Prior authorization

ACCIDENTAL OR WORK-RELATED INJURIES

If the referred condition is from an accident or work-related injury, complete the appropriate area of the Accident and injury incident questionnaire (PDF) with as much information as possible, including any event-specific information.

When you submit a prior authorization request for a work-related accident, Kaiser Permanente will deny the authorization for coverage because the member's Medical Coverage Agreement does not cover these services. Regardless, it is always best to submit a prior authorization request so that it will be on file in case the workers' compensation carrier denies the claim. If the claim is not accepted by the worker's compensation carrier, Kaiser Permanente can then review the original request for coverage of services.

Note: Kaiser Permanente may not cover the service if the care for the injury is provided by a noncontracted practitioner or vendor.

For work-related injuries, submit claims directly to the designated workers' compensation carrier identified by your patient.

DURABLE MEDICAL EQUIPTMENT

Most but not all Kaiser Permanente plans provide some coverage for durable medical equipment (DME). Plans may have variable levels of coverage, deductibles, copayments, or coinsurance.

To determine coverage, use the Eligibility Inquiry tool. To see medical necessity review criteria, see clinical review criteria. Contact the Provider Assistance Unit at 1-888-767-4670 for information about coverage and medical necessity criteria.

Billing and payment

Kaiser Permanente does not reimburse for items or services that are considered inclusive of, or an integral part of, another procedure or service. Sources of commonly accepted standards include The Centers for Medicare and Medicaid Services (CMS), The National Uniform Billing Committee (NUBC) and the National Correct Coding Initiative (NCCI). Billing of durable medical equipment must be in accordance with applicable laws and regulations and industry standard practices.

Authorization process

You can make DME prior authorization requests by contacting Review Services or using our Referral Request tool.

To expedite patient care, please check the CPT code in the PreAuthorization Code Check Tool. The tool will inform you if an authorization is needed. If it is needed and there is documentation indicated for the review, please attach those records to your referral request in Affiliate Link.

Kaiser Permanente has an exclusive partnership with Apria Healthcare for certain core DME services. Under this relationship, Apria provides a list of core services (PDF) for Kaiser Permanente HMO members.

Once your authorized request is received, Review Services will:

- Verify patient eligibility and benefits.

- Review guidelines and authorize or deny requests based on established Medicare or health plan criteria.
- Review and determine cost-effectiveness of equipment purchase versus rental.

For coordination of equipment delivery and pickup, contact the vendor.

Urgent after-hours needs

You may obtain urgent and emergent equipment after normal business hours (Monday-Friday, 8 a.m.-5 p.m.) by contacting Apria Healthcare at 1-888-452-4363. This service is available for all of the Washington region.

DME service delivery standards

Our contracted durable medical equipment (DME) services providers are key members of our members' health care team, coordinating services with other Kaiser Permanente providers, such as nursing homes, home health agencies and area hospitals. These providers procure high quality, state-of-the-art DME that ensures the safety of our members. To that end, the DME provider delivers only the DME authorized by the Kaiser Permanente and will bear the cost of any DME, other than that which was authorized, which is delivered and used by a Kaiser Permanente member.

The DME provider will report hazardous situations or medical problems immediately to the referring Kaiser Permanente physician. The DME provider will train members and their family how to operate, care for, and maintain the DME safely and effectively, and provider a copy of all applicable warranties of equipment provided. If necessary, the DME provider will also provide training for specified Kaiser Permanente staff as well.

To ensure the safety of the member, the DME provider will ensure the equipment provided will be free of defects in materials and workmanship and will perform preventive maintenance on all DME. If DME requires repair, adjustment or otherwise malfunctions, the provider will pick up the defective equipment within twenty-four (24) hours of notification and repair it, adjust it, or provide an equivalent substitute. Patient safety is our highest priority, which will guide the provider in determining the appropriate response time for DME repair. In cases where patient safety may be jeopardized, repair or substitution of equipment will be completed as soon as practicable. If, however, the repair is non-urgent, the provider will establish cost estimates in advance of repair and coordinate with Kaiser Permanente for approval to repair or for authorization to replace the DME.

