# Table of Contents

SECTION 4: UTILIZATION MANAGEMENT ........................................................................................................ 4

4.1 **OVERVIEW OF UM PROGRAM** ........................................................................................................ 4

4.2 **MEDICAL APPROPRIATENESS** ........................................................................................................ 5

4.3 **“REFERRAL” AND “AUTHORIZATION”** .............................................................................................. 5

4.4 **DENVER/BOULDER REFERRAL AND AUTHORIZATION POLICY AND PROCEDURE** ...................... 6

4.4.1 Denver/Boulder Referral Approval Forms ...................................................................................... 7

4.4.2 Secondary Referrals ........................................................................................................................ 9

4.4.3 Inpatient and Outpatient Hospital Services ..................................................................................... 9

4.4.4 Admission to Skilled Nursing Facility (SNF) ................................................................................... 10

4.4.5 Home Health/Hospice Services ....................................................................................................... 11

4.4.6 Durable Medical Equipment (DME) ............................................................................................... 11

4.4.7 Non-Emergent Member Transfers ................................................................................................. 12

4.4.8 Palliative Care .................................................................................................................................. 12

4.4.9 Perinatal Home Care ....................................................................................................................... 13

4.4.10 Chemical Dependency ................................................................................................................... 13

4.4.11 Mental Health ............................................................................................................................... 13

4.5 **SOUTHERN COLORADO REFERRAL AND AUTHORIZATION POLICY AND PROCEDURE** ............ 14

4.5.1 HMO & POS Referral and Authorization Quick Reference Guide .................................................. 15

4.5.2 Referral for Specialist Care: No Authorization Required ................................................................. 15

4.5.3 Required Documentation When Requesting Authorization ............................................................ 15

4.5.4 Authorization Policy and Procedure for Inpatient Admission and Services ........................................... 16

4.5.5 Authorization for Outpatient Services ............................................................................................. 18

4.6 **REQUEST FOR OUT-OF-PLAN / NETWORK AUTHORIZATION** .................................................... 18

4.7 **PROVIDER RECEIVING AUTHORIZATION** .................................................................................... 18

4.8 **CONCURRENT REVIEW PROCESS** ................................................................................................. 19

4.9 **EMERGENCY ADMISSIONS AND SERVICES; HOSPITAL REPATRIATION POLICY** ................. 19

4.10 **CASE MANAGEMENT** ..................................................................................................................... 19
4.11 DISEASE MANAGEMENT .................................................................................... 20
4.12 DRUG FORMULARY........................................................................................... 20
  4.12.1 Requesting Coverage for Non-formulary or Criteria Restricted Medications ................................................................. 21
4.13 GRIEVANCES AND APPEALS............................................................................... 21
  4.13.1 Member Appeals ............................................................................................ 21
    4.13.1.1 Non-Urgent Member Appeals ................................................................. 21
    4.13.1.2 Urgent Member Appeals ......................................................................... 22
Section 4: Utilization Management

4.1 Overview of UM Program
Appropriate utilization management contributes to the success of Kaiser Permanente and its Self-Funded members/Plan Participants. The ultimate goal of utilization management is to determine what resources are necessary and appropriate for an appropriate setting and in a timely manner. Kaiser Permanente utilizes management consisting of prospective, retrospective and concurrent review programs, in which we assess the Member’s/Plan Participants medical condition using evidence based criteria for medical appropriateness and the professional provider’s judgment.

For general or specific Denver/Boulder Resource Stewardship inquiries, please call the administrative staff at 303-636-3233 or fax 303-636-3259. Staff is available and able to accept collect calls during normal business days and hours (Monday through Friday 8:30 a.m. – 4:30 p.m.). Resource Management staff can send outbound communication regarding utilization management issues during normal business hours. After normal business hours, and inside the Denver metro area, please leave a message and your call will be returned the next business day. After normal business hours, and outside the Denver metro area, please call our toll free number, 1-800-632-9700. Your message will be forwarded to our UM staff; your call will be returned the next business day.

