Provider Manual

- Basic Health Plus and Maternity Benefits Program

KAISER PERMANENTE®

Welcome To Kaiser Permanente

It is our pleasure to welcome you as a contracted Provider for Kaiser Permanente. We want this relationship to work well for you, your medical support staff, and our Members.

This section of the Provider Manual was created to provide you and your staff with basic organizational information regarding the Basic Health Plus and Maternity Benefits Program of Kaiser Permanente. It provides a quick and easy resource for key contact phone numbers, and information regarding Kaiser Permanente .

Our Provider Contracting and Relations Department is committed to providing support to you and your staff. This includes responding to your operational inquiries and providing education on our products and plans. If at any time you have a question or concern about the information in this Provider Manual, you can reach our Provider Relations Department by calling 503-813-3376.

Welcome to Kaiser Permanente.

KAISER PERMANENTE®

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Section 12: Basic Health Plus and Maternity Benefits Program

12.1 Introduction

Basic Health Plus and Maternity Benefits Program is a Medicaid program for children under 19 and pregnant women who are Basic Health members and meet the eligibility guidelines for Medicaid. Kaiser Permanente contracts with the State's Washington Basic Health program to provide health services on a case-managed, prepaid, capitated basis to Basic Health Plus eligibles that are required to enroll in a prepaid health plan. Kaiser Permanente Basic Health Plus and Maternity Benefits Program is available to Basic Health clients in Clark & Cowlitz Counties.

This provider manual has been developed to assist you with understanding the administrative tasks related to accessing and providing comprehensive, effective, and quality medical services to Basic Health Plus members, as well as required compliance with applicable State and Federal requirements.

12.1.1 MANUAL UPDATES

This manual will be updated regularly as programs, policies, and procedures change. Updates will be distributed to all providers as they occur. The date in the lower left-hand corner of each page will reflect the most current revision date. When you receive updates, be sure to replace the existing pages in the manual immediately to assure that the information available is current.

12.1.2 KEEP US INFORMED

Please take the time to read through this manual and call us if you have any questions. If you think additional topics would be helpful, or if any information is incorrect or incomplete, please let us know by calling Provider Relations at the phone number included on the Kaiser Permanente Key Contact List. Kaiser Permanente's goal is to make this manual as helpful and easy to use as possible.

12.1.3 INTERPRETATION SERVICES

When providing services to a Basic Health Plus member enrolled in Kaiser Permanente, contracted providers are responsible for assuring that interpreter services are provided in their primary language for enrollees with a primary language other than English, and for enrollees who are deaf or hearing impaired, at no cost to the enrollee, for all interactions with the member including, but not limited to, customer services, all appointments with providers for any covered services, emergency services, and all steps necessary to file grievances and appeals.

12.1.4 AMERICANS WITH DISABILITIES ACT

Contracted providers are required to make reasonable accommodations for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all covered services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining covered services.

12.2 ***Key Contacts***

Department	Contact information	Type of Help or Information from this Department
Provider Relations	500 NE Multnomah Ste 100 Portland, OR 97232 503-813-3376	• Provider demographic updates such as tax ID change, address change, addition of providers, termination of providers • Provider education and training • Contract questions
Member Services	8AM to 6PM 503-813-2000 or 1-800-813-2000	• General enrollment questions • Eligibility and benefit verification • Co-pay, deductible and coinsurance information • Members presenting with no Kaiser Permanente identification number
Claims	Mailing Address Kaiser Permanente Building 500 NE Multnomah St. Suite 100 Portland, OR 97232 From Portland 503-813-2000 From all other areas 1-800-813-2000	• Claims - General • Claim payment status • Claims submission • Coordination of Benefits • Third Party Liability • Workers Compensation

12.3 COVERED BENEFITS AND BENEFIT EXCLUSIONS

KAISER PERMANENTE BASIC HEALTH PLUS BENEFIT COVERAGE 2008

SERVICES COVERED BY KAISER PERMANENTE

Kaiser Permanente covers the following services when they are medically necessary.
For questions about your coverage or our services, call Membership Services.

