KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Care Delivery Medical Necessity Review

Policy: Selective Care Delivery Ownership of Utilization Management

This policy applies to:

☒Kaiser Permanente Health Plan of Washington ☒Kaiser Permanente Health Plan of Washington Options, Inc.

☒Commercial ☒Medicare ☐Medicaid

Background

Kaiser Permanente of Washington (KPWA) exists to provide high quality, affordable health care services and to improve the health of members and communities we serve. Doing so requires a knowledge and commitment to evidence-based care. It also requires restricting care that is not based in evidence and could risk harm to members or diminish health care resources without the reasonable expectation of improved health outcomes. Appropriate medical care is the right care, at the right time delivered in the right setting. There are many ways to promote appropriate care including individual medical education, up to date clinical guidelines, well-designed systems of care and robust safety programs.

Another way to prevent inappropriate care is to subject some services to review according to published, evidence-based medical necessity criteria. Doing so should be used sparingly because utilization management programs can increase bureaucratic tasks that can delay care and add to the total cost of care. These effects should be mitigated, to the degree possible, with efficient processes and the selective application of real-time review.

Policy Summary

This policy outlines the process by which groups or departments may request exemption from real-time, medical necessity review. If such requests are approved, they are not to be interpreted as an exemption from the medical necessity criteria, but rather as an alternative pathway for demonstrating consistent adherence to that criteria. Such an arrangement is a "delegation" of the medical necessity review function and subject to intermittent verification. In so doing, the alternative pathway may provide benefits to the clinician/group/department, members/patients, and the KPWA clinical review unit.

Requests will be considered by the KPWA Medical Policy Committee (MPC) in conjunction with data on prior performance. All care delivery partners may request such an arrangement. The Washington Permanente Medical Group (WPMG) is likely to be well-positioned for such an arrangement if they know the medical necessity criteria, can demonstrate consistent adherence with the criteria and engage with the operations of utilization management.

Areas that are unlikely to be amenable to an alternative arrangement and would require careful review and discussion prior to "delegation" include:

1. Those services that are predominantly sold or labeled as a benefit rider (example bariatric surgery) given the increasing complexity of benefit design and sales
2. Procedures that may have a cosmetic component and would have contract implications
3. Controversial areas where there is disagreement on the utility of the service/ procedure

The process for identification and evaluation of arrangements to delegate utilization management is as follows:

1. Requests should come in from delivery system service line medical directors (or equivalent position such as lead or chief) and business managers or their representatives (such as Provider Services). Agreements may also be suggested by the clinical review unit based on knowledge of the historical performance.
2. MPC representatives will meet with the department/division/group to:
    a. Answer questions about the current criteria as needed. Explain that if they disagree with some part of the criteria, they may petition to MPC in the standard fashion but cannot modify them on their own.
    b. Establish the expectation that the department/division/group educate any new employees in that department on the criteria.
3. MPC representatives will review data on approval/denial rates.
4. MPC representatives will present gold carding proposals to the full medical policy committee for a decision.
5. If an agreement is approved, MPC representatives will set a schedule for regular audits, and extension of the agreement will be subject to audit completion and performance.
6. To facilitate regular audits, MPC representatives will share available cases subject to the medical policy with the relevant department/division/group, but care delivery leaders of the relevant department/division/group must demonstrate continued adherence to the clinical criteria.

MPC will consider the following when approving/denying requests for exemption to real-time medical necessity review:

1. Potential for delays to care from authorization requirements.
2. Potential for harm to patients from inappropriate utilization.
3. Providers historical approval/denial rate.
4. Volume of reviews and their impact on care delivery and review services.
5. Engagement from the group/department/division, including ability to track performance, onboard new clinicians and communicate with MPC representatives.
6. Cost of the service and annual spend as well as potential financial implications of increased utilization.

Care Delivery partners will be responsible for demonstrating adherence to clinical criteria and MPC will verify performance metrics submitted for establishment/renewal of the agreement.

If an agreement is reached, MPC will notify signatories if/when clinical review criteria are updated.

Implementation of agreements is subject to Health Plan ability to ensure that processes are in place in review services to ensure a smooth approval process and appropriate claim payment.