9.0 Utilization Management & Authorization

9.1 Overview

Overview
Kaiser Permanente UM activities include complex case management, skilled nursing facility case management, renal case management, facility-based utilization management, outpatient specialty referral management, home care, 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 and objective decision-making criteria ensure that decisions are fair, impartial, and consistent. Kaiser Permanente utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, and regionally developed Medical Coverage Policies (MCP). Additionally, the opinions of subject matter experts certified in the specific field of medical practice are sought 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 determinations 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**
- MCG™ – formerly called Milliman Care Guideline
- MCP: Medical Coverage Policies (Locally developed by Kaiser Permanente Mid-Atlantic States)
- NCD-LCD: Medicare Coverage Policies (National Coverage Determination & Local Coverage Determination)

<table>
<thead>
<tr>
<th>Referral Service Type</th>
<th>UM Approved Criteria Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Rehabilitation (inpatient)</td>
<td>MCG™</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>MCP</td>
</tr>
<tr>
<td>Behavioral Health: Inpatient</td>
<td>MCG™</td>
</tr>
<tr>
<td>Behavioral Health: Outpatient Services</td>
<td>MCG™</td>
</tr>
<tr>
<td>Behavioral Health: Partial Hospitalization</td>
<td>MCG™</td>
</tr>
</tbody>
</table>
| Durable Medical Equipment (DME) and Supplies  | 1. KPMAS MCP  
2. MCG™  
3. NCD-LCD   |
| Orthotics and Prosthetics                     | 1. KPMAS MCP  
2. MCG™  
3. NCD-LCD   |
| Home Health Services                          | MCG™                                                           |
| Hospice (In-patient/Out-patient)              | MCG™                                                           |
| Inpatient Services                            | MCG™                                                           |
| Neonatal Care                                 | MCG™                                                           |
| Outpatient Services                           | MCP/MCG™ Medical Coverage Policy of revised MCG™ NICU Levels  |
| PT/OT/Speech                                  | 1. KPMAS MCP  
2. MCG™   |
| Skilled Nursing Facility                      | MCG™                                                           |
| Transplant Services                           | NTS - National Transplant Services Patient Selection Criteria  |
| Source: Guide to UM Criteria by Line of Business (LOB), approved by RUMC on 04.2018 |
Note: Numbered criteria sets are used in order of hierarchy
The CMS National and Local Determination Policies are the primary sources for guidelines/criteria utilized in UM review of Medicare Cost members as applicable.

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: http://www.providers.kaiserpermanente.org/html/cpp_mas/newsletters.html.

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 the Kaiser Permanente Interregional New Technologies Committee (INTC) and Medical Technology Assessment Unit to assist physicians and patients in determining whether or not a new drug, procedure, or device is medically necessary and appropriate. TRIC recommends the inclusion or exclusion of new technologies as covered benefits to Health Plan and tracks inquiries for medical technology assessment. Together, they provide answers to important questions about indications for use, safety, effectiveness, and relevance of new and emerging technologies for the health care delivery system.

The INTC is comprised of physicians and non-physicians across Kaiser Permanente. If compelling scientific evidence is found indicating a new technology 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)

