4. Utilization Management/Resource Management (UM)

4.1 Overview of Utilization Management/Resource Management Program

KFHP, KFH, and TPMG share responsibility for Utilization Management/Resource Management (UM), which has been delegated to them by KPIC. KFHP, KFH, and TPMG work together to provide and coordinate UM for Members by reviewing and monitoring the full range of outpatient and inpatient services delivered by physicians, hospitals, and other health care practitioners and providers. UM is a process that determines whether a healthcare service recommended by your treating Provider is medically necessary. If it is medically necessary, the service will be authorized and the Member will receive the services in a clinically appropriate place consistent with the terms of the Member’s health coverage. UM activities and functions include the prospective, retrospective, or concurrent review of health care service requests submitted by providers and the decisions to approve, modify, delay, or deny the request based in whole or in part on medical necessity. KP’s utilization review program is subject to direct regulation under the Know-Keene Act and must adhere to managed care accreditation standards. The determination of whether a service is medically necessary is based upon criteria that are consistent with sound clinical principles and processes, which are reviewed and approved annually by the Plan.

4.1.1 Data Collection & Surveys

UM data collected by KP is used to comply with regulatory and accreditation requirements, to identify areas for improvement in the delivery and management of care for both inpatient and outpatient services, for recredentialing of Providers, and to coordinate the evaluation of utilization.

KP conducts Member and practitioner satisfaction surveys on a regular basis. Survey results are reviewed to identify patterns, trends, success of interventions, opportunities for performance and UM process improvements.

UM staff also collects information about the medical necessity of health care services and the appropriateness of benefits-based coverage decisions. Appropriately licensed health care professionals supervise all UM processes.

The success of KP UM programs depends on the cooperation and commitment of Providers who provide care to Members working to ensure successful outcomes and cost-effective treatment.

4.2 Medical Appropriateness

KP uses written objective criteria based on sound clinical evidence in making utilization management (UM) decisions. We have policies that establish how such clinical criteria are
developed, adopted, and reviewed. When we make a UM decision that denies or modifies provider requested services, we will communicate that decision to you in writing. That notification will include a concise explanation of the reasons for our decision and the criteria or guidelines we used. UM decisions are always independently based on clinical criteria or scientific literature; they are never made on the basis of a financial incentive or reward.

Qualified physicians or other appropriately qualified health care professionals review all prior authorization denials. Physicians who make UM decisions may be physician leaders for Outside Referral Services, physician experts, and/or Members of physician specialty boards. They have current, unrestricted licenses and have appropriate education, training, and clinical experience related to the services being requested. When necessary, they will consult board certified physicians in the associated specialty to assist them in making a UM decision.

4.3 “Referral” and “Authorization” – General Information

Prior authorization must be obtained before rendering certain services unless it can be demonstrated that the Member was suffering from an “emergency medical condition”, as defined in Section 4.5 of this Provider Manual, at the time treatment was rendered.

KP Plan Physicians offer primary medical, behavioral, pediatric, and OB-GYN care as well as specialty care. A KP Plan Physician may refer a Member to a non-plan Provider, when the Member requires covered services and supplies that are not available from us, or cannot be provided in a timely manner. The outside referrals process is managed at the facility level and the Assistant Physicians-In-Chief (APICs) for Outside Services (Referrals) are responsible for reviewing the medical necessity and availability of services for which a referral has been requested.

Additionally, there are service-specific authorization processes for externally referred services such as durable medical equipment (DME), solid organ and bone marrow transplants, transgender surgery and behavioral health treatment for autism spectrum disorder. These processes involve specialty boards and physician experts.

When KP approves services for a Member to be provided by a Provider, KP issues an Authorization for Medical Care form, which details the level and scope of services, and number of visits and/or duration of treatment that have been pre-approved. The Member receives a letter that indicates a referral has been approved for the Member to see a specific outside Provider. Any further services must be pre-approved by KP. To receive approval, the outside Provider must contact the referring physician.

Authorized services must be rendered before the expiration date stated in the Authorization for Medical Care form or Patient Transfer Referral form or notification from KP of authorization cancellation. An additional authorization must be obtained for care that may exceed the scope of the original authorization, including any limits in the number of services (i.e., visits, etc.) or may extend beyond the expiration date of the authorization.
For assistance in resolving administrative and Member-related issues, including clarification of the authorization or referral process, please contact a Referral Coordinator from the referring KP facility.

