office Building
Utilization Management Operations Center
4000 Garden City Drive
Hyattsville, MD 20785

Step 4:

Give a copy of the referral form to the member to take to the 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 UMOC at fax ☎ 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 ☎ 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 PCP 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 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
   - is life threatening, degenerative, chronic, or disabling; and
   - requires specialized medical care, and
3. The specialist
   - has expertise in treating the life threatening, degenerative, chronic, or disabling disease or condition; and
   - 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, and
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 Participating Provider Network (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**
   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 or order the necessary radiological/imaging services via Online Affiliate.
2. Instruct the member to contact Kaiser Permanente to secure a radiology/imaging appointment.

The member may contact the Radiology Department at his/her 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/imagining 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 within our Participating Provider Network.

E. Radiology and Imaging Referral Verification Process

When a Kaiser Permanente member presents to your office with a script for radiology or imaging services, you must confirm that an approved Kaiser Permanente External Referral Summary Report has been issued to your practice or facility prior to rendering the services.

- Kaiser Permanente External Referral Summary Reports are issued electronically to providers with access to Kaiser Permanente HealthConnect® Online Affiliate.
    - If you receive Kaiser Permanente referrals electronically, you may view and print your approved referral by logging-on to Kaiser Permanente HealthConnect® Online Affiliate at kp.org/providers/mas.
    - If you do not receive referrals electronically from Kaiser Permanente, the referral will be sent to your office via fax upon approval by our UMOC.

In the event a member presents to your office for radiology or imaging services without an approved Kaiser Permanente External Referral Summary Report, you must contact our UMOC at 1-800-810-4766 to confirm the status of the referral or direct the member to contact their referring Provider.

Please note that imaging studies requiring fiducial markers will require a separate authorization.

F. Referring Members for Laboratory Services

Kaiser Permanente Signature℠ Members requiring laboratory services under care with your practice should be directed to a Kaiser Permanente Medical Center**.** Laboratory procedures covered under a current the Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a current CLIA Certificate of Provider-Performed Microscopy Procedures may be performed in your office.

Kaiser Permanente Select Members have access to a delivery system that includes MAPMG physicians, health care services provided at Kaiser Permanente Medical Centers, and a wider range of community-based providers within our Participating Provider Network. Members enrolled in this plan may be directed to a Kaiser Permanente Medical Center for laboratory services or may choose to utilize a Participating Provider location for laboratory services.

Laboratory procedures covered under a current CLIA Certificate of Waiver or a current CLIA Certificate of Provider-Performed Microscopy Procedures may be performed in your office laboratory.

Orders can be entered via Online Affiliate or members can be given a signed script to present to the Kaiser Permanente laboratory. The script or order must include the following:

- Provider name
- Provider address
- Practice phone and fax number
- Member name
- Member date of birth
- Description of test (s) requested
- ICD-10 codes.

The laboratory results will be faxed to the number provided on your signed script or order. Participating Providers with access to HealthConnect® Online Affiliate may obtain laboratory results via the web at www.providers.kp.org/mas.

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 UMOC at ☎ 800-810-4766, follow the prompts.

A. Inpatient Services

1. Acute Inpatient Hospital Admissions
2. Short Stay Admissions
3. Observation Services
4. Acute Rehabilitation Admissions
5. Sub-acute Rehabilitation Admissions
6. Skilled Nursing Facility (SNF) Admissions
7. Long-Term Acute Care (LTAC) Admissions
8. Inpatient Hospice Admissions
9. Inpatient Behavioral Health Admissions
10. 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. Biofeedback
6. Blepharoplasty
7. Breast surgery for any reason
8. Chiropractic care
9. Clinical trials
10. Cosmetic and reconstructive or plastic surgery
11. Computerized Tomography (CT Scans)
12. Dental services covered under medical benefit
13. Durable Medical Equipment (DME)
    13.1. Assistive technologies
14. Gastric bypass surgery, Gastroplasty
15. Home Health Care Services (Including Hospice)

