Kaiser Permanente Affiliated Colorado Provider Manual

- **Utilization Management**

Section 4: Utilization Management

INTRODUCTION

Kaiser Permanente's Utilization Management (UM) policies and procedures help guide you and your team to ensure Members get the quality care and services they need, at the right locations, as per their applicable health benefits. This section of the Manual 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 Utilization Management Department by calling 1-877-895-2705.

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4.1 OVERVIEW OF UTILIZATION MANAGEMENT PROGRAM

The Kaiser Permanente Utilization Management program addresses quality management and Utilization Management oversight across the care continuum. The goal is to determine what resources are necessary and appropriate for an individual Member, and to provide those services in the appropriate setting in a timely manner. Kaiser Permanente Utilization Management consists of pre-authorization, inpatient hospital reviews and post-service authorization for both Medical and Behavioral Health services.

Kaiser Permanente Utilization Management (UM) is a collaborative partnership between Permanente physicians of the Colorado Permanente Medical Group, UM nurses, and staff that ensure the appropriate treatment plans and resources are utilized for Member health care needs throughout the care continuum. Medical necessity decisions are made by licensed clinicians and board-certified Permanente physicians trained in utilization management policy.

UM decision making is based only on appropriateness of care and service, for each individual member's needs, and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for UM decision makers. There is no opportunity for promotion or bonuses for decisions that could result in underutilization. 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.

To obtain a copy of the complete Utilization Management program description, please call 1-877-895-2705.

4.2 MEDICAL APPROPRIATENESS

Medically appropriate care is defined as care that is necessary for the diagnosis, treatment, and/or management of a medical, surgical, or behavioral health condition; within accepted standards of medical, surgical, or behavioral health care; and provided in the least intensive setting appropriate to the condition of the Member; not for the convenience of the Member, his/her family and/or provider.

Kaiser Permanente uses evidence based clinical guidelines in its Utilization Management activities. Kaiser Permanente uses nationally developed evidence-based clinical criteria and internally developed criteria for appropriate resource management decisions. These criteria are applied along with medical expert opinions, when necessary, in making decisions and are available to practitioners on request. To obtain a copy of Utilization Management specific UM criteria free of charge, or for making a request to appropriate practitioner reviewer available to discuss any UM denial decision please call 1-877-895-

2705. Criteria are sent out via mail, HealthConnect, email, or fax to practitioners, based upon requested delivery method.

To access the criteria on-line please follow the links listed below:

Medicare NCD/LCD criteria:	https://www.cms.gov/
Kaiser Permanente Internal Guidelines:	https://healthy.kaiserpermanente.org/colorado/pages/utilization-management and then click on Utilization Management.
MCG:	MCG Transparency Portal – Disclaimer

4.2.1 Transplant Services:

All transplant services authorized by the Utilization Management (UM) Department at Kaiser Permanente will be evaluated to determine medical appropriateness based on Patient and Site selection transplant criteria developed by Kaiser Permanente's National Transplant Network.

American Medical Response (AMR) is Kaiser Permanente's contracted clinical transport provider. All facilities should contact Kaiser Permanente's contracted provider, currently American Medical Response (AMR), for non-emergent clinical transportation of a KP patient to and from a facility. AMR is active in the following counties in Colorado, El Paso, Pueblo, Douglas, Jefferson, Denver, Boulder, Broomfield, Adams, and Weld. AMR should be contacted in these counties. The contact number for AMR is 303-308-4000, once contacted, AMR will verify the patient is a KP member, verify the transport is a covered benefit for the member, assign the trip an authorization number and put the request in the system for pick up.

4.2.2 Notification and Timeliness of Coverage Determination

The UM Department has policies and procedures to ensure the timely notifications of adverse decisions when care is determined not to be medically appropriate.

Notification is made through either Verbal Notification or Written Notification :

- **Verbal notification** - given to the member or authorized representative and the requesting provider after decision is rendered for urgent/expedited coverage determinations.
    - Verbal notification to provider includes information on how to contact a UM reviewer or UM physician
- **Written notification** – either generated after the verbal notification is given or as soon as the coverage determination is made.

- Written notification includes information on how to contact Member Appeals Department to file an expedited or standard appeal
- Instructions include how to obtain a copy of the UM criteria applied to make the decision free of charge and how to contact a UM physician when applicable.

4.2.3 Timeliness of Decision and Notification

Kaiser Permanente adheres to regulatory timeframes in its decision making, verbal notifications, and written notifications in accordance with the Member's jurisdiction or line of business. The processing of coverage determinations may vary by Member jurisdiction and/or applicable regulations governed by the laws of the state and accreditation bodies.

The timeframes for making coverage determinations are driven by the urgency of the request, and the type of review required/conducted: pre-service, concurrent, or post service review.

Time to Make and Issue Decision

Line of Business	Type of Request	Time Requirements - from Receipt of Request	If Additional Information is needed	Statutory and Regulatory Requirements
Emergent Care - Per prudent layperson's definition.		We do not require a prior authorization	We do not require a prior authorization	
Commercial/Exchange	Urgent Concurrent	24 Hours	If at least one attempt is documented within 24hrs of receipt of request to obtain but was unable can extend up to 72 hours	29 CFR § 2560.503-1; C.R.S 10-16-113, 4-2-17;
Commercial/Exchange	Urgent Pre-Service	72 Hours		29 CFR § 2560.503-1; C.R.S 10-16-113; 4-2-17;
Commercial/Exchange	Standard (Pre-Service Non-Urgent)	15 Calendar Days	Can extend up to 15 Calendar days	29 CFR § 2560.503-1; C.R.S 10-16-113; 4-2-17;

Commercial/Exchange	Post Service	30 Calendar Days	Can extend up to 15 Calendar days	29 CFR § 2560.503-1; C.R.S 10-16-113; 4-2-17;
Commercial Medications	Standard (Pre-Service Non-Urgent	3 Business Days		DOI - HB22-1370 Section 3.
Commercial Medications	Urgent	24 Hours		DOI - HB22-1370 Section 3.
Medicare	Standard (Pre-Service Non-Urgent)	14 Calendar Days	May delay decision up to 14 calendar days if member requests it or if KP justifies a need for additional information and that it is in the best interest of the member	§ 42 CFR § 422.572 (2), 42 CFR §§ 422.568 (2)
Medicare	Expedited/Urgent Preservice	72 Hours	May delay decision up to 14 calendar days if member requests it or if KP justifies a need for additional information and that it is in the best interest of the member	42CFR422.572
Medicare	Urgent Concurrent	72 Hours	May extend up to 14 calendar days if member requests. If KP extends the time frame, then KP needs to notify the member/authorized rep expeditiously.	§ 42 CFR § 422.572 (2), 42 CFR §§ 422.568 (2)