- Ambulance.
- Blood and blood products.
- Chiropractic for children (only when referred from a well-child exam).
- Dialysis.

- Eye exams.
- Family planning.
- Genetic services when necessary for diagnosis of a medical condition.
- Health education for diabetes, anemia, and heart disease.
- Home health and hospice care.
- Hospital care (including emergency room, inpatient, and outpatient services).
- Immunizations (shots).
- Interpreter for services covered by Kaiser Permanente.
- Lab and X-ray services.
- Maternity care and women's health care.
- Medical supplies and equipment.
- Office visits.
- Organ transplants.
- Outpatient mental health services (up to 12 visits per calendar year).
- Oxygen/respiratory therapy.
- Pharmacy/prescriptions/medicati on management.
- Physical, occupational, and speech therapy.
- Smoking cessation.
- Specialty care (may require a referral).
- Surgery (in the hospital or an ambulatory surgery center).
- Tissue and organ transplants.
- Urgent care.
- Well-baby, well-child, and well-adult checkups.

SERVICES COVERED BY DSHS OR KAISER PERMANENTE

Basic Health Plus members may receive the following services from Kaiser Permanente, or from the local health department or family planning clinic without a referral.

- Family planning services and birth control.
- HIV or AIDS testing.
- Immunizations (shots).
- Sexually transmitted disease treatment and follow-up care.
- TB screening and follow-up care.

SERVICES ONLY COVERED BY DSHS

These benefits are only covered by DSHS, not by Kaiser Permanente. The provider should bill DSHS for payment. The provider should receive pre-approval from DSHS.
Call DSHS 1-800-562-3022.

- Dental care with limited orthodontics.
- Eyeglasses and fitting services.
- First Steps services including: maternity support services and infant case management.

- Genetic counseling (prenatal only).
- Hearing aids.
- Interpreter services for medical visits covered by DSHS.
- Mental health services (inpatient psychiatric care, and outpatient services at Community Mental Health Centers).
- Neurodevelopmental services at DSHS-approved centers.
- School medical services for special needs students.
- Sterilizations under age 21.
- Substance abuse services including detox for alcohol and drugs.
- Transportation (other than ambulance) to and from medical appointments.
- Voluntary pregnancy terminations.

SERVICES NOT COVERED BY KAISER PERMANENTE OR DSHS

These services are not covered by Kaiser Permanente or DSHS.

- Court-ordered services.
- Diagnosis and treatment of infertility, impotence, and sexual dysfunction.
- Experimental and investigational treatment or services.
- Immunizations for international travel.
- Medical exams for Social Security disability benefits.
- Services provided while in jail.
- Orthoptic (eye training) care for eye conditions.
- Personal comfort items.
- Physical exams needed for employment, insurance, or licensing.
- Plastic surgery for cosmetic reasons.
- Reversal of voluntary surgical sterilizations.

12.4 EPSDT (EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT)

The Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) preventive health care program is designed to provide regular medical care for the purpose of early detection and treatment of health problems which, left unidentified, would impair physical, mental and emotional growth and development. EPSDT means a package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act (SSA) Section 1905(r) and the DSHS EPSDT program policy and billing instructions (see weblink below). EPSDT is required for all Medicaid eligible members 20 years old or younger.

EPSDT Screening Components

Comprehensive health, behavioral and developmental history and Testing

- Complete health and developmental history.
- Full scope physical exam.
- Immunizations.
- Lab tests.
- Screens for vision, hearing, dental/oral health, mental health, and substance abuse.
- Medically necessary services (determined to be safe and effective and not experimental) found to be necessary during the EPSDT exam.

The following services are covered when referred as a result of an EPSDT exam:

- Chiropractic services;
- Nutritional counseling; and
- Unlimited psychiatric and psychological testing evaluation and diagnosis.

