KAISER PERMANENTE®

8. Utilization Management/Resource Stewardship (UM)

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8.1 OVERVIEW OF UTILIZATION MANAGEMENT/RESOURCE STEWARDSHIP PROGRAM

KFHP, KFH, and HPMG share responsibility for Utilization Management/Resource Stewardship (UM). KFHP, KFH, and HPMG work together to provide and coordinate UM for Members by reviewing and monitoring the full range of outpatient and inpatient services delivered by physicians, hospitals, and other health care practitioners and providers. The ultimate goal of UM is to determine what resources are necessary and appropriate for an individual Member and to provide those services in an appropriate setting and in a timely manner. KP UM consists of prospective and concurrent review programs in which we assess the Member’s medical condition using both evidence-based criteria for medical appropriateness and the Provider’s professional judgment.

8.2 MEDICAL APPROPRIATENESS

Providers are required to make medical decisions based on the appropriateness of care and service for a Member's medical needs and clinical condition. KP expects Providers to allow open communication with their patients regarding appropriate treatment alternatives without regard to a Member’s benefit plan. Providers are not penalized or discouraged from discussing all available care options with Members. KP will disclose to Members and the public upon request specific criteria or guidelines used to make determinations to authorize, modify, or deny health care services. KP ensures that Members have access to Providers and their staff to discuss UM processes and issues.

Only physicians with current, unrestricted licenses make decisions based on medical appropriateness or medical necessity. Board-certified consultants are used to assist in making medical necessity determinations. KP does not reward Providers for denials of care or provide financial incentives for inappropriate utilization. Ultimately, the final decision regarding a Member’s treatment plan rests with the treating physician. KP makes the clinical criteria available to practitioners and providers upon request.

8.3 REFERRAL AND AUTHORIZATION – GENERAL INFORMATION (See Section 11 for more detailed information on Referrals and Authorization)

Prior authorization must be obtained before rendering certain services unless it can be demonstrated that the Member was suffering from an “emergency medical condition” at the time treatment was rendered. An emergency medical condition means any of the following:

- A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the Member's health, or in the case of a pregnant woman, the health of the woman or her unborn child, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.
- A mental disorder that manifests itself by acute symptoms of sufficient severity that such either the Member is an immediate danger to themselves or others, or the Member is not immediately able to provide for or use food, shelter, or clothing, due to the mental disorder.
- With respect to a pregnant woman who is having contractions: (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or her unborn child.
- As otherwise defined by applicable law [including California law or Emergency Medical Treatment and Active Labor Act (EMTALA)], or as otherwise required by law.

KP plan physicians offer primary medical, pediatric, and ob-gyn care as well as specialty care. A KP plan physician may refer a Member to a Provider when the Member requires covered services and supplies that are not available through KP, or cannot be provided in a timely manner. The outside referrals process is managed at the facility level and the assistant rhysicians-in-chief (APICs) for outside services (referrals) are responsible for reviewing the medical necessity and availability of services for which a referral has been requested.

Additionally, there are service-specific authorization processes for externally referred services for durable medical equipment (DME), solid organ and bone marrow transplants, transgender surgery, and behavioral health treatment for autism spectrum disorder. These processes involve specialty boards and physician experts.

When KP approves outside services for a Member, KP issues an Authorization for Medical Care form, which details the level and scope of services, number of visits, and/or duration of treatment that has been pre-approved. The Member receives a letter that indicates a referral has been approved for the Member to see a specific outside Provider. Any further services must be pre-approved by KP. To receive approval, the Provider must contact the referring physician.

Authorized services must be rendered before the expiration date stated in the Authorization for Medical Care form or Patient Transfer Referral form or notification from KP of authorization cancellation. An additional authorization must be obtained for care that may exceed the scope of the original authorization, including any limits in the number of services (i.e., visits, etc.) or may extend beyond the expiration date of the authorization.

For assistance in resolving administrative and patient-related issues, including clarification of the authorization or referral process, please contact a Referral Coordinator or Outside Services Case Manager from the referring KP facility.