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. You can reach the Kaiser Permanente UM Department by calling 1-800-810-4766 (follow the prompts). The table below provides the specific UM hours of operations and responsibilities:
<table>
<thead>
<tr>
<th>UM Department Section</th>
<th>Hours of Operation</th>
<th>Core Responsibilities</th>
</tr>
</thead>
</table>
| Emergency Care Management (ECM)- Clinical Call Center Department | 24 hours/day, 7 days/ week, including holidays                                    | • Process transfer 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  
• Enter referrals for all in-patient admissions and Emergency Department notifications received from facilities  
• Assist with repatriations 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: 8:30 A.M. to 5:00 P.M.  
Weekends and Holidays: 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  
• Rehabilitative Therapies  
• Physical, Occupational and Speech Therapies | Monday through Friday: 8:30 A.M. to 5:00 P.M.  
Weekends and Holidays: 8:30 A.M. to 5 P.M. for Urgent and routine discharge care coordination referrals | • Conduct pre-service and concurrent review of Home Care, Durable Medical Equipment, Physical Therapy, Occupational Therapy and Speech Therapy  
• Post-service review provided to Kaiser members outside a Kaiser medical facility |
<p>| Non-Behavioral Health located at affiliated hospitals | Seven days a week and Holidays 8:30 A.M. to 5:00 P.M. | Conduct concurrent review and transition care management |
| Skilled Nursing Facility (SNF) and, Rehabilitation | Monday through Friday | Conduct concurrent review and transition care management for |</p>
<table>
<thead>
<tr>
<th>UM Department Section</th>
<th>Hours of Operation</th>
<th>Core Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and Long Term Acute Care Hospitals (LTACH)</td>
<td>8:00 A.M. to 4:30 P.M. Excluding weekends and major holidays</td>
<td>members in the acute rehab and SNF settings</td>
</tr>
<tr>
<td>UM Hospital Services – Behavioral Health located at affiliated hospitals:</td>
<td>Seven days a week: 8:00 A.M. to 4:30 P.M. Including major holidays</td>
<td>Conduct concurrent review and transition care management services of behavioral health service</td>
</tr>
<tr>
<td>UM Outpatient Services – Behavioral Health</td>
<td>Monday to Friday: 8:00 A.M. to 4:30 P.M. Excluding weekends and major holidays</td>
<td>Conduct Pre-service and concurrent review of behavioral outpatient services</td>
</tr>
<tr>
<td>Outpatient Continuing Care, Complex Case Management and Renal Case Management</td>
<td>Monday through Friday: 8:30 A.M. to 5:00 P.M. Excluding weekends and major holidays</td>
<td>Conduct outpatient medical case management and care coordination for medically complex members and End Stage Renal Disease Members</td>
</tr>
</tbody>
</table>

Source: UM Policy # 3, Section 5.0 approved by RUMC on 08/29/2017

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 normal business hours are returned on the next business day.

After business hours, members' first line of contact is through the Kaiser Permanente Member Services Department. Members are instructed to follow prompts to be directed to the Call Center. The phone number is listed on member’s ID card.

After business hours, practitioners and providers may contact the UMOC toll-free number at 1 800-810-4766, Option 2 (Provider) and follow prompts to be directed to Call Center (available 24 hours, 7 days a week).

UM staff receive inbound communication regarding UM issues after normal business hours through:

- Utilization Management Operations Center (UMOC) telephonic toll-free number 800-810-4766, Option 1 (Member) or Option 2 (Provider):
- Facsimile sent to UMOC – (301) 879-6192
- Kaiser Permanente Health Connect Online Affiliate
- Kaiser Permanente Health Connect (KPHC) messaging system-available to those providers linked to the KPHC system
- Direct email to a UM staff person
9.5 Communication Services to Members with Special Needs

Communication with deaf, hard of hearing or speech-impaired members is handled through Telecommunications Device for the Deaf (TDD) or teletypewriter (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 of 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 (Durable Medical Equipment): 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 Primary Care Physician. 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 1-800-810-4766 (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:
  o Completing a Uniform Referral Form (URF) and fax it to the Utilization Management Operations Center (UMOC) at Fax 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 1 (800) 810-4766 to determine if the care is authorized and if so, obtain a referral number, which should be noted on the claim/bill for these services.

Basic diagnostic testing 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
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 Uniform Referral or the KPMAS Referral request to the Utilization Management Operations Center (UMOC) via Fax ☏ 1 (800) 660-2019.
-OR-
MAIL
Mail a copy of the Maryland Uniform Referral or the KPMAS Referral request to:
Utilization Management Operations Center
11900-A Bournefield Way
Silver Spring, Maryland 20904

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 Utilization Management Operations Center (UMOC) at Fax ☏ 1 (800) 660-2019.
Step 4: Ensure that any required clinical documentation accompanies the referral request.
Step 5: Complete the referral form and attach appropriate lab, x-ray results, or medical records. Incomplete referrals will be faxed back to the Participating PCP or Participating Specialist office with request to include required information. Be sure to include fax numbers on the request.
Combined Referral Requirements:

1. **Urgent Referrals**: Determinations will be made within 24 hours of receipt of the request for urgent referrals submitted with appropriate documentation.
   - Questions on urgent referrals call ☎️ 1 (800) 810-4766, follow the prompts.