The Provider shall meet all requirements under the DSHS EPSDT program policy and billing instructions (WAC 388-534-0100):
http://fortress.wa.gov/dshs/maa/download/BillingInstructions/2005Aug_EPSDT_06-41.pdf

NOTE: Do not bill DSHS for EPSDT services as they are included in the managed health care plan's reimbursement rate.
Exception: DSHS covers referrals for a mental health or substance abuse assessment outside the managed care plan. These referrals are paid separately on a fee-for-service basis. Providers must bill DSHS directly for these types of referrals.

12.5 STERILIZATIONS AND HYSTERECTOMIES

Sterilizations for Basic Health Plus enrollees must meet federal and state requirements for both males and females. All sterilizations and hysterectomies for Basic Health Plus members must be in compliance with 42 CFR 441 Subpart F. The DSHS federally approved Sterilization Consent Form (DSHS 13-364) or its equivalent must be used (attached). To download the DSHS form 13-364 or the Spanish version visit: http://www1.dshs.wa.gov/msa/forms/eforms.html

Basic Health Plus members are authorized sterilizations if they are mentally competent individuals, 21 years and older, have voluntarily given informed consent and have waited at least 30 days (72 hours following emergency abdominal surgery or premature delivery) after signing the DSHS consent form 13-364. Complete DSHS instructions are located at the following web address: http://fortress.wa.gov/dshs/maa/download/BillingInstructions/Physician-Related_Services_2006/Sterilization%20Section.pdf

NOTE: Do not bill DSHS for these services as they are included in the managed health care plan's reimbursement rate.

12.6 SPECIAL NEEDS CARE COORDINATION

The *Special Needs Care Coordinator* provides case management services for Kaiser Permanente members with special health care needs who are enrolled in Basic Health Plus. The *Special Needs Care Coordinator* will develop a care plan with the goals of coordination of care services.

Patient Population

A. The Basic Health Plus population consists of pregnant women ("S-Women's") and children under the age of 19 years ("H-Kids").
B. The sub-population eligible for Special Needs Case Management are persons having chronic and disabling medical conditions, including persons with special health care needs that meet all of the following conditions:
    1. Biologic, psychologic or cognitive basis;
    2. Have lasted or are virtually certain to last for at least one year; and
    3. Produce one or more of the following conditions stemming from a disease:
        a. Significant limitation in areas of physical, cognitive, or emotional function;
        b. Dependency on medical or assistive devices to minimize limitation of function or activities; or
        c. In addition, for children, any of the following:
            i. Significant limitation in social growth or developmental function
            ii. Need for psychological, educational, medical, or related services over and above the usual for the child's age, or
            iii. Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

What will the Special Needs Care Coordinator do?

1. The *Special Needs Care Coordinator* will contact members in the targeted population through mail and phone outreach efforts within the first three months of eligibility for services.
2. The *Special Needs Care Coordinator* develops a care plan including an assessment, planned interventions, desired outcomes/goals, and evaluation as to the degree the goals/outcomes have been met.
3. The *Special Needs Care Coordinator* will accept Basic Health Plus member referrals from Kaiser Permanente clinicians and medical office staff to provide case management or coordination services.

How can you refer members to the Special Needs Care Coordinator?
By the *Special Needs Care Coordinator* phone line and voice mailbox (503) 721-6435 or toll free 1-877-721-6435

12.7 ENROLLEE RIGHTS AND RESPONSIBILITIES

Basic Health Plus members enrolled in Kaiser Permanente have certain rights. Contracted providers must comply with any applicable Federal and State laws that pertain to enrollee rights and take these rights into account when furnishing services to enrollees (42 CFR 438.100(a)(2). Enrollee rights and responsibilities are also listed for the member in the Kaiser Permanente Basic Health Plus Member Handbook on pages 18-20. The handbook is attached.

