This section of the Manual was created to help guide you and your staff in working with Kaiser Permanente’s Utilization Management (UM) policies and procedures. It provides a quick and easy resource with contact phone numbers, important websites and detailed processes for UM services.

If, at any time, you have a question or concern about the information in this Manual, you can reach our Resource Stewardship Department by calling D/B (303) 636-3233, Southern Colorado (719)867-2100.
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Section 4: Utilization Management

4.1 Overview of UM Program

Appropriate utilization management contributes to the success of Kaiser Permanente and its Members/Plan Participants by insuring that the medical services provided to our Members are appropriate for the Member’s condition, provided in a timely manner in the right setting and are in accordance with the Plan’s benefits.

For general or specific Denver/Boulder Resource Stewardship inquiries, please call 303-636-3233 or fax 303-636-3259. Individuals who are deaf or hard of hearing may contact us by calling Relay Colorado at 1-800-659-2656 (toll free TTY or dial 711). Staff is available to receive and send calls by using Relay Colorado. Staff will provide a telephone interpreter to assist with UM issues to individuals who speak limited or no English free of charge.

Staff is available to accept collect calls during normal business days and hours (Monday through Friday 8:30 a.m. – 4:30 p.m.). Resource Management staff can send outbound communication regarding utilization management issues during normal business hours. After normal business hours and within the Denver metro area, please leave a message and your call will be returned the next business day. After normal business hours, and outside the Denver metro area, please call our toll free number, 1-800-632-9700. Your message will be forwarded to our UM staff; your call will be returned the next business day.

For general or specific Southern Colorado Resource Stewardship inquiries, please call 719-867-2100 or fax 719-867-2144. Individuals who are deaf or hard of hearing may contact us by calling Relay Colorado at 1-800-659-2656 (toll free TTY or dial 711). Staff is available to receive and send calls by using Relay Colorado. Staff will provide a telephone interpreter to assist with UM issues to individuals who speak limited or no English free of charge.

Staff is available to accept collect calls during normal business days and hours (Monday through Friday 8:30 a.m. – 4:30 p.m.). Resource Management staff can send outbound communication regarding utilization management issues during normal business hours. After normal business hours, and outside the Southern Colorado service area, please call our toll free number, 1-888-681-7878. Your message will be forwarded to our UM staff; your call will be returned the next business day.

One of the key components of the Resource Stewardship program is authorization requests (urgent and non-urgent, pre-service or concurrent, and post-service). These authorization requests are reviewed for member’s current eligibility, plan benefits, and medical appropriateness for internal and external inpatient/outpatient services (physician and nurse review). Once these elements are reviewed, a determination can be made regarding eligibility for coverage. To obtain a copy of the complete

On occasion, denials are issued for medical necessity reasons, benefit coverage, member eligibility, etc. If the services requiring authorization are not approved, the requesting practitioner/provider and member will be notified of the denial. The denial documentation will identify the UM Physician Reviewer who will be available to discuss the decision when contacting the Resource Stewardship Department. The Resource Stewardship Department has policies and procedures with specific details on the denial process.

4.2 Medical Appropriateness

Resource Stewardship/UM decisions are based on appropriateness of care and service and existence of coverage. Resource Stewardship/UM decisions take into account individual Member/Plan Participant needs, patient safety concerns, and assessment of the local delivery system. In making these decisions, criteria that are objective and based on medical evidence are used. The criteria are reviewed and approved by Colorado Permanente UM Physician Reviewers on an annual basis.

These criteria are applied along with medical expert opinions, when necessary, in making decisions. To obtain a copy of Resource Stewardship/UM criteria, please call Resource Stewardship at 303-636-3200 in Denver/Boulder or 719-867-2100 in Southern Colorado.

No practitioner, provider or other staff member is rewarded for issuing denials of coverage or care. Additionally, financial incentives for Resource Management decisions do not encourage decisions that result in underutilization. Kaiser Permanente will ensure that all benefit/coverage determinations are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Kaiser Permanente will not make decisions regarding issues like hiring, compensation, termination, or promotion based on the likelihood that the person will support the denial of benefits.

Current arrangements with contracted and select non-contracted facilities include on-site review by Quality Resource Coordinators or other licensed professional staff, during normal business days (Monday – Friday) and during business hours (7:30am – 4:30pm). No additional advanced scheduling is required. If/when new facilities are reviewed by Quality Resource Coordinators or other licensed professional staff, specific arrangements will be made with each facility to assure adherence to facility rules and expectations.

4.3 “Referral” and “Authorization”

Kaiser Permanente Colorado has separate processes for Denver/Boulder and Southern Colorado authorizations and referrals. Each process is described below.
Denver / Boulder

**Authorization:** The contracted provider is required to contact the Kaiser Permanente Resource Stewardship Department for approval for a specific service before the service is rendered.

**Referral:** The routine referral is the most frequently issued referral. After being seen or treated by their Colorado Permanente Medical Group, P.C. (CPMG) physician, a member is referred to an affiliated practitioner, provider or facility. The appointment with the affiliated practitioner/provider can be made by the member who can call the Central Referral Center at (303) 636-3131 to research the appropriate appointment phone number.

Southern Colorado

**Authorization:** The contracted provider is required to contact the Kaiser Permanente Resource Stewardship Department for approval for a specific service before the service is rendered. Please see section 4.7 for a detail list of services that require authorization.

**Referral:** A member may self refer or a Kaiser Permanente contracted provider may direct the member to any Kaiser Permanente contracted provider that is listed in the published Provider Directory, that is available on-line at KP.org or by contacting Provider Services at 1-888-681-7878.

4.4 Denver/Boulder Referral and Authorization Policy and Procedure

You are required to obtain a prior authorization before service delivery for all but emergency services provided in the Emergency Department. Prior written authorization ensures that only necessary and benefit-covered services are provided to our members and that you, in turn, are paid for those services. Authorization is provided with the use of the Referral Approval form, which is generated from either Kaiser Permanente’s HealthConnect (electronic medical record) or the claim system.

The completed Referral Approval form is sent to the affiliated provider via AffiliateLink, faxed or mail. All information related to pre-authorization of services is coordinated through the Central Referral Center.

Kaiser Permanente
CENTRAL REFERRAL CENTER
Hours of Operation Monday through Friday 8:30 a.m. - 4:30 p.m.
Phone 303-636-3131
FAX 303-636-3101

A referral is required prior to billing. If services are provided to a Member/Plan Participant prior to receiving a written referral, it is your responsibility to obtain the
written referral from the Medical Group physician. Communication with the Medical Group Physician can be coordinated by contacting a Referral Review Nurse in our Resource Stewardship Department. Phone 303-636-3200 or Fax 303-636-3259.

Clinical information may be needed in some cases. In these instances, a Request to Pre-authorize Outside Service form or printed records may be attached to the approval form. Please send clinical information or results to the referring provider. The Request to Pre-authorize Outside Service is not authorization for services or payment. It is simply a referral request from a CPMG physician. Please send your clinical information or results to the referring provider.

<table>
<thead>
<tr>
<th>The Routine Referral</th>
<th>Emergent/Urgent Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPMG Physician refers member to contract provider or facility.</td>
<td>1. Contract Provider provides services.</td>
</tr>
<tr>
<td>2. Referral Center Authorizes and processes Referral Approval Form. A Resource Stewardship Referral, RN may review prior to processing.</td>
<td>2. Provider contacts Central Referral Center (leave a detailed message if after hours) Resource Stewardship Referral, RN is contacted</td>
</tr>
<tr>
<td>3. Contract Provider Provides Services</td>
<td>3. Resource Stewardship Referral, RN contacts referring CPMG physician and RN Authorizes Care, Referral Center issues a Referral Approval Form to provider of care.</td>
</tr>
<tr>
<td>4. Contract provider bills for services</td>
<td>4. Contract provider bills for services</td>
</tr>
</tbody>
</table>

- Contact Referral Center
  - for additional visits
  - for referral extensions
  - for authorization for further services

- Contact Referring CPMG Physician
  - to discuss clinical information and findings

- Contact Referral Center
  - for additional visits
  - for referral extensions
  - for authorization for further services

- Contact Referring CPMG Physician
  - to discuss clinical information and findings

### 4.4.1 Denver/Boulder Referral Approval Forms

The following two pages are samples of the Referral Approval forms. There are two different versions; The Professional Referral Approval and The Facility Referral Approval. These forms are intended to provide authorization for treatment and care. In order to be valid, the forms must be complete. If you have any questions related to the services, you have been requested to provide, call the Central Referral Center at 303-636-3131.
## EXPLANATION OF THE PROFESSIONAL REFERRAL APPROVAL FORM

<table>
<thead>
<tr>
<th>Number</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Referral Inquiries</td>
<td>The phone number of the Central Referral Center, 303-636-3131. If you have any questions or need modification of the referral, call this number.</td>
</tr>
<tr>
<td>2</td>
<td>Billing Inquiries</td>
<td>The phone number of the Claims and Referral Department, 303-338-3600. Direct billing questions to this number.</td>
</tr>
<tr>
<td>3</td>
<td>Pre-Authorization Number</td>
<td>The preauthorization number will be computer generated in the member/plan participant’s health record. This number is required on any bill submitted for payment.</td>
</tr>
<tr>
<td>4</td>
<td>Member Name and HRN</td>
<td>The member’s name and Kaiser Permanente unique Health Record Number. This number is not the member's Social Security Number.</td>
</tr>
<tr>
<td>5</td>
<td>Referring Provider</td>
<td>The name and identification number of the Kaiser Permanente physician or provider that authorized services. The name and address of the medical office where the provider is located.</td>
</tr>
<tr>
<td>6</td>
<td>Referred to Professional</td>
<td>The name and Servicing number of the external provider that has authorization to treat the member.</td>
</tr>
<tr>
<td>7</td>
<td>Referring Diagnosis Range</td>
<td>The ICD9 diagnosis for this episode of care.</td>
</tr>
<tr>
<td>8</td>
<td>Estimated Service Dates</td>
<td>The estimated span of time the referral is valid.</td>
</tr>
<tr>
<td>9</td>
<td>Approved Units or Approved Visits</td>
<td>Number of approved visits is indicated in this space. To ensure appropriate payment, it is your responsibility to track the number of authorized visits.</td>
</tr>
<tr>
<td>10</td>
<td>Procedures</td>
<td>These CPT procedure codes are given as a guide for the services authorized (This is not official authorization or guarantee of payment). If you have a question related to the services that are authorized, call the Central Referral Center. Additional information may be found on either the Request to Pre-authorize Outside Services form or the medical records from the CPMG physician.</td>
</tr>
<tr>
<td>11</td>
<td>Evaluation/Consultations</td>
<td>If your referral only authorizes an evaluation or a consultation, any additional services are not covered by this referral.</td>
</tr>
</tbody>
</table>