### 4.4 Authorization of Services

Prior authorization is a prerequisite before payment can be made for any inpatient and outpatient services that would otherwise be covered by a Member’s benefit plan, except for emergency services and any other situations expressly allowed by the Agreement or this Provider Manual.

Authorization can be requested from KP by contacting the appropriate Referral Coordinator or Outside Services Case Manager.

**NOTE:** Authorization from KP is required even when KP is the secondary payor.

#### 4.4.1 Hospital Admissions Other Than Emergency Services

A KP Plan physician or KP designated specialist may refer a Member for a hospital admission without prior authorization. The RM staff conducts an initial review within 24 hours of admission to determine medical necessity, appropriate level of care and the provision of services, except for emergency services for all admissions and the provision of services, except for emergency services. Such authorization can be requested as described above by contacting the appropriate Referral Coordinator.

#### 4.4.2 Admission to Skilled Nursing Facility (SNF)

A KP Plan Physician or KP designated specialist may refer a Member for skilled level of care at a SNF. Such authorization will include a description of specific, approved therapies and other medically necessary skilled nursing services.

The initial skilled care authorizations or denials are based on the Member’s medical needs at the time of admission, and the Member’s benefits and eligibility status. The Member is informed by the Care Coordinator what his or her authorized anticipated length of stay will be.

The Care Coordinator conducts telephonic or onsite reviews at least weekly to evaluate the Member’s clinical status and level of care needs and to determine if continuation of the authorization is appropriate. The SNF may request extension of an authorization for continued stay from the Care Coordinator. Based on the Member’s skilled care needs and benefit eligibility, more SNF days may be approved. If additional days are authorized, then the SNF will receive an authorization from KP.
Other services in connection with a SNF stay are authorized when either the Member’s primary care physician or other KP designated specialist expressly orders such services. These services may include, but are not limited to, the following items:

- Laboratory and radiology services
- Special supplies or DME
- Ambulance transport (when Member meets medical necessity)

Kaiser requires that authorization numbers be included on all claims submitted by not only SNFs, but all ancillary providers that provide services to Kaiser Members.

These authorization numbers **must** be provided by the facility that requests the services, preferably at time of service. Because authorization numbers change frequently it is critical that the authorizations be valid for the date of service provided. Please note that the correct authorization number for the ancillary service providers may not be the latest authorization you have.

It is the responsibility of the SNF to provide the correct authorization number(s) to all ancillary service providers at time of service. If you are not sure of the correct authorization number, please contact Kaiser’s authorization department for confirmation.

### 4.4.3 Home Health/Hospice Services

All home health and hospice services must be authorized by KP prior to providing services. Home health or hospice services are provided subject to the following criteria:

- A KP Plan Physician must order and direct the requests for home health and hospice services
- The patient is an eligible Member
- Services are provided in accordance with benefit guidelines
- The patient requires the care in the patient’s place of residence. Any place that the patient is using as a home is considered the patient’s residence
- The home environment is a safe and appropriate setting to meet the patient’s needs and provide home health or hospice services
- There is a reasonable expectation that the patient’s clinical needs can be met by the Provider

#### 4.4.3.1 Home Health Only

- The services are medically necessary for the Member’s clinical condition
- The patient is homebound, which is defined as an inability to leave home without the aid of supportive devices, special transportation or the assistance of another person. A patient may be considered homebound if absences from the home are infrequent
and of short distances. A patient is not considered homebound if lack of transportation or inability to drive is the reason for being confined to the home

- The patient and/or caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals

4.4.3.2 Hospice Only

The patient is certified as being terminally ill and meets the criteria of the benefit guidelines for hospice services.

4.4.4 Durable Medical Equipment (DME)/ Prosthetics and Orthotics (P&O)

Prior Authorization is required for DME and P&O. KP evaluates authorization requests for appropriateness based on, but not limited to:

- The Member's care needs
- The application of specific Plan Sponsor's benefit guidelines
- Utilization of DME and Soft Goods formulary guidelines and P&O Clinical Criteria which are available at the Clinical library: http://clm.kp.org

4.4.5 Psychiatric Hospital Services

Initial verbal authorizations will be made to the psychiatric facility by a KP Psychiatry Department/Call Center Referral Coordinator at the direction of a KP Plan Physician or clinician. When a Member is admitted to your facility for psychiatric services, you must notify KP at the appropriate facility number to activate the initial authorization. You may be asked to complete supplemental documentation, such as an “Insurance Admission Information” form.