Medicare	Post Service	30 Calendar Days	May extend up to 15 days	
Medicare Part D	Standard	72 Hours	N/A	
Medicare Part D	Expedited	24 Hours	N/A	
Medicare Part D	Post Service	14 Calendar Days		
Medicare Part B Drug Requests	Standard	72 Hours	N/A	§ 42 CFR § 422.572 (2), 42 CFR §§ 422.568 (2)
Medicare Part B Drug Requests	Expedited	24 Hours	N/A	§ 42 CFR § 422.572 (2), 42 CFR §§ 422.568 (2)
CHP+	Standard	10 Calendar Days	May extend up to 14 calendar days - If member/provider requests extension and the extension is in the best interest of the member	
CHP+	Expedited	72 Hours	May extend decision up to 14 calendar days if member/provider requests it or if KP justifies a need for additional information and that it is in the best interest of the member	
CHP+	Post Service	30 Calendar Days	Can extend up to 15 Calendar days	

4.2.4 Adverse Decision Information

If an authorization for services is unable to be approved for an urgent concurrent (hospital) admission, due to clinical situation or does not meet medical necessity guidelines for service being requested, the requesting hospital staff will be notified via phone, email or fax of decision and the option to request and/or complete a peer to peer between the

attending physician in the hospital and the UM physician who made the decision. All urgent concurrent peer to peer conversations must be completed by 11am the following calendar day after the oral, written, or fax notice is given to the hospital utilization and / or care management department.

4.2.5 Retrospective Review of Authorization requests within the Utilization Department

Kaiser Permanente Colorado (KPCO) Utilization Management (UM) department will review retrospective and or post-service authorization requests that are not submitted timely only in the following circumstances:

A retrospective review is the process of reviewing and making a coverage decision for services that have already been received (e.g., post-service decision).

A retrospective review by the KPCO UM team is only afforded in the below situations:

Inpatient Urgent Concurrent requests will be accepted any time during member hospital admission, and or up to 5 days post discharge in the following situations:

1. Member and or family could not provide insurance information at the time of admission due to extenuating circumstances, including unconsciousness, altered mental status, or member received a tracheostomy tube upon admission,
2. No identification on member at time of admission and or
3. Family is unaware of member's current insurance coverage.

Pre-service requests where authorization was not obtained before service was provided will be accepted in the following situations:

1. Urgent DME supplies that would jeopardize a member's health or wellbeing if not received immediately.
2. Home Health requests (including all requests even home IV antibiotics given by HH nurse) that if not received expeditiously could potentially cause admission into a higher level of care.

These will be allowed for submission up to seven (7) calendar days after products/services are obtained/started.

1. ABA and IOP as prompt services are necessary to prevent a higher level of care.
   a) These will be allowed for submission up to seven (7) calendar days after products/services are obtained/started.

2. Nephropathology Associates: post-service requests are entertained because billing codes aren't known until they have tissue in-hand.

Any requests after the five (5), seven (7), and or thirty (30) calendar days from discharge or service or supplies being rendered, the facility must submit a claim and once the claim has been denied for no authorization, the review of the stay or services/supplies with supporting medical records can be submitted for an appeal to conduct a medical necessity review. Members are held harmless and have no financial liability for services rendered to a contracted provider.

If a provider has a contract with a clause that requires review of an authorization request, even if post service (retro review), UM will review.

Air Ambulance emergency transportation claims' requests will be reviewed retroactively as each claim request doesn't come in until after the transportation has already been completed.

For retrospective review determinations, Kaiser Permanente's Utilization Management shall make the determination and notify the member or health care provider of the determination within a reasonable period, but in no event later than thirty (30) calendar days after the receipt of the benefit request. Whenever the determination is an adverse determination, Kaiser Permanente's Utilization Management shall provide notice of the adverse determination to the medical facility and health care provider (3 CCR 702-4 § 7.C.1).

4.2.6 Referral Contact List

For general or specific Utilization Management inquiries, please call 1-877-895-2705 or fax to 1-866-529-0934. Staff are available to accept collect or toll-free calls during normal business days and hours (Monday through Friday 8:00 a.m. – 5:00 p.m.). Staff are identified by name, title, and organization name when initiating or returning UM issues. 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 will provide a telephone interpreter free of charge to assist with UM issues for individuals who speak limited or no English. After normal business hours for the Colorado service area, please call our toll-free number, 1-877-895-2705, your message will be forwarded to our UM staff; your call will be returned the next business day.

Mental Health or Chemical Dependency Outpatient Services	303-471-7700 or toll-free 1-866-359-8299. **Southern Colorado Behavioral Health:** 1-866-702-9026.
Mental Health or Chemical Dependency Inpatient Services	**Northern Colorado**

	Inpatient Authorizations and Concurrent Review: Carelon Behavioral Health (Formerly Beacon Health Options), 1-866-702-9026 **Southern Colorado** Inpatient Authorizations and Concurrent Review: Carelon Behavioral Health (Formerly Beacon Health Options), 1-866-702-9026 **Denver/Boulder** Inpatient Psychiatry Authorization: Contact Psychiatry Pager at 303-203-5563. Inpatient Chemical Dependency Authorization: Contact Psychiatry Pager at 303-203-5563.
Inpatient Concurrent Review (including notification upon admission of an authorized patient):	Secure fax and team email: 1-877-516-0825 Behavioral-Health-UM@kp.org

All Visiting Members: *regardless of market area or level of care (including routine outpatient services) will be managed by the KP Colorado UM team, not by Carelon (Formerly Beacon Health Options). The Denver/Boulder process will be followed for any visiting member.*

4.3 PRIOR AUTHORIZATION

You are required to contact Kaiser Permanente Utilization Management at 1-877-895-2705 and obtain prior authorization before services are rendered, or to determine whether a service requires prior authorization. Service prior authorization requirements are also available online by clicking the link below. Failure to obtain prior authorization may result in denial of payment.

Community Providers (kaiserpermanente.org)

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 Prior Authorization Request form (see 4.5.9 below).

When interpreting requirements for prior authorization, please consider the general notes and list of services that require prior authorization. *The services listed below are not exhaustive and are subject to change*. For the most recent updated prior-authorization list, you may contact our Provider Experience Consultants at 1-866-866-3951.