## FACILITY REFERRAL APPROVAL

A Facility Referral Approval Form
EXPLANATION OF THE FACILITY REFERRAL APPROVAL FORM

<table>
<thead>
<tr>
<th>Number</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Referral Inquiries</td>
<td>The phone number of the Central Referral Center, 303-636-3131. If you have any questions or need modification of the referral, call this number.</td>
</tr>
<tr>
<td>2</td>
<td>Billing Inquiries</td>
<td>The phone number of the Claims and Referral Department, 303-338-3600. Direct billing questions to this number.</td>
</tr>
<tr>
<td>3</td>
<td>Pre-Authorization Number</td>
<td>The preauthorization number will be computer generated in the member/plan participant’s health record. This number is required on any bill submitted for payment.</td>
</tr>
<tr>
<td>4</td>
<td>Member Name and HRN</td>
<td>The member’s name and Kaiser Permanente unique Health Record Number. This number is not the member’s Social Security Number.</td>
</tr>
<tr>
<td>5</td>
<td>Referring Physician/Provider</td>
<td>The name and identification number of the Kaiser Permanente physician or provider that authorized services. The name and address of the Medical office where the provider is located.</td>
</tr>
<tr>
<td>6</td>
<td>Referred to Facility</td>
<td>The name and servicing number of the facility provider that has authorization to treat the member.</td>
</tr>
<tr>
<td>7</td>
<td>Servicing/Attending Provider</td>
<td>The name and servicing number of professionals authorized by the referral.</td>
</tr>
<tr>
<td>8</td>
<td>Svc Beg and Svc End Dates</td>
<td>The estimated dates of service the referral covers.</td>
</tr>
<tr>
<td>9</td>
<td>Admit, Principal, and Additional ICD-9 Diagnosis</td>
<td>The known ICD9 diagnosis for this episode of care.</td>
</tr>
<tr>
<td>10</td>
<td>From and Thru Dates</td>
<td>The estimated span of time the referral is valid.</td>
</tr>
<tr>
<td>11</td>
<td>Revenue Codes</td>
<td>From UB92 the authorized services by Revenue Code.</td>
</tr>
<tr>
<td>12</td>
<td>Procedure</td>
<td>These CPT procedure codes may be given as a guide for the services authorized.</td>
</tr>
<tr>
<td>13</td>
<td>Approved Units or Approved Visits</td>
<td>Number of approved days or visits are indicated in this space. To ensure appropriate payment, it is your responsibility to track the number of authorized visits.</td>
</tr>
</tbody>
</table>

4.4.2 Secondary Referrals

Except in emergency cases, an affiliated provider may not refer Kaiser Permanente members to another provider without obtaining prior authorization. A Referral Approval form, authorized by a CPMG physician, is required for any secondary referrals. Please call the Central Referral Center for assistance. Failure to comply with contract terms regarding secondary referrals will result in a deduction from future compensation to cover the cost of the unauthorized services by an unauthorized provider.
4.4.3 Inpatient and Outpatient Hospital Services

The following hospital services require separate referrals for authorized care:

- Inpatient Admissions
- Ambulatory Surgery
- Outpatient Treatment
- Outpatient Diagnostic Services
- Emergent Authorized Care
- Long-Term Acute Care

Non-Emergent Hospitalization You must obtain a pre-authorization for Kaiser Permanente members admitted or treated at your hospital. Contact the Central Referral Center at 303-636-3131. The Central Referral Center can confirm the referral information.

Emergency Hospitalization: Kaiser Permanente must be notified as soon as possible. If the emergency admission occurs after normal clinical hours (after 5:00 PM, weekends or holidays), contact the Emergency Care Management Department at 303-831-6683 regarding the admission.

Emergency Hospitalization at Boulder/Longmont: If a member is treated in the emergency room of Boulder Community Hospital contact a CPMG physician will determine if hospitalization is appropriate. The CPMG physician will generate a referral to the appropriate specialist physician.

Non-covered services, co-pays and deductibles are not paid by Kaiser Permanente and must be billed to the member. This amount is indicated on the Statement of Remittance (SOR) with your payment.

Continuing Care

The following services are coordinated and administered by the Kaiser Permanente Continuing Care Department:

- Adult Home Health
- Durable Medical Equipment
- Comprehensive Inpatient / Outpatient Rehabilitation
- Skilled Nursing Facilities
- Oxygen

4.4.4 Admission to Skilled Nursing Facility (SNF)

Nursing Home stays may be planned or come upon the patient unexpectedly, and may be either short or long-term. Kaiser Permanente does not cover custodial, long-term care. Please call the facility directly for placement.
**APPROVED NURSING FACILITIES**  
**PHONE NUMBER**

<table>
<thead>
<tr>
<th>Nursing Facility</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azura of Lakewood Rehabilitation</td>
<td>720-388-1042</td>
</tr>
<tr>
<td>Cherrelyn Manor</td>
<td>303-798-8686</td>
</tr>
<tr>
<td>Garden Terrance</td>
<td>303-750-8418</td>
</tr>
<tr>
<td>Life Care at Longmont</td>
<td>303-776-5000</td>
</tr>
<tr>
<td>Life Care at Westminster</td>
<td>303-412-9121</td>
</tr>
<tr>
<td>Life Care Center of Aurora</td>
<td>303-751-2000</td>
</tr>
<tr>
<td>Manor Care of Boulder</td>
<td>303-440-9100</td>
</tr>
<tr>
<td>Manor Care of Denver</td>
<td>303-355-2525</td>
</tr>
<tr>
<td>Villa Manor</td>
<td>303-986-4511</td>
</tr>
<tr>
<td>Western Hills Health</td>
<td>303-232-6881</td>
</tr>
</tbody>
</table>

**4.4.5 Home Health/Hospice Services**

The ordering physician should call the phone numbers listed below to coordinate and order services. Most providers need a written order, signed by a physician. Additional documentation or medical information may also be required to properly care for patients in specific medical settings. These providers will contact Kaiser Permanente to follow through with the referral and pre-authorization process.

**Oxygen**

To request oxygen services use the DME Order Referral Letter in Healthconnect and fax to Apria Health Care. Questions can be directed to Apria Health Care at 720-922-4600. Servicing providers and ordering physicians should call the Continuing Care Department at 303-636-3300 if they have questions regarding the policies and procedures pertaining to the above services.

**Adult Home Health**

Members must be homebound and require the skill of a nurse or therapist to be eligible. Providers may order these services by filling out the Home Health Referral Letter in Healthconnect and faxing to one of our 2 Home Health Care agencies, Denver Visiting Nurses Association or Interim Home Health.

**Hospice Benefit**

Hospice is appropriate for patients whose life expectancy is 6 months or less and have accepted the hospice philosophy of comfort care rather than cure. To request hospice services from a contracted provider call The Denver Hospice at 303-321-2828 or HospiceCare of Boulder/Broomfield County at 303-449-7740 and request an evaluation visit. Medicare patients may choose from any hospice in the city since Hospice is a carve out benefit.
Rehabilitation/Long-Term Acute Care Hospital
Most rehabilitation occurs in the home or Skilled Nursing facility. In catastrophic cases involving head injury or spinal cord injury, acute rehabilitation may be needed. Referrals for these services are approved Monday – Friday by calling the referral line: 303-941-4113. Inpatient Rehabilitation/Long Term Acute Care providers are as follows; Craig Hospital, Spalding, North Valley Rehab, Kindred, Select Hospital, and Mapleton Rehabilitation.

4.4.6 Durable Medical Equipment (DME)
Durable Medical equipment is equipment that is appropriate for use in the home, able to withstand repeated use, medically necessary, not of use to a person in the absence of illness or injury, and approved for coverage. Kaiser Permanente uses a formulary for durable medical equipment. Most durable medical equipment is provided by Apria Health care and follows the process outlined above for oxygen therapy. For specialty wheelchairs, including powered mobility devices, Kaiser Permanente uses a mobility clinic located at the Skyline facility, physical medicine department. KP members must be evaluated in this clinic prior to receiving a specialty wheelchair. Other durable medical equipment, appliances and braces, orthotics and prosthetics or supplies are covered for most of our members according their benefit level. If you wish to prescribe these items for a Kaiser Permanente member, please call the Central Referral Center or contact the vendor directly in some circumstances. Verification of member benefit coverage and assistance in obtaining the products or services is done by the Central Referral Center and Continuing Care.

4.4.7 Non-Emergent Member Transfers
Non-emergent member transfers can be arranged by contacting Resource Stewardship for Denver/Boulder at (303) 636-3200 or Southern Colorado at (719)-867-2184.

