



Transplant Provider Manual Kaiser Permanente Self-Funded Program

Utilization Management

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4 Section 4: Utilization Management

4.1 Overview of UM Program

The ultimate goal of utilization management is to determine what resources are necessary and appropriate for an individual Self-Funded Member, and to provide those services in an appropriate setting and in a timely manner. Kaiser Permanente utilization management consists of prospective and concurrent review programs, in which we assess the Self-Funded Member's medical condition using evidence based criteria for medical appropriateness and the professional Provider's judgment.

Kaiser Permanente's utilization management program and procedures are:

- Based on objective guidelines adopted by Kaiser Permanente
- Used to determine medical necessity and appropriateness of care, and
- Intended to establish whether services provided or to be provided are covered under a Self Funded Member's benefit plan

The ultimate decision on whether to proceed with treatment rests with the Provider and Self Funded Member.

4.2 Medical Appropriateness

Kaiser Permanente and affiliated hospitals, physicians and health care professionals make medical decisions based on the appropriateness of care for the Self-Funded Member's medical needs. Kaiser Permanente does not compensate anyone for denying coverage or service, nor does Kaiser Permanente use financial incentives to encourage denials. In order to maintain and improve the health of Members, all Providers should be especially vigilant in identifying any potential under utilization of care or services.

Kaiser Permanente encourages open Provider-patient communication regarding appropriate treatment alternatives. We do not penalize Providers for discussing medically necessary or appropriate care with our Health Plan Members.

Our Health Plan Members have the right to choose treatment or service options regardless of benefit coverage limitations. Providers are encouraged to communicate appropriate treatment options, even when the options are not covered by the Self Funded Members benefit plan. If the Provider and patient decide upon a course of treatment that is not covered under the Self-Funded Member's benefit plan the Member should be advised to contact the Member Services Department in his/her Kaiser Permanente home region for possible coverage options. Members must be made aware that there is a cover over and above their benefit plan coverage for that care.

If the Member is dissatisfied with this arrangement, the Members should be advised to contact the Member Services Department for an explanation of their benefit plan. If the Member persists in requesting non-covered services, and the Provider is willing to provide such service, the Provider should make payment arrangements directly with the Member in advance of any non-emergent treatment provided and have the SF Member sign the financial responsibility form.

4.3 Advance Directives

An Advance Directive is a written instruction recognized under State and Federal law, such as a living will or Durable Power of Attorney for Healthcare.

Kaiser Permanente requires that all contracted Providers comply with the federal Patient Self-Determination Act of 1990 which mandates that a patient must have the opportunity to participate in determining the course of his/her medical care, even when patient is unable to speak for him or herself. The federal law applies to emancipated minors, but does not apply to all other minors.

To ensure compliance with governing law, the existence of any Advance Directive must be documented in a prominent place in the medical record. The Provider shall provide written information regarding Advance Directives to all Members admitted to the hospital, and provide staff and patient education regarding Advance Directives.

If a Self Funded Member who is a patient wishes to execute or modify an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss the decision with the Member. The attending physician will write a progress note in the Members medical record to reflect the adoptions of, or change to, an Advance Directive.

An Advance Directive may be revoked by the Member at any time, orally or in writing, as long as the Member is capable of doing so. An Advance Directive is automatically invalidated by divorce if the spouse was designated as the surrogate decision-maker prior to the divorce.

Self Funded Members are provided with information regarding Advance Directives in the Evidence of Coverage, the Healthwise Handbook, as well as "New Member" materials. Self Funded Members may also contact Member Services regarding Advance Directives for an informational brochure and appropriate forms.

4.4 Transplant Authorization

All authorization decisions include review for medical necessity. All requests for authorizations should be done in advance. Claims will be denied for lack of authorization.

Failure to obtain authorization prior to providing services will result in a denial of payment. UM decisions will be issued to your office and to the Self-Funded Member upon completion of the review process. Receipt of complete clinical information with the initial request will expedite the process.

Authorized services must be rendered before the expiration date stated on the Transplant Authorization Form. Each authorization identifies a specific number of approved visits, as well as, specific services. Additional authorization must be obtained by contacting the Transplant Coordinator for care beyond the expiration date.