2. **Standard Referrals**: Standard referral requests will be handled within two (2) working days of receipt of the information necessary to make the determination.

3. Once processed and approved, the referral form with the authorization number will be returned by fax to the Participating PCP and to the Participating Specialist. It is the responsibility of the Primary Care Physician office and Participating Specialist office to ensure that Kaiser Permanente has accurate fax numbers on file to ensure timely and efficient communication of referral information.

4. Participating Specialists must send a written report of their findings to the Participating PCP, and should call the Participating PCP, if their findings are urgent.

5. All consulting specialists’ reports must be reviewed, initialed, and dated by the referring physician and maintained in the member’s chart.

6. After an initial consult, if the Participating Specialist believes the member will require continued treatment, the Participating Specialist must submit a referral request to the Utilization Management Operations Center (UMOC).

7. For laboratory or radiology services, members should be directed to Participating laboratory or radiology providers, or to a Kaiser Permanente Medical Center.

C. **Standing Referral Requirements (Authorization Required)**

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

The Participating PCP may request a “Standing Referral” to a Participating Specialist for care which will most appropriately be coordinated by the Participating Specialist for such condition. A Participating Specialist is a physician who is part of the Health Plan’s provider panel. Standing referral to a specialist is provided if:

1. The primary care physician of the member determines, in consultation with the specialist, that the member needs continuing care from the specialist,
2. The member has a condition or disease that
   - 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
2. The Health Plan cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

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

Following patient consultation, Participating Providers should follow the procedures below when referring a member for radiology services:
1. Provide the member with a script for the necessary radiological/imaging service.
2. Instruct the member to contact Kaiser Permanente to secure a radiology/imaging appointment.

The member may contact the Radiology Department at 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/imaging service requested is not available at a Kaiser Permanente Medical Office Building or Imaging Center, an external referral request may be provided to a community-based group or facility within our Participating Provider Network. Kaiser Permanente Select Members may elect a referral to a community-based provider 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 KP 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 AffiliateLink.
  o If you receive Kaiser Permanente referrals electronically, you may view and print your approved referral by logging-on to Kaiser Permanente HealthConnect AffiliateLink at www.providers.kp.org/mas.
  o If you do not receive referrals electronically from Kaiser Permanente, the referral will be sent to your office via fax upon approval by our Utilization Management Operations Center.

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 Utilization Management Operations Center 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 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 Mid-Atlantic Permanente Medical Group (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.

Members should be given an order or 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 KP HealthConnect AffiliateLink 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 Utilization Management Operations Center (UMOC) at 1-800-810-4766, 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. CT Scans (Computerized Tomography)
   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 Marrow

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

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 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
Commercial¹: DC, Federal, Maryland and Virginia