4.4.8 Palliative Care
The following services are coordinated and administered by the Kaiser Permanente Palliative Care Department:

1. Inpatient Palliative Care Consultation:
   • Providers can call for an inpatient consultation if they believe that their patients could die within 12 months, and that an Interdisciplinary team would benefit their patients/families in discussing Goals of Care, and with symptom management.
     • St. Joseph’s Hospital 303-909-2882
     • Good Samaritan Hospital 303-345-8156.
2. Home Based Palliative Care:
In partnership with our community agencies, a member may be eligible for Home Based Palliative Care if they have a terminal illness, are currently seeking active medical treatment, and are homebound generally. The diagnoses accepted at this time are CHF, COPD, Cancer or ALS. To refer, please call 303-636-3329.

3. Clinic Based Palliative Care

| AMBULATORY patients (= can travel to clinic for care) who need either full team or social work-only support | Rock Ck: full team (M-F) | Skyline: social worker only (M-F) | Westminster: social worker only (M-F) |
| Any life-limiting diagnoses; for patients with dementia, an involved caregiver is required | Via HealthConnect: Ref_palliative clinic | Questions: call 720-536-6404 |

4. Kaiser Special Services (KSS)

| AMBULATORY patients (= can travel to clinic for care) who need either full team or social work-only support | Rock Ck: full team (M-F) | Skyline: social worker only (M-F) | Westminster: social worker only (M-F) |
| Any life-limiting diagnoses; for patients with dementia, an involved caregiver is required | Via HealthConnect: Ref_palliative clinic | Questions: call 720-536-6404 |

4.4.9 Perinatal Home Care
To coordinate and order these types of services for pediatric members please call Kaiser Permanente Perinatal Services Department at 303-636-2929.

4.4.10 Chemical Dependency
Members can self refer to a Kaiser Permanente Chemical Dependency provider for treatment without prior authorization. Most Kaiser Permanente members are treated internally at one of the two Kaiser Permanente Chemical Dependency Treatment facilities. These are located at Highline Center Chemical Dependency 10350 E. Dakota Ave. Denver, CO. 80247 and at the Hidden Lake Medical Office at 7701 Sheridan Blvd. Westminster, CO 80003. The phone number for both facilities is 303-367-2800. The member’s benefit is explained at the assessment session with each patient. Medical treatment for alcoholism, drug abuse or addiction, including detoxification and counseling are provided in hospitals and medical offices in accordance with the applicable benefit schedule. Treatment consists of matching the patient to the most appropriate level of care and moving them to the least restrictive level as clinically appropriate.
Mental Health services needed in conjunction with the treatment of alcoholism, drug abuse or drug addiction are provided in accord with the applicable Benefit Schedule. All referrals for chemical dependency services must be authorized through the Kaiser Permanente Chemical Dependency Program.

Rehabilitative and Detoxification Services in a Specialized Alcoholism, Drug Abuse or Drug Addiction Treatment Facility:
The determination of the need for services of a specialized facility or program and referral to such a facility or program is made by a Chemical Dependency Treatment Provider. To reach a Chemical Dependency Provider, please call the Provider Line at 303-367-2808.

For Southern Colorado, chemical dependency services may be accessed upon referral from a primary care or specialist physician or by member self referral. Referrals, or self-referrals, should be made to:

ValueOptions
866-702-9026 (24 Hours/Day, 7 Days/Week)

ValueOptions will verify membership eligibility and benefit status with Kaiser Permanente for each member seen and submit a preauthorization request form at the beginning of treatment.

4.4.11 Mental Health

Most Kaiser Permanente members are treated internally at one of the three Kaiser Permanente Behavioral Health facilities. The member’s benefit is explained at the time the initial appointment is scheduled. All treatment by contracted providers must be pre-authorized by a Behavioral Health Manager. For information regarding authorization for services, contact the referring provider at the appropriate facility. Patient Confidentiality laws are observed.

<table>
<thead>
<tr>
<th>Facility</th>
<th>New Appointments</th>
<th>Provider Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highline Center Behavioral Health</td>
<td>303-367-2900 or 303-367-2950</td>
<td>303-367-2990</td>
</tr>
<tr>
<td>10350 E. Dakota Ave. Denver, CO 80247</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Center Mental Health</td>
<td>303-467-5850</td>
<td>303-467-5767</td>
</tr>
<tr>
<td>4851 Independence St. #270 Wheat Ridge, CO 80033</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hidden Lake Behavioral Health</td>
<td>303-650-3900 or 303-650-3950</td>
<td>303-650-3939</td>
</tr>
<tr>
<td>7701 Sheridan Blvd. Westminster, CO 80003</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For Southern Colorado, Mental Health services may be accessed upon referral from a primary care or specialist physician or by member self referral. Referrals, or self-referrals, should be made to:

ValueOptions  
866-702-9026 (24 Hours/Day, 7 Days/Week)

Value Options will verify membership eligibility and benefit status with Kaiser Permanente for each member seen and submit a preauthorization request form at the beginning of treatment. Coverage appeals must be handled through Kaiser Permanente. Kaiser Permanente is the responsible party to contact the member. For Mental Health appeals, please notify Kaiser Permanente Member Services at 888-681-7878.

For PCP and ValueOptions behavioral communication expectations, Value Options provides behavioral health services to Kaiser Permanente members. Value Options’ behavioral health practitioners are required to participate in all quality management activities. One important quality activity is improving the level of communication from behavioral health to the medical delivery system. Behavioral health practitioners are required to obtain a signed release of information form from members before they are able to communicate to the member’s primary care physician or other medical care provider. Value Options promotes and encourages the obtaining of this release whenever possible in all behavioral health treatment settings. When an ROI is signed, behavioral health practitioners must send diagnostic and treatment plan information to the primary care or other medical care practitioner on a regular basis. In complex cases, telephonic consultation is encouraged to minimize the potential for adverse reactions or occurrences. Annually, ValueOptions monitors behavioral health practitioner compliance with these requirements through an audit of medical records. Individual scores and feedback is provided to each audit provider participant. Aggregate findings and audit results are given in provider communications along with reminders of communication requirements. These efforts are designed to improve communication. Medical care providers are likewise encouraged to obtain a release of information from members allowing them to communicate medical conditions that might negatively impact the course of behavioral healthcare and optimally improve the care and coordination Kaiser Permanente members receive. For more information, please reference VO Provider Handbook regarding provider responsibility:


In addition, the VO Provider Manual contains information concerning Network Credentialing and the Quality Management and Utilization Management Programs.
4.5 Southern Colorado Referral and Authorization Policy and Procedure

Referrals may be made to specialists and contracted providers within the Southern Colorado provider network only.

Referral to another Kaiser Permanente provider for specialty services or to a contracted provider not listed in the Kaiser Permanente Provider Directory requires a referral request.

The referral form allows the PCP to:
- Order treatment for the patient
- Identify the services the Member requires
- Communicate pertinent information to the specialist

4.5.1 HMO & POS Referral and Authorization Quick Reference Guide

Referral requests are submitted by faxing the completed referral request form. Additional clinical information may be required when submitting a referral request.

Important Referrals Information
- Referrals may be extended to one (1) year on a case by case basis
- Only one (1) visit is authorized per referral, unless otherwise indicated
- The referral form is valid only if:
  - The Member is eligible on the date of service and
  - The Member has the benefit which covers the stated condition

NOTE: Members may self refer to most specialty physicians in the Southern Colorado Provider Directory. Those physicians requiring a referral from the Primary Care Physician are designated as such in the Directory.

NOTE: PPO members may self refer to Kaiser Permanente Providers within the PPO Kaiser Permanente network.

Kaiser Permanente specific referral request forms can be obtained by calling the Central Referral Center (CRC) at 303-636-3131.

Please call URGENT referrals to KP Member Services at 1-888-681-7878.

The medical necessity review decision and authorization number will be issued to the office of the referring provider and to the member upon completion of the review process.
Failure to obtain authorization prior to providing the services may result in a denial of payment.

CENTRAL REFERRAL CENTER
Hours of Operation Monday through Friday 8:30 a.m. - 4:30 p.m.
Phone 303-636-3131
Toll free 888-681-7878
FAX 866-529-0934

4.5.2 Referral for Specialist Care: No Authorization Required

1. Verify the consulted specialist is a Kaiser Permanente Network Affiliate Provider in the Kaiser Permanente directory.
2. Verify services are covered by the Member’s health plan benefit.

4.5.3 Utilization Management and Authorization

You are required to contact Kaiser Permanente Central Referral Center by faxing the authorization request to (866) 529-0934 for approval before the following services are rendered.

- Non-emergent admissions
- Surgery
- Dietary Consultations only, (NOT Diabetic Education)
- DME services
- Gamma Knife
- Genetic Testing
- Growth Hormone Therapy
- Home Care, including Home IV therapy (except through Physician’s Offices)
- Hospice
- Hyperbaric Oxygen Therapy
- Insulin Pumps
- Perinatal Monitoring
- PT/OT/ST
- Pulmonary Rehabilitation
- Synagist Immunization for RSV
- Transplants
- Weight Loss Clinic
- Skilled Nursing Facility
- Memorial Hospital Wound Care
- Referrals to University Physician’s in Denver
- Referrals to Children’s Hospital in Denver
• Referrals to CPMG Physician’s in Denver
• Referrals to out of area
• Physician’s not in the Southern Colorado Kaiser Permanente Directory-Memorial Pediatric Specialty Clinic, Kidney Stone Center, Colorado Neurology, Colorado Limb Consultants, Rocky Mountain Cancer Center in Denver, and Presbyterian St. Luke’s Physician’s. (This is not a complete list.

• For details please contact the Resource stewardship Department (719) 867-2184.