16. Infertility assessment and treatment
17. Infusion therapy and injectables (Home IV, excluding allergy injections)
18. Intensity Modulated Radiation Therapy (IMRT) – Modulated Therapy
19. Interventional Radiology
20. Investigational/Experimental services
21. Magnetic Resonance Imaging (MRI)
22. Narrow Beam Radiation Therapy Modalities
    22.1. Cyberknife
    22.2. Gamma Knife
    22.3. Stereotactic Radiosurgery
23. Nasal surgery (Rhinoplasty or Septoplasty)
24. Non-Participating Provider Requests
25. Nuclear Medicine
26. Obstructive sleep Apnea Treatment including Sleep Studies
27. Oral Surgery
28. Orthognatic Surgery
29. Outpatient Surgery – All Hospital Settings/Ambulatory Surgery Centers
30. Pain Management Services
31. Penile implants
32. Positron Emission Tomography (PET) Scan
33. Podiatry services
34. Post Traumatic (Accidental) Dental Services
35. Prosthetics/Braces/Orthotics/Appliances
36. Prostate biopsies - Ambulatory Surgery Center or Outpatient Hospital Surgery setting
37. Radiation Oncology
38. Radiology Services (all radiology and imaging services, including diagnostic plain films)
    38.1. Imaging studies requiring fiducial markers
39. Rehabilitation Therapies
    39.1. Cardiac Rehabilitation
    39.2. Occupational Therapy
    39.3. Physical Therapy
    39.4. Pulmonary Rehabilitation Therapy
    39.5. Speech Therapy
    39.6. Vestibular Rehabilitation
40. Scar Revision
41. Sclerotherapy and Vein Stripping Procedures
42. Screening Colonoscopy – Consultations
43. Uvulopalatopharyngoplasty (UPPP)
44. Social Work Services
45. Temporo Mandibular Joint Evaluation and Treatment
46. Transplant Services – Solid Organ and Bone Marrrow

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.

9.13 Denials & Appeals

The UM Department has policies and procedures in place to ensure that timely notifications are rendered for adverse determinations. These policies require discussion with the requesting practitioner, review by the UM physician, or review by a board-certified practitioner/specialist if necessary, as well as provisions for verbal and written notifications of the denial decision based on timeliness requirements by local, Federal, Medicare, Patient Protection and Affordable Care Act **(**PPACA), and the National Committee for Quality Assurance (NCQA) rules.

Referral Timeliness Determination Guideline
Referrals are processed based on the urgency of the referral request and according to designated timeframes as described in the table below. The ordering physician determines the urgency of the referral. KPMAS must abide with the decision of the ordering provider to determine the urgency of the requested referral.

Guide to Referral Processing Turn-Around Time by Product Line
Commercial[1]: DC, Federal, Maryland and Virginia

Referrals are processed based on the urgency of the referral request and according to designated timeframes as described in the table listed below. The ordering physician determines the urgency of the referral. KPMAS must abide with the decision of the attending provider to determine the urgency of the requested referral.

Priority of Request	Jurisdiction	Determination Timeframe	Telephonic, Oral or Electronic Notification to Provider (For Approvals)	Written Notification
Urgent Request • Concurrent	Maryland Virginia District of Columbia Self-Funded	Within one (1) day of receipt of request	Within one (1) day of receipt of request	Within one (1) day of receipt of request
Urgent Request • Preservice	Maryland	Within one (1) day of receipt of request	Within one (1) day of decision	Within one (1) day of decision
	Virginia	Within 72 hours of receipt of request	Within one (1) day of decision	Within 72 hours of receipt of request
	District of Columbia FEHB Self-Funded	Within three (3) calendar days of receipt of request	Within one (1) day of determination	Within three (3) calendar days of receipt of request
Non-Urgent Request	Maryland	Within two (2) business days after receipt of all necessary information	Within one (1) business day after decision is made	Within five (5) business days after decision is made
	Virginia	Within two (2) business days	Within one (1) business day	Within two (2) business days