4.4.6 Non-Emergent Transportation

To serve our Members and coordinate care with our Providers, KP has a 24 hour, 7 day per week, centralized medical transportation department called the “HUB”, to coordinate and schedule non-emergency medical transportation.
4.4.6.1 Non-Emergency Medical Transport (Gurney Van/Wheelchair Van)

Providers must call KP to arrange for KP physician-authorized non-emergency medical transportation through the HUB. If a Member requires non-emergency medical transportation to a KP Medical Center or any other location designated by KP, Providers may contact the HUB to arrange for the transportation of the Member.

Non-emergency medical transportation may or may not be a covered benefit for the Member. Payment may be denied for the medical transportation of a Member that is not coordinated through the HUB and not properly documented as an authorized referral.

4.4.6.2 Non-Emergency Ambulance Transportation

If a Member requires non-emergency ambulance transportation to a KP Medical Center or any other location designated by KP, Providers may contact the KP to arrange the transportation of the Member through the HUB. Providers should not contact any ambulance company directly to arrange an authorized non-emergency ambulance transportation of a KP Member.

Non-emergency ambulance transportation may or may not be a covered benefit for the Member. Payment may be denied for ambulance transport of a Member that is not coordinated through the HUB and not properly documented as an authorized referral.

4.4.7 Authorization for KP Emergency Department Visits

If, due to a change in a Member's condition, the Member requires a more intensive level of care than your facility can provide, you can request a transfer of the Member to a KP Medical Center. The Care Coordinator or designee will arrange the appropriate transportation through KP’s medical transportation HUB.

Transfers to a KP Medical Center should be made by the facility after verbal communication with the appropriate KP staff, such as a TPMG SNF physician or the Emergency Department physician. Contact a Care Coordinator for a current list of telephone numbers for emergency department transfers.

If a Member is sent to the Emergency Department via a 911 ambulance and it is later determined by KP that the 911 ambulance transport or emergency department visit was not medically necessary, KP may not be obligated to pay for the ambulance transport.
4.4.7.1 **Required Information for Transfers to KP**

Please send the following written information with the Member:

1. Name of Member’s contact person (family member or surrogate) and telephone number
2. Completed inter-facility transfer form
3. Brief history (history and physical; discharge summary; and/or admit note)
4. Current medical status, including presenting problem, current medications and vital signs
5. A copy of the patient’s Advance Directive/Physician Orders for Life Sustaining Treatment (POLST)
6. Any other pertinent medical information, i.e., lab/x-ray

If the Member is to return to the sending facility, KP will provide the following written information:

1. Diagnosis (admitting and discharge)
2. Medications given; new medications ordered
3. Labs and x-rays performed
4. Treatment(s) given
5. Recommendations for future treatment; new orders

4.5 **Emergency Admissions and Services; Hospital Repatriation Policy**

Consistent with applicable law, Members are covered for emergency care needed to stabilize their situation. An emergency medical condition means any of the following (i) a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (a) serious jeopardy to the Member’s health, or in the case of a pregnant woman, the health of the woman or her unborn child, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or (ii) a mental disorder that manifests itself by acute symptoms of sufficient severity that such either the Member is an immediate danger to themselves or others, or the Member is not immediately able to provide for or use food, shelter, or clothing, due to the mental disorder, or (iii) with respect to a pregnant woman who is having contractions (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or her unborn child, or (iv) as otherwise defined by applicable law (including California law or EMTALA), or as otherwise required by law.
Services provided to Members to screen and stabilize a patient suffering from an emergency medical condition as defined above do not require prior authorization.