For general or specific Southern Colorado Resource Stewardship inquiries, please call 719-867-2100 or fax 719-867-2144. Staff is available and able to accept collect calls during normal business days and hours (Monday through Friday 8:30 a.m. – 4:30 p.m.). Resource Management staff can send outbound communication regarding utilization management issues during normal business hours. After normal business hours, and inside the Southern Colorado service area, please leave a message and your call will be returned the next business day. After normal business hours, and outside the Southern Colorado service area, please call our toll free number, 1-888-861-7878. Your message will be forwarded to our UM staff; your call will be returned the next business day.

One of the key components of the Resource Stewardship program are authorization requests (urgent and non-urgent pre-service, concurrent, and post-service). These authorization requests are reviewed for member’s current eligibility, plan benefits, and medical appropriateness for internal and external inpatient/outpatient services (physician and nurse review). Once these elements are reviewed, a determination can be made regarding eligibility for coverage. To obtain a copy of the complete Resource Stewardship/UM program description, please call the Resource Stewardship Department at 303-636-3372.
4.2 Medical Appropriateness

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

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

No practitioner, provider or other staff member is rewarded for issuing denials of coverage or care. Additionally, financial incentives for Resource Management decision makers do not encourage decisions that result in underutilization.

4.3 “Referral” and “Authorization”

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

Denver / Boulder
Authorization: When the contracted provider is required to contact the Kaiser Permanente Resource Stewardship Department for approval for a specific service before the service is rendered.

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

Southern Colorado
Authorization: When the contracted provider is required to contact the Kaiser Permanente UM Department for approval for a specific service before the service is rendered. Please see section 4.7 for a detail list of services that require authorization.

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

You are required to obtain a prior authorization before service delivery, with the exception of defined emergency services. Prior written authorization ensures that only necessary and benefit-covered services are provided to our members. Authorization is provided with the use of the Referral Approval form, which is generated from Kaiser Permanente’s HealthConnect (electronic medical record) systems.

The completed Referral Approval form is sent to the affiliated provider via AffiliateLink, faxed or mailed to the affiliated provider. All information related to pre-authorization of services is coordinated through the Central Referral Center located at our Water Park III Administrative offices.

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

If services are provided to a Member/plan participant prior to receiving a written referral, it is your responsibility to obtain the written referral from the Medical Group physician before billing for such services. (Communication with the Medical Group Physician can be coordinated by contacting a Referral Review Nurse in our Resource Stewardship Management Department located at Kaiser Permanente, Waterpark III, Administrative Offices. Phone 303-636-3200 Fax 303-636-3259). Pre-authorization is required for routine care.

In some instances, when necessary, clinical information may need to accompany the Referral Approval form. In these instances, a Request to Pre-authorize Outside Service form or printed records may be attached to the approval form. Please send clinical information or results to the referring provider.

The Request to Pre-authorize Outside Service is not authorization for services or payment! It is simply a referral request from a CPMG physician. Please send your clinical information or results to the referring provider.

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

4. Contract provider bills for services 4. Contract provider bills for services

<table>
<thead>
<tr>
<th>Contact Referral Center</th>
<th>Contact Referral Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ for additional visits</td>
<td>☐ for additional visits</td>
</tr>
<tr>
<td>☐ for referral extensions</td>
<td>☐ for referral extensions</td>
</tr>
<tr>
<td>☐ for authorization for further services</td>
<td>☐ for authorization for further services</td>
</tr>
<tr>
<td>Contact Referring CPMG Physician</td>
<td>Contact Referring CPMG Physician</td>
</tr>
<tr>
<td>☐ to discuss clinical information and Findings</td>
<td>☐ to discuss clinical information and findings</td>
</tr>
</tbody>
</table>

4.4.1 Denver/Boulder Referral Approval Forms
The following two pages are samples of the Referral Approval forms. There are two different versions; The Professional Referral Approval and The Facility Referral Approval. These forms are intended to provide authorization for treatment and care. In order to be valid, the forms must be complete. If you have any questions related to the services, you have been requested to provide, call the Central Referral Center at 303-636-3131.