Priority of Request	Jurisdiction	Determination Timeframe	Telephonic, Oral or Electronic Notification to Provider (For Approvals)	Written Notification
		after receipt of all necessary information	after decision is made	after decision is made
	District of Columbia FEHB Self-Funded	Within 15 calendar days of receipt of request	Within one (1) business day after decision is made	Within 15 calendar days of receipt of request
Post Service	Maryland Virginia District of Columbia Federal Self-Funded	Within 30 calendar days of receipt of request	Not Applicable	Within 30 working days of receipt of request

Medicare

Medicare Urgent/Expedited Referrals

Determination Timeframe	Oral Notification to the Member (See Section 7.2)	Written Notification to the Member and Requesting Provider
Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Within 3 calendar days after providing oral notification 42 CFR § 422.572 - Timeframes and notice requirements for expedited organization determinations.

Oral Notification is required for expedited coverage determinations.
A telephone call is made to the member or authorized representative within 72 hours of request. The UM staff must demonstrate a reasonable effort to inform the member, or member's authorized representative for all urgent/expedited referrals and must document all attempts to notify the member, or member's representative.

Medicare Standard Referrals

Determination Timeframe	Written Notification to the Member and Requesting Provider
Within fourteen (14) calendar days of receipt of request	Within fourteen (14) calendar days of receipt of request

- Participating Providers requesting reconsideration of a service denial on behalf of the KPMAS member may call ☎ 888-989-1144, and request to speak with the UM physician on-call within 24 hours of the verbal notification of the adverse decision.

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 grievances and appeals 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. To request an expedited appeal a member or provider should contact our Member Services Department at: ☎ 800-777-7902 toll-free; ☎ 866-513-0008 (TTY) or by fax ☎ 404-949-5001. Requests for expedited appeals for Medicare members should be directed to ☎ 888-777-5536.

Member Services will notify the member or Participating Provider as expeditiously as the medical condition requires, but no more than 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 Participating or non-Participating 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 themother and/or fetus.

Emergency Medicine physicians are responsible for providing evaluation, triage, and telephone services 24 hours a day, 7 days a week.

If a Participating PCP or coverage/on-call physician is unavailable, members may call Kaiser Permanente's Medical Advice Nurse by calling ☎ 703-359-7878 or ☎ 800-777-7904. Medicare Members should call ☎ 888-777-5536.

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 ED of the nearest hospital. The Participating PCP should notify the ED physician that the member has been referred.

The Emergency Care Management (ECM) Department coordinates the following:

- Emergency room (ER) visits for non-core hospitals
- Medical, surgical, or behavioral health care admission to acute care facilities.
- Ambulance transports
- CDU/Urgent Care
- Provider call-in line for member information and triage
- Follow up Primary Care Practitioner.
- Behavioral Health Care Practitioner follow up appointments are made via ☎ 866-530-8778.

The ECM Department can be reached by phone at ☎ 844-552-0009 or toll free at ☎ 800-810-4766.

If a member requires inpatient admission after an ED visit, please be sure to notify the ECM Department 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 ECM Department to arrange ambulance transportation other than 911, please submit the request via order entry for immediate assistance. This order once transmitted will be sent electronically to ECM with all the required information.
Medical necessity of ambulance transport. Please refer to the KPMAS Ambulance Transportation guidelines accessible through the Kaiser Permanente Provider website.

9.15 DME 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 DME are reviewed by the UMOC home health and DME 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 DME staff coordinates these services with a Participating Provider and/or vendor. Medical necessity determinations for denials are made by the UM Medical Directors. The Participating PCP and member are notified once a determination has been made.

To request a referral for DME, prosthetics, orthotics, and supplies:

1. Complete the URF; include correct CPT and ICD codes.
2. Send the completed Uniform Consultation Referral form along with all required

clinical documentation such as notes and treatment plans to the UMOC via fax to 855-414-1695.

Please do not specify a particular vendor when requesting referrals, the Kaiser Permanente Utilization staff will refer to the appropriate vendor.

Once your request is received and processed by the UMOC, a Kaiser Permanente External Referral Summary Report will be faxed to the Medicare approved vendor.