GENERAL NOTES AND DISCLAIMERS:

- Failure to obtain authorization prior to service initiation may result in payment denial.
- Emergent & urgent care services do not require authorization.
- This list is a guide for which services require pre-authorization. *The services listed are not exhaustive and are subject to change*. Actual benefits are still dictated by plan design.
- Services that require authorization assume they are billed independently.
- Any emergency admissions require notification within 24 hours or the next business day. Failure to provide notification may result in payment denial.

4.3.1 Hospice Benefit

Hospice is appropriate for patients whose life expectancy is six months or less and have accepted the hospice philosophy of comfort care rather than curative care.

1. **Commercial and HMO Members** must use a contracted hospice provider.

2. **Medicare Advantage Members** may choose any Medicare Certified Hospice. Hospice care is carved out of the benefit and paid by Medicare directly to the hospice provider.

4.3.2 Palliative Care

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

1. **Inpatient Palliative Care Consultation (available at certain Core hospitals):** Providers can call for an inpatient consultation within the Core hospital if they believe that their patients are seriously ill and that a consultation with an interdisciplinary team would benefit their patients/families in discussing goals of care.

2. **Outpatient Palliative Care**: There are home and clinic-based palliative care programs available to members with serious illness and who need help managing pain or other troubling symptoms, understanding, and coping with complex illness, finding comfort and control, as well as discussing wishes,

goals, and planning. Each program has specific eligibility guidelines, but when a patient is referred to outpatient palliative care, a Palliative Care Specialist RN or LCSW will contact the patient to assess palliative care needs and can then schedule patient for a visit with the appropriate team/service. To refer to any outpatient palliative care program in Health Connect, type in "ref pal" in order entry and select REF Palliative Care.

4.4 EXEMPTION PROCESS FOR A NON-CONTRACTED PROVIDER REFERRAL

If you are requesting authorization for services from a provider who is not included or covered by the Membership Agreement, please provide this information within the Prior Authorization Request Form via Affiliate Link or via fax to the Kaiser Permanente Central Referral Center Department at 1-866-529-0934.

4.5 REFERAL PROCEDURE

The routine referral is the most frequently issued referral. After being seen or treated by a Colorado Permanente Medical Group, P.C. (CPMG) physician, or an affiliated network provider, the member may be referred to an affiliate practitioner, provider, or facility.

All information related to pre-authorization of services is coordinated through the Central Referral Center, unless otherwise noted herein.

Kaiser Permanente
CENTRAL REFERRAL CENTER
Hours of Operation Monday through Friday 8:00 a.m. – 5:00 p.m.
Phone 1-877-895-2705
FAX 866-529-0934

It is your responsibility to obtain the written authorization prior to rendering services. Authorization is required prior to claim submission if one is required.

Clinical information is required in essentially all cases. Printed clinical records may be faxed with the Authorization Request form or submitted electronically via Affiliate Link. After consultation, please send clinical information reports and/or results to the referring provider.

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 all secondary referrals. Please call the Central Referral Center if assistance is needed. Failure to comply with contract terms regarding secondary referrals will result in a deduction from compensation to cover the cost of the unauthorized services by an unauthorized provider.

An approved standardized Letter with the authorization number will be returned by KP Health Connect/Affiliate Link, fax, or mail to the requesting provider and to the service provider. The member will be notified by either telephone (in the case of Urgent or Expedited requests), U.S. mail, email if requested, or the Letters section of the member's My Chart on KP.org account.

4.5.1 Behavioral Health

Inpatient Mental Health or Chemical Dependency Services:
Follow these steps to request an authorization for any inpatient mental health or chemical dependency services:

Denver/Boulder Market Area:
For members assigned to the Denver/Boulder market area, follow these steps to request a referral for any inpatient, acute treatment unit or partial hospital admission for mental health or chemical dependency issues:

1. Review the need for psychiatric or chemical dependency admission, verify benefits, and receive authorization for admission by paging the on-call psychiatrist at *303-203-5563*.

Southern Colorado or Northern Colorado Market Areas:
For members assigned to the Southern Colorado or Northern Colorado, home market areas, *y*ou are required to contact Carelon Behavioral Health (Formerly Beacon Health Options) at 866-702-9026 to obtain authorization for an admission.

Outpatient Mental Health or Chemical Dependency Services:
Follow these steps to request an authorization for any outpatient mental health or chemical dependency services that require authorization:

Denver/Boulder Market Area:
In Denver/Boulder and Northern Colorado, services are available through our primary care clinics, Kaiser Permanente Behavioral Health Clinics, or our contracted affiliated network, including *Carelon Behavioral Health (Formerly Beacon Health Options)* Services that require authorization versus those that do not are determined by the billable code. In

general, therapy, medication management, and intake/assessment codes do not require authorization as of 7/30/2021. Please refer to guidance from your PEC representative or the on-line portal.

Members can always call Kaiser Permanente's Behavioral Health Access Center at 303-471-7700 for assistance with navigation to behavioral health services. Failure to obtain an authorization for services that require such may result in denial of payment.

Southern Colorado or Northern Colorado Market Areas:
In Southern Colorado, *please* contact Carelon Behavioral Health (Formerly Beacon Health Options) at 866-702-9026 to get connected with services. Failure to obtain a referral may result in denial of payment.

Visiting Members:
All Visiting Members regardless of market area or level of care (including routine outpatient services) will be managed by the KP Colorado UM team, not by Carelon (Formerly Beacon Health Options). The Denver/Boulder process will be followed for any visiting member.

4.5.2 Skilled Nursing Facility (SNF)

Kaiser Permanente contracts with selected Skilled Nursing Facilities to provide nursing and therapy rehabilitation to members who meet clinical criteria and/ or Medicare guidelines for admission. Hospital Case Managers are trained on how to place eligible members in a contracted SNFs where KP Care Coordinators follow their rehabilitation progress weekly.

4.5.3 Home Health Services

Members must meet the Medicare definition of being "homebound" and must also require the skill of a nurse or therapist to be eligible. Providers may order these services by faxing an order to one of our contracted Home Health Agencies. Prior authorization is required for all home health services. (HealthConnect users can utilize the Home Health Referral order.)

4.5.4 Durable Medical Equipment (DME)

DME requests will follow the same prior authorization process in 4.5.5 ***except*** *in the following situation: DME requests to Apria (except oxygen and enteral requests), Byram, Numotion, Sizewise, Joerns, or Daavlin in the Denver/Boulder area will be ordered via a DME letter to the vendor. The vendor will then submit to KP a prior auth request if required.*

4.5.5 Required Documentation When Requesting an Authorization for Services

To request a referral for a service you need to submit a completed referral request/Prior Authorization form and submit that to the KP UM Department. The Prior Authorization form is attached below in section 4.5.9. It may also be obtained by calling the Central Referral Center at 1-877-895-2705. Detailed information regarding referral procedures, including information required for a referral for specific types of services starts in Sections 4.3. The Prior Authorization form is also available at <providers.kaiserpermanente.org> and following the selections for Colorado and Prior Authorization requests.