Contracted providers shall guarantee each enrollee the following rights:

- Be treated with respect and with consideration for their dignity and privacy.
- Receive services without being treated unfairly because of their race, religion, gender, sexual orientation, national origin, cultural background, disability, age, or financial status.
- Be given full information about their care in a way that they will understand (and in a different language if they need it, at no cost to them).
- Have an interpreter provided for them free of charge.
- Be told about their health condition, treatment options, and the risks involved, regardless of cost or coverage.
- Help make decisions about their health care.
- Be actively involved in developing their treatment plan and choosing treatment options.
- Give their consent to treatment or care.
- Be supported if they choose to refuse treatment. Be told what could happen if they don't have treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Refuse to take part in medical training programs or research projects.
- Choose or change their primary care provider at any time.
- Receive services in a timely way and as close to their home as possible.
- Get a second opinion from another provider within Kaiser Permanente.
- Make decisions about their future medical care in case they are ever too sick to do so. They can tell us their wishes in documents called advance directives. This includes the right to choose a person to make medical decisions for them if they are unable to do so.
- File a grievance with Kaiser Permanente or DSHS if they disagree with how we handle their advance directive.
- Say what they think about their health care without any negative results.

- Make complaints and grievances, and get a timely answer from us. They can call Member Services to file a complaint or grievance.
- Make suggestions or complaints about our policies or the care or service we provide.
- Have their medical records and information about their health care kept private and confidential.
- Ask for copies of their medical records and ask for changes when necessary.
- They have the right to ask for a variety of information from Kaiser Permanente. They can call Member Services at 1-800-813-2000 for:
  - The names, titles, qualifications, and education of the people treating them.
  - How to choose or change their primary care provider.
  - Which primary care providers are available, their locations, qualifications, practice restrictions, and languages they speak.
  - Which specialists are available, their locations, qualifications, any practice restrictions, and languages they speak.
  - When they need a referral and how to get one.
  - An explanation of Kaiser Permanente's structure and operations.
  - How Kaiser Permanente pays for care and covered services, including how we pay doctors.
  - A copy of our grievance and appeals policy.
  - A copy of our *Notice of Privacy Practices.*

ENROLLEE RESPONSIBILITIES

Basic Health Plus members enrolled in Kaiser Permanente have these responsibilities.

Enrollees have the responsibility to:

- Treat their health care team and other Kaiser Permanente members with respect.
- Give the best information they can about their health history and symptoms so we can help them get the care they need.
- Help make decisions about their health care. Ask for more information if they need it to help them make care decisions.
- Ask questions if they do not understand any part of their medical condition or treatment.
- Help create a plan for their treatment and then follow it. Tell their provider if they have trouble following those instructions.
- Tell their provider if they are not happy with any part of their care.
- Tell us about their suggestions for improvements, concerns and complaints by calling Member Services.
- Call Member Services if they do not understand how their health plan works or what services are covered.
- Use covered health care services when they need them.
- Have both of their membership ID cards handy when they call or come in for care.
- Keep appointments and be on time. Call ahead of time if they know they will be late or have to cancel an appointment.
- Help Kaiser Permanente get their records from other providers. They may have to sign a release for this information.

- Notify Kaiser Permanente if they have other health insurance coverage. We will coordinate benefits if the other plan is their primary plan.
- Help Kaiser Permanente try to get payment from any responsible third party. For example, this could be someone who injured them in an accident. Also, if they've gotten a payment from a claim for an injury, to pay Kaiser Permanente the amount of benefits we paid to treat the injury.

12.8 AUTHORIZATIONS

12.8.1 How Members Are Referred To Outside Providers

Kaiser Permanente members almost always use providers, medical offices, and hospitals within the Kaiser Permanente Program. However, when one of our providers determines that a patient needs services not available from Kaiser Permanente, he or she may make a referral to an outside provider.