Authorizations are valid for 6 months
PCP may extend the authorization to 1 year on a case by case basis.
Only one (1) visit or service is allowed per authorization, unless otherwise indicated.
The authorization form is valid only if:
   Member is eligible on the date of service and
   Member has the benefit which covers the stated condition

Southern Colorado Resource Stewardship Department
Referrals and authorization management
Pre-service, concurrent and post-service review
Emergency Department notifications
DME and Home Health services
Ambulance transportation

Registered Nurses are available 8:30 a.m.- 4:30 p.m. Monday - Friday and can be reached by phone at (719) 867-2184 and by fax at (719) 867-2144.
Calls/messages left on our after hours line (719) 867-2100 will be addressed the next business day.

4.5.4 Authorization Policy and Procedure for Inpatient Admission and Services

All non-emergent and elective admissions require authorization.

   1. Verify requested procedure(s) requires authorization, and that the service provider is a Participating Kaiser Permanente Provider.
   2. Verify the service is covered by Member’s health plan benefit by calling (888) 681-7878.
   3. Fill out a Kaiser Permanente Authorization Form
   4. Ensure any required information and documentation accompanies the Authorization request for appropriateness of care. The required information and documentation may vary depending on the type of service authorized. You may be asked to provide the following information when requesting authorization.
      • Kaiser Permanente provider name
Member identification number
Referring physician’s name
Admitting Hospital or Facility
Type of service being requested (ex: Inpatient surgery)
Patient’s Diagnosis
Significant patient history (physician notes)
Signs/symptoms
A copy of lab or radiology test results
Date of service
Diagnosis code
Location of service
Procedure code
Plan of Care

1. Fax Kaiser Permanente Authorization Form to (866)-529-0934. To ensure authorizations are handled efficiently and timely, please complete all areas of the authorization form and include as much clinical information as necessary.

2. Routine authorization requests will be handled within 14 days of receipt of the referral request for Medicare and 15 days for Commercial members. Determination for urgent authorization requests will be made within 72 hours of receipt. Upon receipt of a completed authorization, Kaiser Permanente will:
   - Verify Member eligibility
   - Verify that the request is covered by the Member’s health insurance benefit package.
   - Apply clinical criteria (medically appropriate and necessary).
   - Determine appropriate level and place of care.
   - Provide assistance with arrangements for care to prevent delays.

3. Once processed and approved, the Authorization Form with the authorization number will be returned by fax to the participating PCP and to the Participating specialist. An authorization number will be generated for all admissions.

Kaiser Permanente must receive all calls and requests in a timely manner prior to the admission for all elective admissions. Referral request determinations will be made within 14 days for Medicare and 15 days for Commercial members of receipt of the request. Failure to notify Kaiser Permanente within this time frame may result in the denial of authorization and payment for services.

Medically urgent service requests will be processed within 72 hours
For information, guidelines or preferred facilities for other covered in-patient services such as Acute Rehabilitation or Skilled Nursing Facility (SNF) please refer to the Kaiser Permanente website at www.kp.org or you may contact Member Services 888-681-7878

4.5.5 Authorization for Outpatient Services

1. Verify requested procedure(s) requires authorization and specialist is a Participating Kaiser Permanente provider.
2. Verify the service is covered by Member’s health plan benefit by calling (888) 681-7878.
3. Fill out a Kaiser Permanente Authorization Form
4. Ensure any required information and documentation accompanies the Authorization request. The required information and documentation may vary depending on the type of service authorized. You may be asked to provide the following information when requesting authorization.
   - Kaiser Permanente provider name
   - Member identification number
   - Referring physician’s name
   - Servicing physician’s name and specialty
   - Type of service being requested (ex: ambulatory surgery)
   - Patient’s Diagnosis
   - Significant patient history (physician notes)
   - Signs/symptoms
   - A copy of lab or radiology test results
   - Date of service
   - Diagnosis code – see sample list below of required codes.
   - Location of service
   - Procedure code
   - Plan of Care

For information, guidelines or preferred providers for other covered out-patient services such as:

Home Health Services
Hospice and Palliative Care
Durable Medical Equipment and Oxygen

Please refer to the Kaiser Permanente website at KP.org or you may contact Member Services 888-681-7878
4.6 Request to expand or extend the limits of an Authorization

Extension or expansion of a previously received authorization will be considered on a case-by-case basis by contacting Resource Stewardship at Denver/Boulder (303) 636-3200, Southern Colorado (719)-867-2184.

4.7 Request for Out-of-Plan / Network Authorization

You must submit supporting documentation to the Kaiser Permanente Resource Stewardship Department for any out-of-plan requests prior to the services being rendered. Authorization is required. The PCP, specialist, and Member are notified in writing of the decision to approve or deny.

4.8 Provider Receiving Authorization

Kaiser Permanente can direct the referral information to your office by AffiliateLink, fax or mail. In the event, a Kaiser Permanente member is scheduling an appointment and a completed Referral Approval form has not been received or the referral information has not been given to your office, please contact the Central Referral Center.

Upon receipt of the forwarded authorization form, you should:

- Place a copy of the Authorization Forms in the Member’s chart
- Forward all work-up results to the referring PCP with any other pertinent clinical information pertaining to the consultation, and should call the participating PCP, if their findings are urgent.
- Note: All consulting Kaiser Permanente reports must be reviewed, initialed, and dated by referring physician and maintained in the Member’s chart.
- After all initial consults, if you believe the Member will require continued treatment or if additional care is necessary other than what was originally stated on the authorization, you must submit an authorization request to the Central Referral Center at 303-636-3131.

4.9 Concurrent Review Process

The Kaiser Permanente Utilization Review Department performs concurrent review of all hospital and/or facility admissions. On-site hospital review may be performed on a case-by-case basis. The participating hospital and/or facility’s Utilization Review Department is responsible for providing clinical information to Kaiser Permanente Utilization Management by telephone where on-site reviews are not conducted. The Utilization Management may contact the attending physician if further clarification of the Member’s clinical status and treatment plan is necessary. The Kaiser Permanente Utilization Management nurses use approved criteria to determine medical necessity for acute hospital care. If the clinical information meets Kaiser Permanente’s medical
necessity criteria, the days/service will likely be approved. If the clinical information does not meet medical necessity criteria, the case will be referred to the Utilization Management physician. Once the Kaiser Permanente Utilization Management physician reviews the case, the Utilization Management nurse will notify the attending physician and the facility of the results of the review. The attending physician may request an appeal of any adverse decision.

4.10 Appeals

Kaiser Permanente has separate processes for member and provider appeals. Each process is described below.

**Member Appeals**

If a member is not satisfied with the services received, a complaint may be filed by:

- Filing a written complaint with Kaiser Permanente Member Services Department
- Request to meet with a Member Services representative at the Health Plan Administrative Offices; or
- Calling Member Services at 303-338-3800 (TTY number for the deaf and hard of hearing is 303-338-3820) in the Denver/Boulder service area.
- Medicare Advantage members may call toll free 1-800-476-2167 (TTY 1-866-513-9964)
  - A Member Services representative reviews the complaint and initiates a thorough investigation.
  - The Member Services representative, a physician or health plan representative evaluates the facts and makes a recommendation for corrective action, as appropriate.
  - A written response to written complaints will be issued within 20 calendar days.
  - A telephone response to verbal complaints will be made within 5 working days.

Members who are dissatisfied with the resolution of a complaint have the right to request a second review by a different reviewer. They should put the request for further review in writing and mail it to Member Services.

A written request for a second review will be reviewed by Member Services administration or a health plan representative, who will respond in writing within 20 calendar days of the date we receive the request.
Using this customer satisfaction procedure gives us the opportunity to correct any problems and meet your expectations and your health care needs.

DEFINITIONS:
Complaint - A complaint is defined as an expression of dissatisfaction with any aspect of Kaiser Permanente or its affiliated practitioners or providers that is made orally, in writing, or electronically. This dissatisfaction may be due to a service complaint (grievance) or a complaint involving an adverse organization determination. A complaint could include both. Every complaint must be handled under the appropriate grievance or appeal process. If a member addresses two or more issues in one complaint, then each issue will be processed separately and simultaneously (to the extent possible) under the proper procedure.

Service Complaint (Grievance) – A service complaint is defined as dissatisfaction with any aspect of Kaiser Permanente or its affiliated practitioners or providers that does not involve an adverse organization determination. This procedure is separate and distinct from a complaint involving an adverse organization determination and appeal procedure. Following is a list of some of the aspects of dissatisfaction that are considered to be a service complaint:

- Kaiser Permanente’s decision not to expedite an adverse organization determination or reconsideration.
- Kaiser Permanente’s decision to extend the time to review an expedited appeal of an adverse organization determination.
- Delays in getting an appointment (Note: For Medicare members, if the delay adversely affects the health of the member, this becomes an adverse organization determination).
- Difficulty getting information by telephone.
- Mix-up of appointment times or unavailability of the requested practitioner.
- Long wait times.
- Delayed communication of test results.
- Unsatisfactory interactions with care providers.
- Unsatisfactory quality of care or services provided (note: when quality of care complaints involve a denial of services, they are simultaneously processed as a complaint and an adverse organization determination).
- Breach of confidentiality.
- General dissatisfaction with costs associated with receipt of care.
• Delays in processing referrals, claims, and payments (note: if a Medicare claim is not paid within 60 days, it constitutes an adverse organization determination and an appeal can be filed).

• Delays and mix-ups in processing membership accounts.

• Unsatisfactory member materials.

• Undesirable environment at medical offices.

• Displeasure with the locations where care must be received.

• Medical record unavailability.

• Dissatisfaction with contractually covered and previously rendered services.

Review of adverse organization determinations is managed by Appeals Analysts in the Quality, Risk and Legal Department. Members or their designee have the right to request an appeal. Time frames and processes are governed by the type of plan the member has. The member’s coverage will determine the regulations under which the appeal will be processed. For example, regulations differ for Medicare enrollees, federal government employees, and commercial group members.