Referrals are reviewed for medical appropriateness based on MCG, Medicare, and Kaiser Permanente criteria guidelines. If your request is approved, we will issue an authorization number, which must be used when submitting claims. If your request is denied, we will notify you and the Member and provide information regarding the process for appealing the determination.

Note the following limitations on approved authorizations:

- Authorizations are valid as detailed on the authorization letter unless the member's plan was terminated or revoked by KP (the member needs to have an active Kaiser policy at the time services were provided).
- If the referral expires or you recommend additional or different services, you must seek an extension or modification of the referral, or you may submit a new referral.
- Only one (1) visit or service is allowed per referral, unless otherwise indicated
- A referral is valid only if:
  - The Member is eligible on the date of service and
  - The Member has coverage for the services under the Membership Agreement.

4.5.6 Pre-Service Review

Pre-service authorization requests are reviewed by the Pre-Service Utilization Management clinicians. Pre-service reviews are processed according to the urgency of the request.

Urgent care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (1) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, *or* (2) Seriously jeopardize the life, health or safety of the member or others due to the member's psychological state, *or* (3) in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

4.5.7 Concurrent Review (Inpatient & Outpatient)

Inpatient admissions (acute and sub-acute) and outpatient requests are reviewed by Utilization Management clinicians. The above reviews are performed for medical, surgical, and behavioral health care settings. Concurrent review involves a combination of reviewing medical records against approved criteria; gathering information from practitioners, providers, and patients; and consulting with UM physicians and nurse managers as needed.

Concurrent review is performed on care delivered in acute, sub-acute , and outpatient settings:

- Observation (Short Stay)
- Acute Inpatient Hospitals
- Long Term Acute Care Hospitals
- Skilled Nursing Facility
- Inpatient Rehabilitation
- Partial Hospitalization and Intensive Outpatient Behavioral Health Services
- Home Health Services

If member no longer meets clinical criteria for continuation of care an adverse decision notification will be supplied to the member or member's representative and provider along with a peer-to-peer opportunity (for inpatient levels of care this will be given orally before adverse decision is rendered) and appeal information.
Continuing Care, Skilled Nursing Facilities and Acute Rehabilitation facilities have bi-weekly Care Coordinator review. **Home Health Services** review is provided for recertification and/or visits above the initial authorization.

4.5.8 Post-Service Review (Retrospective)

The Utilization Management department uses approved criteria to perform retrospective utilization review of medical, surgical, or behavioral healthcare services that required, but did not receive, pre-authorization (please see section 4.2.4 for those services that would qualify for a retrospective review).

4.5.9 Continuity of Care

Providers who are leaving Kaiser Permanente's network and qualify for continuity of care may request to continue to see some of their patients at in-network benefit levels, for a short time, while out-of-network. For members to qualify for continuity of care, with the terming provider, the request would need to be medically necessary and meet one of the below criteria:

- Undergoing treatment for a serious or complex condition
- Institutionalized or inpatient

- Scheduled for a non-elective surgery including post-operative care form the provider/facility
- Pregnant
- Receiving postpartum care
- Receiving current ongoing treatment of a condition that the treating provider indicates would worsen or interfere with the anticipated outcomes
- Terminally ill or;
- Receiving treatment for life-limiting illness

Please fax any continuity of care request to *1-866-529-0934 along with the prior authorization form.*

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/co/ever/prior-authorization-request-form-en.pdf

4.5.10 Prior Authorization Form

KAISER PERMANENTE®

COLORADO PRIOR AUTHORIZATION (PRE-CERTIFICATION) REQUEST FORM

Fax the completed form to: **866-529-0934**. Call **877-895-2705** if you have questions.

Please fill in every field; requests **cannot** be processed if they are missing Clinical Information, CPT, or ICD codes.

This form is available online: http://providers.kaiserpermanente.org/html/cpp_cod/authorizationstoc.html?

1. FORM COMPLETED BY:

Name (Print):	Phone:	Fax:	Date:

2. MEMBER INFORMATION:

Medical Record Number:	Last Name:	First Name:	
Date of Birth:	Phone:		
Address:	City:	State:	Zip:

3. PRIORITY OF REQUEST:

☐ Routine (care required within 3 to 15 days) ☐ Urgent (care required within 24 to 72 hours) ☐ Post Service (service has been rendered)	☐Modification; Existing Authorization #: ☐Renewal of Authorization; Existing Authorization #: Is this a continuity of care request: ☐Yes or ☐No

☐Pre-Service (In-Office Procedures/Service, Medication and Radiology)	☐Post-Service (Home Health, SNF, LTACH and AIR)	☐Durable Medical Equipment	☐Observation ☐Transplant	☐ Initial/Concurrent Hospital Admission

Behavioral Health/SUD Services: ☐Residential ☐Outpatient ☐Partial Hospital ☐Intensive Outpatient ☐Inpatient	Pre-Service Surgery: ☐ASC ☐Inpatient ☐Outpatient

4. PROVIDER INFORMATION:

☐Check box if treating provider is not contracted with Kaiser Permanente.

Requesting Provider		
Physician:		
Specialty:		
NPI:		
Phone:		
Fax:		
Address:		
City:	State:	Zip:

Treating Provider	
Physician:	
Facility Name:	
TIN:	NPI:
Specialty:	
Phone:	
Fax:	
Address:	

5. SERVICE INFORMATION:

Start Date:	End Date:	
Diagnosis ICD Code(s):	Diagnosis Description:	
CPT/HCPCS Code(s)	Procedure or Description	Quantity/# of Visits
1.		
2.		
3.		

6. COMMENTS:

Revision February 2024

4.6 EMERGENCY CARE AND INPATIENT ADMISSION

Emergent request for care: A request for care arising from a sudden, severe, and unexpected sickness, injury, or condition (including severe pain) that a prudent layperson would believe threatens his or her life or limb (or with respect to a pregnant woman, the health of the woman or her unborn child) in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. Emergent care does not require prior authorization.

Once the patient is evaluated (screened) and stabilized in the emergency room, the contracted facility is responsible for notifying KP of all emergency admissions into the

hospital setting from emergent care (Observation or Inpatient services). If your hospital has an ADT pathway, there is no need to take the following steps for medical surgical admissions. Hospitals without an ADT feed, please follow the instructions below for medical surgical admission.