PROFESSIONAL REFERRAL APPROVAL

A Professional Referral Approval Form

EXPLANATION OF THE PROFESSIONAL REFERRAL APPROVAL FORM

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

**FACILITY REFERRAL APPROVAL**

_A Facility Referral Approval Form_

**EXPLANATION OF THE FACILITY REFERRAL APPROVAL FORM**

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

**4.4.2 Secondary Referrals**

Except in emergency cases, an affiliated provider may not refer Self-Funded members to another provider without obtaining prior authorization. A Referral Approvalform, authorized by a CPMG physician, is required for any secondary referrals. Please call the Central Referral Center for assistance. Failure to comply with contract terms regarding secondary referrals will result in a deduction from future compensation to cover the cost of the unauthorized services by an unauthorized provider.

**4.4.3 Inpatient and Outpatient Hospital Services**

The following hospital services require separate referrals for authorized care:

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

**Non-Emergent Hospitalization** You must obtain a pre-authorization for Kaiser Permanente members admitted or treated at your hospital. Contact the Central Referral Center at 636-3131. The Central Referral Center can confirm the referral information.
Emergency Hospitalization In the event of an emergency admission, Kaiser Permanente must be notified as soon as possible. If the emergency admission occurs after normal clinical hours (after 5:00 PM, weekends or holidays), contact the Emergency Care Management Department at 831-6683 regarding the admission.

Emergency Hospitalization - Boulder/Longmont If a member is treated in the emergency room of Boulder Community Hospital, a CPMG physician is contacted and will determine if hospitalization is appropriate. The CPMG physician generates a referral to the appropriate specialist physician.

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

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

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

4.4.4 Admission to Skilled Nursing Facility (SNF)
Nursing home stays may be planned or come upon the patient unexpectedly, and may be either short or long-term. Kaiser Permanente does not cover custodial, long-term care. Plan Sponsor benefits may vary. Please call the facility directly for placement. For Plan Sponsor payment and coverage, the care must be provided in an approved contract facility and must meet all coverage guidelines for Skilled Nursing Care as described by Medicare.

**APPROVED NURSING FACILITIES**

<table>
<thead>
<tr>
<th>Approved Facility</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berkley Manor (Used for overflow only)</td>
<td>303-320-4377</td>
</tr>
<tr>
<td>Boulder Manor Care Center</td>
<td>303-494-0535</td>
</tr>
<tr>
<td>Briarwood Health Care Center</td>
<td>303-399-0350</td>
</tr>
<tr>
<td>Cherrelyn Health Care Center</td>
<td>303-798-8686</td>
</tr>
<tr>
<td>Garden Terrace (Alzheimer’s Care Only)</td>
<td>303-750-8418</td>
</tr>
<tr>
<td>Life Care Center at Longmont</td>
<td>303-776-5000</td>
</tr>
<tr>
<td>Life Care Center at Westminster</td>
<td>303-412-9121</td>
</tr>
<tr>
<td>Life Care Center of Aurora</td>
<td>303-751-2000</td>
</tr>
<tr>
<td>Villa Manor</td>
<td>303-986-4511</td>
</tr>
<tr>
<td>Western Hills Health Care Center</td>
<td>303-232-6881</td>
</tr>
</tbody>
</table>
4.4.5 Home Health/Hospice Services
The ordering physician should call the phone numbers listed below to coordinate and order services. Most providers need a written order, signed by a physician. Additional documentation or medical information may also be required to properly care for patients in specific medical settings. These providers will contact Kaiser Permanente to follow through with the referral and pre-authorization process.

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

Adult Home Health
Home health services may be provided to Self-Funded members when skilled services are indicated and the Plan Sponsor provides for such care. Members must be homebound and require the skill of a nurse or therapist to be eligible. Providers may order these services by filling out the Home Health Referral Letter in healthconnect and faxing to one of our 2 Homehealth care agencies, Denver Visiting Nurses Association, or Interim Home Health.

Hospice Benefit
Hospice is appropriate for patients whose life expectancy is 6 months or less and have accepted the hospice philosophy of comfort care rather than cure. To request hospice services from a contracted provider call Hospice of Metro Denver at 303-321-2828 or Hospice of Boulder County at 303-449-7740 and request an evaluation visit.

