Kaiser Foundation Health Plan - Hawaii

Utilization Management Process

Kaiser Permanente (KP) provides services directly to our members through an integrated care delivery system made up of Kaiser Foundation Health Plan, Inc. (the Plan), Kaiser Foundation Hospitals, and the Permanente Medical Groups. These three parts of the Kaiser Permanente care delivery system work together to help ensure that members receive quality care.
Managing how health care services and related resources are used helps improve the delivery of health care services and controls health care costs for you.
At KP, physicians and health care professionals determine whether a service or treatment is clinically appropriate. Care is determined by the treating clinician based on their judgement of clinical appropriateness.

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

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

The medical care and services provided or authorized by your physician are subject to UM review to ensure you receive the right care, at the right time, in the right place. KP's UM program staff works with practitioners and providers to ensure quality, cost-effective care for members. Some of the services include:

- Reviewing hospital admissions, and referrals for covered services.

KP staff who make decisions about your medical treatments and services have a primary focus on providing the level of care that is appropriate for your needs. All UM decision-making is based on evidence that service and care are covered under your health plan are medically necessary. There are no financial incentives that encourage decisions that may result in underutilization or barriers to care and service.

The Kaiser Permanente Medical Care Program

As a KP member, you have chosen to receive health care services from our integrated care delivery system.
In general, benefits are available only for care you receive from or arranged by your Personal Care Physician (PCP), and at a KP facility. There are few exceptions that are described in your EOC, such as authorized referrals to non-KP providers, emergency care, and out-of-state urgent care when traveling. Your PCP will refer you to a KP Specialist when appropriate, and in most cases, you will need a referral to see a KP Specialist for the first time.

Referrals and Prior Authorization

In the majority of cases, when your provider prescribes a course of treatment or plan of care for you, he or she is not required to request for authorization from the Plan to provide you those services. Care is determined by the treating clinician based on their judgement of clinical appropriateness and not by Health Plan UM criteria.

In some specific situations, your provider will need to request permission from the Plan to provide you the recommended care under a process called Prior Authorization. If, in the professional judgement of Permanente Medical Group, you require medical or hospital services covered in the EOC which requires skills or services not available within KP, and Permanente Medical Group determines that it would be of best interest for you to obtain care from another source (outside of KP), your PCP will work with the Plan and submit a referral order request review prior to services being rendered by a non-KP or out-of state physician or facility. Referrals and authorizations are required before accessing services to avoid being responsible for the full cost of the medical services.

Clinical Decision-Making Criteria

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

Qualified Medical Professionals

Qualified physicians or other appropriately qualified health care professionals review prior authorization denials for medical necessity. Physicians who make UM decisions may be physician leaders for Outside Referral Services/specialty services, and/or

members of physician specialty boards. When necessary, they will consult board-certified physicians in the associated specialty to assist them in making a UM decision.

UM Decision Time Frames

UM decision-makers will make the UM decision within the time frame appropriate for your condition, and no later than 14 calendar days after receiving your provider's request for the services along with all the information reasonably necessary to make the UM decision and you will receive notification of UM decision within 14 calendar days from the receipt of the request for services. Decisions about urgent services will be made no later than 72 hours after receipt of the request for services. If more time is needed to make the decision because necessary information has not been received or because the physician UM decision-maker has requested consultation by a specialist, you and your treating provider will be informed about the need for additional information and the date the decision will be made. Please refer to your Evidence of Coverage for information on the appeal process if you disagree with a UM decision.

Assistance with UM Inquiries and Processes

For information about UM and processes, if you have UM inquiries, or to request for copies of criteria, please call our Member Services Contact Center at:
1-800-966-5955 (Monday through Friday, 8 a.m. to 5 p.m.)
1-800-805-2739 (Medicare, 8 a.m. to 8 p.m. seven days a week)
TTY 711 (hearing/speech impaired)

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