Calls must be received within 24 hours or the next business day of admission (Observation or Inpatient services). Failure to notify Kaiser Permanente within this time frame may result in the denial of payment for services. Contact the Telephonic Medicine Center at 303-743-KPMD (5763) to notify Kaiser Permanente of admissions (Observation or inpatient services.)

For Behavioral Health admissions to any inpatient mental health or chemical dependency services:

Denver Boulder Members:
Denver Boulder members, *page the on-call psychiatrist at* 303-203-5563.

Southern and Norther Colorado Members:
For Southern and Northern Colorado members, *y*ou are required to contact Carelon Behavioral Health (Formerly Beacon Health Options) at 1-866-702-9026 to obtain a referral for admission.

Provide the following information:

- Member Name
- Member Identification Number
- Your name
- Admitting Hospital or Facility
- Admitting Diagnosis
- Proposed Treatment and LOS
- Date of Admission

4.6.1 Peer-to-Peer Timeframes

KPCO will attempt to provide an Oral Decision Notification on all **inpatient** cases in which the UM provider has made an adverse determination. At time of the notification the UM RN will provide the UM provider phone number for a peer-to-peer discussion. The provider will have until 11:00am the following day to outreach the UM provider for a peer-to-peer. This will be the only time a peer-to-peer will be offered. If the provider does not outreach within the defined timeframe a denial letter will be issued. For **outpatient** cases that denied because of medical necessity; the peer-to-peer option will be in the adverse determination

letter when a peer-to-peer reconsideration is allowed (peer-to-peer options are not allowed for CHP+, self-funded plans, or benefit denials).

4.6.2 Concurrent Reviews of Urgent Emergent Inpatient Hospitalizations – Medicare

All inpatient Medicare cases will be concurrently reviewed. . If the case is no longer meeting medical necessity based on Medicare or other acceptable criteria, a stop payment notice will be issued to the provider.

4.7 POPULATION CARE MANAGEMENT PROGRAM

The Department of Population Management and Integrated Care provides regional oversight through partnership with the care delivery system. The program uses multiple interventions to keep members healthy, provide recommended screenings, manage chronic conditions, and support members at advanced stages of illness. Our care management services range from disease specific programs to ensuring seamless coordination of care for our members within the patient centered medical home. As we transition to the new model some of the same specific programs continue to be offered throughout the year.

The overall goal is to improve the quality and efficiency of health care for members across the continuum from wellness to prevention to managing members with complex and chronic conditions. To achieve this goal, the population health department partners with the patient centered medical home, led by the Primary Care Physician (PCP), to manage the health of these members. The Population Health team and the EMR identify members who qualify for wellness, prevention, disease management and complex case management programs.

4.7.1 Prevention and Wellness Solutions

Prevention and Wellness Solutions partners closely with all areas within PCM, Population Care Management, as well as with Primary and Specialty Care. Members are supported through the following programs:

Prevention Programs:

- Breast Cancer Screening: Proactive outreach and in-reach to women 40- through 74 years of age and those at high risk.
- Cervical Cancer Screening: Proactive outreach and in-reach to women 21 through 64 years of age.

- Colorectal Cancer Screening: Proactive outreach and in-reach to members 45 through 75 years of age and those at high risk.
- Lung Cancer screening: In-reach to members 55-80 years of age with a 30-pack year smoking history and currently smoke or have quit smoking in the past 15 years.
- Osteoporosis Program: In-reach to members >65 years of age with a fracture in last 6 months; developing primary prevention outreach program.
- Chlamydia: In-reach and outreach for sexually active females 18+ and in-reach 16/17 years of age.

Immunizations Program:

- Outreach and in-reach to members overdue for immunizations. Oversight of the CDC Vaccines for Children (VFC) Program for KPCO.

Flu Program:

- Flu Clinic in collaboration with Primary Care to provide annual flu vaccinations

Integrated Cardiovascular (CV) Health:

- Multifaceted program based on evidence-based systems which addresses and identifies each member's (age 18-75 years) health and risk of having a cardiovascular event in the next 10 years and provides preventive measures.

Tobacco Cessation Programs:

- Partnership with Colorado QuitLine that provides a supportive team for telephonic health coaching, on-line encouragement, texting programs, and mobile applications (or apps) and no charge Nicotine Replacement Therapy (NRT).
- Tobacco cessation webinars and educational self-guided podcasts/programs are free to employees/members along with no-charge NRT. For Medicare patients, there is a charge for NRT.

Adult Weight Management and Nutritional Services:

- Provides nutrition information, weight management and Medical Nutrition Therapy to members via outreach, individual consults, and group classes.

- Facilities Healthy Connections, an evidence-based Diabetes Prevention Program (year-long program based on CDC-recognized curriculum for lifestyle change).
- Focus on the prediabetic populations.

Pediatric Weight Management and Nutritional Services

- Preventive, medical nutrition therapy for complex cases, outreach to members with risk of CVD and diabetes.
- Healthy Eating/Active Living (HEAL) Programs

4.8 DISEASE MANAGEMENT AND CARE MANAGEMENT SOLUTIONS

Care Management is one of the foundations of the clinical care strategy that provides evidence-based, systematic support to the physicians and health care teams and who care for members. Care management supports care delivery to populations of members with preventive care and chronic diseases and conditions. It is explicitly designed to augment and support the foundational relationship between PCP and the member used in the PCMH model. The level of care management and frequency of touches is determined by the area of a member's health at greatest risk or impact to ongoing health.

The care management strategy is based on several key concepts, to include:

- Development of clinical pathways that direct care and interventions.
- Member registries, based on claims, encounters, laboratory, pharmacy, and more; that support monitoring.
- Customized information technology to support the program with tracking and feedback.
- Patient-centered medical home-based care that supports the physician-patient/member relationship.
- Involvement of the member in his/her own care.
- Monthly and annual performance assessments and annual population analysis regarding program resources and activities.
- Interventions and care designed and tailored to address specific and special needs of members, including social determinants health, age -specific opportunities, different abilities, and serious and persistent mental illness.

The overall goal of care management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of

available benefits and resources; and development and implementation of a care management plan with performance goals, monitoring, and follow-up.

4.8.1 Diabetes Management

Population Health partners with the patient centered medical home to ensure management of diabetes is done with a multidisciplinary approach. These teams work collaboratively with the primary care team to manage patients with diabetes and to address open care gaps.

Components of the multidisciplinary approach include:

- Utilizing the scope and skill of the different disciplines to create a person-centered care plan.
- Ensuring patients goals are incorporated in the individualized care plan.
- Information that is shared, coordinated, and integrated among health professionals and patients.
- Data systems to support better outcomes and facilitation of patient continuity of care.