<table>
<thead>
<tr>
<th>Priority of Request</th>
<th>Jurisdiction</th>
<th>Determination Timeframe</th>
<th>Approval: Telephonic, Oral or Electronic Notification to Provider</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Request</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Concurrent</td>
<td>Maryland</td>
<td>Within one (1) day of receipt of request</td>
<td>Within one (1) day of receipt of request</td>
<td>Within one (1) day of receipt of request</td>
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<tr>
<td></td>
<td>Virginia</td>
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<td></td>
<td>District of Columbia</td>
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<td>Self- Funded</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Urgent Request</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Pre-Service</td>
<td>Maryland</td>
<td>Within one (1) day of receipt of request</td>
<td>Within one (1) day of receipt of request</td>
<td>Within one (1) day of receipt of request</td>
</tr>
<tr>
<td></td>
<td>Virginia</td>
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<tr>
<td></td>
<td>District of Columbia</td>
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<tr>
<td></td>
<td>FEHBP</td>
<td></td>
<td>3 calendar days of receipt of request</td>
<td>3 calendar days of receipt of request</td>
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<tr>
<td></td>
<td>Self-Funded</td>
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<td></td>
<td></td>
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<tr>
<td>Non-Urgent Request</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(Routine)</td>
<td>Maryland</td>
<td>Within two (2) business days after receipt of all necessary information</td>
<td>Within one (1) business day after decision is made</td>
<td>MD: Within five (5) business days after decision is made</td>
</tr>
<tr>
<td>• Pre-Service</td>
<td>Virginia</td>
<td></td>
<td>Within two (2) business days after receipt of all necessary information</td>
<td>Within two (2) business days after decision is made</td>
</tr>
<tr>
<td></td>
<td>District of Columbia</td>
<td></td>
<td>Within 15 calendar days of receipt of request</td>
<td>Within 15 calendar days of receipt of request</td>
</tr>
<tr>
<td></td>
<td>FEHBP</td>
<td>Self-Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post service</td>
<td>Maryland</td>
<td>Within 30 calendar days of receipt of request</td>
<td>Not Applicable</td>
<td>Within 30 working days of receipt of request</td>
</tr>
<tr>
<td></td>
<td>Virginia</td>
<td></td>
<td></td>
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<td></td>
<td>District of Columbia</td>
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<td></td>
<td>Federal</td>
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<tr>
<td></td>
<td>Self-Funded</td>
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</table>

Source: UM Policy #11, Section 6.0 approved by RUMC on 04.27.2018.

¹ Commercial Lines of Business includes Federal, Maryland, D.C and Virginia. Timeliness guideline is based on State of Maryland requirement. Maryland Insurance Article Section 15-10B-06.
² NCQA UM 5: Timeliness of UM Decisions: post service decision.
Medicare

Medicare Urgent/Expedited Referrals

<table>
<thead>
<tr>
<th>Determination Timeframe</th>
<th>Oral Notification to the Member (See Section 7.2)</th>
<th>Written Notification to the Member and Requesting Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 72 hours of receipt of the request</td>
<td>Within 72 hours of receipt of the request</td>
<td>Within 3 calendar days after providing oral notification</td>
</tr>
</tbody>
</table>

Source: UM Policy # 17, Section 8 approved by RUMC on 09/27/2017.

3 Medicare members based on Medicare Managed Care Manual Chapter 13: Medicare Managed Care Beneficiary Grievances, Organization Determinations and Appeals.

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

<table>
<thead>
<tr>
<th>Determination Timeframe</th>
<th>Written Notification to the Member and Requesting Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within fourteen (14) calendar days of receipt of request</td>
<td>Within fourteen (14) calendar days of receipt of request</td>
</tr>
</tbody>
</table>

Source: UM Policy # 17, Section 9 approved by RUMC on 09/27/2017.

• Participating Providers requesting reconsideration of a service denial on behalf of the KPMAS member may call 1-888-989-1144, and request to speak with the UM physician on-call within 24 hours of the verbal notification of the adverse decision.

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) 777-7904 toll-free; (866) 513-0008, TTY or by fax (301) 816-6192.

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:
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 the mother and/or fetus.

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

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

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

The Emergency Care Management Department coordinates the following:
  • Emergency Room visits
  • 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 or Behavioral Health Care Practitioner.

The Emergency Care Management Department can be reached by phone at 844-552-0009 or
fax at (301) 879-6192 or toll free 1-855-414-2634.

Notification or referrals regarding an ED visit can be done by simply using the Emergency Room
(ER) Hospital Notification Form. The form can be faxed to 1 (855) 414-2634. Additionally,
notification can be made by calling 1 (844) 552-0009. (Please reference Attachment B at end
of Utilization Management section of this manual for the ER Hospital Notification Form).
If a member requires inpatient admission after an ED visit, please be sure to notify Emergency Care Management (ECM) 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 Emergency Care Management (ECM) Department to arrange ambulance transportation other than 911, please call our ECM at ☏ 1 (844) 552-0009. Please provide the following information to the ECM representative:

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

**9.15 Durable Medical Equipment and Home Health Care**

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

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

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

1. Complete the Uniform Consultation Referral form; 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 at 1-844-552-0009 and/or fax 1-855-414-2634.

