KAISER PERMANENTE® Mid-Atlantic States	**Medical Necessity Review for Pre-Authorization of a Single Visit Medical Coverage Policy**

I. Service Description

Referral for a single visit is a pre-authorization request for a service where no Utilization Management (UM) criteria, standards or protocol could be applied or when there is lack of sufficient information to make a determination of medical necessity prior to or after a procedure, treatment, or service.

II. Referral for a single visit could be one of the following categories:

A. Pre-service, treatment or procedure *(i.e., request for consultation to specialty services where no applicable UM criteria, standard or guideline could be referenced*)
B. Follow-up visit post non-surgical procedure, treatment, or service (*i.e., radiation oncology*)
C. Post-operative follow-up outside of the surgical global period[1], if applicable *(i.e., post neurosurgical or cardiovascular surgery follow up 6, 12 or more months after surgery)*

III. Policy

A. The decision to determine medical necessity for a single visit should be substantiated by documentation of compelling medical necessity which supports the amount, duration and/or scope of service(s) at the time of request as evidenced by the following but not limited to:
   1. Presence of signs or symptoms of a disease or condition;
   2. Abnormal laboratory values;
   3. Abnormal imaging studies;
   4. Current and future treatment plan
B. Request for care that lacks sufficient clinical information for medical necessity or those that do not meet the above requirements will not be approved.
C. In the absence of any applicable criteria, standards or Medical Coverage Policies, the UM Physician may communicate with a licensed, board-certified physician in the same specialty as the requested service.
D. The reviewing physician bases his or her determination on their professional medical judgment, training, experience, current standards of practice in the community, published scientific and peer-reviewed literature, needs of the individual member's (age, co-morbidities, complications, progress of treatment, psychosocial/cultural situation, member safety, availability of community resources, and home environment, when applicable), and characteristics of the local delivery system.
E. The following documentation must be included in the adverse decision notice:

[1] The surgical period, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Payment for the surgical procedure includes the preoperative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

1. The resource document such as a scientific or peer-reviewed literature which support the rationale to determine the decision by the reviewing physician should be referenced in the notice;
2. Member specific information to support insufficient clinical information in order to make a sound decision such as imaging studies, laboratory values and specific clinical notes by the specialist;
3. The clinical specialty of the board-certified specialist who was consulted to review the referral request;
4. The medical necessity definition from the member's benefit plan such as explanation of coverage (EOC), benefit brochure or benefit manual.

IV. Benefit Alert

A. The member's eligibility and subscriber's benefits and exclusions must be verified as reflected in the member's Evidence of Coverage (EOC), benefit brochure or benefit manual prior to making a determination of a requested service.

B. Request for a single visit should be provided within the Kaiser Permanente Mid-Atlantic States (KPMAS) in-network or plan provider and the determination of appropriateness of care should be coordinated through the Kaiser Permanente Mid-Atlantic Permanente Medical Group, (MAPMG), unless the member's benefit plan allows coverage to an out of network or affiliated provider.

References

1. Evidence-Based Guidelines to Determine Follow-up Intervals: A Call for Action Emilia Javorsky, MPH; Amanda Robinson, MD; and Alexa Boer Kimball, MD, MPH Vol. 20, No. 1 The American Journal of Managed Care January 2014
2. Health Affairs 27, no.6 (2008):1642-1653. Evidence-Based Decision Making: When Should We Wait For More Information? Kalipso Chalkidou, Joanne Lord, Alastair Fischer and Peter Littlejohns
3. Maryland Insurance Administration Section 15-10A-02 of the Insurance Article (ii) references the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";
4. NCQA Health Plan Standards and Guidelines, UM Elements 1, 2 and 7
5. Eickerson, Jane A.; Cole, Bonnie; Conta, Jessie H.; Wellner, Monica; Wallace, Stephanie E.; Jack, Rhona M.; Rutledge, Joe; Astion, Michael L. Improving the Value of Costly Genetic Reference Laboratory Testing With Active Utilization Management. *Archives of Pathology & Laboratory Medicine*, Jan2014; 138(1): 110-113. 4p. (Journal Article - research, tables/charts) ISSN: 0003-9985 PMID:
6. KPMAS UM Program Description 2024 Section II: Clinical Criteria for UM Decisions All Lines of Business
7. KPMAS UM Policy 01 Policy Title: Scope, Periodic Review and Application of UM Criteria. Approved 02/21/2024
8. KPMAS Policy Number: UM 02 Policy Title: Policy and Procedure Development and Approval Process Approved 02/21/2024

Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
12/07/2016	12/07/2016
03/30/2017	03/30/2017
04/25/2017	04/25/2017
04/27/2018	04/27/2018
04/25/2019	04/25/2019
04/23/2020	04/23/2020
04/16/2021	04/16/2021
04/25/2022	04/25/2022
04/25/2023	04/25/2023
03/19/2024	03/19/2024

***** The Regional Utilization Management Committee received *delegated authority* from the Regional Quality Improvement Committee to review and approve designated Utilization Management and Medical Coverage Policies in 2011.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Whenever possible, Medical Coverage Policies are evidence-based and may also include expert opinion. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.