8.3.1 AUTHORIZATION OF SERVICES

Prior authorization is a prerequisite before payment can be made for any inpatient and outpatient services that would otherwise be covered by a Member's benefit plan, except for emergency services and any other situations expressly allowed by the Agreement or this Provider Manual.

Notwithstanding that services were provided to a Member without prior authorization (other than investigational or experimental therapies or other non-covered services), the Provider will be paid for the provision of such services in a licensed acute care hospital if related to services that were previously authorized and when all of the following conditions are met: (1) the services were medically necessary at the time they were provided; (2) the services were provided after KP normal business hours; and (3) a system that provides for the availability of a KP representative or an alternative means of contact through an electronic system, including voicemail or email, was not available, such that KP could not respond to a request for authorization within 30 minutes after the request was made.

Authorization can be requested from KP by contacting the appropriate referral coordinator or Outside Services case manager.

8.3.2 Hospital Admissions Other Than Emergency Services

A prior authorization is required for all admissions and the provision of services, except for emergency services. Such authorization can be requested as described above by contacting the Outside Services Coordination department case managers.

8.3.3 Admission to Skilled Nursing Facility (SNF)

If the medical necessity of hospitalization or other care is an issue or other services exist to better meet the Member's clinical condition and needs, the Outside Services Coordination department case managers or KP care coordinator will notify the appropriate physician to discuss alternative treatment plans.

A SNF stay may be authorized when a KP plan physician or KP designated specialist refers a Member for skilled level of care at a SNF. Such authorization will include a description of specific, approved therapies and other medically necessary skilled nursing services per Medicare guidelines.

The initial skilled care authorizations or denials are based on the Member's medical needs at the time of admission, and the Member's benefits and eligibility status. The Member is informed by the KP care coordinator what his or her authorized anticipated length of stay will be.

The KP care coordinator conducts telephonic or on-site reviews at least weekly to evaluate the Member's clinical status and level of care needs and to determine if continuation of the authorization is appropriate. The SNF may request extension of an authorization for continued stay from the patient care coordinator. Based on the Member's skilled care needs and benefit eligibility, more SNF days may be approved. If additional days are authorized, then the SNF will receive verbal or written notice of authorization from KP.

Other services in connection with a SNF stay are authorized when either the Member's plan physician or other KP-designated specialist expressly orders such services. These services may include, but are not limited to, the following items:

- Laboratory and radiology services
- Special supplies or DME
- Ambulance transport (when patient meets medical necessity)

8.3.4 Home Health/Hospice Services

As described below, all home health and hospice services must be authorized by KP prior to providing services. Home health or hospice services are provided subject to the following criteria, as applicable to the specific situation:

- A KP plan physician must order and direct the requests for home health and hospice services.
- The patient is an eligible Member.
- Services are provided in accordance with benefit guidelines.
- The patient requires care in his or her place of residence. Any place that the patient is using as a home is considered the patient's residence.
- The home environment is a safe and appropriate setting to meet the patient's needs and provide home health or hospice services.
- There is a reasonable expectation that the patient's clinical needs can be met by the Provider.

8.3.5 Home Health Only

KP evaluates authorization requests for home health services based on, but not limited to, the following criteria:

- The services are medically necessary for the Member's clinical condition.
- The patient is homebound, which is characterized by an inability to leave home without the aid of supportive devices, special transportation or the assistance of

another person. A patient may be considered homebound if absences from the home are infrequent and of short distances. A patient is not considered homebound if lack of transportation or inability to drive is the reason for being confined to the home.

- The patient and/or caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals.

8.3.6 Hospice Only

KP evaluates hospice service requests based on whether the patient is certified as being terminally ill and meets the criteria of the benefit guidelines for hospice services.

8.3.7 Durable Medical Equipment (DME)

KP evaluates authorization requests for DME for appropriateness based on, but not limited to:

- The Member's care needs.
- The application of specific benefit guidelines.
- Utilization of DME formulary guidelines.