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 1 (800) 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 Permanante participating facility where you have privileges, or to the nearest emergency room. (See Section 2 for listing)

Step 2: Contact the ECM at 1-844-552-0009 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 1-844-552-0009 or ED visits can also be faxed to 1-855-414-2634. Emergency Care Management 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 Emergency Department for urgent and/or emergent care services. This notification will ensure that our members are being given the best coordination and follow-up care possible.

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

Option 1: Fax Option: Complete the Emergency Department Visit Notification Form and fax to the ECM Department at 855-414-2634. A copy of the Emergency Department Visit Notification Form can be located at the end of this section.

Option 2: Contact ECM by calling 1-844-552-0009.

All emergency room notifications should include the following information:
- Member Name
- Member Medical Record Number (MRN)
- Name of the Referring Physician (if applicable)
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 Utilization Management nurses by telephone. **Failure to provide the clinical information within the required timeframe may result in an administrative denial due to lack of information.** The Participating Hospital cannot hold the member financially responsible for the denial. The Utilization Management nurse may contact the attending physician if further clarification of the member’s clinical status and treatment plan is necessary. The Utilization Management nurse uses Kaiser Permanente approved criteria to determine medical necessity for acute hospital care. If the clinical information meets Kaiser Permanente’s medical necessity criteria, the days/service will be approved. If the clinical information does not meet medical necessity criteria, the case will be referred to the Utilization Management Physician. Once the Utilization Management Physician reviews the case, the Utilization Management nurse will notify the attending physician and the facility of the outcome of the review. The attending physician may request an appeal of any adverse decision. The Participating Hospital cannot hold the member financially responsible 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 coverage. They include the following:

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

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

- **Delay in service denial:** An administrative denial rendered when a service ordered in a facility was delayed; the delay was avoidable (i.e., not the result of a change in the member’s condition or for other clinical reasons); and the delay resulted in a longer length of stay than expected if the delay did not occur (avoidable day or days). This also includes denials where a provider failed to follow an approved course of treatment.
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, SNF or physician category. This table lists hospital and SNF services that hospitals and SNFs, respectively, are expected to be able to deliver seven days a week, provided that such services are within the scope of the provider/facility’s services. Note: This is not an exclusive list.

### I. Hospital Delays

#### Diagnostic Testing/Procedures
- MRI CT scans (test performed/read/results available)
- Other Radiology delays (test performed/read/results available)
- Laboratory tests (test performed/read/results available)
- Cardiac catheterization delays (including weekends and holidays)
- PICC Line placement
- Echocardiograms
- GI Diagnostic procedures (EGD, Colonoscopy, ERCP, etc.)
- Stress tests
- Technical delays (i.e., machine broken or machine is not appropriate for patient, causing delay)
- Dialysis
- Transfusions
- AFBs
- Pathology

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

#### Ancillary Service
- PT/OT/Speech evaluation
- Social Work/Discharge Planning

#### Nursing
- Delay in carrying out or omission of physician orders
- Medications not administered
- NPO order not acknowledged
- Kaiser Utilization Management not notified that the patient refuses to leave when discharged

### II. SNF Delays

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

#### 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
III. Physician Delays

Hospital
- Delays in Specialty consultations
- Delay in discharge order for alternative placement
- 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 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 24 hours/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 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 Renal Case Management 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 Department at (301) 625-6201 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.

