Kaiser Permanente
UTILIZATION MANAGEMENT PROCESS
September 2026

Kaiser Permanente provides services directly to our members through an integrated care delivery system made up of Kaiser Foundation Health Plan, Inc. (the Plan), Kaiser Foundation Hospitals, and Permanente Medical Groups. These three parts of the Kaiser Permanente care delivery system work together to help ensure that members receive quality care.
Managing how health care services and related resources are used helps improve the delivery of health care services and controls health care costs for you.

At Kaiser Permanente, physicians and healthcare professionals determine whether a service or treatment is clinically appropriate. Care is determined by the treating clinician based on their judgment of clinical appropriateness and not by Health Plan UM criteria. The Health Plan does not require prior authorization once members are referred to a service, except for the services listed below.

Utilization Management (UM) is a health plan process that reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by your treating provider. If the service or item is medically necessary, then you will be authorized to receive that care in a clinically appropriate place consistent with the terms of your health coverage. The determination of whether a service is medically necessary is based upon criteria that are consistent with and supported by sound clinical principles and processes, which are reviewed and approved annually by the Plan. For Medi-Cal members, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Guidelines may apply.

Please note that the UM process only addresses whether a healthcare service or item is medically necessary for you. It is separate from questions about whether the health plan you have selected covers a particular health care service or item, as described in your Evidence of Coverage. For example, your Evidence of Coverage may exclude coverage for supplemental Durable Medical Equipment, such as a wheelchair. In that case, you would not be covered for a wheelchair, even if the wheelchair could be found medically necessary for you in the UM process.

Prior Authorization

In the majority of cases, when your provider prescribes a course of treatment or plan of care for you, he or she is not required to request permission or authorization from the Plan to provide you with those services. Care is determined by the treating clinician based on their judgment of clinical appropriateness and not by Health Plan UM Criteria. In some specific situations, your provider will need to request permission from the Plan to provide you the recommended care under a process called Prior Authorization. The services that require Prior Authorization include:

Northern California Region	Southern California Region
Acupuncture Services	Acupuncture Services
Community-Based Adult Services for Medi-Cal members	Community-Based Adult Services for Medi-Cal members
Dental Anesthesia	Dental Anesthesia
Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods	Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
Home Health Continuous Shift Care and Home Health Shift Care/Private Duty Nursing for Medi-Cal Children (EPSDT)	Home Health Continuous Shift Care and Home Health Shift Care/Private Duty Nursing for Medi-Cal Children (EPSDT)
External (Out-of-Network) Referrals	External (Out-of-Network) Referrals
Occupational, Speech, and Physical Therapies	Home Venipuncture
Transplants – Solid Organ and Bone Marrow	
Hyperbaric Oxygen Therapy	
Chiropractic Care	

Please keep in mind that this list is subject to change without notice. In addition, please refer to your Evidence of Coverage to determine whether you have coverage for the services and items listed above. If you have coverage for these services and items, the Prior Authorization process will apply, and you will be authorized for these services if they are found to be medically necessary for you.

Northern and Southern California Regions

Acupuncture. Acupuncture may be considered a component of a comprehensive treatment program for members with a history of chronic pain (defined as pain of three months or more duration) or for the treatment of severe nausea, particularly due to chemotherapy. There is currently sufficient evidence to support the use of acupuncture as a treatment modality for these conditions; other conditions are reviewed on a case-by-case basis. If your provider prescribes acupuncture, a UM physician decision-maker will review your condition and determine if the services requested meet our formal coverage criteria.[1]

[1] *If you have supplemental coverage for acupuncture services through American Specialty Health Plan (ASH), you may self-refer for these services, and ASH will be responsible for the UM decision-making process.*

Community Based Adult Services (CBAS) (Medi-Cal Only). CBAS is a program for Kaiser Permanente Medi-Cal managed care members that stresses partnerships with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence for the frail elderly or adults (18 years old or older) with disabilities. You must also have one or more chronic or post-acute medical, cognitive, or mental health conditions, and you must need assistance with at least two activities of daily living. A UM physician decision-maker will determine if you meet these criteria for these services.

Dental Anesthesia. Dental Anesthesia and associated facility charges for dental procedures are a covered benefit when dental anesthesia is medically necessary based on clinical status or a qualifying medical condition. Medical necessity for dental anesthesia requires that specific medical criteria are met in accordance to the established Dental Anesthesia Utilization Guidelines for Commercial, CMS and Medi-Cal.

Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods. If your provider prescribes durable medical equipment such as a wheelchair, he or she will submit a written referral. If your coverage includes the item and it is listed on our durable medical equipment formulary for your condition, it will be approved. If the equipment requested doesn't appear to meet our formulary guidelines, it will be submitted to a UM physician decision-maker for review.