Appeals involving a clinical or medical necessity determination will be reviewed by a physician reviewer. The Physician Reviewer consults with a physician with the appropriate expertise who was not involved in the initial determination and who is not subordinate to the initial decision maker, and whose specialty is the same or is in a similar specialty that would typically manage the patient’s care. Any denial of an appeal involving a medical necessity issue must be signed by a physician.

After completing the first level of this internal review process, a commercial member who is not enrolled in a non-grandfathered individual plan (or their designee) can request a Voluntary Second Level appeal; or an additional review by an outside, independent reviewer if the denial is based on medical necessity, efficacy; investigational; or experimental as provided for by federal or state law, accreditation rules, or regulations. Individual members in a non-grandfathered plan are entitled to only one level of internal appeal and may then request independent external review if their appeal meets the criteria for medical necessity reviews. In situations involving an “urgent” medical condition, members may request an expedited appeal, and may in some situations request simultaneous expedited internal and external review. An independent external appeal may also be available following a contractual denial where the member presents documentation from a medical professional that there is a reasonable medical basis that the contractual limitation may not apply.

For Medicare Advantage members, if an initial adverse determination is upheld by the Appeals Department, the appeal will automatically be forwarded for review by an
Independent External Review Entity (IRE) designated by the Centers for Medicare & Medicaid Services.

For Medicare Part D appeals the member is notified of their right to request further review by an Independent External Review Entity (IRE) designated by the Centers for Medicare & Medicaid Services.

Provider Appeals

If you disagree with the handling of a claim, you should first call Member Services at (303)338-3600 in the Denver/Boulder service area or (888) 681-7878 in the Southern Colorado service area to inquire about the claim. In most cases, they should be able to answer and resolve any issues you may have. If resubmission or reconsideration is necessary please send in the information and make sure you stamp or write resubmission or reconsideration on your claim form.

Pursuant to the Division of Insurance criteria of regulation 4-2-23, when a Provider disagrees with a claim determination, a request for reconsideration on the claim must be forwarded in writing to Kaiser Permanente within 60 days from the date of the statement of remittance (SOR). Provider’s failure to submit written requests for reconsideration within 60 days shall result in the request being denied by Kaiser Permanente with no further action being allowed by the Provider.

The Provider Appeals Committee reviews written appeals submitted by affiliated providers regarding claims payment or denial. The Committee reviews appeals submitted for provider liability issues only. The Provider Appeals Committee reviews the circumstances and determines the disposition of the following types of appeals:

- Timely Filing
- Other Carrier
- No Referral or Authorization
- Date of Authorization Different Than Date of Service
- Contract Dispute
- Coding Issues
- Other

TO ACCESS THE PROVIDER APPEALS COMMITTEE: Submit your request in writing, along with supporting documentation, within 60 calendar days of statement of remittance to:

Kaiser Permanente Provider Appeals
P.O. Box 372970
Denver, CO 80237

Uphold denial – You will be notified in writing by the Kaiser Permanente Appeals Unit. The letter contains the rationale for the decision. For payment appeal, if the Member
may potentially be held financially liable, the Member will also receive a copy of the letter and instructions on any further appeal rights.

Overtures denial – You will be notified via phone/fax or in writing on the outcome of the appeal and action taken by Kaiser Permanente Appeals Unit, e.g., payment processes or referral/authorization approved.

Provider Appeal Form
Provider Reconsideration Form

4.11 Emergency Admissions and Services; Hospital Repatriation Policy

The centralized repatriation team (physicians, Resource Stewardship Coordinators and support agents) review inpatient cases at non-core hospitals for quality and resource management issues and transfer stable patients to core facilities. Physicians at non-core hospitals can talk directly with doctors on the centralized repatriation team 24 hours a day, seven days a week at 303-743-5763 for Denver/Boulder, 719-867-2184 for Southern Colorado, to facilitate a safe transfer. If, after physician review and discussion with the attending physician, there are any issues around approvals/denials, the appropriate documentation process will occur and the member/physician will be notified.

4.12 Case Management

Our team of Collaborative RN Coordinators are available to provide care coordination for acutely ill, chronically ill, or injured members on a case-by-case basis that supports the achievement of realistic treatment goals. Nurses will work with the member, participating affiliated PCP or Kaiser Permanente staff and participating Kaiser Permanente Providers to develop and implement plans of care to optimize the Members’ level of independence and quality of life. This team works in collaboration with providers to proactively assess, identify, coordinate, monitor and evaluate medical problems and service needs of the Member’s condition.

Additionally, Kaiser Permanente offers enhanced care management for patients suffering from both chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) conditions with recent hospitalizations. This special case management program is facilitated by our Collaborative RN Coordinators to assist patients in regaining an optimal health status and improved function.

The program is also offered to members who suffer from a catastrophic event or are admitted to a long-term acute care facility. Regional Case Managers (Catastrophic Case Managers) manage cases that require care external to the Kaiser Permanente system, which include acute rehabilitation facilities and Long Term Acute Care (LTAC) hospitals. The goal of Regional Case Management is to coordinate care from the acute care setting and transitions in between. Case Managers direct, monitor, and evaluate patient treatment and outcomes or responses to treatment. Case Managers also provide
assistance in assessment of patient's psych/social, emotional, physical, and financial needs. Case Managers are instrumental in assisting patients and families negotiate the goals of care. If you believe your patient may benefit from this program, please contact 303-941-4113 in the Denver/Boulder service area or 719-867-2100 in the Southern Colorado service area. **Beginning January 1, 2012, calls for the Southern Colorado Service Area, please call 719-282-2560 or 1-877-870-6735 or TTY: 719-282-2569 or 1-877-282-2569.**

### 4.13 Disease Management

The disease management program is managed by the Prevention and Population Services (PPS) Department, in collaboration with Primary Care, Pharmacy and Specialty Departments, and the Care Management Institute (“CMI”), an NCQA-certified disease management program that was formed in 1997 to support and promote Kaiser Permanente nationally by delivering evidence-driven, cost effective, population-based care for priority populations. CMI-led, inter-regional collaborations have defined and revised care management programs for priority populations such as asthma, diabetes, coronary artery disease, and heart failure. CMI is committed to delivering culturally competent care and supporting patients in self-care, self-management of chronic conditions and shared decision making.

**Denver/Boulder Service Area:**

The Kaiser Permanente disease management program in Denver/Boulder consists of: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Artery Disease (CAD) including Heart Failure, and Hypertension. These specialized disease management programs are part of an integrated delivery system designed so that care is guided by a personal physician who works collaboratively with the patient, Population and Prevention Services (PPS) Disease Management nurses and specialty care services (at varying degrees depending on the program). These population strategies reinforce patient-care interaction and promote shared-decision making. Members are identified and stratified for each of the below programs through the use of HealthTRAC registries. Each registry has program-specific clinical protocols built within HealthTRAC to facilitate the monitoring and reporting of health service utilization and outcomes for our disease management patient population.

**ASTHMA PROGRAM**

The Asthma disease management program provides specialized support to practitioners and their patients diagnosed with asthma. Staffed by registered nurses, the Asthma/COPD Care Coordinators (ACCs) work closely with Primary Care, Specialty Care, Nursing and Pharmacy to:

- Outreach to patients overusing Albuterol or under filling Inhaled Corticosteroids (ICS);
- Outreach to patients with an Emergency Department (ED) visit for an asthma exacerbation;
• Provide patient education when requested by the Primary Care Physician or specialists in the Allergy or Pulmonology Department;
• Perform Spirometry to better assess asthma;
• Provide education for staff to correctly perform and document spirometry;
• Support implementation of region-wide use of the “Albuterol Refill Algorithm”;
• Develop asthma Action Plans in collaboration with patients.
• Allocation of 1.0 RN FTE dedicated to the Child Health Plans (CHP) population to begin relationship-building, identifying barriers and system issues common with the challenges of the demographics of this population. This will set the foundation for anticipated growth of CHP+ and Medicaid populations.

The ACC team coordinates four letter campaigns each year; two that are pediatric-focused and two that are adult-focused. The letter campaigns strategically address issues such as ICS under use, beta agonist overuse, back to school asthma education, and promotion of the Flu Vaccine.

The asthma program is also supported by the Allergy Department, which sees patients who were hospitalized for asthma. In addition, the Clinical Pharmacy Department supports our regional asthma program from a medication therapy perspective and outreaches unique groups of patients who are at risk.

If you believe your patient may benefit from this program, please contact 303-614-1065 or 1-800-659-2656 (TTY).

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

The COPD disease management program has led the way in a collaborative region-wide focus to improve spirometry rates in addition to refining and validating the registry. The COPD Governing Board oversees all COPD population management efforts. The Asthma/COPD Care Coordinators (ACCs) work closely with Primary Care, Specialty Care, Nursing and Pharmacy to:

• Identify the mild to moderate risk patients and provide education, smoking cessation advice and support, symptom recognition and information on medications in an effort to help them manage their disease and prevent ED visits and/or hospitalizations to maintain best quality of life.
• Outreach to newly diagnosed COPD patients that do not have a confirmatory spirometry to improve the HEDIS rate.
• Give Pneumovax vaccine during visit if needed
• Initiate staff messages to providers for patients on oxygen to enter Chronic Hypoxic Respiratory Failure (CHRF) diagnosis in problem list and link it to oxygen order.

Chronic Care Coordinators(CCC) also consists of a team of registered nurses, but focused on preventing readmissions of COPD patients by:

• Outreaching to patients with phone call within 24-72 hours post discharge;
• Facilitate scheduling of 3-5 day post discharge appointment with PCP;
• Making appointments to have spirometry at 4-6 weeks after an exacerbation to look for changes in spirometry that would necessitate a change in their management;
• Referring patients who have had 2 or more COPD ED visits or hospitalizations in the prior 12-month period to the Pulmonology department.