Rehabilitation/Long-Term Acute Care Hospital
Most rehabilitation occurs in the home or skilled nursing facility. In catastrophic cases involving head injury or spinal cord injury, acute rehabilitation may be needed. Referrals for these services are approved Monday – Friday by calling the referral line: 303-941-4113. Inpatient Rehabilitation/Long Term Acute Care providers are as follows; Craig Hospital, Spalding, North Valley Rehab, Kindred, Select Hospital, and Mapleton Rehabilitation.

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

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

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

1. Inpatient Palliative Care Consultation:
   • Providers can call for an inpatient consultation if they believe that their patients could die within 12 months, and that an Interdisciplinary team would benefit their patients/families in discussing Goals of Care, and with symptom management.
     - St. Joe’s 303-909-2882
     - Good Sam’s 303-345-8156.

2. Home Based Palliative Care:
   • In partnership with our community agencies, a member may be eligible for Home Based Palliative Care if they have a terminal illness, are currently seeking active medical treatment, and are homebound generally, they must have the diagnoses of CHF, COPD, Cancer or ALS. To refer, please call 303-636-3329

3. Hospice:
   • Hospice is appropriate for patients whose life expectancy is 6 months or less and have accepted the hospice philosophy of comfort care rather than cure.
• To request hospice services from a contracted provider call The Denver Hospice at 303-321-2828 or HospiceCare of Boulder/Broomfield County at 303-449-7740 and request an evaluation visit.

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

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

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

4.4.11 Mental Health
If the Plan Sponsor so permits members may be permitted to self refer to a Kaiser Permanente Mental Health provider for treatment without prior authorization. Most Kaiser Permanente members are treated internally at one of the three Kaiser Permanente Behavioral Health facilities. The member’s benefit is explained at the time the initial appointment is scheduled. All treatment by contracted providers must be pre-authorized by a Behavioral Health Manager. For information regarding authorization
for services, contact the referring provider at the appropriate facility. Patient Confidentiality laws are observed.

<table>
<thead>
<tr>
<th>Facility</th>
<th>New Appointments</th>
<th>Provider Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highline Center Behavioral Health 10350 E. Dakota Ave. Denver, CO 80247</td>
<td>303-367-2900 or 303-367-2950</td>
<td>303-367-2990</td>
</tr>
<tr>
<td>Executive Center Mental Health 4851 Independence St. #270 Wheat Ridge, CO 80033</td>
<td>303-467-5850</td>
<td>303-467-5767</td>
</tr>
<tr>
<td>Hidden Lake Behavioral Health 7701 Sheridan Blvd. Westminster, CO 80003</td>
<td>303-650-3900 or 303-650-3950</td>
<td>303-650-3939</td>
</tr>
</tbody>
</table>

4.5 Southern Colorado Referral and Authorization Policy and Procedure

When the primary care provider (PCP) sends the patient for specialty services performed by another Kaiser Permanente Provider or contracted provider that is not listed in the Provider Directory, the PCP issues a referral form. You can only refer to specialists or other contracted providers who are within the network of the Member’s primary care physician. The referral form serves to assist in coordination of care and communication with the specialty care provider.

The referral form allows the PCP to:

- Authorize treatment for the Member
- Identify the services the Member requires
- Communicate pertinent information to the specialist

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

EXCEPT: Members may be permitted to self refer to any Kaiser Permanente contracted provider listed in the Provider Directory for select services.

NOTE: PPO members may self refer to Kaiser Permanente Providers within the PPO Kaiser Permanente network.
4.5.1 HMO & POS Referral and Authorization Quick Reference Guide

4.5.2 Referral for Specialist Care: No Authorization Required
Verify requested procedure(s) does not require authorization and referral specialist is a Participating Kaiser Permanente Provider in the Kaiser Permanente directory.

Verify services are covered by the Member’s health plan benefit.

Kaiser Permanente specific referral request forms can be obtained by calling the Resource Stewardship Department (719) 867-2184.