Contact the KP HI DME department for questions regarding the KP HI DME Formulary:
Office: 808-432-5692

8.3.8 Psychiatric Hospital Services

Initial verbal authorizations will be made to the psychiatric facility by a KP Psychiatry epartment/Call Center referral coordinator at the direction of a KP plan physician or clinician. When a Member is admitted to your facility for psychiatric services, in order for the initial authorization to be activated you must notify KP at the appropriate facility number. You may be asked to complete supplemental documentation such as an Insurance Admission Information form.

8.4 NON-EMERGENT TRANSPORTATION

8.4.1 Non-Emergency Medical Transport (Gurney Van/Wheelchair Van)

Providers may call KP to arrange for KP physician-authorized non-emergency medical transportation. Non-emergency medical transportation may or may not be a covered benefit for the Member.

8.4.2 Non-Emergency Ambulance Transportation

If a Member requires non-emergency ambulance transportation to a KP medical center or any other location designated by KP, Providers may contact KP Hospital Operations Center (HOC) to arrange the transportation of the Member. Provider should never contact any ambulance company directly to arrange an authorized non-emergency ambulance transportation of a Member.

Non-emergency ambulance transportation may or may not be a covered benefit for the Member. Payment may be denied for ambulance transport of a Member that is not coordinated by KP and not properly documented as an authorized referral.

8.5 Authorization for KP Emergency Department Visits (See Section 10 for more detailed information on Emergency Transfers)

If, due to a change in a Member's condition, the Member requires a more intensive level of care than your facility can provide, you can request a transfer of the Member to a KP medical center. HOC or designee will arrange the appropriate transportation. Transfers to a KP medical center should be made by the facility after verbal communication with the appropriate KP staff, such as an HPMG SNF physician or the emergency department physician.

If a Member is sent to the emergency department via a 911 ambulance and it is later determined by KP that the ambulance transport or emergency department visit was not medically necessary, KP may not be obligated to pay for the ambulance transport.

8.5.1 Required Information for Transfers to KP

Please send the following written information with the Member:

1. Name of Member’s contact person (family member or surrogate) and telephone number.
2. Completed inter-facility transfer form.
3. Brief history (history and physical; discharge summary; and/or admit note).
4. Current medical status, including presenting problem, current medications and vital signs.
5. A copy of the patient’s Advance Directive/Physician Orders for Life Sustaining Treatment (POLST).
6. Any other pertinent medical information, i.e., lab/X-ray.

If the Member is returned to the sending facility, KP will provide the following written information:

1. Diagnosis (admitting and discharge).
2. Medications given; new medications ordered.
3. Labs and X-rays performed.
4. Treatment(s) given.

5. Recommendations for future treatment; new orders.

8.6 EMERGENCY ADMISSIONS AND SERVICES; HOSPITAL REPATRIATION POLICY

Consistent with applicable law, KP Members are covered for emergency care needed to clinically stabilize their situation. An emergency medical condition means any of the following:

- A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the Member's health, or in the case of a pregnant woman, the health of the woman or her unborn child, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.
- A mental disorder that manifests itself by acute symptoms of sufficient severity that such either the Member is an immediate danger to themselves or others, or the Member is not immediately able to provide for or use food, shelter, or clothing, due to the mental disorder.
- With respect to a pregnant woman who is having contractions, (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or her unborn child.
- As otherwise defined by applicable law (including California law or EMTALA), or as otherwise required by law.

Services provided to Members to screen and stabilize a patient suffering from an emergency medical condition as defined above **do not** require prior authorization.

8.6.1 Emergency Services

- If emergency services are provided to screen and stabilize a patient, they are covered in situations when a prudent layperson would have believed that an emergency condition existed.
- Once a patient is stabilized, the treating physician is required to communicate with KP for approval to provide further care or to effect transfer.

8.6.2 Emergency Claim

The following circumstances will be considered when the bill is processed for payment:

- Whether services and supplies are covered under the Member's benefit plan.
- Whether services have been ordered, authorized, prescribed, or directed by a KP Plan Physician.
- Whether services provided were immediately required because of unforeseen illness or injury.