INJECTABLE DRUGS REQUIRING PRIOR AUTHORIZATION

Injectable drugs requiring prior authorization

Kaiser Permanente requires prior authorization of certain injectable medications administered in the office or home infusion setting. These reviews ensure that benefits are adjudicated and that use is in line with Pharmacy & Therapeutics Committee criteria.

Review Timeframes

Medicare:

Expedited requests: No later than 24 hours from receipt of the prescriber’s supporting statement.

Standard request: No later than 72 hours from receipt of the prescriber’s supporting statement.

Commercial:

Non ePA expedited requests: No later than 2 calendar days from Receipt of request if all information is provided.

Non ePA standard requests: No later than 5 calendar days from Receipt of request if all information is provided.

ePA expedited requests: No later than 1 calendar days from Receipt of request if all information is provided.

ePA standard requests: No later than 3 calendar days from Receipt of request if all information is provided.

NOTE: For standard requests: If Kaiser Permanente contacts the provider for additional information, please respond within 5 calendar days. If the supporting statement is sufficient, we will render our decision and provide notification within 4 calendar days of receipt of your statement.

For Expedited requests: If Kaiser Permanente contacts the provider for additional information for an expedited request, please respond within 2 calendar days. We will render our decision and provide notification within 2 calendar days of receipt of your statement.

Current lists of injectable drugs requiring prior authorization:

- Non-Medicare drug list (PDF)
- Medicare Advantage drug list (PDF)
- Medicare Part B step therapy (PDF)

Kaiser Permanente's preferred biosimilar products:

- Biosimilar FAQ (PDF)

Policies regarding site of care and site of service:

- Infusion Site of Care Policy (PDF)
- Infusion Site of Service Policy (PDF)

PRIOR AUTHORIZATION REQUIREMENT AND MANAGEMENT GUIDELINES

Prior authorization requirements vary by health plan. Kaiser Permanente must authorize all inpatient hospital care, regardless of plan type.

Members who have out-of-network benefits may use First Choice Health and First Health Network providers. Out-of-network provider office visits do not require prior authorization. Some treatments may require prior authorization.

Authorization management guidelines

We developed the following prior authorization management guidelines for our Core plans.

New requests

- Number of visits and duration are limited by the scope of the authorization, unless the request is for services that are noted as exceptions below. See standard visits and exceptions tables.
- The start date of the authorization is dependent on the request date and receipt date. Requests for authorization should be received prior to or within 14 calendar days of the requested start date. If the request is received more than 14 days after the requested start date, it will be considered a retroactive request and may be denied.

Standard visits

When you are referring your patient for specialty care, you can choose the appropriate scope of care. By using one of these options you can ensure your patient is getting the right level of care.

SCOPE OF CARE	CPT	MAXIMUM VISITS/DURATION	APPROVED ACTIONS
Consult only	99202	3/12 months	Office visits only
Second opinion only	99203	1/12 months	Office visits only
Evaluate and treat; surgery if indicated	99214	3/12 months	Office visits, routine diagnostics, in-office procedures. Evaluate and treat, and requests for surgeries can come directly from the consulting specialist on a separate authorization request.
Evaluate and treat; surgery if indicated	99214	6/12 months	Office visits, routine diagnostics, in-office procedures. Evaluate and treat, and requests for surgeries can come directly from the consulting specialist on a separate authorization request.
Oncology and radiation therapy			
Evaluate and treat; surgery if indicated	99214	999/12 months	Office visits, routine diagnostics, in-office procedures. Requests for surgeries can come directly from the consulting specialist on a separate authorization request.

Exceptions to standard visits

The following table lists exception guidelines for authorizing services. Services are subject to the member's eligibility and benefit coverage. Some services are limited or not covered by the member's health plan. For more information on a specific member's benefits, contact the Provider Assistance Unit at 1-888-767-4670.

