KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Policy: Provider Requests for Exemption from Prior Authorization Requirements for Selected Services

This policy applies to:		
☒Kaiser Permanente Health Plan of Washington	☒Kaiser Permanente Health Plan of Washington Options, Inc.	
☒Commercial	☒Medicare	☐Medicaid

Policy Summary

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) will permit exemptions from prior authorization requirements to an internal Kaiser Permanente care delivery group OR an external contracted provider group for specific tests or procedures*, if certain conditions are met. The provider group must demonstrate a high degree of consistent understanding and application of Kaiser Permanente clinical review criteria so patients receive the best evidence-based care. To be considered, the selected test or service must have clear evidence of improvement of clinical management of the patient – the clinical benefit is not in doubt.

*Note: this policy excludes pharmacy services.

The process for identification, evaluation, and implementation of the services is as follows:

1) The request to exempt a provider from certain prior authorization processes will go to the Medical Policy Committee (MPC).
    a. **Internal Kaiser Permanente care delivery group:** Request may come from the internal delivery system service line chief and business manager to request exemption from prior authorization requirements for specific service.
    b. **External contracted provider group:** Request may come from the Kaiser Permanente regional medical director and provider services teams on behalf of an external contracted network specialty group interested in being exempt from prior authorization requirements for specific services.
2) The Medical Policy Committee (MPC) reviews applicable data on the provider's approval/denial rates. MPC uses the following criteria:
    a. Cost data; annual spend
    b. Denial rate
    c. Potential benefits to patients by removing delays related to prior authorization
    d. Potential harm to patients from inappropriate utilization
    e. Provider's historical prior authorization approval rate
    f. The test or service in question has clear evidence of improvement of clinical management of the patient – the clinical benefit is not in doubt
    g. The volume of reviews and its impact with review services

h. Is the service line or contracted physician group willing and able to monitor overall utilization and perform audits, and share results with MPC annually? If not, the prior authorization requirements will continue.

3) The Clinical Review Unit (CRU)/Review Services representatives discusses the request with the delivery system stakeholders, such as
    a. Care Delivery leadership or medical group leadership if external
    b. Division chiefs
    c. Radiology, laboratory leadership, etc.
    d. Epic support
4) The Clinical Review Unit (CRU) reviews the current criteria with the requesting specialty group and discusses how the current Utilization Review (UR) process works.
    a. Share available metrics on their past performance from CRU
    b. Affirm the expectation that clinical review criteria must be used by both internal and external providers. If any specialist disagrees with some part of the criteria, the specialist can petition MPC but cannot modify criteria independently. CRU owns the clinical review criteria.
    c. Discuss audit processes to be followed. An audit is required annually to produce reportable results on a recurring basis, including both changes in utilization (either increase or decrease) and as well as agreement with published clinical review criteria. If the audit shows that clinical review criteria is not followed consistently, Kaiser Permanente reserves the right to resume the prior authorization process.
    d. Discuss the method for providers to send to Kaiser Permanente cases in which a member requests a test that is not indicated.
    e. The prior authorization exemption will not automatically extend to new employees in that department or provider group. The decision to add a new provider will be made by the service line chief or external medical group leadership in conjunction with CRU.
6) Prior to implementation, Kaiser Permanente will validate that all health plan Review Services and Claims processes are in place to ensure review process and appropriate claim payment.
7) CRU will notify the internal and external contracted groups through Provider Services whenever clinical review criteria are updated. CRU will remain the owners of the clinical review criteria through the Medical Policy Committee.

Clinical services that routinely would not be authorized will require careful review and discussion prior to any prior authorization exemption, including:

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.

Internal Kaiser Permanente care delivery group: To request consideration to be exempt from Kaiser Permanente's prior authorization requirements for a clinical service, please contact the Director of Referral and Review Services.

External contracted provider group: To request consideration to be exempt from Kaiser Permanente's prior authorization requirements for a clinical service, please contact the regional medical director and/or provider services consultant via the Provider Assistance Unit (PAU) at 1-888-767-4670.