If you believe your patient may benefit from this program, please contact 303-614-1065 or 1-800-659-2656 (TTY).

DIABETES CARE PROGRAM
While the vast majority of diabetes management is handled by primary care, practitioners and eligible patients are supported by various care teams within the Diabetes Care Program.

1. Planned Care Team
   This team reviews several quality gap lists and sends charts to the primary care team with recommendations to resolve gaps. This proactive management is designed to improve:
   - Lipid Lowering (LL) therapy
   - Hypertension control
   - A1C screening and control
   - Retinal screening
   - Diabetes foot exam screening

2. Centralized Glycemic Management RNs
   Our centralized team of registered nurses provide a wealth of diabetes services and focused outreach to diabetic adults over the age of 18 on insulin. Glycemic Management RNs will evaluate the patient holistically to provide patients with, but not limited to:
   - Focused outreach and individualized goal development
   - Medication titration and adherence
   - Self-monitoring consultation
   - Educational materials
   - Community resource information

   Support is also provided to primary care and your teams in the management of patients with diabetes through and advice/consult line 303-614-1728 (Toll Free 1-877-452-1250) or 1-800-659-2656 (TTY).

3. Diabetes Clinical Pharmacy Specialist
   Diabetes Clinical Pharmacy Specialist focuses on adults with uncontrolled blood sugars on oral medications. Support includes titration of oral medications, recommending lifestyle modifications and discussing the need for insulin where appropriate.
4. **Health Education**
   Patients can explore total health resources for themselves and their families, including fitness, nutrition, mind and body health, weight maintenance, and more.

5. **Endocrinology**
   Endocrinology is available as a consultative service for any provider in the region. They manage type 1 diabetes and complicated type 2 diabetes, as well as, all insulin pump patients. At each visit they review all quality gaps related to diabetes.

If you believe your patient may benefit from the Diabetes Care Program, please contact Case and Care Coordination Services at 303-614-1065 or 1-800-659-2656 (TTY).

**CORONARY ARTERY DISEASE (CAD) PROGRAM**
The CAD disease management program consists of a collaborative effort between the Cardiac Rehabilitation team, the Clinical Pharmacy Cardiac Risk Service (CPCRS) and Chronic Care Coordination. These teams work alongside each other to achieve optimal cardiac outcomes.

Cardiac Rehabilitation focuses on optimizing cardiovascular risk reduction to eligible patients following hospitalization for an acute coronary event, while CPCRS focuses on long-term management of patients with a history of CAD. Cardiac Rehabilitation services are provided by registered nurses (under the direction of Kaiser Permanente Cardiologists) and CPCRS services are provided by pharmacists (under the direction of Kaiser Permanente primary care physician). Eligible patients will receive a customized care plan that includes, but not limited to: medication reconciliation making adjustments as needed, quality checks for medication adherence, educational materials and secondary risk-factor modification assistance.

Some patients in the CAD disease management program have needs that extend beyond their cardiac condition. These patients receive services from Chronic Care Coordinators, in addition to services offered by Cardiac Rehabilitation and CPCRS. Chronic Care Coordinators are located in primary care offices and work closely with physician teams. They will facilitate transitions, partner with other coordinators and prevent re-hospitalization by collaborating with primary care and specialty care.

If you believe your patient may benefit from these programs, please contact Cardiac Rehabilitation at 303-861-3441 or CPCRS at 303-326-7666. Chronic Care inquiries can be routed through Case and Care Coordination Services at 303-614-1091 or 1-800-659-2656 (TTY).

**Southern Colorado Service Area:**

Through December 31, 2011, comprehensive disease management for the Southern Colorado membership is provided through the Kaiser Permanente Healthy Solutions (KPHS) program. Kaiser Permanente also works collaboratively with Memorial Hospital and our contracted physicians to provide disease management programs for our
members. The disease management program is found within the Regional Integrated Patient Care Quality Program Description and is available upon request by calling 303-344-7293 in Denver/Boulder, 719-867-2100 in Southern Colorado, or 1-800-659-2656 (TTY), Monday through Friday, 8:00 a.m. to 4:00 p.m.

The KPHS program is designed to help you and your patients manage chronic conditions and partner to make informed health care decisions. KPHS is based upon the Shared Decision-Making® principle that the best clinical decisions are shared between physicians and their fully informed patients, utilizing the best available clinical evidence, blended with the patient's values and preferences.

The program places special emphasis on the importance of managing co-morbidities that exist in many patients. Especially helpful for patients with diabetes and other chronic conditions, KPHS also provides preference sensitive decision support services to patients facing treatment decisions related to specific conditions, such as back pain, fibroids, abnormal uterine bleeding, osteoarthritis, breast and prostate cancer.

KPHS provides patients with access to educational materials and personal health coaching to help them learn self-care skills and adhere to your treatment plan. Health coaches provide objective, evidence-based information to help patients understand their diagnosis, available treatment options, and potential benefits and risks of each option.

KPHS health coaches are specially trained professionals, such as nurses, dietitians, and respiratory therapists, who support patients through telephone interactions 24 hours a day, 7 days a week. The goal of the health coach is to teach patients new self-care skills, increase their self-confidence and help them work effectively with you to manage their health conditions. The health coach is meant to enhance, not replace, the doctor-patient relationship you have already established.

Beginning January 1, 2012, you and your Kaiser Permanente patients in Southern Colorado will see an exciting change in how we offer health coaching and chronic condition management support. We will be changing from our current Kaiser Permanente Healthy Solutions program to a local Kaiser Permanente Care Connections program. The Care Connections team is comprised of trained health care professionals that can assist your Kaiser Permanente patients with prevention, wellness and chronic care needs. You can reach the Care Connections team by calling 719-282-2560 or 1-877-870-6735 or TTY: 719-282-2569 or 1-877-870-7646, Monday through Friday, 7 a.m. to 7 p.m.

The Care Connections team will provide:

- Health Coaching
  - Providing information and support on a variety of health topics
  - Helping your Kaiser Permanente patients make a healthy change in their lifestyle by providing support and educational resources
- Support with managing ongoing health conditions
Helping your Kaiser Permanente patients with Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Artery Disease (CAD), Heart Failure and Hypertension to manage their conditions in partnership with you.

Helping your Kaiser Permanente patients identify key questions to ask at office visits

Helping your Kaiser Permanente patients weigh the risks and benefits of treatment options

- Coordination of care when your Kaiser Permanente patients are discharged from the hospital or emergency department
- Assistance with Kaiser Permanente members who have complex medical needs
- Assistance with helping Kaiser Permanente members to understand preventive health care needs
- Resources for health education opportunities and information

The goal of this program is to support you in providing comprehensive, coordinated care to our members in Southern CO.

Clinical Guidelines:

Kaiser Permanente Colorado has a Guidelines Committee that supports monitoring and approving clinical practice guidelines. These guidelines are developed to focus on the provision of care and services that are relevant to the population enrolled.

The Committee is chaired by a CPMG physician. Membership currently includes physicians representing primary care, clinical research, and administration. Non-physician representatives include a clinical pharmacist and managers from prevention, nursing, and quality. The Committee meets monthly.

Our Guidelines Committee has approved the clinical practice guidelines provided for your use in the Kaiser Permanente Clinical Library or may also be accessed through the Provider Relations Manual (see attachments A, B, C and D). For additional information, please contact the Network Development & Provider Contracting department at 303-344-7943 or the Program Manager for Guidelines on the Clinical Library, 303-614-1149.

Attachment A Guideline: ADHD:

Attachment B Guideline: Adult Diabetes:

Attachment C Guideline: Coronary Artery Disease:

Attachment D Guideline: Depression
In addition to the above guidelines, Southern Colorado service area also has KPHS guidelines for the effective care of patients with chronic conditions, which are available below as attachments E, F and G


Attachment F Guideline: 2011-2012 Clinical Insights: Effective Care for Patients with Chronic Conditions

Attachment G Clinical Insights, 2011-2012 Summary of Changes

4.14 Overview Medicare Advantage Plan

The U.S. Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (commonly called MMA) in December 2003. This law includes numerous changes to the Medicare program by establishing the Medicare Advantage program. Most significantly, it created the Medicare Prescription Drug program, Medicare Part D. The MMA also changed the name of the Medicare managed care program from Medicare+Choice to Medicare Advantage (MA). As a result, Kaiser Foundation Health Plan of Colorado (Kaiser Permanente) is now a Medicare Advantage organization that offers Medicare prescription drug coverage (MA-PD) and Kaiser Permanente Senior Advantage is a Medicare Advantage plan offering prescription drug coverage.

Kaiser Permanente is responsible to the Centers for Medicare & Medicaid Services (CMS) for providing oversight in the administration of the requirements governing the Medicare Advantage Program. All practitioners and providers of Kaiser Permanente are also subject to the requirements of the Medicare Advantage program. In order to be a Kaiser Permanente Medicare Advantage practitioner or provider you must be eligible for payment by Medicare. This means that you cannot be excluded from participation in any federal health care program or that you have not opted out of the Medicare program. All practitioners and providers who provide services to Kaiser Permanente Senior Advantage members must be informed of their responsibilities through their provider contract or through a provider manual or other provider communications. As a Medicare
Advantage practitioner or provider, you must comply with certain requirements as described in this section.

The Kaiser Permanente Senior Advantage plan is offered to all eligible individuals who reside in the Denver/Boulder Service Area. The Kaiser Permanente Senior Advantage plan must include all benefits covered under Original Medicare and may include additional benefits contracted for on behalf of the Medicare enrollee. Kaiser Permanente is responsible for maintaining written agreements with practitioners and providers to provide adequate access to covered services.

Kaiser Permanente is also required to comply with National Coverage Determinations (NCD) issued by CMS. An NCD is a national policy statement granting, limiting, or excluding Medicare coverage for a specific medical item or service. If the new NCD or legislative change in benefits meets the "significant cost" threshold, Kaiser Permanente is not required to assume the risk for the costs of the service until CMS has included the cost of the NCD in Kaiser Permanente's capitation payment.