AUTHORIZATION TYPE	AUTHORIZATION LIMITS
Mental health and wellness	Mental health, including addiction and recovery authorizations are processed through that department. For details, see Mental health, including addiction and recovery.
Complimentary & alternative health services	**Acupuncture:** Subject to limitations based on member's coverage. Member can self-refer to contracted acupuncturist for limited number of visits. After self-referred visits are exhausted, an authorization request from the treating acupuncturist, primary care physician, or specialist is required to authorize additional visits. **Chiropractic care:** Most patients can self-refer to participating chiropractor for limited number of visits. **Massage therapy:** Preauthorization is not required for massage therapy for most members. Massage therapy must have a valid order or prescription from the member’s ordering provider. The number of visits is limited by the member’s coverage and benefits. **Naturopathy:** Subject to limitations based on member's coverage. Member can self-refer to contracted naturopathic practitioner for limited number of visits. After self-referred visits are exhausted, an authorization request from the treating naturopath, primary care physician, or specialist is required to authorize

	additional visits. For more information, see Complementary and alternative medicine.
Diabetic education	999/12 months
Diabetic retinopathy	999/12 months
Dialysis	999/12 months
Durable medical equipment	DME, prosthetics, and orthotics are processed through Review Services. For more information, see Prior authorization for durable medical equipment.
Nutritional counseling	6/12 months
Occupational therapy	When preauthorization is required, up to 15 visits upon initial request. Subsequent visits in 15-visit increments up to the member's benefit limit.
Oncology (including chemotherapy and radiation therapy)	999/12 months
Phenylketonuria (PKU)	15 visits/12 months
Physical therapy	When preauthorization is required, up to 15 visits upon initial request. Subsequent visits in 15-visit increments up to the member's benefit limit.
Radiation therapy	999/12 months
Speech therapy	When preauthorization is required, up to 15 visits upon initial request. Subsequent visits in 15-visit increments up to the member's benefit limit.
Transplants/mechanical hearts	999/12 months for follow-up. Requires prior authorization.
Applied behavioral analysis therapy (ABA)	Units approved are measured in hours and defined by Clinical Review over a six-month duration when preauthorized.
Procedures	Units vary by procedure/12 months

Extensions

- Requests for more visits or more time require a new request for authorization which can be submitted using the Referral Request tool

Authorizations for Medicare coordination of benefits

- We don't require and won't offer a prior authorization when we are secondary to Medicare (except for massage therapy). If Medicare covers a service, we will cover as secondary. If Medicare does not cover a service, we will process the claim applying the member commercial contract and medical necessity review, if required. Requesting a prior authorization when Kaiser Permanente is secondary to Medicare is discouraged.

Medicare coordination with a maintenance of benefits plan

When a Kaiser Permanente Medicare-eligible member is not eligible for our Medicare Advantage plans, we will coordinate benefits with traditional Medicare.

When Medicare is the primary payer, you must bill Medicare directly for services through the Medicare crossover process.

Note: Do not bill Kaiser Permanente for claims that will crossover electronically. This creates duplicate billing or payment. Remember to check your Medicare explanation of payment form, Reason Code MA18.

Provider Requests for Exemption from Prior Authorization Requirements for Selected Services (PDF)

RADIOLOGY SERVICES

Advanced imaging services

Advanced imaging includes CT, CTA, MRA, MRI, and PET services. Submit your request through the Referral Request tool

Puget Sound region providers: All radiology requests for services at a Kaiser Permanente facility must include a completed Radiology imaging request form (PDF)

***Radiology requests for MRIs** must also include a completed MRI questionnaire (PDF)

Kaiser Permanente requires prior authorization for computed tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and positron emission tomography (PET) services to ensure clinically appropriate imaging for our members.

Note: Claims adjudication requires prior authorization for payment. If no authorization is present, we will deny the claim to the provider's financial liability. The denial will impact the rendering provider's claims; that is, the provider providing the imaging service, not the provider ordering the service.