9.16 Hospital & Facility Admissions

All urgent and emergent admissions require notification **within 24 hours of the admission** to the ECM Department by the Participating PCP, his/her agent, or the participating hospital/facility toll-free at ☎ 844-552-0009 or ☎800-810-4766 and/or fax ☎ 855-414-2634.

In the event that a member requires emergency care and is then transitioned to "inpatient status", Kaiser Permanente must be notified of the admission to inpatient status within 24 hours of the admission. Upon notification, Kaiser Permanente reserves the sole discretion to provide authorization for continuation of care. Kaiser Permanente also maintains the right to transfer the member to another facility. Failure to notify Kaiser Permanente may result in a denial of payment of claims. The participating hospital may not hold the member financially responsible for lack of authorization or late notification.

Subsequently, Kaiser Permanente must be notified of all births within 24 hours of the birth. Timely notification of births will allow for pre-enrollment and/or enrollment of the newborn in order to properly provide authorizations as necessary.

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 UMOC at ☎ 1800-810-4766. An authorization number will be generated for all approved admissions. The Participating Hospital or Facility is responsible for notifying Kaiser Permanente 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 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 ECM at ☎ 844-552-0009 to immediately report the admission, 24-hours a day, and 7-days a week.

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

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 ECM by calling ☎ 844-552-0009 or ED visits can also be faxed to ☎ 855-414-2634. ECM and ECM Physicians are available 24-hours/day including weekends and holidays.

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 Hospital or 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 ED 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 ED Visit Notification Form and fax to the ECM Department at ☎ 855-414-2634. A copy of the ED Visit Notification Form can be located at the end of this section.

Option 2: Contact ECM by calling ☎ 844-552-0009.

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 Management 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 UM 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 UM nurse may contact the attending physician if further clarification of the member's clinical status and treatment plan is necessary. The UM nurse uses Kaiser Permanente approved criteria to determine medical necessity for acute inpatient 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 UM physician. Once the UM physician reviews the case, the UM 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 medical facility cannot hold the member financially responsible for day(s) that are not deemed medically necessary.

Managing our members in Participating Hospitals/Facilities
Once a member has been admitted and Kaiser Permanente has been notified of the admission, the participating hospital must provide daily notification (seven days a week) of a member's continued stay. Daily notification will be accepted via a daily census and submission of the necessary and meaningful clinical medical records, including any peer-to-peer interactions, to determine the member's stability and continued need for additional hospitalization. Failure to provide daily clinical records may result in partial denial of the authorization.

Administrative Denials
KPMAS 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 benefit 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 24hours 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.

All authorized services and procedures, including but not limited to testing and imaging, must be completed within 24 hours of the authorization. Denial of payment for an inpatient day may

occur if the lack of timely completion of such services and/or procedures results in a medically unnecessary extension of the member's hospital stay.

Please note that imaging studies requiring fiducial markers will require a separate authorization.

The tables below outline specific examples of common delays in service/procedure by hospital, skilled nursing facility (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.

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)
- Peripherally inserted central catheter (PICC) Line placement
- Echocardiograms
- GI Diagnostic procedures (esophagogastroduodenoscopy (EGD), colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), etc.)
- Stress tests
- Technical delays (i.e., machine broken or machine is not appropriate for patient, causing delay)
- Dialysis
- Transfusions
- Acid-fast bacillus (AFBs)
- Pathology

Operating Room (OR)

- Coronary artery bypass graft (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
- Medications not administered
- Nil per os (NPO) order not acknowledged
- Kaiser Permanente UM not notified that the patient refuses to leave when discharged

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

SNF

- Physician delays in facilities that do not have Kaiser Permanente on-site reviewers

Physician Delays

Hospital

- Delays in specialty consultations
- Delay in discharge order for alternative placement
- Delays in scheduling procedures in the Operating Room or Catheterization Lab
- Member not seen by attending physician or not seen in a timely manner

9.17 Daily Hospital Censuses

Kaiser Permanente requires Participating Hospitals to submit daily censuses for the following:

- Daily newborn census
- Daily emergency department visits w/diagnoses
- Daily emergency department visits converted to observation
- Daily current inpatient census

9.18 Skilled Nursing Facility Transitions

Kaiser Permanente partners with Post Acute Analytics (PAA) to automate the Skilled Nursing Facility (SNF) Prior Authorization and SNF Concurrent Review processes by using the Anna™ software platform. All contracted hospitals and skilled nursing facilities that admit Kaiser Permanente Medicare Advantage, Commercial, and Medicaid members are required to work with PAA and use Anna™.

