KAISER PERMANENTE®

11. Authorizations and Referrals (Hawaii)

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11.1 OUT-OF-PLAN REFERRAL

Out-of-plan referral means a physician-initiated request for medical care which is not presently available within the Plan. The referral (request) is subject to final authorization by the UM areas of the Regional Authorizations and Referrals Management department.

The participating Provider is required to contact the Kaiser Permanente Authorization and Referral Management department for approval for a specific service before the service is rendered. All of the following criteria must be met before authorization is complete:

- The requested service is medically necessary.
- The requested service is a covered Health Plan benefit.
- The requested service is not available within the Plan.
- The patient is an eligible Health Plan Member.
- The patient has benefits available (i.e., the patient has not exhausted capped/limited benefits).
- Referral parameters (frequency/duration/intensity) are clearly defined.
- Selected Provider is credentialed and contracted by the Plan.
- Selected Provider is available to see the patient.
- When a participating Provider sends a Member to a specialty service that does require pre-approval from the Kaiser Permanente UM department, the participating Provider issues a referral.

Referrals for services provided by non-Plan/non-Network Providers must be reviewed and authorized through the established Plan referral authorization process. This process assures that Members are:

- Referred to the appropriate specialty Provider.
- Referred to the Providers who have met our service, quality, and credentialing requirements.

- Eligible for the requested medical service.

The Kaiser Permanente Authorization and Referrals department, along with the HPMG clinical chief or designee, and/or the Outside Services medical director, is responsible for the final review and authorization of out-of-plan requests.

Referrals are authorized for specific services, including frequency and duration of treatment. According to Kaiser Permanente's authorization guidelines:

- Services or care beyond the scope of the initial authorization need additional authorization. Requests are processed by the Kaiser Permanente Authorization and Referrals Management department.
- Services provided without authorization are subject to the claims review process and may not be reimbursed.
- Referral requests for mainland services or services provided by non-credentialed practitioners must be approved by the Kaiser Permanente specialty chief and the executive committee of the Hawaii Permanente Medical Group or designee.

In cases of emergency, when immediate care or treatment is necessary, Kaiser Permanente will reimburse services that are required for stabilization. Services beyond stabilization require Plan authorization.

To receive authorization for inpatient services in the state of Hawaii, affiliated and non-affiliated Providers must contact Kaiser Permanente's Outside Services Coordination department at **808-432-7252** or the MD Call Center at **808-643-6363** prior to admission. To receive authorization for services outside the state of Hawaii, Providers must contact the Authorization and Referrals Management department at **808-432-5687**.

11.2 REFERRAL CARE DIRECTIONS

All physicians have at times found the need to consult with another physician regarding their patient's care. At Kaiser Permanente, we value the services of our Providers who, in partnership with our own physicians, provide our Members with the highest quality of care available.

These directions are intended to be a helpful resource for you when managing patients. These documents contain information provided to you by the Kaiser Permanente chiefs for each specialty in partnership with the Kaiser Permanente Authorization and Referrals Management department.

11.3 OUT-OF-PLAN REFERRAL PROCESS

All out-of-plan requests require an authorization. Please submit the outside referral form for review/determination to the Kaiser Authorization and Referrals department via fax at 808-432-5691.

Except for covered services that do not require an authorization and are specifically set forth in the Provider Manual, authorization is required for the payment of covered services.

Urgent and emergent services do not require an authorization but will be reviewed upon receipt of submitted claim(s) along with emergency/clinical/progress notes. If services are denied, a formal denial letter will be sent to both the Provider and Member.

According to Kaiser Permanente's authorization guidelines:

- Only one visit is authorized per referral, unless otherwise indicated.
- Each referral has a unique referral number. This referral number must be reflected on the claim/bill to receive appropriate processing and payment.
- The referral form is valid only if:
    - The Member is eligible on the date of service, and
    - The Member has the benefit which covers the stated condition.

Referral for Specialist Care:

Refer to Kaiser Permanente authorization guidelines.

1. Verify requested procedure(s) require authorization and that the referral specialist is a participating Provider.
2. Verify services are covered by the Member's health plan benefit.
3. If referring to an out-of-plan Provider, submit a completed Kaiser Permanente referral management form along with pertinent clinical documentation as requested below to the Kaiser Permanente Authorization and Referrals department via fax at 808-432-5691. Information should include, but is not limited to:
    a. Patient's latest progress notes, labs, and tests that have been done in the last year. If none on record, please indicate that.
    b. Test requisition forms (as applicable), including but not limited to: cardiac testing order form, MRI orders, protocol forms, sleep study requisition form, and pulmonary function test form.

4. Check the status of the authorization/referral by calling **808-432-5687**. Routine prior authorization determinations are made within 14 business days.

11.4 AUTHORIZATION POLICY AND PROCEDURE

You are required to contact the Kaiser Permanente Authorization and Referrals department at **808-432-5687** for approval before the following services are rendered:

- Outpatient surgery and outpatient services
- Transplant services
- SNF and hospice care
- Acute inpatient rehabilitation services
- DME services
- Transportation services
- Non-emergent transfers

A medical necessity review decision and an authorization number will be issued to your office and to the Member upon completion of the review process. Failure to obtain authorization prior to providing the services may result in a denial of payment.

When services provided to a Member are not covered under the Member's service agreement, or according to the Kaiser Permanente authorization guidelines, a formal denial letter will be sent to the Provider. The Kaiser Permanente Authorization and Referrals department may terminate an authorization prior to its expiration date if the Member's Health Plan status changes and the Member is not eligible or covered for services rendered. The Member is financially responsible for those services and all bills should be sent directly to him/her.

- Authorizations are valid for three months, but may vary.
- The personal physician may extend the authorization with a valid authorized referral.
- Only one visit or service is allowed per authorization, unless otherwise indicated. The number of visits or services will vary depending on the type of service.
- Each authorization has a unique authorization number. This authorization number must be reflected on the claim/bill to receive appropriate processing and payment.
- The authorization form is valid only if:
    - The Member is eligible on the date of service, and
    - The Member has the benefit which covers the stated condition.

Kaiser Permanente Authorization and Referrals department may terminate an authorization prior to its expiration date due to a change in status or membership.

Kaiser Permanente Authorizations and Referrals (Hawaii)
Phone: 808-432-5687
Fax: 808-432-5691
Monday–Friday, 8 a.m.–4:30 p.m.
Closed weekends and most holidays.

11.5 REFERRAL CARE DIRECTIONS AND FORMS

These directions are intended to be a helpful resource for you when managing patients. These documents contain information provided to you by the Kaiser Permanente chiefs of each specialty in partnership with the Kaiser Permanente Authorization and Referrals department.