4.8.2 Hypertension Program

The Hypertension Program is a regional multidisciplinary program which develops and implements evidence-based systems and processes that support the diagnosis, treatment, and management of all pediatric and adult patients with hypertension.

4.8.3 Complex Case Management

The Complex Case Management (CCM) Program consists of focused, high-intensity case management and care coordination services for members at high risk for readmissions to the hospital and multiple chronic conditions. The program is designed to ensure members receive evidence-based comprehensive assessments, care management plans, care coordination and post-hospitalization follow-up. KPCO is currently aligning programs that address chronic diseases and complex case management needs to increase enrollment and remove duplicative outreaches in the system. Within KPCO there have been several programs that address the complex needs of the members. The programs are being combined into one to ensure seamless care for our complex members and broaden the number of members that are included.

The CCM Program consists of the following objectives:

- Improve coordination with primary, specialty and /or population management teams to ensure that members with complex health conditions have the needed assistance in achieving their optimal health goals.
- Increase member satisfaction with complex care needs.

4.8.4 Senior Programs

Quality Oversight of the PATHWAAY for Seniors program*:*
Tracks and reports KPCO's strategy to improve our Health Outcome Survey metrics. The department coordinates work with the Member Experience, Outreach to Drive Care, Call Center, Physical Therapy, Behavioral Medicine Specialists, and Women's Health teams to ensure all components of the PATHWAAY for Seniors program are in place and receive continued focus – it is the foundation of our region's Medicare 5 Star geriatric strategy.

Community Specialists for all members:
The Community Specialists provide information and referral services to members who have non-medical needs that impact their social determinants of health. They support members who screen positive for any of the four domains of social health, food, finances, housing, and transportation.

Life Care Planning (LCP):
The Life Care Planning program is KPCO's advance care planning service that is free to adult members 18 years of age and older but targeted to members 55+. The goal of the program is to ensure our adult members' wishes for future health care are elicited, known and honored. The "heart" of LCP is having effective advance care planning conversations with members and their loved ones to help them reflect upon, discuss, and document their wishes around future health care decisions. This process of communication is guided by a trained facilitator who engages in a structured conversation with a member and their chosen health care agent. These conversations occur in stages – throughout a member's life and health continuum (titled First, Next and Advanced Steps).

Affinity Partner Programs and other geriatric services*:*
The Senior Programs team acts as regional lead for the Elder Abuse Mandatory Reporting Law requirements and for the VAIS (Value Add Items & Services) Program. The VAIS Program was launched in 2010 with a goal of helping Kaiser Permanente members live safely and independently in their homes. Kaiser Permanente partners with companies (Affinity Partners) who offer a variety of non-medical services and products at a discounted rate for members. These include Life Station, Mom's Meals, and Comfort Keepers. They also act as the regional lead for the Silver Sneakers program.

4.8.5 Special Needs Plan (SNP)

KFHP offers a Medicare Advantage Special Needs Plan (SNP), enrolling beneficiaries who are eligible for Medicare and benefits under Medicaid-Colorado. SNP offers enhanced benefits that address the health complexities of these high risk, vulnerable members. The objectives for these members are to improve access to care and better health outcomes by reducing hospitalizations and nursing home placements, and to improve overall health.

SNP members are assigned to local Interdisciplinary Care Teams (ICT) for each service area. These teams are responsible for care needs oversight, including pre- and post-discharge contact, transitions of care support, annual health risk assessment, care plan/patient goal development and unmet care needs, supporting CMS Medicare 5-Star work. Staff also help members with complex health needs to identify community resources that support psychosocial needs.

The SNP ICT is comprised of staff within medical, nursing and social services disciplines. The ICT roles include a Medical Director, RN, Disease Management Technicians (DMT), and a Community Specialist. The ICT collaborates with a SNP member's clinic-based primary care physician and team to coordinate care. The SNP Model of Care and the SNP Transition Program Description both provide additional program details.

4.8.6 Medical Aid in Dying (MAID)

In response to the State's passage Colorado's End of Life Options Act – Kaiser Permanente-Colorado developed and implemented a system of support for members interested in participating in Medical Aid in Dying. This program allows eligible terminally ill individuals with a prognosis of six months or less to request and self-administer medical aid-in-dying medication to voluntarily end his or her life. The program ensures patient eligibility (as dictated by Colorado law) and promotes informed consent and access to Specialty Supportive Care, as desired, for terminally ill patients.

4.9 TRANSPLANT COMPLEX CASE MANAGEMENT

All transplant services require pre-authorization prior to rendering services. Transplant authorizations are issued for three stages of a transplant case:

1. **Pre-transplant Evaluation and Care:** Services provided to a patient being evaluated for transplantation or waiting for transplantation. This stage usually begins when a patient is referred for transplantation.
2. **Transplant Period:** In most cases this period begins on the day of transplant surgery. However, Children's Colorado auth begins the day before transplant.
3. **Post-Transplant:** This stage covers outpatient follow-up services following the transplant period and may also include inpatient and home health services.

Failure to obtain authorization prior to providing services will result in a denial of payment.

4.9.1 Transplant Authorization Form

The following pages are samples of the Transplant Authorization forms. These forms are intended to provide authorization for treatment and care.
Please call the Utilization Management Department at Kaiser Permanente for questions regarding services authorized. Medical appropriateness based on Patient and Site selection transplant criteria developed by Kaiser Permanente's National Transplant Network.
If you have any questions related to the services requested on the authorization form, call the referral department at 303-636-3131.

General Referral questions for Liver, Heart, and Lung Transplant Contact:

- Blair Laigo RN, BSN (Jennifer Laigo in HC) - Liver, Pancreas, and Islet
  Phone – 303-764-5372 Fax – 303-788-1260
  Blair.B.Laigo@kp.org

- Laura Cook RN – Kidney, Heart, and Lung
  Phone – 303-788-1139 Fax: 303-788-1260
  Laura.Cook@kp.org

- Chad Roybal LPN – Kidney
  Phone 303-788-1232 Fax: 303-788-1260
  Chad.m1.Roybal@kp.org

Bone Marrow Transplant Contacts:

- Pre-transplant Coordinator: LaVinia Smith @ 240-610-5687
- Post-transplant Coordinator: Annette Wilhite @ 202-819-3771

NTS Transplant Coordinator, Solid Organs, and Out of State Transplant Contact:

- Pre-transplant coordinator: Amy Carter @ 571-651-1458

4.10 DRUG FORMULARY MANAGEMENT

Kaiser Permanente uses several drug formularies depending on the type of benefit plan and/or service area the member resides in. 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 uses closed formularies and relies upon the prescription benefit plans to determine if and how non-formulary medications will be covered. Kaiser Permanente also uses medication utilization management tools such as quantity limits, step therapy, physician specialty requirement,

day supply limitations, and prior authorization requirement for various prescription drugs. These tools may be utilized differently amongst the various drug formularies. You will find detailed information regarding the drug formularies and our various formulary management policies in the sections to follow. To obtain a copy of any of our drug formularies, please visit the provider website at: http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html. For a hard copy request, please contact Member Services at 303-338-3800 or 1-888-681-7878.