Prostheses are artificial devices attached or applied to the body to replace a missing part (for example, following a medically necessary mastectomy). Orthoses are devices externally applied to the body to aid the neuromuscular and skeletal system (for example, leg braces). If your provider prescribes a prosthetic or orthotic device, he or she will submit a written referral. If the device is covered by the guidelines or regulations that apply to you, it will be approved. If the device doesn't appear to meet these criteria, it will be submitted to an UM physician decision-maker for review.

Home Health Continuous Shift Care. This is defined as care for 8 hours or greater for an ongoing period of time or for a transitional period of time. The purpose of a transitional period of time is to assist the family member or other layperson caregivers with the completion of their training in order for them to assume 24-hour responsibility for the patient's care in the home setting.

The criteria to be met for continuous hourly Home Health care for an ongoing period of time are:

1. The services the patient requires in the home setting cannot be safely and effectively performed by an unlicensed family member or other layperson even with appropriate training and supervision, and
2. The services of the licensed nurse are required on a continuous hourly basis throughout a 24-hour period.

The criteria to be met for continuous hourly Home Health care for a transitional period of time are:

1. There is evidence that the family member or other layperson caregivers require further teaching, observation, and/or monitoring in order to safely and effectively perform the services the patient requires in the home setting, and
2. This is required for a defined temporary period of time that has a definite start and end point, and
3. There is a transition plan developed that shows a continuous gradual reduction in hours over a defined temporary period of time to less than 8 hours/day.

Home Health Shift Care/Private Duty Nursing for Medi-Cal Children (Medi-Cal Only). To be eligible for Home Health Shift care under the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT), you must be a Medi-Cal member under the age of 21 and must be stable enough that care can be safely delivered in a home setting. The home must be adequate to accommodate needed equipment, supplies, and personnel. Other eligibility requirements include:

- the family caregivers have been appropriately trained,
- all necessary supports and an emergency back-up plan are in place, and

- The primary caregiver demonstrates the willingness, skills and ability to provide the direct care, not paid for in the EPSDT supplemental services plan of care

The primary care physician must order the home health shift care evaluation. Once the necessary clinical assessments/documentation have been completed and reviewed, the primary treating physician will make a referral for the medically necessary EPSDT Supplemental Shift Nursing Services needed and submit the referral to the local KP Home Health Agency. Requests for EPSDT Supplemental Nursing Shift Care Services are authorized through the Home Health Continuous Hourly Care Committee.

External (Out-of-Network) Referrals. If your provider prescribes covered services that cannot be provided by a Kaiser Permanente health care provider, he or she will recommend that you be referred to a non-Kaiser Permanente provider (also known as Out-of-Network Referrals or services). Some Out-of-Network services are listed within this document because specific criteria apply to them (for example: Acupuncture, Chiropractic Care, Occupational, Speech, and Physical Therapies reauthorization). If the UM physician decision-maker determines that the Out-of-Network services are medically necessary for you, and are not available in Plan, they will be approved.

Occupational, Physical, and Speech Therapies (OT/PT/ST) (NCAL Only). The vast majority of habilitation and rehabilitation services are available at your local medical center. In some locations, some or all of the services are provided by contracted therapists. If you are referred for evaluation to a contracted therapist, ongoing treatment by the contracted therapist will be reviewed by a Plan provider to determine if the treatment plan is medically necessary and the services require the skill of a licensed OT, PT or ST provider.

Transplants (NCAL Only). In most cases, when your provider generates a consultation to the appropriate organ-specific specialist, the specialist performs diagnostic evaluation including consultation with other appropriate specialists to further ascertain if you are a potential candidate for organ transplant. The specialist may discuss your case in an organ-specific case conference. The case conference reviews and recommends whether you are a potential candidate for organ transplant. If deemed to be a potential candidate for transplant, you and the referring physician are notified and a referral to the selected Center of Excellence (COE) is arranged. The COE provides the consultation and makes the final determination as to whether you are a suitable candidate for transplantation.

Chiropractic Care (NCAL Only)**.** If you are a Kaiser Permanente Senior Advantage Member, your chiropractic care is limited to manual manipulation of the spine to correct subluxation (or restricted range of motion) of the spine related to pain. If you are a Medi-Cal member, your chiropractic care is limited to manual manipulation when prescribed by a Plan physician, with a maximum of two treatments per month. For all other members, a UM physician decision-maker will review your condition and will determine if the services are medically necessary for you.[2]

[2] *If you have supplemental coverage for chiropractic care through American Specialty Health Plan (ASH), you may self-refer for these services, and ASH will be responsible for the UM decision-making process.*

Hyperbaric Oxygen Therapy (NCAL Only)**.** Hyperbaric Oxygen (HBO) therapy provides a therapeutic dose of oxygen by creating a pressurized environment that increases the concentration of oxygen in the blood. It helps to stimulate the growth of new blood vessels and

acts to help to kill bacteria. There are very specific conditions in which HBO may be indicated. We will authorize these services if the UM physician decision-maker determines that they are medically necessary for your condition.