To expedite patient care, please check the CPT code in the PreAuthorization Code Check Tool. The tool will inform you if an authorization is needed. If it is needed and there is documentation indicated for the review, please attach those records to your referral request in Affiliate Link.

Imaging services requiring prior authorization

Services requiring prior authorization include but are not limited to:

- CT scans of abdomen, chest, head, lumbar spine, soft-tissue neck, facial bone, pelvis, sinus, and extremities
- MRI/MRA scans of abdomen, head, chest, cervical spine, hip, knee, lumbar spine, soft-tissue neck, shoulder, thoracic spine, and extremities

- Positron emission tomography (PET)
- Breast MRI
- CT colonography
- CT angiography
- Whole body CT
- Discography
- Single photon emission computed tomography (SPECT) for behavioral health indications
- MRA for behavioral health indications

Imaging services not requiring prior authorization

Imaging services that do not require prior authorization include those ordered and provided during:

- Emergency room visits
- Hospital-based urgent care
- Hospital inpatient services
- Ambulatory surgery procedures

For questions, contact the Provider Assistance Unit (PAU) at 1-888-767-4670.

REFERRING KAISER PERMANENTE MEMBERS FOR SPECIALTY CARE AND SERVICES

Referring for specialty care

When appropriate, you may need to refer a patient for specialty care and services. When referring a Kaiser Permanente Core member, you should always refer to a network specialist. You can use the provider directory to determine who is in network for your patient's plan.

The specialist's office may need to contact our Review Services Department to obtain prior authorization for the situations listed below.

Click here for exceptions to our prior authorization requirements.

Emergency room

If a specialist provides consultation for a member in an emergency room (in person), regardless of the provider's contract status, the specialist may be able to see that member for appropriate follow-up care with prior authorization, if necessary.

Request for authorization of follow-up care will be reviewed on an individual basis to determine medical necessity.

An emergency room specialist may refer a patient directly to an ophthalmologist or optometrist for care, regardless of the specialist's contract status. The scope and length of that authorization will be determined by a clinical review of the request.

Inpatient care

Contracted specialty physicians in a member's network who have consulted on a patient during an inpatient stay are allowed appropriate follow-up care with the patient in accordance with our authorization guidelines, provided that care begins within 30 days of the hospital discharge.

Non-contracted or non-network physicians who have consulted with a patient during an inpatient stay can see the patient for consultative follow-up care — for the purpose of transitioning care to a network provider — provided that care begins within 30 days of the hospital discharge.

The patient's primary care provider or contracted specialist may need to submit a request to authorize any additional visits to both contracted and non-contracted specialists.

The use of non-contracted providers for a Kaiser Permanente Core member

A provider may use or order services from other physician groups, facilities, or vendors in the course of patient care. Contracted and network entities should always be used for Kaiser Core members in these instances. The use of non-contracted providers without the proper authorization from Kaiser Permanente may lead to a denial where we are unable to protect our members from balance billing or for being held financially liable for the full charge.

Examples of this may include (but are not limited to:

A lab test that is ordered and drawn at a contracted laboratory but is sent to a non-contracted pathology vendor for analysis.

A nebulizer is given to a member from an on-site supply closet that is stocked by a non-contracted vendor.

A member is referred by a PCP to non-contracted specialist and no preauthorization is obtained.

It is our expectation that our contracted providers work with us to ensure the best care and coverage for members.

REQUESTING PREAUTHORIZATION FOR COVERAGE

Clinical specialists review the request based on clinical criteria and medical records. Supporting documentation must be submitted with the request. If the initial reviewer cannot approve it, the request is forwarded to a physician, pharmacist, or psychiatrist.

Second-level reviews:

If the first-level review results in a denial, a second-level reviewer may consult with the referring practitioner. If the second-level review is denied, a written notice of noncoverage will be mailed to the member and to the provider.

Notice or noncoverage:

This notice includes the denial rationale, review criteria, appeal instructions, and contact information for the reviewer.