4.10.1 Drug Formularies

Kaiser Permanente uses closed formularies, which means that only those medications included in the formulary are covered under the Member's prescription drug benefit. Non-formulary or medications with limitations/restrictions may be covered but require authorization through the medication exception process as described in Section 4.11. The drug formularies are developed, updated, and maintained by groups of Kaiser Permanente physicians, pharmacists, and nurses who meet regularly to evaluate medications that are most effective, safe, and useful in caring for our members. Drugs are selected for the formulary based on several factors including safety, efficacy, and cost. Kaiser Permanente reviews and updates the formularies regularly throughout the year.

HMO Benefits (non-Medicare)	• Follow the formulary titled Colorado Commercial HMO formulary
Marketplace Plans	• Follow the formulary titled Colorado Marketplace formulary
EPO (KPIC Self-Funded and Level Funded) HMO plans	• Follow the formulary titled Colorado Self-Funded/Level-Funded/EPO formulary
Federal Employee Commercial Group	• Follow the formulary titled the Federal Employees Health Benefits (FEHB) Formulary
Postal Service Health Commercial Group	• Follow the formulary titled the Postal Service Health Benefits (PSHB) Formulary
Managed Medicaid Plan	• Follow the formulary under Medicaid titled Colorado CHP+ Formulary
Medicare Part D Benefits	• Follow the formulary titled the Kaiser Permanente Medicare Part D formulary

These drug formularies and preferred products lists can be found within the Community Provider Portal at:
http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html
Or you may obtain a copy of any of our drug formularies by contacting Member Services at 1-888-681-7878.

4.10.2 Limitations

Kaiser Permanente uses medication utilization management tools such as quantity limits, step therapy, physician specialty requirement, day supply limitations, and prior authorization requirement for various prescription drugs.

Tools utilized include:

- **Restricted to Specialty**: A drug that needs to be written by a provider specialized in the treatment of certain conditions for the drug to be covered under the member's prescription benefit. For example, budesonide (oral), a drug used for colitis, may be restricted to providers specialized in Gastroenterology.
- **Prior Authorization:** Some drugs require specific medical criteria be met prior to dispensing the drug for the members prescription benefit.
- **Quantity Limits or Quotas:** For certain drugs, Kaiser Permanente limits the amount of medication dispensed to a certain quantity per copay. For example, the migraine medication Zomig® may be limited to 18 tablets per 30-day copay. In addition, other drugs may be limited to a specific day supply. For example, Tarceva® may be limited to a 30-day supply. Lastly, in the event of a national shortage of a drug, Kaiser Permanente may limit the quantity of the drug dispensed per prescription per copayment.
- **Restricted to Benefit:** Some drugs are not covered unless the member's benefit specifically covers such medications. For example, Viagra® and similar drugs used for sexual dysfunction are not covered unless the members prescription benefit specifically states to cover them.
- **Step therapy:** Some medications require a similar therapy be attempted first. For example, before lansoprazole can be dispensed, a drug such as omeprazole must be tried first.

These tools may be utilized differently amongst the various Kaiser Permanente drug formularies. Please refer to the specific drug formulary for details. The drug formularies may be found at:
http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html

To request a Formulary Exception please refer to section 4.11 below.

In addition to the limitations listed above, Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs in the event of a drug shortage or to reduce waste or abuse. These specific quantity limitations may not be reflected in the drug formularies. For more information, please contact Kaiser Permanente Drug Information at 303-739-3550.

4.10.3 Fraud, Waste & Abuse

An important component of our prescription drug program and a requirement of the Medicare Modernization Act (MMA) is the responsibility of Kaiser Permanente to ensure the integrity of the prescription drug program. Kaiser Permanente will work closely with the Centers for Medicare and Medicaid Services (CMS), CMS' contractors, and others 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 Compliance Hotline at 1-888-774-9100.

4.10.4 Therapeutic Interchange

Kaiser Permanente utilizes Therapeutic Interchange programs to promote rational, safe, and effective drug therapy. Prescribing provider approval is required before an exchange occurs. Affiliated providers may be notified of a request for therapeutic interchange via phone, fax, email or mailed letter. This notice will be prior to the implementation of a change.

4.10.5 Generic Utilization

To ensure cost effective therapy, generic equivalents are utilized when available and appropriate. Only generic equivalents approved by the FDA are used. Pharmacies may substitute a preferred generic drug for a prescribed name brand drug unless prohibited by the physician as "Dispense as Written". Prescriptions written for brand products, with a Dispense as Written, when the generic equivalent is included on the formulary will require an authorization prior to coverage.

4.10.6 Specialty Medications

Kaiser Permanente utilizes a list of medications which are considered to be specialty drugs. These medications are typically medications which require special dispensing and/or monitoring or are high-cost medications. Some prescription drug plans may have a defined copay/coinsurance tier for specialty drugs, and these drugs may be limited to a 30-day supply. These drugs may also be restricted to being dispensed by a Kaiser Permanente pharmacy. In select cases involving rural areas, Kaiser Permanente will courier the prescription directly to the member. To verify a member's drug coverage, or to obtain or view the Kaiser Permanente Specialty Drug List please refer to the Community Provider Portal at:

http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html

4.10.7 Changes to the Formularies

Kaiser Permanente may add or remove drugs from the drug formularies throughout the year. If we remove drugs from our formularies, add limitations or restrictions, or move a drug to a higher cost sharing tier, affected members and providers will be notified prior to the effective date of the change. Regulations require that plans notify affected Medicare Part D members and providers at least 60 days before and affected FEHB and Commercial members and providers as least 30 days before the date that the change becomes effective or at the time the member requests a refill of the drug. FEHB members may continue the original drug, if the drug is not removed from the market, through the end of the year, if desired. Kaiser Permanente also notifies our pharmacy personnel of changes to the drug formularies.
In the event the FDA deems a drug on the formulary to be unsafe or the drug's manufacturer removes the drug from the market, Kaiser Permanente will remove the drug from our formulary and provide notice to members who take the drug and the providers prescribing the drug. Kaiser Permanente will also notify our pharmacies and pharmacists.