Coverage of the services will be provided under the Medicare Fee-for-service program. Medicare fiscal intermediaries and carriers will make payments on behalf of Medicare Advantage organizations directly to providers and practitioners for cost associated with a NCD. Medicare Advantage enrollees may be liable for any applicable coinsurance amounts under Original Medicare.

For more information on NCDs go to the CMS Web site at http://cms.hhs.gov/CoverageGenInfo

Kaiser Permanente is a Medicare contractor and is therefore a recipient of federal payments. As contractors of an organization that receive federal funds, Kaiser Permanente’s practitioners and providers are subject to the laws and requirements of the federal government.

4.14.1 Record Keeping and Reporting

**Encounter Data**

You must submit to Kaiser Permanente complete, accurate and timely data, including medical records, necessary to characterize the content and purpose of each encounter with a member. It is important to code to the highest specificity of ICD-9 diagnosis codes for Kaiser Permanente member visits. This requires using the 4th and 5th digit to identify the diagnosis. You must submit the data in the format prescribed by Kaiser Permanente. Periodic random audits for coding completeness and accuracy will be conducted. Complete and accurate coding prevents fraud and abuse. Kaiser Permanente cannot meet its reporting requirements to CMS unless it has the full cooperation of its practitioners and providers. If you have questions about this process, please contact us.
Certification of Encounter Data

As a Medicare Advantage organization, Kaiser Permanente is required to certify the accuracy, completeness and truthfulness of data which CMS requests. Such data include encounter data, payment data, and any other information provided to Kaiser Permanente by its contractors and subcontractors. Encounter data supplied by practitioners and providers must be certified by your and your subcontractors and is subject to audit.

Disclosure of Information to CMS

Practitioners and providers must provide Kaiser Permanente or CMS with all information that is necessary for CMS to administer and evaluate the Medicare Advantage program.

Simultaneously, practitioners and providers must cooperate with Kaiser Permanente in providing CMS with the information CMS needs to establish and facilitate a process to enable current and potential beneficiaries to get the information they need to make informed decisions with respect to the available choices for Medicare coverage.

Maintenance and Audit of Records

The purpose of this requirement is to allow CMS to evaluate the quality, appropriateness and timeliness of services, the facilities used to deliver the services and other functions and transactions related to CMS requirements. It applies to all parties in relation to service performed, reconciliation of benefit liabilities and determination of amounts payable.

All parties are required to have their records available for a ten-year period after Kaiser Permanente terminates its contract with CMS or the completion of an audit by the government, whichever is later (or longer in certain circumstances, if required by CMS). You must have books and records (including, but not limited to, financial, accounting, administrative and patient medical records and prescription drug files) available to support any activity with Kaiser Permanente.

4.14.2 Provisions that Apply to Health Care Services

Direct Access to Mammography Screening

Female members age 40 and older must be allowed to self-refer for mammography screening. CMS has disseminated frequency guidelines for screening.

Access to Specified Vaccines
Members may not be required to get a referral or prior authorization for influenza vaccines. In addition, members may not be charged copayments (including office visit copayments) for influenza or pneumonia vaccines. Members must be able to access these services without charge. However, members may be charged the applicable office visit copayment when other services are received at the same time. For example, a member who makes an appointment for a complaint of back pain may be charged an office visit copayment for the office visit, even if the vaccines are received during the course of the exam.

The influenza, pneumonia and hepatitis B vaccine are covered under Medicare Part B. Vaccines to treat an injury or given as a result of a direct exposure are also covered under Medicare Part B. All other vaccines are covered under the Medicare Part D prescription drug benefit.
Adequate Access to Covered Services

Kaiser Permanente will monitor its provider network to ensure that adequate access to covered services is maintained. Members will be surveyed on a regular basis to help assess the accessibility of services and the adequacy of the provider network. Affiliated practitioners and providers agree to comply with the access standards developed by Kaiser Permanente. Each practitioner and provider contract is subject to survey and the results used to evaluate contract performance.

Direct Access to Women's Health Specialist

This requirement applies to providers of primary care and to those with primary responsibility for coordination of care. Female Senior Advantage members must be provided direct access to a women’s health specialist for routine and preventive health care services provided as basic benefits. Women’s health specialists may be gynecologists, certified nurse midwives, or other qualified health care providers. At the same time, women members must be provided with continued access to their primary care physician to ensure continuity of care.

Complex or Serious Medical Conditions

Practitioners and providers who are responsible for primary care agree to comply with Kaiser Permanente’s guidelines for the identification and treatment of members with complex or serious medical conditions. Individuals with serious or complex medical conditions must be identified, their conditions assessed and monitored, and appropriate treatment plans implemented. All practitioners involved in the treatment of members with complex or serious medical conditions agree to provide care in accord with the guidelines developed by Kaiser Permanente.

Benefits Provided in a Manner Described by CMS

Practitioners and providers must cooperate with Kaiser Permanente to ensure continuity of care and integration of services. Services must be provided during hours of operation that are convenient to and do not discriminate against members. All information about treatment options must be provided to members in a culturally competent manner, including the option of no treatment. Affiliated practitioners and providers must ensure that members with disabilities are able to communicate effectively with all health care professionals in making decisions regarding treatment options.

Initial Health Assessment

Primary care physicians are responsible for conducting an initial health assessment of all new Senior Advantage members within 90 days of the effective
date of membership. Kaiser Permanente will choose the form and substance of the initial assessment.

Emergency Care, Urgent Care and Post Stabilization Care

Prior authorization cannot be required for services needed to evaluate or stabilize an emergency medical condition by a qualified provider. An emergency medical condition is defined as: (applies to Medicare Advantage organizations). A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Post Stabilization Care:

This care is medically necessary, non-emergency services needed to ensure the member remains stabilized from the time the treating hospital requests authorization from the Medicare Advantage Organization. Until the member is discharged, a plan physician arrives and assumes responsibility for the member's care, or the treating physician and Kaiser Permanente agree to another arrangement. Kaiser Permanente is responsible for the cost of the post-stabilization care provided outside the plan if it was pre-approved or if Kaiser Permanente did not respond within one hour to the request by the provider of the post-stabilization care services for pre-approval, or Kaiser Permanente could not be contacted for pre-approval.

Urgent Care:

Urgently needed services means covered services that are not emergency services as defined under the emergency medical condition, provided when an enrollee is temporarily absent from the Medicare Advantage plan's service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the organization's network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required—(A) As a result of an unforeseen illness, injury, or condition; and (B) It was not reasonable given the circumstances to obtain the services through the organization offering the Medicare Advantage plan.

4.15 Drug Formulary

Kaiser Permanente uses drug formularies, which means that only those medications included in the formulary are covered under the Member’s prescription drug benefit. Drugs not appearing on the formulary are considered “Non-Formulary”. Non-formulary
medications may be covered under the member’s benefit for a different co-payment/coinsurance based on their specific coverage. In some instances, as in the Denver/Boulder service area, the non-formulary drug is only covered for benefit if approved through the formulary exception process.

Kaiser Permanente utilizes several drug formularies depending on the type of product the member has and the service area where care is provided. The drug formularies are developed, updated and maintained by Kaiser Permanente physicians, pharmacists, and nurses who meet regularly to evaluate medical literature and research. Drugs are selected for the formulary based on a number of factors including safety, efficacy and cost. Using formulary medications helps Kaiser Permanente maintain a high quality of care for our Members while helping to keep the cost of prescription medications affordable. Kaiser Permanente reviews and updates the formularies regularly throughout the year. To obtain a copy of any of our drug formularies, please visit the provider website at http://www.providers.kp.org/cod/pharmacy.html. For a hard copy request, please contact Member Services at 303-338-3800 for Denver / Boulder or 1-888-681-7878 for Southern Colorado.

Kaiser Permanente offers a Medicare Prescription Drug Plan (Part D) to all members with Medicare. The plan has been offered since January 2006 in the Denver Boulder area and is now offered in Southern Colorado. Kaiser Permanente provides prescription drug coverage in individual plans and group plans. Members will receive their medical care and prescription drug coverage from Kaiser Permanente. Employers can select the Medicare Part D drug coverage as part of their benefit plan or they can choose to offer prescription drug coverage under the Retiree Drug Subsidy requirements. Either way, Senior Advantage members enrolled through their group will receive prescription drug coverage from Kaiser Permanente.

The Medicare Part D outpatient prescription drug benefit provides coverage for certain classes of prescription drugs. The particular Medicare Part D drugs covered by Kaiser Permanente’s MA-PD plans are listed in Kaiser Permanente’s Part D Drug Formulary which is posted on-line. For a hard copy request, please contact Member Services at 303-338-3800 for Denver / Boulder or 1-888-681-7878 for Southern Colorado.

Kaiser Permanente may add or remove drugs from the drug formulary throughout the year. If we remove drugs from our formulary, add quantity limits, or move a drug to a higher cost sharing tier, we must notify affected members, providers and pharmacists at least 60 days before the date that the change becomes effective or at the time the member requests a refill of the drug. If the FDA deems a drug on the formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will remove the drug from our formulary and provide notice to members who take the drug. Kaiser Permanente will also notify providers and pharmacists.

An important requirement of the MMA is the responsibility of the MA-PD to ensure the integrity of the prescription drug program. Kaiser Permanente will work closely with the Centers for Medicare and Medicaid Services (CMS) and CMS’ contractors to prevent
fraud, waste and abuse of the prescription drug program. If you have questions or want to report suspected or potential fraud, waste and abuse problems, please call our hotline at 1-800-774-9100 or you may contact Scott Nelson, Anti-Fraud Compliance Program Manager at 303-344-7584. If you have questions about Kaiser Permanente’s coverage of Medicare Part D, please call Member Services at 303-338-3800.

