

# Preauthorization Grid

Updated: 01/01/2023



To identify clinical review requirements for a specific service, see <a href="#">Clinical Review Criteria</a> .  <a href="#">Preauthorization Code Check Tool</a> by code and line of business.	KAISER FOUNDATION HEALTH PLAN OF WASHINGTON				
	<b>PPO and Options Federal</b> <ul style="list-style-type: none"> <li>Access PPO</li> <li>Elect PPO</li> <li>Summit PPO</li> <li>Options Federal</li> </ul> ***See <a href="#">Access PPO, Elect PPO, Summit PPO and Options Federal Preauthorization Requirements</a> for full list of preauthorization requirements.	<b>Point of Service -</b> <ul style="list-style-type: none"> <li>Options</li> </ul> Authorization may be required for network benefit.	<b>Managed Care -</b> <ul style="list-style-type: none"> <li>Core</li> <li>CoreSelect</li> <li>Exchange plans</li> <li>Individual &amp; Family</li> <li>Virtual Plus</li> </ul>	<b>Medicare Advantage –</b> <ul style="list-style-type: none"> <li>Anchor</li> <li>Basic</li> <li>Centennial</li> <li>Columbia</li> <li>Essential</li> <li>Harbor</li> <li>Key</li> <li>Optimal</li> <li>Vital</li> </ul>	<b>Maintenance of Benefits (MOB)</b> <ul style="list-style-type: none"> <li>Federal HMO</li> <li>Association of Washington Cities</li> <li>Providence Health &amp; Services</li> <li>Seattle Children's Healthcare System</li> <li>Swedish Caregivers</li> </ul> Plans with MOB require prior authorization, even if Kaiser is not the primary plan.
Skilled nursing facilities	Notification upon admission	p	p	p	p
Mental health facilities	Notification upon admission	p	p	p	p
Substance Abuse Disorder facilities	Notification upon admission	p	p	p	
Long-term care facilities	Notification upon admission		p	p	p
Rehabilitation facilities	p	p	p	p	p
All scheduled inpatient admissions require preauthorization	p	p	p	p	p
Emergency admission in a community facility – Must notify within 24 hours of admission	Notification upon admission	p	p	p	p
Inpatient rehabilitation admission	p	p	p	p	p
Hospital admission	p	p	p	p	p

p = Indicates that preauthorization is required for coverage of the service.

Blank = Indicates that preauthorization is not required. See page 4 of this document on MEDICAL NECESSITY/RETROSPECTIVE REVIEW REQUIRED FOR CLAIM PAYMENT for more details.

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Advanced Care at Home	p	p	p	p	p
Transplants, artificial hearts, and ventricular assist devices	p	p	p	p	p
Stem cell transplant	p	p	p	p	p
Bariatric surgery	p	p	p	p	p
Orthognathic and sleep apnea study			p	p	p
Advanced Care at Home	p	p	p	p	p
Durable medical equipment	***		p	p	p
Extremity and limb prosthesis	p		p	p	p
Home health care	Notification upon admission		p	p	p
Hospice	Notification upon admission		p	p	p
Potentially cosmetic procedures	***		p	p	p
Investigational services	***	p	p	p	p
Planned home births		p	p	p	p
Advanced imaging (High-end radiology)	p	p	p	p	p
Specialty Care and specialists inside the network		p	p	p	p
Outpatient mental health			p for non-network providers Members can contact Mental Health and Wellness access line toll-free at 1-888-287-2680.		

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Outpatient chemical substance abuse treatment			p for non-network providers Members can contact Mental Health and Wellness access line toll-free at 1-888-287-2680.		
Bariatric surgery and obesity related services	p	p	p	p	p
All office visits – except women's health services			p	p	p
Podiatry services, including all services related to foot care			p	p	p
Outpatient rehabilitation therapy			p *Massage therapy may require preauthorization	p	
Outpatient surgery			p	p	p
Genetic testing	p		p	p	p
Potential dental services	***		p	p	p
Applied Behavioral Analysis Therapy – When benefit is available	p	p	p	p	p
Services outside of the network and outside the state			p	p	p
Clinical trials	p	p	p	p	p
New technology that has yet to receive a CPT code being billed with a miscellaneous code	p		p	p	p
For Medicare – All services related to national coverage decisions and local coverage decisions				p	

- Managed Care Plans require preauthorization for claim adjudication.
- PPO and Point of Service plans require services to be medically necessary. This means both preauthorization for certain services and medical necessity review for coverage determination upon receipt of the claim for services not requiring preauthorization.

**MEDICAL NECESSITY/RETROSPECTIVE REVIEW REQUIRED FOR CLAIM PAYMENT:**

<p>To identify clinical review requirements for a specific service, see <a href="#">Clinical Review Criteria</a>.  <a href="#">Preauthorization Code Check Tool</a> by code and line of business.</p>	<p><b>PPO and Options Federal</b></p> <ul style="list-style-type: none"> <li>• Access PPO</li> <li>• Elect PPO</li> <li>• Summit PPO</li> <li>• Options Federal</li> </ul> <p>***See <a href="#">Access PPO, Elect PPO, Summit PPO and Options Federal Preauthorization Requirements</a> for full list of preauthorization requirements.</p>	<p><b>Point of Service -</b></p> <ul style="list-style-type: none"> <li>• Options</li> </ul> <p>Authorization may be required for network benefit.</p>	<p><b>Managed Care -</b></p> <ul style="list-style-type: none"> <li>• Core</li> <li>• CoreSelect</li> <li>• Exchange plans</li> <li>• Individual &amp; Family</li> <li>• Virtual Plus</li> </ul>	<p><b>Medicare Advantage –</b></p> <ul style="list-style-type: none"> <li>• Anchor</li> <li>• Basic</li> <li>• Centennial</li> <li>• Columbia</li> <li>• Essential</li> <li>• Harbor</li> <li>• Key</li> <li>• Optimal</li> <li>• Vital</li> </ul>	<p><b>Maintenance of Benefits (MOB)</b></p> <ul style="list-style-type: none"> <li>• Federal HMO</li> <li>• Association of Washington Cities</li> <li>• Providence Health &amp; Services</li> <li>• Seattle Children’s Healthcare System</li> <li>• Swedish Caregivers</li> </ul> <p>Plans with MOB require prior authorization, even if Kaiser is not the primary plan.</p>
	<p>Specific services not requiring preauthorization must be medically necessary and will suspend post-service for medical necessity review.</p> <p><a href="#">Clinical Review Criteria</a></p>	<p>Specific services not requiring preauthorization must be medically necessary and will suspend post-service for medical necessity review.</p> <p><a href="#">Clinical Review Criteria</a></p>	<p>Authorized referral prior to delivery and billing of service. All medical necessity review is conducted prior to deliver of the service.</p>	<p>Authorized referral prior to delivery and billing of service. All medical necessity review is conducted prior to deliver of the service.</p>	<p>Authorized referral prior to delivery and billing of service. All medical necessity review is conducted prior to deliver of the service.</p>

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**To notify us about a current inpatient admission, use the [Inpatient Admission Notification](#) tool.**

**To request prior authorization for other services, use the [New Referral Request](#) tool (available only with OneHealthPort password).**