Transplant authorizations are issued for three stages of a transplant case:

1. Pre-transplant Evaluation and Care Period: Services provided to a patient being evaluated for transplantation or are waiting for transplantation. This stage usually begins when a patient is listed for transplantation.
2. Transplant Period: This stage begins the day of transplant and concludes at the end of the follow up period as defined in the Agreement. This authorization will cover both inpatient and outpatient services. When services are reimbursed by a case rate payment methodology, the case rate is inclusive of all charges, including, but not limited to, both hospital and physician services.
3. Post Transplant Period: This stage covers outpatient follow-up services following the transplant period, but may also include inpatient and home health services.

4.5 Referral Procedure

Members that have been deemed potential candidates for transplant services are referred by their local Kaiser Permanente Medical Group physician to a contracted COE for evaluation. The referring region and physicians work with the NTN Hub Transplant Coordinator to ensure that patient selection criteria are applied consistently and appropriately. The referrals are issued for non-emergency hospital or physician services. All referrals must be authorized by the Self-Funded Member's Kaiser Permanente home region before transplant services are rendered. If you have any questions or need assistance with authorized referrals contact the NTN Hub Transplant Coordinator responsible for the Self-Funded Member's care.

If treatment is required, but is not specified in the authorized referral, you must obtain additional authorization for the service. Please contact the appropriate NTN Hub

Transplant Coordinator to obtain authorization. Hub telephone numbers can be found in the Key Contacts Section of this Manual.

Hub personnel do not authorize or deny service, rather, they act as a liaison between the Center of Excellence, the referring Kaiser Permanente Region, and referring physician. In addition, Hub personnel receive Member eligibility and benefit information from the Self-Funded Member's Health Plan Representative. Hub personnel do not make determinations regarding Member eligibility or benefits.

4.5.1 Admission to Skilled Nursing Facility (SNF)

Transfers from the contracted COE to SNF facilities will be facilitated by the hospital discharge planning staff. All SNF services require an authorization. Please contact the appropriate NTN Hub Transplant Coordinator to obtain authorization. Hub telephone numbers can be found in the Key Contacts Section of this Manual.

4.5.2 Home Health/Hospice Services

All Home Health/Hospice services require an authorization. Please contact the appropriate NTN Hub Transplant Coordinator to obtain authorization. Hub telephone numbers can be found in the Key Contacts Section of this Manual.

4.5.3 Durable Medical Equipment (DME)

All DME services require an authorization. Please contact the appropriate NTN Hub Transplant Coordinator to obtain authorization. Hub telephone numbers can be found in the Key Contacts Section of this Manual.

4.6 Emergency and Urgent Care Services

When Members present in your Emergency Room for treatment, we expect that you will triage and treat them in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements, and that you will contact the NTN Transplant Hub that issued the transplant authorization after the patient has been stabilized, but prior to the patient's diagnostic evaluation.

In the event that an emergent inpatient admission or other emergent service is needed, in order to expedite reimbursement and facilitate case management, please follow these procedures:

1. Contact the NTN Transplant Hub to immediately report the admission. Hub telephone numbers can be found in the Key Contacts Section of this Manual.
2. Provide the NTN Transplant Coordinator with the following information:

- Member Name
- Member Identification Number
- Your name
- Admitting Hospital or Facility
- Admitting Diagnosis
- Proposed Treatment and LOS
- Date of Admission

The contracting facility is also responsible for notifying KP of all inpatient emergency admissions. Calls must be received within *24 hours* of the admission. Failure to notify Kaiser Permanente within this time frame may result in the denial of payment for services.

4.7 Case Management

Kaiser Permanente has a transplant support structure of nurse transplant coordinators. The coordinators assure continuity of care by acting as liaisons between Kaiser Permanente and the transplant COE. The Transplant Coordinator manages all phases of the transplant continuum of care for Kaiser Permanente Self-Funded Members. There are three NTN Hubs located in the Rockville, MD, the Northern California Hub located in Oakland, CA and the Southern California Hub located in Los Angeles, CA.