Special Needs
For Moms who have special needs during pregnancy Kaiser Permanente has the Comprehensive Perinatal Program. This program is designed to provide case management 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 NICU admissions. Based on the initial and on-going assessments, OB providers can refer a woman to the program at any time during pregnancy. Nurse case managers will work with the member to develop a care plan to maximize her chances of having a healthy baby. Nurse case managers 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 ETOH and tobacco)

**Perinatal Service Center:** telephonically manages pregnant women who are experiencing specific medical issues (i.e., gestational diabetes, gestational hypertension and preterm labor)

**High-Risk Case Management:** provides information and referrals for pregnant women with specific social determinants that might increase their risk of delivering a pre-term, low birth weight or otherwise compromised babies (i.e., homelessness, inadequate food, domestic violence, transportation barriers and unemployment)
High–Risk Case Management
Our commitment to the health and well-being of Moms and their babies continues after a baby is born. For 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

<table>
<thead>
<tr>
<th>Date of Referral:</th>
<th>Carrier Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name: Kaiser Permanente</td>
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</table>

<table>
<thead>
<tr>
<th>Patient Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: (Last First, MI)</td>
</tr>
<tr>
<td>Date of Birth: (MM/DD/YY)</td>
</tr>
<tr>
<td>Phone: ( )</td>
</tr>
<tr>
<td>Member #:</td>
</tr>
<tr>
<td>Site #:</td>
</tr>
<tr>
<td>Phone Number: 1-(800)-810-4766 listen for prompts</td>
</tr>
<tr>
<td>Facsimile/Data #: 1-855-414-1695</td>
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<table>
<thead>
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<th>Primary or Requesting Provider: Physician</th>
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<tbody>
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<tr>
<td>Institution/Group:</td>
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<tr>
<td>Address: (Street #, City, State, Zip)</td>
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<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Provider ID#: 1</td>
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<tr>
<td>Provider ID#: 2 (If Required)</td>
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<tr>
<td>Specialty:</td>
</tr>
<tr>
<td>Consultant/Facility Provider: Location for service</td>
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<tr>
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<tr>
<td>Provider ID#: 2 (If Required)</td>
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<tr>
<td>Specialty:</td>
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<table>
<thead>
<tr>
<th>Referral Information:</th>
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</thead>
<tbody>
<tr>
<td>Reason for Referral:</td>
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<tr>
<td>Brief History, Diagnosis, Test Results:</td>
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<table>
<thead>
<tr>
<th>Include CPT Codes</th>
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<tbody>
<tr>
<td>Services Desired: Provide Care as Indicated:</td>
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<tr>
<td>□ Initial Consultation Only:</td>
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<td>□ Consultation With Specific Procedures: (specify)</td>
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<td>□ Specific Treatment:</td>
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<td>□ Other: (Explain)</td>
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<td>Place of Service:</td>
</tr>
<tr>
<td>□ Office</td>
</tr>
<tr>
<td>□ Outpatient Medical/Surgical Center *</td>
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<tr>
<td>□ Radiology □ Laboratory</td>
</tr>
<tr>
<td>□ Inpatient Hospital *</td>
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<tr>
<td>□ Extended Care Facility *</td>
</tr>
<tr>
<td>□ Other: (Explain)</td>
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<table>
<thead>
<tr>
<th>Number of Visits:</th>
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<tbody>
<tr>
<td>□ If Blank, 1 Visit is assumed.</td>
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<tr>
<td>Authorization #:</td>
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<tr>
<td>Referral is Valid Until: (Date)</td>
</tr>
<tr>
<td>(If Required)</td>
</tr>
<tr>
<td>(See Carrier Instruction)</td>
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<table>
<thead>
<tr>
<th>Signature: (Individual Completing This Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorizing Signature: (If Required)</td>
</tr>
</tbody>
</table>

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.

Each request is required to include supporting documentation and the signed physician order.
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____________________________________

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>KP Medical Record Number</th>
<th>Date of Birth</th>
<th>Date of Service</th>
<th>Complaint/ Diagnosis</th>
<th>To Be Completed by KPMAS ECM Staff</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Visit entered? (Y or N)</td>
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<td>Message sent to health care team? (Y or N)</td>
</tr>
</tbody>
</table>

To Be Completed by Kaiser Permanente
Date Received ____________ECM Rep

If Visit or Message was not completed above, please explain below

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