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

• Surgery
• Dietary Consultations only, (NOT Diabetic Education)
• DME services
• Gamma Knife
• Genetic Testing
• Growth Hormone Therapy
• Home Care, including Home IV therapy (except through Physician’s Offices)
• Hospice
• Hyperbaric Oxygen Therapy
• Insulin Pumps
• Perinatal Monitoring
• PET scans
• PT/OT/ST
• Pulmonary Rehabilitation
• Synagist Immunization for RSV
• Transplants
• Weight Loss Clinic
• Skilled Nursing Facility
• Memorial Hospital Wound Care
• Referrals to University Physician’s in Denver
• Referrals to Children’s Hospital in Denver
• Referrals to CPMG Physician’s in Denver
• Referrals to out of area
A medical necessity review decision and an authorization number will be issued to your office and to the member upon completion of the review process. Failure to obtain authorization prior to providing the services may result in a denial of payment.

Routine Referral Worksheet

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

The Resource Stewardship Department provides referral management, authorization, case management and concurrent review. The RN care managers are available 8 a.m.-5 p.m. Monday thru Friday and can be reached by phone at (719) 867-2184 and by fax at (719) 867-2144.

The Resource Stewardship Department may be able to provide information about and answer questions relating to the following services:
- Referral management
- Authorizations
- Emergency Department notifications
- Transfer to Skilled Nursing Facilities
- DME and Home Health services
- Ambulance Transports
- Urgent Referrals should be called to customer service at (888) 681-7878

For all UM related issues, including but not limited to, those services stated above, please call the Resource Stewardship Department at (719) 867-2184 8 a.m.-5 p.m. Monday thru Friday. You may leave a message on our after hours line by calling (719) 867-2100.

4.5.4 Authorization Policy and Procedure for Inpatient Admission and Services
All non-emergent and elective admissions require authorization.

1. Verify requested procedure(s) requires authorization, and that the service provider is a Participating Kaiser Permanente Provider.
2. Verify the service is provided by Plan Sponsor to Member by calling (877) 883-6698.
3. Fill out a Kaiser Permanente Authorization Form
4. Ensure any required information and documentation accompanies the
Authorization request for appropriateness of care. The required information and documentation may vary depending on the type of service authorized. You may be asked to provide the following information when requesting authorization.

- Kaiser Permanente provider name
- Member identification number
- Referring physician’s name
- Admitting Hospital or Facility
- Type of service being requested (ex: Inpatient surgery)
- Patient’s Diagnosis
- Significant patient history (physician notes)
- Signs/symptoms
- A copy of lab or radiology test results
- Date of service
- Diagnosis code
- Location of service
- Procedure code
- Plan of Care

<table>
<thead>
<tr>
<th>Service/Procedures</th>
<th>Documentation/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Surgery, not related to cancer</td>
<td>PCP notes, consultant notes, all pertinent information.</td>
</tr>
<tr>
<td>Breast, Mastectomy for Benign Conditions</td>
<td>Pathology reports, age at onset (for gynecomastia) and results of hormonal evaluation, actual or expected date of surgery, facility where surgery will be performed.</td>
</tr>
</tbody>
</table>

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

6. Routine authorization requests will be handled within 15 days of receipt of the referral request. Determination for urgent authorization requests will be made within 72 hours of receipt. Upon receipt of a completed authorization, Kaiser Permanente will:

- Verify Member eligibility
- Verify that the request is covered by the Member’s Plan Sponsor.
- Apply clinical criteria (medically appropriate and necessary).
- Right setting (level of care & place of service).
- Right time (treatment is not delayed).

7. Once processed and approved, the Authorization Form with the authorization number will be returned by fax to the participating PCP and to the Participating specialist. An authorization number will be generated for all admissions.
Kaiser Permanente must receive all calls and requests 24 hours prior to the admission for all elective admissions. Failure to notify Kaiser Permanente within this time frame may result in the denial of authorization and payment for services. An exception to this policy is applied when it is not medically feasible to delay treatment due to the Member’s medical condition.