**EMERGENCY SERVICES**

- If emergency services are provided to screen and stabilize a patient, they are covered in situations when a prudent layperson would have believed that an emergency condition existed
- Once a patient is stabilized, the treating physician is required to communicate with KP for approval to provide further care or to effect transfer

**EMERGENCY CLAIM**

The following circumstances will be considered when the bill is processed for payment:

- Whether services and supplies are covered under the Member's benefit plan
- Whether services have been ordered, authorized, prescribed, or directed by a KP Plan Physician
- Whether services provided were immediately required because of unforeseen illness or injury

Payment is dependent on the advice of the treating physician, as well as the KP determination of the situation in which care was provided and in consideration of the prudent layperson guideline as stated above. Members have varying benefit plans, and some benefit plans may not cover continuing or follow-up treatment at a non-plan facility. Therefore, the Provider should contact KP's Emergency Prospective Review Program (EPRP) prior to furnishing post-stabilization services.

**4.5.1 Emergency Prospective Review Program (EPRP)**

EPRP provides a statewide notification system relating to emergency services for Members. It also provides authorization for requested post-stabilization care and must be contacted prior to a stabilized Member's admission to a facility. KP may make arrangements for necessary continued hospitalization or for transferring the Member to a designated hospital after the Member is stabilized.

When a Member presents in an emergency room for treatment, we expect the Provider to triage and treat the Member in accordance with EMTALA requirements, and to contact EPRP once the Member has been stabilized or stabilizing care has been initiated.* The Provider may contact EPRP at any time, including prior to stabilization to the extent legally and clinically appropriate, to receive relevant patient-specific medical history information which may assist the Provider in its stabilization efforts and any subsequent post-stabilization care. EPRP has access to Member medical history, including recent test results, which can help expedite diagnosis and inform further care. In addition, EPRP can authorize post-stabilization care at the facility, subject to the requirements under the
Member’s benefit plan, in order for non-emergency care to be a covered service, or can assist in making other appropriate care arrangements.

* Please note: Under the EMTALA regulations, Providers may, but are not required to, contact EPRP once stabilizing care has been initiated but prior to the patient’s actual stabilization, if such contact will not delay necessary care or otherwise harm the patient.

EPRP
(800) 447-3777
Available 7 days a week
24 hours a day

EPRP is available 24 hours a day, every day of the year and provides:

- Access to clinical information to help the Provider in evaluating a Member’s condition and to enable our physicians and the treating physicians at the facility to quickly determine the appropriate treatment for the Member
- Emergency physician to emergency physician discussion regarding a Member’s condition
- Authorization of post-stabilization care or assistance with making appropriate alternative care arrangements

### 4.5.2 Post-Stabilization Care

If there is mutual agreement at the time of the phone call as to the provision of post-stabilization services, EPRP will authorize the Provider to provide the agreed-upon services and issue a confirming authorization number. If requested, EPRP will also provide, by fax or other electronic means, a written confirmation of the services authorized and the confirmation number. KP will send a copy of the authorization to the facility's business office within 24 hours of the authorization decision. This authorization number must be included with the claim for payment for the authorized services. The authorization number is required for payment, along with all reasonably relevant information relating to the post-stabilization services on the claim submission consistent with the information provided to EPRP as the basis for the authorization.

EPRP must have confirmed that the Member was eligible for and had benefit coverage for the authorized post-stabilization services provided prior to the provision of post-stabilization services.

If EPRP authorizes the admission of a clinically stable Member to the facility, KP’s Outside Services Case Manager will follow that Member’s care in the facility until discharge or transfer.

EPRP may request that the Member be transferred to a KP-designated facility for continuing care or EPRP may authorize certain post-stabilization services in your facility.
In many cases, such post-stabilization services will be rendered under the management of a physician who is a member of your facility’s medical staff and who has contracted with KP to manage the care of our Members being treated in community hospitals.

EPRP may deny authorization for some or all post-stabilization services. The verbal denial of authorization will be confirmed in writing. If EPRP denies authorization for requested post-stabilization care, KP shall not have financial responsibility for services if the Provider nonetheless chooses to provide the care. If the Member insists on receiving such unauthorized post-stabilization care from the facility, we strongly recommend that the facility require that the Member sign a financial responsibility form acknowledging and accepting his or her sole financial liability for the cost of the unauthorized post-stabilization care and/or services.

If the Member is admitted to the facility as part of the stabilizing process and the facility has not yet been in contact with EPRP, the facility must contact the local Outside Services Case Manager in order to discuss authorization for continued admission as well as any additional appropriate post-stabilization care once the Member’s condition is stabilized.