Payment is dependent on the advice of the treating physician, as well as the KP determination of the situation in which care was provided and in consideration of the prudent layperson guideline as stated above. Members have varying benefit plans, and some benefit plans may not cover continuing or follow-up treatment at a non-Plan facility.

8.7 POST-STABILIZATION CARE

If the Member is admitted to the facility as part of the stabilizing process and the facility has not yet been in contact with Kaiser Permanente, the facility must contact the local Outside Services Coordination department case manager at the appropriate number in order to discuss authorization for continued stay as well as any additional appropriate post-stabilization care once the Member's condition is stabilized.

8.7.1 Repatriation Contact Information

Below you will find the contact information for the Hawaii Repatriation Hub:

Oahu Contact Number Information:

- Main Line: 808-432-7252

8.8 DENIALS AND PROVIDER APPEALS

Information about a denial or the appeal procedures is available by contacting the appropriate department that issued the denial letter.

When a denial is made, the Provider is sent a denial letter accompanied by the name and direct telephone number of the decision-maker. All medical necessity decisions are made by physicians or licensed clinicians (as appropriate for mental health services). Physician decision-makers include, but are not limited to, DME physician champions, APICs for Outside Services, UM department chiefs, other board-certified physicians, or behavioral health practitioners.

If the physician or behavioral health practitioner does not agree with a medical necessity decision, the Provider may discuss the case by contacting the physician-in-chief at the local facility. Providers may also contact the issuing department that is identified in the letter for additional information.

8.9 DISCHARGE PLANNING

Providers such as hospitals, SNFs, psychiatric facilities, home health and hospice agencies are expected to provide discharge planning services for Members, and to cooperate with KP to assure timely and appropriate discharge.

Providers should designate staff to provide proactive, ongoing discharge planning. Discharge planning services should begin upon the Member's admission and be completed by the medically appropriate discharge date. The Provider's discharge planner will identify barriers to discharge and determine an estimated date of discharge. Upon request by KP, Provider will submit documentation of the discharge planning process.
The Provider's discharge planner, in consultation with the KP care coordinator, will arrange and coordinate transportation, DME, follow-up appointments, appropriate referrals to community services and any other services requested by KP.

Unless the Provider has received prior authorization to furnish follow-up care, the Provider must contact KP to arrange for and to coordinate covered medically necessary care after discharge.

8.10 UM INFORMATION

The Provider may be requested to provide information for the KP UM activities concerning Members in the Provider’s facility. Such additional information may include, but is not limited to, the following data:

- Number of inpatient admissions
- Number of inpatient re-admissions within the previous seven days
- Number of emergency department admissions
- Type and number of procedures performed
- Number of consults
- Number of deceased Members
- Number of autopsies
- ALOS

- Quality Assurance/Peer Review process
- Number of cases reviewed
- Final action taken for each case reviewed
- Committee membership (participation as it pertains to Members and only in accordance with the terms of your contract)
- Utilization of psychopharmacological agents
- Other information KP may reasonably request

8.11 CASE MANAGEMENT

KP care coordinators work with treating Providers to develop and implement plans of care for acutely ill, chronically ill, or injured Members. KP case management staff may include nurses and social workers who assist in arranging care in the most appropriate setting and help coordinate other resources and services.

While any Provider may request authorization for services, or may seek a Member's inclusion in a particular KP UM program (for example, case management), the personal physician continues to be responsible for managing the Member's overall care. It is the Provider's responsibility to send a report to the referring physician of any consultation with, or treatment rendered to, the Member, regardless of whether the referring physician is the Member's personal physician.

8.12 PHARMACY SERVICES / DRUG FORMULARY

KP has developed a quality, cost-effective pharmaceutical program which includes therapeutics and formulary management. The Regional Pharmacy and Therapeutics (P&T) Committee reviews and promotes the use of the safest, most effective, and cost-effective drug therapies, and shares best practices with all KP regions. The Regional P&T Committee's formulary evaluation process is used to develop the applicable KP Drug Formulary (Formulary) and the National Medicare Part D Formulary for use by KP practitioners. Contracted practitioners are encouraged to use and refer to the Regional Drug Formulary when prescribing medication for Members (available at http://kp.org/formulary).