4.10.8 Formulary Addition/Deletion Requests

Our KP Pharmacy and Therapeutics Committee and Formulary Committee will consider requests to add or delete medications on our drug formularies by affiliated providers, members, and pharmacists. To download a form to submit a formulary addition/deletion request please visit the Community Provider Portal at:

http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html

4.10.9 Drug Recalls

In the event of a drug recall Kaiser Permanente will provide timely written notification to prescribing providers and affected members of a Class I recall and other recalls as deemed appropriate. Once all required recall information is available notifications by telephone or other electronic means will be sent within 48 hours. Follow up letters will be sent within 14 calendar 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 Drug Recall Review Group.
For a sample drug recall notice please visit the Community Provider Portal at:
http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html

4.11 EXCEPTION PROCESS FOR NON-FORMULARY MEDICATIONS

There may be occasions when non-formulary or medications with limitations are medically necessary to provide the best care for a Kaiser Permanente member. The Medication

Exceptions Process facilitates prescription drug coverage for medically necessary non-formulary, restricted or limited drugs. The following medication exception process exists for these instances. Note, there are different processes for Medicare Part D and Commercial HMO requests.

4.11.1 Medication Exception Request Contact Information

For Commercial benefit plans and EPO Plans (Self-Funded and Level-Funded benefit plans administered by KPIC):
You may request a medication authorization via the following methods:

- Telephone 1-866-523-0925, Monday through Friday 8:00 a.m. to 5:30 p.m.
- Fax a completed Medication Request Form to 858-357-2615
- Use Cover My Meds services at www.covermymeds.com and choosing the **Kaiser Permanente Colorado General Form** and using the **Fax Request** option
- Mail a Medication Request Form to:
  - Kaiser Permanente Pharmacy Benefits Dept.
    16601 E Centretech Parkway
    Aurora, CO 80011

A medication request form can be found on the Community Provider Portal at:
http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html

For Medicare Part D benefit plans:
You may request a medication authorization via the following methods:

- Telephone OptumRx at 1-888-791-7255
- Use SureScripts for all electronic prior authorization needs (ePA directly with OptumRx, the Pharmacy Benefits Manager)
- Use Cover My Meds services at www.covermymeds.com and choosing the Kaiser Permanente Medicare option
- Fax a request directly to OptumRx at 1-844-403-1028

4.11.2 Medication Exception Process

Timeframe:
Once received, the request will be logged and reviewed for thoroughness. If a supporting statement of medical necessity is not evident, Kaiser Permanente or OptumRx will request that one be submitted. Once Kaiser Permanente or OptumRx receives a supporting statement and all necessary information an intensive review will be performed, and a determination will be made. Determinations will be made on non-urgent requests for Commercial members within 3 business days of receipt of all necessary information and 24 hours for urgent pre-service requests. For Marketplace and Medicare Part D members

determinations will be made within 72 hours for non-urgent and within 24 hours of receipt of all necessary information for urgent pre-service requests.

Determination:
For Non-formulary medication requests approvals will be granted only if there is documentation of ineffectiveness of formulary alternatives or the reasonable expectation of harm from the use of formulary medications. In most cases, members must have failed at least two formulary alternatives or have experienced adverse effects from the use of formulary medications. For medications with limitations approval will be granted if there is sufficient documentation to meet the specific criteria related to the limitation. If a request does not meet criteria, formulary alternatives will be recommended.

Notification:
Notification of a determination will occur the same day as the determination. For approvals Kaiser Permanente may call, response via electronic PA (ePA) and/or will fax the requesting provider a notice of approval including any limitations placed on the approval. For denials Kaiser Permanente may call and/or will fax a copy of the denial notice the same day as the determination, in addition to mailing the denial notice to the requesting provider.

Rights After Denial:
When medication exception requests are denied, the member has the option of purchasing the drug at full price, requesting coverage through a secondary insurance or appeal the decision. As a provider you also have a right to request a reconsideration under most plans (a peer-to-peer conversation) which is an opportunity to discuss the denial further. You may find more detailed information regarding rights after denial in Section 4.12 below.

4.11.3 Medications Requiring Authorization

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", in addition to drugs designated as Non-Formulary or Non-Preferred within a formulary document. Non-formulary medications may be covered under the member's benefit for a different co-payment/coinsurance based on the members' specific prescription benefit coverage. However, the non-formulary drug is only covered for benefit if approved through the medication exception process.

In addition to the non-formulary drugs, authorization will be necessary if the prescription exceeds the restriction or limitation that is placed on that specific medication. For details regarding the limitations used please refer to the drug formularies on the Community

Provider Portal at:
http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html

For specific information regarding the guidelines, restrictions or limitations Kaiser Permanente utilizes please refer to the Community Provider Portal at:
http://www.providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc_db.html

4.11.4 Urgent Versus Non-Urgent Requests

There are some instances where a medication request requires an urgent decision. In these cases, please mark the request as urgent or expedited. These instances are:

- 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/non-urgent 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/non-urgent process

4.11.5 Medicare Part D Transition Process

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 to be offered when an eligible Part D drug is not on the drug formulary or if the ability for a member to receive that drug is limited. In the case of a transition, Part D plan sponsors are to cover a temporary 30-day supply (unless the prescription is written for fewer days) during the first 90 days the member's coverage is effective. 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 member's coverage is effective with Kaiser Permanente.
More details on our Medicare Part D Transition Process can be found on www.kp.org

4.11.6 Medicare Part D Exceptions

Kaiser Permanente offers a closed formulary to our Medicare Part D members. This means that most medications designated as Part D eligible are covered in one of the tiers of the members benefit, and medications not listed on the formulary are not covered without requesting an exception. There are a few medications that are specifically excluded from Part D by CMS, and these are not covered. Tier exceptions may apply to Kaiser Permanente

Part D members but are not offered for prescriptions drugs in the specialty tier of the benefit or which are not included on the formulary. The official Medicare Part D Coverage Request Form can be found on the KP Medicare Part D information page at: Coverage redetermination form (kaiserpermanente.org)

Or you may use the contact information found in 4.11.1 to submit a request.

4.11.7 Marketplace Transition Process

Colorado Marketplace plan sponsors are required to establish an appropriate transition process for new and current members to assure timely access to drugs. A transition supply is to be offered when an eligible drug is not on the drug formulary or if the ability for a member to receive that drug is limited. In the case of a transition Marketplace plan sponsors are to cover a temporary 30-day supply (unless the prescription is written for fewer days) during the first 90 days the members' coverage is effective. The transition process applies to both current members that may be affected by year-to-year formulary changes as well as new members 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 initial transitional supply is supplied.