### 4.6 Concurrent Review

The Outside Utilization Review Services Case Management Hub for Northern California (OURS-NCAL) and KP Plan Physicians will conduct concurrent review in collaboration with contracted facilities. The review may be done telephonically or on site in accordance with the facility’s protocols and KP’s onsite review policy and procedure, as applicable.

If the Member needs continued services, OURS-NCAL will either confirm or obtain authorization from a KP Plan Physician or licensed clinician (as appropriate for mental health services) for continued stay/services. If continued stay/services are not authorized, the Provider will be notified of the reasons for the denial and appeal procedures.

When utilization problems are identified, we will work with the facility to develop and implement protocols that are intended to improve the provision of services for our Members. A joint monitoring process will be established to observe for continued improvement and cooperation.

OURS-NCAL and the Providers collaborate on concurrent review activities that include, but are not limited to:

- Monitoring length of stay/visits
- Providing day/service authorization, recertification, justification
- Attending patient care conferences and rehabilitation meetings
- Utilizing community benchmarking for admissions and average length of stay (ALOS)
- Setting patient goal for Members
- Conducting visits or telephonic reports, as needed
- Developing care plans

### 4.7 Case Management Hub Contact Information

The specific contact for information OURS-NCAL is as follows:

- **Main Phone Line:** (925) 926-7303
- **Toll free phone line:** 1-888-859-0880
- **eFax:** 1-877-327-3370

The office is located in Walnut Creek, providing support for all Northern California KP Members admitted in any non-KP hospital, including those admitted Members out of the KP service area and out of the country.

### 4.8 Denials And Provider Appeals

Information about a denial or the appeal procedures is available by contacting OURS-NCAL or Member Services.

When a denial is made, the requesting Provider is given the information below. Providers may also contact the issuing department that is identified in the letter for additional information.

The name and direct telephone number of the decision-maker accompanies a copy of the denial letter that is sent to the requesting Provider. All medical necessity decisions are made by physicians or licensed clinicians (as appropriate for mental health services). Physician decision-makers include, but are not limited to, DME physician champions, APICs for Outside Services (Referrals), UM department chiefs, other board certified physicians or behavioral health practitioners.

If the physician or behavioral health practitioner does not agree with a medical necessity decision, the Provider may contact the Physician-in-Chief for discussion at the local facility. Providers may also contact the issuing department that is identified in the letter for additional information.

### 4.9 Discharge Planning

Providers such as hospitals, SNFs, psychiatric facilities, home health and hospice agencies are expected to provide discharge planning services for Members, and to cooperate with KP to assure timely and appropriate discharge.

Providers should designate staff to provide proactive, ongoing discharge planning. Discharge planning services should begin upon the Member's admission and be completed
by the medically appropriate discharge date. The Provider's discharge planner will identify barriers to discharge and determine an estimated date of discharge. Upon request by KP, Provider will submit documentation of the discharge planning process.

The Provider's discharge planner, in consultation with the Care Coordinator, will arrange and coordinate transportation, DME, follow-up appointments, appropriate referrals to community services and any other services requested by KP.

Unless the Provider has received prior authorization to furnish follow-up care, the Provider must contact KP to arrange for and to coordinate covered medically necessary care after discharge.

### 4.10 UM Information

The Provider may be requested to provide information for the KP UM activities concerning Members in the Provider’s facility. Such additional information may include, but is not limited to, the following data:

- Number of inpatient admissions
- Number of inpatient readmissions within the previous 7 days
- Number of emergency department admissions
- Type and number of procedures performed
- Number of consults
- Number of deceased Members
- Number of autopsies
- Average length of stay
- Quality Assurance/Peer Review process
- Number of cases reviewed
- Final action taken for each case reviewed
- Committee Membership (participation as it pertains to Members and only in accordance with the terms of your contract)
- Utilization of psychopharmacological agents
- Other relevant information KP may request

### 4.11 Case Management

Care Coordinators work with treating Providers to develop and implement plans of care for acutely ill, chronically ill or injured Members. KP case management staff may include
nurses and social workers, who assist in arranging care in the most appropriate setting and help coordinate other resources and services.