8.12.1 Pharmacy Benefits

Pharmacy services are available for Members who have benefit plans that provide coverage for a prescription drug program. For information on specific member benefit plans, please contact Member Services.

8.12.2 Filling Prescriptions

The Formulary can be accessed online in a searchable format. It provides the list of drugs approved for general use by prescribing practitioners. For access to the online version of the Formulary, or to request a paper copy, please refer to the instructions at the end of this section.

KP pharmacies do not cover prescriptions written by non-Plan physicians unless an authorization for care by that non-Plan physician has been issued. In order to avoid confusion, when writing the prescription, please remind Members to bring a copy of their authorizations to the KP pharmacy when filling the prescription.

Practitioners are expected to prescribe drugs included in the Formulary unless at least one of the exceptions listed under "Prescribing Non-Formulary Drugs" in this section is met. If there is a need to prescribe a non-Formulary drug, the exception reason must be indicated on the prescription.

Members will be responsible for paying the full price of their medication if the drugs requested are: (i) non-Formulary drugs not required by their health condition, (ii) excluded from coverage (i.e., cosmetic use), or (iii) not prescribed by an authorized Plan Provider. Any questions should be directed to Member Services.

8.12.3 Prescribing Non-Formulary Drugs

Non-Formulary drugs are those that have not yet been reviewed, and those drugs that have been reviewed but given non-Formulary status by the Regional P&T Committee. However, the situations outlined below may allow a non-Formulary drug to be covered by the Member's drug benefit.

- **New Members**
  If needed and the Member's benefit plan provides, new Members may be covered for an interim supply (up to 100 days) of any previously prescribed non-Formulary medication to allow the Member time to make an appointment to see a KP provider. If the Member does not see a KP provider within the 100 days, he or she must pay the full price for any refills of non-Formulary medications.
- **Existing Members**
  A non-Formulary drug may be prescribed for a Member if he or she has an allergy, or intolerance to, or treatment failure with all Formulary alternatives, or has a special need that requires the Member to receive a non-Formulary drug. In order for the Member to continue to receive the non-Formulary medication covered under their drug benefit, the exception reason must be provided on the prescription.

NOTE: Generally, non-Formulary drugs are not stocked at KP pharmacies. Therefore, before prescribing a non-Formulary drug, call the pharmacy to verify the drug is available at that site.

8.12.4 Pharmacies

KP pharmacies provide a variety of services including: the filling of new prescriptions, transferring prescriptions from another pharmacy, providing refills, and consulting about new medications.

8.12.5 Telephone and Internet Refill Lines

Members may request refills on their prescriptions, with or without refills remaining, by re-ordering it via kp.org, KP mobile app, or by calling 808-643-7979. Refills can be mailed directly to Members or picked up at their preferred pharmacy location.

8.12.6 Mail Order

Members with a prescription drug benefit are eligible to use the KP Mail Order pharmacy service. For more information regarding mail-order prescriptions go to kp.org, use the KP mobile app, or call **808-643-7979**.

Only maintenance medications should be ordered through the mail. Acute prescriptions such as antibiotics or pain medications should be obtained through a Plan pharmacy to avoid delays in treatment.

8.12.7 Restricted Use Drugs

Some drugs (i.e., chemotherapy) are restricted to prescribing only by approved KP specialists. Restricted drugs are noted in the Formulary. If you have any questions regarding prescribing restricted drugs, please call 808-643-7979.

8.12.8 Emergency Situations

If emergency medication is needed when Plan pharmacies are not open, Members may use pharmacies outside of KP. Since the Member will have to pay the full retail price in this situation, he or she should be instructed to call Member Services at **808-432-5955** to obtain a claim form in order to be reimbursed for the cost of the prescription less any copays that may apply.

It is your responsibility to submit itemized claims for services provided to Members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. KP is responsible for payment of claims in accordance with your Agreement. Please note that this Provider Manual does not address submission of claims for fully insured or self-funded products underwritten or administered by KPIC.