Home Venipuncture (SCAL Only)**.** We cover medically necessary phlebotomy services in the home only if prescribed by a Plan Provider and only if you meet the criteria for being Homebound. A member is considered to be homebound if he/she has a condition due to an illness or injury which causes the individual to be normally unable to leave home and, consequently, leaving his/her home would require a considerable and taxing effort; the blood draw requires the skills of a lab technician; the member lives within the Health Plan service area; and a Kaiser physician or pharmacist has certified your homebound status.

Clinical Decision-Making Criteria

Kaiser Permanente uses written objective criteria based on sound clinical evidence in making utilization management (UM) decisions. We have policies that establish how such clinical criteria are developed, adopted, and reviewed. When we make a UM decision that denies or modifies provider-requested services, we will communicate that decision to you in writing. That notification will include a clear and concise explanation of the reasons for our decision and the criteria or guidelines we used. UM decisions are always independently based on clinical criteria or scientific literature; they are never made on the basis of a financial incentive or reward. You will also be apprised of your right to appeal a decision and given the contacts to do so.

Qualified Medical Professionals

Qualified physicians or other appropriately qualified health care professionals review all Prior Authorization denials. Physicians who make UM decisions may be physician leaders for Outside Referral Services, physician experts, and/or members of physician specialty boards. They have appropriate education, training, and clinical experience related to the services being requested. When necessary, they will consult board-certified physicians in the associated specialty to assist them in making a UM decision.

UM Decision Time Frames

The physician UM decision-makers will make the UM decision within the time frame appropriate for your condition. A decision will be made no later than five (5) business days after receiving your provider's request for the services (or 7 calendar days for Medicare and Medi-Cal members). Decisions about urgent services will be made no later than 72 hours after receipt of the request. If more time is needed to make the decision because necessary information has not been received or because the physician UM decision-maker has requested consultation by a particular specialist, you and your treating provider will be informed about the additional information, testing, or specialist that is needed, and the date that the physician UM decision-maker expects to make a decision. Please refer to your Evidence of Coverage for information on the appeal process if you disagree with a UM decision.

The Kaiser Permanente Medical Care Program

As a Kaiser Permanente member, you have chosen to receive health care services from our integrated care delivery system made up of Kaiser Foundation Health Plan, Inc., the Permanente Medical Groups, and Kaiser Foundation Hospitals. The Kaiser Permanente Medical Care Program gives you access to all of the covered services you may need, such as routine care, hospital care, laboratory and pharmacy services, emergency services, urgent care, and other benefits as described in your Evidence of Coverage.

Generally, you must receive all covered care from Kaiser Permanente providers inside our designated service area (there are a few exceptions that are described in your Evidence of Coverage, such as authorized referrals to non-Kaiser Permanente providers, emergency services, and out-of- area urgent care).

Assistance with Utilization Management (UM) Issues and Processes

For more information about policies regarding financial incentives and how we control utilization of services and expenditures, or for information about UM issues or Processes, generally, call our Member Service Contact Center[3] at:

1-800-464-4000 (English)
1-800 788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
711 – California Relay Service (hearing/speech impaired)[4]
1-800-443-0815 (Medicare)[5]
1-855-839-7613 (Medi-Cal)

You may also inquire about UM processes or specific UM issues by leaving a voice mail after hours. Please leave your name, medical record number and/or birth date, telephone number where you can be reached, and your specific question. Messages will be responded to no later than the close of the next business day.

This description is only a brief summary of the Prior Authorization process. The precise criteria that are used for services that require Prior Authorization are available upon request from our Member Service Contact Center. Also, please refer to your Evidence of Coverage for authorization requirements that apply to Post-Stabilization Care from Non-Plan providers.

[3] Open 24 hours a day, seven days a week (except closed on holidays and closed after 5 p.m. on the day after Thanksgiving, on Christmas Eve, and on New Year's Eve.

[4] Open from 5 a.m.to 8 p.m. and from8 p.m.to 5 a.m., seven days a week (except closed on Holidays and closed after 5 p.m. on the day after Thanksgiving, on Christmas Eve and on New Year's Eve).

[5] Open from 8 a.m. to 8 p.m. seven days a week.