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

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

4.7 Provider Receiving Authorization
Kaiser Permanente can direct the referral information to your office by AffiliateLink, fax or mail. In the event, a Kaiser Permanente member is scheduling an appointment and a completed Referral Approval form has not been received or the referral information has not been given to your office, please contact the Central Referral Center.
Upon receipt of the forwarded authorization form, you should:

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

4.8 Concurrent Review Process

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

4.9 Emergency Admissions and Services; Hospital Repatriation Policy

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

4.10 Case Management

The case management process includes arranging care in the appropriate setting for acutely ill, chronically ill, or injured Members on a case-by-case basis that
supports the achievement of realistic treatment goals. Nurses will work with the Member, Participating PCP and the Kaiser Permanente staff and Participating Kaiser Permanente Providers to develop and implement plans of care to optimize the Members’ level of independence and quality of life. They proactively assess, identify, coordinate, monitor and evaluate medical problems and service needs of the Member’s condition.

Health Coaching for our members is available through Kaiser Permanente Healthy Solutions. The member may self refer by calling (800) 574-8460 or the Kaiser Permanente contracted provider may refer the member by contacting Resource Stewardship at Denver/Boulder (303) 636-3200 or Southern Colorado (719) 867-2184.

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

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

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

Attachment D Guideline for Medical Records
Attachment E Guideline for Behavioral Health Records
Attachment F Guideline: Substance Abuse
Attachment G Guideline: Depression Summary
Attachment H Guideline: Diabetes
Attachment I Guideline: CAD

4.12 Drug Formulary
Kaiser Permanente’s drug formulary is developed, updated and maintained by a group 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. Using formulary medications helps Kaiser Permanente maintain a high quality of care for our Members while helping to keep the cost of prescription medications affordable. Kaiser Permanente reviews and updates the formulary regularly throughout the year. To obtain a copy of our drug formulary, please visit the provider website at http://www.providers.kp.org/cod/pharmacy.html.

Kaiser Permanente uses a closed formulary, which means that only those medications included in the formulary are offered under the Member’s prescription drug benefit. Non-formulary medications may be covered under the member’s benefit if the medication is approved through the formulary exception process.

### 4.12.1 Requesting Coverage for Non-formulary or Criteria Restricted Medications

If a Self-Funded Member raises a question about grievances or appeals with your office, please refer the Self-Funded Member to the Self-Funded Customer Service Department at 1-877-883-6698. The phone number is also located on the back of the Self-Funded Member’s identification card. Self-Funded Customer Service will provide information to the Self-Funded Member on grievances and member appeal rights.

### 4.13 Grievances and Appeals

If a Self-Funded Member raises a question about grievances or appeals with your office, please refer the Self-Funded Member to the Self-Funded Customer Services Department at 1-877-833-6698. The phone number is also located on the back of the Self-Funded Member’s identification card. Self-Funded Customer Service will provide information to the Self-Funded Member on grievances and member appeal rights.

#### 4.13.1 Member Appeals

Adverse benefit determinations may be appealed only by a Self-Funded Member. Self-Funded Members are made aware of their right to appeal through their Summary Plan Description (SPD) provided by the Plan Sponsor, or by calling the Self-Funding Customer Service Department, 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.

#### 4.13.1.1 Non-Urgent Member Appeals

An appeal may be initiated by the Self-Funded Member or the Self-Funded Member’s authorized representative, who may be a Provider who is authorized in writing by the Self-Funded Member to act on behalf of the Self-Funded Member.
Formal appeals should be submitted using one of the options provided below 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 contracted PCP
- Service that was denied
- Name of initial Kaiser Permanente reviewing physician, if known

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
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<tbody>
<tr>
<td>#1</td>
<td>By mailing directly to: Kaiser Permanente Insurance Company Member Appeals Unit 3701 Boardman - Canfield Rd. Canfield, Ohio 44406</td>
</tr>
<tr>
<td>#2</td>
<td>By faxing to the following number: ATTN: Kaiser Permanente Insurance Company Member Appeals Unit 614-212-7110</td>
</tr>
</tbody>
</table>

KPIC will provide a complete review of the claim and will notify the Self-Funded Member and any authorized representative of the decision in writing. If the initial denial is upheld following the review of the appeal, KPIC will send an explanation of the decision and any further appeal rights.

4.13.1.2 Urgent Member Appeals

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

Please call Self-Funded Customer Service at 1-877-833-6698 to initiate an urgent appeal.

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