8.13 HAWAII REGION RESOURCE STEWARDSHIP PROGRAM

This section describes benefits and services and programs reflecting continuity of care. Kaiser Permanente Members are covered for these services based upon their covered group benefits.

8.13.1 Utilization Management

8.13.2 HI Region 2012 Utilization Management Program Description

8.13.3 Physician Advisors List

8.13.4 Clinical Criteria for UM Decisions-Criteria Table

8.13.5 Pharmaceutical Management Procedures and Drug Formulary

The Kaiser Permanente Hawaii Drug Formulary lists medications approved through a scientific review process by the Pharmacy and Therapeutics (P&T) Committee. Its intent is to enhance the quality of patient care by promoting safe, effective, and economical drug therapy.

The Kaiser Permanente Hawaii Region's Drug Formulary is considered a closed Formulary, in which listed medications are usually covered under Plan benefits. However, listing of a medication in our Drug Formulary does not necessarily mean it is covered under your patient's prescription drug benefit Plan since prescription benefit coverage varies depending on your patient's Plan. Affiliated Providers who have questions regarding KP's pharmaceutical management procedures may call the Pharmacy Administration department at 808-432-5854.

The Formulary approval process ensures that available drugs meet established quality standards and that adequate information for their optimal use is provided, while limiting the availability of unsafe, less than effective, or ineffective drugs, and drugs with a high potential for toxicity or abuse.

The Drug Formulary also supports cost management by promoting the use of effective but less costly therapeutic equivalents, reducing the number of therapeutically redundant drugs,

optimizing pharmacy management or drug inventories, and maximizing leverage through the drug purchasing and bid process.

Non-Formulary drugs are drugs not officially accepted for inclusion into our Drug Formulary. This includes new drugs not yet reviewed for addition, drugs that have been reviewed but denied admission to the Formulary, or a brand, strength, or dosage form of a Formulary drug not stocked in Kaiser Permanente pharmacies.

Non-Formulary drugs are excluded from drug plan coverage unless your patient is allergic to a Formulary drug, fails to respond to Formulary drug therapy at maximum doses, or has special circumstancing requiring the use of a non-Formulary drug. If your patient meets any or all of these medically necessary conditions for use of a Formulary drug, as documented in the patient's medical record, your patient may obtain his/her prescription at his/her usually supplemental charge or receive a refund on a prescription for which they initially paid full price. Non-Formulary drugs are not usually stocked in our pharmacies, therefore, there may be a delay before such a medication is dispensed or administered.

The following are three methods in which you as an affiliated Provider of Kaiser Permanente may access the Drug Formulary:

1. Access the Formulary online.
   See instructions for accessing the Lexi-Comp FormuLink™ Online site below.

   KP Online Formulary Quick Guide
   (For EXTERNAL Use - Contract Providers)
2. Access the Formulary via downloads

   KP HI Lexicomp Software Instructions

3. Accessing the Formulary via the kp.org website.

   Formulary (list of covered drugs)
   If you do not have access to the internet or have difficulties in accessing the Formulary, you may email the Pharmacy Administration department at Hawaii.Drug.Info@kp.org or call 808-432-5854 to request for a hardcopy to be sent to you.

8.13.6 Continuum of Care

8.13.6.1 Complex Care Policy

- Information on the Complex Care Policy Appendix

- Information on the Complex Care Policy

8.13.6.2 Continuing Care Services

Affiliated network practitioners can access these services by calling our Continuing Care department at 808-432-7100 for Oahu-based services. For Neighbor island services, call the Neighbor Island Community Based Program department at 808-243-6681.

8.13.6.2.1 Durable Medical Equipment, Braces, and Prosthetic Devices

Some members have durable medical equipment (DME) and/or brace and external prosthetic benefits, which are subject to certain limitations. Medicare guidelines are followed for all Senior Advantage Members and the Kaiser Permanente DME Formulary for Health Plan.

All DME/O&P orders under the benefit must be pre-authorized by the DME Department. Kaiser Permanente will designate the supplier. Experimental or research devices and appliances are not covered.