While any provider may request authorization for services, or may seek a Member’s inclusion in a particular KP UM program (for example, case management), the PCP continues to be responsible for managing the Member’s overall care. It is the Provider’s responsibility to send a report to the referring physician, regardless of whether the referring physician is the Member’s PCP, of any consultation with, or treatment rendered to, the Member.

4.12 Clinical Practice Guidelines (CPGs)

Clinical Practice Guidelines (CPGs) are developed to support clinical decisions by practitioners at the point of care in the provision of acute, chronic and behavioral health services. The use of CPGs by practitioners assists KFHP by ensuring that the care provided to members is evidence-based and consistent with professionally recognized standards of care. Development of CPGs is prioritized based on established criteria, which include: number of patients affected by a particular condition/need, quality of care concerns and excessive clinical practice variation, regulatory issues, payor interests, cost, operational needs, leadership mandates and prerogatives.

Physicians and other practitioners are involved in the identification of CPG topics, as well as the development, review, and endorsement of all CPGs. The CPG team includes a core, multi-disciplinary group of physicians representing the medical specialties most affected by the CPG topic, as well as health educators, pharmacists, or other medical professionals.

The CPGs are sponsored and approved by one or more Clinical Chiefs groups, as well as by the Guidelines Medical Director. Established guidelines are routinely reviewed and updated at least every two years or earlier when new evidence emerges. CPGs are distributed to practitioners and are available on two internal KP intranet websites.

4.13 Pharmacy Services / Drug Formulary

KP has developed a quality, cost effective pharmaceutical program which includes therapeutics and formulary management. The Regional Pharmacy and Therapeutics (P&T) Committee reviews and promotes the use of the safest, most effective, and cost-effective drug therapies, and shares “Best Practices” with all KP Regions. The Regional P&T Committee’s Formulary evaluation process is used to develop the applicable KP Drug Formulary (Formulary) and the National Medicare Part D Formulary for use by KP practitioners. Contracted practitioners are encouraged to use and refer to the Regional Drug Formulary when prescribing medication for Members (available at http://kp.org/formulary).
4.13.1 Member Benefits

Pharmacy services are available for Members who have benefit plans that provide coverage for a prescription drug program. For information on specific Member benefit plans, please contact Self-Funded Customer Service.

4.13.2 Filling Prescriptions

The Formulary can be accessed online in a searchable format. It provides the list of drugs approved for general use by prescribing practitioners. For access to the online version of the Formulary on the Internet or to request a paper copy, please refer to the instructions at the end of this section.

KP pharmacies do not cover prescriptions written by non-Plan Physicians unless an authorization for care by that non-Plan Physician has been issued. In order to avoid confusion, when writing the prescription, please remind Members to bring a copy of their authorizations to the KP pharmacy when filling the prescription.

Practitioners are expected to prescribe drugs included in the Formulary unless at least one of the exceptions listed under “Prescribing Non-Formulary Drugs” in this section is met. If there is a need to prescribe a non-Formulary drug, the exception reason must be indicated on the prescription.

A Member may request an exception by contacting their physician directly through secure messaging or the Member Services Contact Center for referral to their physician and should usually receive a response, including the reason for any denial, within 2 Business Days from receipt of the request.

Members will be responsible for paying the full price of their medication if the drugs requested are (i) non-Formulary drugs not required by their health condition, (ii) excluded from coverage (i.e., cosmetic use) or (iii) not prescribed by an authorized or Plan Provider. Any questions should be directed to Customer Services.

4.13.2.1 Prescribing Non-Formulary Drugs

Non-Formulary drugs are those that have not yet been reviewed, and those drugs that have been reviewed but given non-Formulary status by the Regional P&T Committee. However, the situations outlined below may allow a non-Formulary drug to be covered by the Member’s drug benefit.

- New Members

If needed and the Member’s benefit plan provides, new Members may be covered for an interim supply (up to 100 days) of any previously prescribed “non-Formulary” medication to allow the Member time to make an appointment to see a KP provider. If the Member does not see a KP provider within the 100 days, he or she must pay the full price for any refills of non-Formulary medications.
• **Existing Members**
  A non-Formulary drug may be prescribed for a Member if he or she has an allergy, or intolerance to, or treatment failure with all Formulary alternatives or has a special need that requires the Member to receive a non-Formulary drug. In order for the Member to continue to receive the non-Formulary medication covered under their drug benefit, the exception reason must be provided on the prescription.