Hospitals are required to:

- Request and receive SNF authorization via Anna™
- Identify the accepted SNF
- Communicate that authorization to the SNF

SNFs are required to:

- Notify Kaiser Permanente of a member's arrival into a SNF (admission verification notification) through Anna™
- Conduct SNF concurrent review processes, including providing clinical documentation to receive authorization of additional days beyond the initial approved days within Anna™

9.19 Case Management Programs

Making a referral for Case Management Services

You or the member may request case management services via the self-referral telephone line by calling ☎ 301-321-5126 or toll free ☎ 866-223-2347. This confidential self- referral line is available 24hours/7 days a week. Please leave a detailed message and contact information.

CareConnect Program for Complex Case Management

Kaiser Permanente CareConnect program supports the social and medical needs of our most vulnerable members with the goal of helping them make progress and stabilize their health status. The mission of CareConnect program is to assist members with an intense need for management and coordination of care or an extensive use of services. Core features of the program include consent from the member for participation, an extensive initial assessment and the development of a detailed care plan as well as a self-management plan.

Key to the success of CareConnect is the identification of appropriate members for enrollment in the program. The program makes use of two primary strategies to identify members, i.e., referrals (including self -referral) and data reports. CareConnect is available to all members who meet the program criteria.

Renal Case Management (RCM)
The RCM program is designed as an outcome-based, continuous quality improvement model that requires physician collaboration and inter -agency cooperation in order to utilize disease management tools, including multidisciplinary pathways and guidelines. Clinical practice guidelines published by the National Kidney Foundation, Kidney Disease Outcomes Quality Initiative (KDOQI) provide the evidence-based framework for Kaiser Permanente renal case management protocols. The goals of the program are: (1) to improve quality of life and continuity of care; (2) maximize member self-care and health-preserving behaviors, and (3) decrease costs associated with avoidable member morbidities and system inefficiencies. Currently, case management interventions are initiated for the member population with a Glomerular Filtration Rate (GFR) of < 30.

To refer members to the RCM Program, please call ☎ 301-816-5955 or ☎ 800-368 5784 Extension 8897 5955.

Transplant Services
KPMAS contracts with local and national centers of excellence for transplant services. Referring Participating Providers should work with our transplant coordinators when they identify a member who may be a candidate for transplantation or requesting a referral for transplant from the PCP.

Transplant candidates should be routed through the Transplant Coordination. Please call the National Transplant Services (NTS) Department at ☎ 888-989-1144, then ask to be connected to the transplant on-call coordinator to refer a member for an evaluation for a transplant or to receive additional information about the NTS.

Pre-Natal and Infant Program Overview
At Kaiser Permanente, we provide a comprehensive prenatal and postnatal program to support positive outcomes for mothers and babies. Our program is designed to support maximum health of mothers to help reduce infant mortality and morbidity. To support mothers throughout pregnancy and after the birth of their babies we focus on all their needs including medical and non-medical that impact their well-being and that of their babies.

Neonatal Care for Premature and Medically Complex Newborns
Kaiser Permanente partners with ProgenyHealth, a company which specializes in Neonatal Care Management Services. Progeny Health's Neonatologists, Pediatricians and Neonatal Nurse Care Managers work closely with Kaiser Permanente members, as well as attending physicians and nurses, to promote healthy outcomes for Kaiser Permanente premature and medically complex newborns.

For contracted and non-contracted facilities, please send transfer requests that require prior authorization directly to ProgenyHealth by secure fax 877-485-4872 or by phone 1-888-832-2006 prior to the transfer occurring. For adverse benefit determinations, a Peer-to-Peer may be requested with ProgenyHealth by calling 1-888-832-2006 and following the prompts for the Physician Advisor Line. ProgenyHealth will send notification of determinations via secure fax and provide verbal notification as applicable.