Each Hub Manager is responsible for management, oversight and continued development of the daily Hub operations. Clinical oversight of the Hub is provided by a Hub Medical Director. Additional staff includes transplant assistants, data analysts, and other support personnel.

Patient referral and case management is the responsibility of the Hub assigned to the Self-Funded Member's home region. The Transplant Coordinators are responsible for case managing the patients from the beginning of the transplant care path with the COE, until they return home to the care of a local Kaiser Permanente physician. The Hub staff also facilitates return appointments to the COE, if determined to be necessary.

4.8 Drug Formulary

Kaiser Permanente's drug formulary is developed, updated and maintained by a group of Kaiser Permanente physicians, pharmacists, and nurses who meet regularly to evaluate medications that are most effective, safe, and useful in caring for our Members. Using formulary medications helps Kaiser Permanente maintain a high quality of care for our Members while helping to keep the cost of prescription medications affordable. Kaiser Permanente reviews and updates the formulary regularly

throughout the year. To obtain a copy of our drug formulary, please contact our Provider Contracting & Network Management Department at 510-268-5448.

Kaiser Permanente uses a closed formulary, which means that only those medications included in the formulary are offered under the Member's prescription drug benefit. Non-formulary or designated criteria restricted medications may be offered, but require prior authorization.

4.9 Grievances and Appeals

If a Self-Funded Member raises a question about grievances or appeals with your office, please refer the Self-Funded Member to the Self-Funded Customer Service Department at 866-213-3062 1-800-533-1833 may be the right number. The phone number is also located on the back of the Self-Funded Member's identification card. Self-Funded Customer Service will provide information to the Self-Funded Member on grievances and Member appeal rights.

4.9.1 Member Appeals

Adverse benefit determinations may be appealed only by a Self-Funded Member. Self-Funded Members are made aware of their right to appeal through their Summary Plan Description (SPD) provided by the Plan Sponsor, or by calling the Self-Funding Customer Service Department, which can provide information about the time frames for submitting appeals and for responses. Time frames may vary, depending on whether the adverse benefits determination relates to urgent care, or a pre-service or post-service claim.

4.9.2 Non-Urgent Member Appeals

An appeal may be initiated by the Self-Funded Member or the Self-Funded Member's authorized representative, who may be a Provider who is authorized in writing by the Self-Funded Member to act on behalf of the Self-Funded Member.

Formal appeals should be submitted using one of the options provided below with the following information included:

- All related information (any additional information or evidence)
- Name and identification number of the Member involved
- Name of Member's contracted PCP
- Service that was denied
- Name of initial Kaiser Permanente reviewing physician, if known

Option	Description
#1	By mailing directly to: Kaiser Permanente Insurance Company Member Appeals Unit 3701 Boardman - Canfield Rd. Canfield, Ohio 44406
#2	By faxing to the following number: ATTN: Kaiser Permanente Insurance Company Member Appeals Unit 614-212-7110

KPIC will provide a complete review of the claim and will notify the Self-Funded Member and any authorized representative of the decision in writing. If the initial denial is upheld following the review of the appeal, KPIC will send an explanation of the decision and any further appeal rights.

A non-ERISA Self-Funded Member should also call Self-Funding Customer Service for a description of appeal rights applicable to Members of Self-Funded non-ERISA groups.” It is possible that that state law UM and appeals requirements might apply to non-ERISA groups. State insurance laws usually have appeal rights and some state insurance laws will be applicable to non-ERISA groups. This will vary by state and it could vary among non-ERISA groups. This would have to be considered on a case-by-case basis.

The second possibility is that the non-ERISA Plan Sponsor may by contract (in the benefit plan) provide appeal rights. In any case, it is likely a non-ERISA Self-Funded Member will have a right to appeal adverse benefit determinations.]

4.9.3 Urgent Member Appeals

Urgent appeals are available in circumstances where the normal processing time could result in serious jeopardy to the Members’ health, life or ability to regain full function.

Please call Self-Funded Customer Service at 866-213-3062 to initiate an urgent appeal.

For urgent appeals, the decision will be rendered as quickly as possible, contingent upon the promptness of the Self-Funded Member/Provider in providing necessary additional information requested, but no later than 72 hours after receipt of the claim.