**NOTE:** Generally, non-Formulary drugs are not stocked at KP pharmacies. Therefore, before prescribing a non-Formulary drug, call the pharmacy to verify the drug is available at that site.

### 4.13.2.2 Pharmacies

KP pharmacies provide a variety of services including: the filling of new prescriptions, transferring prescriptions from another pharmacy, providing refills and consulting about new medications.

### 4.13.2.3 Telephone and Internet Refill Lines

Members may request refills on their prescriptions, with or without refills remaining, by calling the 24-hour Refill Recorder at the facility of choice for prescription pick up. The phone number is listed in the KP Health Care directory or by calling the facility operator. All telephone requests should be accompanied by the Member's name, MRN, daytime phone number and prescription number. Members may also refill their prescriptions online by accessing the Member website at [https://healthy.kaiserpermanente.org](http://healthy.kaiserpermanente.org).

### 4.13.2.4 Mail Order

Members with a prescription drug benefit are eligible to use the KP “Prescription by Mail” service. For more information regarding mail order prescriptions or to request an order form, please contact the Mail Order Pharmacy at **(888) 218-6245**.

Only maintenance medications should be ordered through the mail. Acute prescriptions such as antibiotics or pain medications should be obtained through a KP pharmacy to avoid delays in treatment.

The complete list of restricted use drugs may be found at [http://pharmacy.kp.org/](http://pharmacy.kp.org/).

### 4.13.2.5 Restricted Use Drugs

Some drugs (i.e., chemotherapy) are restricted to prescribing only by approved KP specialists. Restricted drugs are noted in the Formulary. If you have any questions regarding prescribing restricted drugs, please call the main pharmacy at the local facility.
4.13.2.6 Emergency Situations

If emergency medication is needed when KP pharmacies are not open, Members may use pharmacies outside of KP. Since the Member will have to pay the full retail price in this situation, he or she should be instructed to call Self-Funded Customer Service at (800) 663-1771 to obtain a claim form in order to be reimbursed for the cost of the prescription less any co-pays that may apply.

4.13.3 Drug Utilization Review

Information regarding utilization of drugs is tracked for trending and review purposes. Utilization information assists the development of educational and information communications for Providers relative to prescribing decisions.

4.14 Grievances and Appeals

If a Member raises a question about grievances or appeals with your office, please refer the Member to Self-Funded Customer Service at (800) 663-1771. The phone number is also located on the back of the Member’s identification card. Self-Funded Customer Service will provide information to the Member on grievances and Member appeal rights.

4.14.1 Member Appeals

Adverse benefit determinations may be appealed by a Member. Members are made aware of their right to appeal through their Summary Plan Description (SPD) provided by the Plan Sponsor, or by calling Self-Funding Customer Service, which can provide information about the time frames for submitting appeals and for responses. Time frames may vary, depending on whether the adverse benefits determination relates to urgent care, or a pre-service or post-service claim.

4.14.1.1 Non-Urgent Member Appeals

Formal appeals should be submitted to:

KPIC Appeals
3701 Boardman–Canfield Rd., Bldg B
Canfield, Ohio 44406

Fax: (614) 212-7110

with the following information included:

- All related information (any additional information or evidence)
- Name and identification number of the Member involved
- Name of Member's PCP
- Service that was denied
- Name of initial KP reviewing physician, if known

A complete review of the claim will be provided and the Member and any authorized representative will be notified of the decision in writing. If the initial denial is upheld following the review of the appeal, an explanation of the decision will be sent along with any further appeal rights.

A non-ERISA Member should also call Self-Funding Customer Service for a description of appeal rights applicable to Members of self-funded non-ERISA groups.

4.14.1.2 Urgent Member Appeals

Urgent appeals are available in circumstances where the normal processing time could result in serious jeopardy to the Member’s health, life or ability to regain full function.

Please call Self-Funded Customer Service at (800) 663-1771 to initiate an urgent appeal.

For urgent appeals, the decision will be rendered as quickly as possible, contingent upon the promptness of the Member/Provider in providing necessary additional information requested, but no later than 72 hours after receipt of the appeal.