High Risk Pregnancies
For moms who have special medical or psychosocial needs during pregnancy, Kaiser Permanente has the Comprehensive Perinatal Program (CPP). This program is designed to provide support to women experiencing high risk pregnancies due to medical and/or psychosocial issues. The program also aims to improve a woman's chance of having a healthy, full-term infant and to decrease neonatal intensive care unit (NICU) admissions. Based on the initial and on-going assessments, obstetric (OB) providers can refer a woman to the program at any time during pregnancy. Registered Nurses with high-risk OB expertise, licensed counselors, and clinical social workers will work with the member to develop a care plan to maximize her chances of having a healthy baby. CPP staff coordinate needed medical and non-medical assistance and provide on-going follow-up to women in the program.

The Comprehensive Perinatal Program consists of:

Early Start: provides support for pregnant women experiencing issues of substance abuse, including alcohol and tobacco. After delivery, women have the option to continue in the Early Start Program for one year to prevent relapse.

Perinatal Service Center: telephonically manages pregnant and early postpartum women who are experiencing specific medical issues (i.e., gestational, or pre-gestational diabetes, gestational hypertension, preeclampsia, and preterm labor).

Perinatal Case Management: provides information and referrals for pregnant and early postpartum women with specific social determinants that might increase their risk of delivering a pre-term, low birth weight or otherwise compromised baby (i.e., unstable housing, food insecurity, domestic violence, transportations barriers and unemployment).

Pediatric High–Risk Case Management
Our commitment to the health and well-being of moms and their babies continues after a baby is born. Babies or moms who need extra assistance to make the transition home from the hospital can be referred to our Pediatric Case Management Department for follow-up.

Attachment A

Uniform Consultation Referral Form

Date of Referral:		**Carrier Information:**
Patient Information		Name: Kaiser Permanente
Name: (Last First, MI)		Address:
Date of Birth: (MM/DD/YY)	Phone:	Phone Number: 1-800-810-4766
Kaiser Member #:		Facsimile/Data #: 1-800-660-2019
Site #:		

Primary or Requesting Provider

Name: (Last, First, MI)	Specialty:	
Institution/Group:	Provider ID#: 1	Provider ID#: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number:	Facsimile/ Data Number:	

Consultant/Facility Provider

Name: (Last, First, MI)	Specialty:	
Institution/Group:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone #: (703) 698-7100	Facsimile/ Data #: (703)-207-9457	

Referral Information

Reason for Referral:

Brief History, Diagnosis, Test Results:

Services Desired: Provide Care as Indicated:	Place of Service:
☐ Initial Consultation Only: ☐ Diagnostic Test: (specify) _____ ☐ Consultation with Specific Procedures: (specify) _____ ☐ Specific Treatment: ☐ Global OB Care & Delivery ☐ Other: (Explain)	☐ Office ☐ Outpatient Medical/Surgical Center * ☐ Radiology ☐ Laboratory ☐ Inpatient Hospital * ☐ Extended Care Facility * ☐ Other: (Explain) * (Specific facility must be named.)

Number of Visits: (If blank, 1 visit is assumed)	Authorization #: (If required)	Referral is Valid Until: (Date) _____ (See Carrier Instruction)

Signature: (Individual completing form)	**Authorizing Signature:** (If required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

Attachment B
Emergency Department Visit Notification Form

Emergency Care Management (ECM) Department
Contracted Facility_____
ECM Fax Number: 855-414-2634
Name/Department_____
ECM Telephone Number: 844-552-0009
Date _____Fax Number_____

Telephone Number_____

Patient's Name	KP Medical Record Number	Date of Birth	Date of Service	Complaint/ Diagnosis	To Be Completed by KPMAS ECM Staff	
					Visit entered? (Y or N)	Message sent to health care team? (Y or N)

To Be Completed by Kaiser Permanente	If Visit or Message was not completed above, please explain below
Date Received _____ **ECM Rep_____**	

CONFIDENTIALITY NOTICE
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