Call the Kaiser Permanente Durable Medical Equipment department on Oahu for all orders at 808-432-5692 or fax 808-432-5689; Monday–Friday, 8 a.m.–4 p.m.
For urgent needs after hours or on weekends and holidays:

> On Oahu, call 808-432-0000 to reach the hospital operator and ask to have the patient care coordinator (PCC) paged.
>
> For Maui and Kauai, call 808-243-6681
> For Hilo, call 808-934-4067
> For Kona, call 808334-4459

8.13.6.2.2 Home Health Services

Home health services are medically necessary health services that are limited to the homebound (as defined by Medicare), which can be safely and effectively provided in a Member's home by health care personnel and under the care of a physician. These services are provided without charge.

Home health services do not include: (1) custodial care, (2) homemaker care, (3) domiciliary care, or (4) care that a Medical Group Home Health Committee determines may be appropriately provided in a medical office, hospital or skilled nursing facility. Such care is provided or offered in such setting in accord with the Member's Service Agreement.

8.13.6.2.3 Hospice and SNF Services

These services are to be prescribed and directed by a Kaiser Permanente physician or an affiliated network physician, and provided by a licensed and contracted SNF facility or hospice agency. To be eligible for the SNF benefit, a Member must meet Medicare guidelines, except that a prior three-day stay in an acute hospital is not required. These services can also be coordinated by our Continuing Care/Home Health Department.

Covered services under the SNF benefit include nursing care; bed and board; physical, occupational, and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and durable medical equipment ordinarily furnished by the skilled nursing facility. Services not covered are personal comfort items such as a telephone, television, and take-home medical supplies.

8.13.6.3 Outside Services Coordination

Kaiser Permanente's Outside Services Coordination department case manager reviews, monitors, and promotes appropriate utilization of services for in-area and out-of-area admissions to non-Plan hospitals. Our Outside Services Coordination department ensures high-quality care delivery and continuity of care by identifying and transferring appropriate members to either Kaiser Permanente or contract facilities where care can be managed and coordinated by a Kaiser Permanente physician utilizing established transfer policies.

Pertinent clinical information regarding each out-of-plan admission is obtained by the Outside Services Coordination department case manager and shared with the UM physician advisor as needed. The UM physician advisor communicates as needed with the out-of-plan attending physician.

Each case is discussed and evaluated for the appropriateness of transfer based on such criteria as quality of services offered at current non-KFH facilities, medical stability, anticipated additional length of stay, and the need for further procedures. The physician advisor authorizes all transfers as needed, after which the Outside Services Coordination department case manager coordinates all aspects of transfer and integration back into the care of Kaiser Permanente physicians.

For routine and emergency transfers, please call our Outside Services Coordination department at 808-432-6363. For emergency transfers, refer to the "Emergency and Urgent Care Services" section. For hospital transfers, refer to the "Hospital Care" section.

8.13.6.4 Concurrent Review Program

Kaiser Permanente is committed to providing care of the very highest quality to our members in the most efficient, cost-effective manner possible. The goal of our Concurrent Review Program

is to coordinate the effective management of care and facilitate improved resource management strategies that result in better utilization of resources, while striving to provide a positive Member experience. It includes issuing and reviewing expedited, pre-service, and post-service denials.

The Outside Services Coordination department case manager is responsible for a wide variety of functions for Members in out-of-plan facilities. This includes coordinating all case management activities; performing inpatient concurrent reviews; retrospective reviews; collecting, analyzing and reporting inpatient data; and overseeing the use of continuing care services such as home, sub-acute, hospice care, and transfer to in-plan facilities when appropriate. Criteria used for inpatient concurrent and retrospective reviews is reviewed by the medical staff and updated annually. The criteria is available to medical staff by request from the Continuing Care department.

A physician reviewer is available to discuss by telephone determinations based on medical appropriateness. Contact the Outside Services Coordination department at **808-432-7252** to be directed to the appropriate UM physician advisor. For Behavioral Health, contact the Integrated Behavioral Health department at **808-243-6031**.

Additional information regarding our Concurrent Review Program may be obtained by contacting the Outside Services Coordination department at **808-432-7252**.