The Kaiser Permanente Formulary Committee will consider requests from Kaiser Permanente members, affiliated physicians or affiliated pharmacists to add or delete medications. Please use the following form to submit your request.

Contact the Drug Information Service for Denver Boulder at 303-739-3550 or the Pharmacy Benefits and Compliance Department for Southern Colorado at 719-867-2177 for inquiries regarding the form.

Denver/Boulder Formulary
Southern Colorado Formulary

4.15.1 Requesting Coverage for Non-Formulary or Criteria Restricted Medications

The Pharmacy and Therapeutics / Formulary Committee may limit prescribing for any drug on the Kaiser Permanente formularies. There are certain drugs on the Kaiser Permanente formularies that are only covered for the member’s prescription drug benefit if certain restrictions or criteria are met.

- Drugs may be restricted to use by one or more specialty groups. This means that only physicians of a designated specialty should write for prescriptions for that drug. Drug may also be restricted by benefits, age restrictions or quantity limits.
- Drugs requiring prior authorization. Prior authorization may be required for medications with safety concerns or high cost agents with a significant risk for inappropriate use. Prior authorization criteria is determined by the appropriateness of use, safety and effectiveness of the drug. Prior authorization criteria is specific to the drug.
- Drugs requiring step therapy.

There may be occasions when non-formulary or restricted medications are medically necessary to provide the best care for a Kaiser Permanente member. The Non-Formulary Exceptions / Prior Authorization Process facilitates prescription drug coverage for medically necessary non-formulary or restricted drugs. The following non-formulary exception processes exist for the respective service areas:
When formulary exceptions are denied, the member has the option of paying full price for the non-formulary drug or appeal the decision by sending an appeal request to:

Appeals Analyst  
Kaiser Permanente  
PO Box 378066-8066  
Denver, CO 80237  
Phone: 303-344-7933  
Fax: 303-344-7951

Pharmaceutical procedures are updated annually to incorporate any changes, as needed, and posted on our member and physician websites.

Denver/Boulder Service Area:

**Commercial Members**

To request coverage for a non-formulary drug under the drug benefit, the prescribing provider will need to contact the Drug Information Service at 303-739-3550. The provider will be required to complete a *Request for Drug Plan Coverage for a Non-Formulary Drug Form* for Commercial Members.

**Non-Formulary Drug Request**

Submit a separate form for each patient and for each drug you wish to have reviewed. Keep a copy for your records.

Mail or Fax the form to:  
Kaiser Permanente – Denver/Boulder  
Non-Formulary Medication Request Form  
ATTN: Drug Information Service  
16601 E. CentreTech Pkwy  
Aurora, CO 80011  
Phone: 303-739-3550  
Fax: 303-344-7005

Requests with a supporting statement of medical necessity will be processed within 14 days of receipt and should include the reason why formulary alternatives cannot be used.

Expedited requests may be made by calling the Drug Information Service at 303-739-3550. The expedited process can take up to 72 hours upon receipt of the request form with supporting statement of medical necessity.
necessity. One of the following criteria must be met to make an expedited request:

- The drug is necessary to complete a specific course of therapy after discharge from an acute care facility.
- The time frame required for a standard review would compromise the member’s life, health or functional status.
- The drug requires administration in a time frame that will not be met using the standard process.

Each request will be reviewed and approvals will be granted only if you can document the ineffectiveness of formulary alternatives or the reasonable expectation of harm from the use of formulary medications. In most cases, patients must have failed at least two formulary alternatives or have experienced adverse affects from the use of formulary medications. If a request does not meet criteria, a clinical pharmacist will recommend other formulary alternatives.

The criteria for requesting non-formulary coverage include:

- **Allergic to formulary alternatives**
- **Intolerant to formulary alternatives**
- **Failed formulary alternatives**
- **Patient safety considerations**

**Prior Authorization Process for Use of Somatropin for the Commercial Formulary**

A. Somatropin requires prior authorization approval for coverage under the prescription benefit. Prior authorization approval must meet certain clinical criteria and must be prescribed by a Pediatric Endocrinologist or Endocrinologist.

B. For pediatric patients, a request for review either in writing or verbally will be made to the Kaiser Permanente pediatrician reviewer designee who will complete the prior authorization form (Appendix A). Call the Drug Information Service (303-739-3550) for the name of the pediatrician reviewer designee and contact information.

C. For adult patients, the requesting endocrinologist must complete the prior authorization form (Appendix A). Once completed, the form should be submitted to the Kaiser Permanente adult endocrinologist reviewer designee for review. Call the Drug Information Service (303-739-3550) for the name of the adult endocrinology reviewer designee and contact information.
D. If the drug is approved after review by the Kaiser Permanente pediatrician or endocrinologist reviewer designee, the reviewer designee will notify the prescribing physician.

E. If prior authorization is not approved, a letter of denial with appeals right will be sent to the patient and the requesting endocrinologist/pediatric endocrinologist by the Kaiser Permanente Resource Stewardship Department.

Somatropin Criteria

Southern Colorado Service Area: Commercial Members

To request coverage for a non-formulary drug under the drug benefit, prescribing provider will need to contact MedImpact Customer Service at 1-800-788-2949. The provider will be required to fill out a Medication Request Form (MRF).

The Medication Request Form will need to be completed using specific laboratory data, physical exam findings, and other supporting documentation regarding the medical necessity of the requested medication.

Medication Request Form

- Complete all information requested. When requesting coverage of a COX-2 inhibitor, please use the specific form for these drugs. All other medications should be requested using the standard Medication Request Form.

- Submit a separate form for each patient and for each drug you wish to have reviewed. Keep a copy for your records.

- Mail or Fax the form to:
  Kaiser Permanente–Southern Colorado Medication Request Form (MRF)

Kaiser Permanente – Southern Colorado
Medication Request Form (MRF)
MedImpact Healthcare Systems, Inc.
ATTN: Prior Authorization Department
Phone: 1-800-788-2949
Fax directly to KP at: 1-866-455-1053

Requests will be processed within 14 days from the time of receipt. Expedited requests may be made by calling MedImpact Customer Service at 1-800-788-2949. The expedited process can take up to 72 hours. One of the following criteria must be met to make an expedited request:
The drug is necessary to complete a specific course of therapy after discharge from an acute care facility.

The time frame required for a standard review would compromise the Member’s life, health or functional status.

The drug requires administration in a time frame that will not be met using the standard process.

Each request will be reviewed and approvals will be granted only if you can document the ineffectiveness of formulary alternatives or the reasonable expectation of harm from the use of formulary medications. In most cases, patients must have failed at least two formulary alternatives or have experienced adverse affects from the use of the formulary medications. If a request does not meet criteria, a clinical pharmacist will recommend other formulary alternatives.

Medicare Part D Members: Denver/ Boulder and Southern Colorado Service Area.

To request coverage for a non-formulary drug under the Medicare Part D drug benefit, the prescribing provider will need to contact Kaiser Permanente Member Services Department at 1-800-476-2167. You may be asked to fill out a CMS Physicians Supporting Statement Form. Please note that you can only request an exception for drugs that are considered Medicare Part D prescription drugs by CMS. Exception will not be granted for drugs excluded by Medicare or requests for a brand name drug at the copayment that applies to generic drugs. Additionally, you cannot ask for a cost-sharing exception (tier exception) for a prescription drug in the specialty tier. Instructions for completing the CMS Physician Supporting Statement Form:

Part D Coverage Request Form

- Complete all information requested
- Submit a separate form for each patient and for each drug you wish to have reviewed. Keep a copy for your records.
- Mail or Fax completed form to:

  Denver/ Boulder:
  Kaiser Permanente Member Services Department
  2500 South Havana Street
Requests will be processed in accordance with CMS’s coverage determination timelines. Standard determinations will be made as expeditiously as the enrollee’s health condition requires, but no later than 72 hours after the receipt of the request. Expedited requests may be made by calling Kaiser Permanente Member Services Department at 1-800-476-2167 and stating that this request must be expedited. The expedited process can take up to 24 hours after receiving the CMS Physician Supporting Statement Form. The following criteria must be met to make an expedited request:

- There is a medical reason for the patient to have a non-formulary drug and applying the standard timeframe for making a determination may seriously jeopardize the life or health of the member.

Transition Process for Medicare Part D Members:

Part D plan sponsors are required to establish an appropriate transition process for new and current enrollees to assure timely access to Part D drugs. A transition supply is offered when an eligible Part D drug is not on our formulary or if the ability for a member to receive that drug is limited. In this case of a transition we will cover a temporary 30-day supply (unless the prescription is written for fewer days) during the first 90 days the members coverage is effective with Kaiser Permanente. The transition process applies to both current enrollees that may be affected by year-to-year formulary changes as well as new enrollees transitioning into Kaiser Permanente. If the member is unable to receive a medication exception for the non formulary drug or have the drug switched to a formulary alternative, the member will have to pay full price after the first 30-day supply.
If a member resides in a Long Term Care facility we will cover up to a 31-day supply of a transition medication during the first 90 days the members coverage is effective with Kaiser Permanente.


For additional information contact Member Services at 303-338-3800 for Denver Boulder or 888-684-7878 for Southern Colorado.

4.15.2 Drug Recalls
Kaiser Permanente will provide timely written notification to prescribing providers and affected members of a Class I recall and other recalls as deemed appropriate. A sample letter is provided below. Notifications will be sent within 10 days of a Class I recall or within 30 days of a Class II or Class III recall, public health advisory or product withdrawal notice if deemed necessary for safety reasons by the Kaiser Permanente pharmacy benefits and compliance staff.

Denver/Boulder Drug Recall Sample Letter
Southern Colorado Drug Recall Sample Letter