RETROACTIVE AUTHORIZATIONS, EXTENUATING CIRCUMSTANCES, AND PROVIDER RECONSIDERATION REQUESTS

Kaiser Permanente requires that providers request authorization for services prior to or within fourteen calendar days of services rendered. Exceptions to this policy are made only under standard extenuating circumstances as defined by the WorkSMART Institute's best practice recommendations (PDF), and under Washington State Administrative Code 284-43-2060.

Retroactive authorizations

Kaiser Permanente will accept a request for retroactive authorization if the request meets either of the following guidelines:

- The request precedes a bill for services (no claim received by Kaiser Permanente) and is within fourteen days of the service OR
- The request precedes a bill for services (no claim received by Kaiser Permanente) and one of the extenuating circumstances applies

Extenuating circumstances

If your request for retroactive authorization qualifies under the guidelines above, you may submit your request to Review Services via One Health Port, or telephone. If your request is more than fourteen days after the date of service, please indicate which of the extenuating circumstances apply.

Extenuating circumstances fall into three categories:

- Unable to Know Situation-The provider and/or facility is unable to identify from which health plan to request an authorization. The patient is not able to tell the provider about their insurance coverage, or the provider verified different insurance coverage prior to rendering services.
- Not Enough Time Situations-The patient requires immediate medical services and the provider is unable to anticipate the need for a preauthorization immediately before or while performing a service.

- An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

Requirements for retroactive preauthorization consideration:

In each case, the provider is unable to request prior authorization for services as required by the provider's contract and the member's coverage agreement. Kaiser Permanente will accept the request for authorization more than fourteen calendar days after services are delivered as long as the provider made the request prior to submitting the claim for payment. The provider must provide proof of the extenuating circumstance in the retroactive request for authorization. If this documentation is not provided, Kaiser Permanente will deny the request and will not reconsider the decision. Please refer to the Washington Administration Simplification Guidelines for more information on extenuating circumstances and preauthorization rules.

Providers are encouraged to request the authorization as soon as they are able.

Reconsiderations of a denial

- If your claim or request for retroactive authorization is denied, and you are required to write off the charges, you have the option to request a reconsideration of the denial.
- **Note:** If there is any member financial responsibility for the denial, a request for reconsideration or appeal MUST go through the member appeals process.
- Subject to the provisions of your contract with Kaiser Permanente, including obtaining a member's prior written agreement to be financially responsible for the specific non-covered service, providers may bill a member for non-covered services.

Submitting a reconsideration

- When submitting reconsideration requests and medical records, please fax these requests and records to our team at 844-660-0747 or use the online reconsideration request form, within 24 months of the claim denial. These are sent directly to our team via Outlook and are stored with the reconsideration case. We will review your case within 60 days.
- We do not have a way to process, download, save or store CDs. When hard copies or CDs are sent to the post office box in Seattle, our Provider Reconsideration team does not have a way to monitor or ensure those documents are received.

Alternatively, you may mail the request to:

Kaiser Foundation Health Plan of Washington
Attn: Provider Reconsideration ACN-2
PO Box 30766
Salt Lake City, UT 84130-0766

For reconsiderations that did not deny for medical necessity see, Post service: Claims payment review & reconsideration process.

TRANSPLANT SERVICES

Kaiser Permanente covers medically necessary organ transplants for its members. In order to assure the highest quality of care and affordability for its members, effective January 1, 2022, Kaiser Permanente is partnering with Kaiser Permanente National Transplant Services (NTS) for all transplants except kidney transplant surgeries, which will continue to be managed within the Kaiser Permanente Washington region.

The NTS’s goal is to provide members with access to a network of transplant programs located at premier medical centers known nationally for their respective transplant programs and where successful outcomes are

predictably high.

Requesting a transplant

Please refer to the Transplant Process job aid for instructions on how to proceed with preauthorization for all transplants.

Member benefits

Benefits may vary for member and living donor travel/lodging expenses. Members should contact Member Services at 1-888-901-4636 to inquire about their coverage.