KAISER PERMANENTE®

FREQUENTLY ASKED QUESTIONS

Removal of administrative authorization requirements

January 2024

What specialties no longer require an authorization when the member is seeing a network provider?

- Anesthesia Pain
- Allergy
- ENT/Otolaryngology
- Endocrinology
- Gastroenterology
- General Surgery
- Genetic Counseling
- Infectious Disease
- Lactation
- Nephrology
- Physiatry (Physical Medicine & Rehab)
- Pulmonology
- Urology
- Vascular/Interventional Radiology
- Cardiac surgery
- Thoracic surgery
- Gynecological oncology

How do I know if a specialist is a "network provider"?

The Kaiser Permanente Provider Directory shows the providers who are considered in network for a member's plan. You can search the directory and filter by specialty to see the network providers for that specialty.

What Kaiser Permanente plans are included in this change?

Kaiser Permanente commercial and self-funded HMO and Point of Service plans and Kaiser Permanente Medicare Advantage plans are included in this change. Kaiser Permanente PPO plans already do not require authorization for specialty care office visits.

Is pre-authorization required for surgeries and procedures?

If the surgery or procedure is happening outside the office setting (such as a hospital or Ambulatory Surgery Center), Kaiser Permanente will continue to require pre-authorization. Also, any service that requires medical necessity review also requires pre-authorization (Please refer to this list of services that require medical necessity review).

For a full list of codes that would be covered without authorization, please see our standard code range document.

Can a patient just self-refer to a specialist if that specialist is a network provider?

While a member can self-refer to the in-network specialists identified above, Kaiser Permanente strongly encourages the use of referrals between providers to facilitate coordinated care and effective use of specialty care. Most specialists prefer (and sometimes require) an initial evaluation by a Primary Care provider and a referral or communication from that provider before seeing a patient. However, providers are not required to send a referral to Kaiser Permanente.

Is any communication to Kaiser Permanente required when referring a member to a network provider in one of the above specialties?

No, Kaiser Permanente members can be referred to an in-network specialist and the referring provider will no longer need to submit their referral to Kaiser Permanente for authorization. The Kaiser Permanente member should be able to schedule with their provider right away.

What can the specialist expect when Kaiser Permanente is referring a member?

Kaiser Permanente ordering providers will continue to provide a referral when referring a member to any provider. Specialists in the network will receive a Summary of Care and referral letter. The only difference is that in-network specialists from the above list will no longer need to wait for the authorization to schedule the patient, and they will not need an authorization number for claim payment.

What if the Kaiser Permanente member is referred to a provider outside of their network?

A Kaiser Permanente authorization is still required for coverage of any care with providers who are outside of the member's network.

The last bullet in the specialty list says "All specialties", what does "Removal of the "Evaluate and Treat authorization from PCP" requirement mean for all specialties?

When there is still a requirement for an Evaluate and Treat authorization, we no longer require that the authorization request must come from the PCP. For example, if the patient was referred to the specialist but the referring provider did not request an authorization from Kaiser Permanente, the specialist can contact Kaiser Permanente directly and ask for authorization to ensure payment. In the past, we would have denied that request and asked that the specialist contact the PCP to initiate the authorization instead.