12.8.2 Routine Referral Services

The Kaiser Permanente referral center and Member Services will coordinate referrals to you and to our members. These departments will:

- Verify the member's eligibility and benefits.
- Ensure that the referral meets established criteria.
- Explain benefit and referral limitations.
- Provide all necessary eligibility and billing information on the "Referral for Outside Medical Care" authorization form, including the name of the referring provider, the reason for a referral, the patient's diagnosis, the number of authorized visits, the date after which the authorization expires, pertinent billing information, and supplemental charges.

When Kaiser Permanente authorizes you to treat one of our members, the referral form always specifies the authorized provider as well as the number of authorized outpatient visits or inpatient treatments. Kaiser Permanente will pay for only those services specified on the referral form.
Attached to the Authorization will be the following statement:
"Please note this patient is a Basic Health Plus member. Only services that are included on the enclosed authorization will be reimbursed."

12.8.3 How To Obtain Authorization To Provide Additional Care

You will need a separate authorization to:

- Provide additional services.
- Extend the authorized time for treatment.
- Send the patient to any other provider for treatment. To obtain this separate authorization, you must contact the Kaiser Permanente referring physician or our Referral Center.

12.8.4 SECOND OPINION

Basic Health Plus members are authorized for a second opinion regarding their health care from a qualified health care professional within our network, or outside our network if we determine that our network is unable to provide for a qualified health care professional, at no cost to the enrollee. This is not to be construed to require us to cover unlimited second opinions, nor to require us to cover any services other than the professional services of the second opinion provider (42 CFR 438.206(b)(3).

12.8.5 WOMEN'S HEALTH CARE SERVICES

Basic Health Plus female enrollees have the right to direct access to a women's health specialist within our network, without a referral, for covered care necessary to provide women's routine and preventive health care services in accord with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2). Women's health care services includes maternity and childbirth care, routine exams such as pap tests, advice on birth control or mammograms, treatment of reproductive problems, and follow-up care. Women's health care services also includes any appropriate service for other health problems discovered and treated during the course of a visit to a women's health care participating provider for a women's service, which is in the provider's scope of practice.

12.8.6 AUTHORIZATION NOT A GUARANTEE OF PAYMENT

Please remember that a referral does not guarantee payment for services. Kaiser Permanente cannot pay for services if:

- The member's Kaiser Permanente benefits do not cover services that you have provided.
- You provide treatment after the expiration date on the referral form.

12.9 ELIGIBILITY

The purpose of this section is to define the tools and processes available to contracted practitioner/provider offices when verifying if a patient is eligible for covered services under the Basic Health Plus & Maternity Benefit Program.

Verifying eligibility each time a patient presents him/herself at the practitioner's office helps avoid providing services to someone who may not be eligible. After receiving a health plan identification card, members may lose their eligibility, change health plans, or attempt to access services fraudulently.

Please Note:
In addition to verifying eligibility with Kaiser Permanente, providers must verify eligibility with Basic Health Plus, contact at 1-800-335-1062.

RESOURCES AVAILABLE TO VERIFY ELIGIBILITY

MEMBER IDENTIFICATION CARDS

Kaiser Permanente issues a health plan identification (ID) card to each member. The

identification card for the appropriate benefit plan/type of coverage is included in the New Member Enrollment Packet. Members are instructed to present their ID card each time they access services.

For recordkeeping purposes, a practitioner's office may wish to photocopy the front and back of the ID card and place it in the member's medical record file at the initial visit and at subsequent visits only if information has changed.

All ID cards include:

- member name
- health record number (HRN)
- local Kaiser Permanente telephone numbers
- emergency information for non-Kaiser Permanente facilities

Note: **Do not assume that because a member has a Kaiser Permanente ID card that their coverage is in effect. Please call Kaiser Permanente to verify the validity of the ID Card.**

TELEPHONE VERIFICATION OF ELIGIBILITY

Kaiser Permanente Eligibility may always be verified by calling the Kaiser Permanente Member Services Department between the hours of 8 a.m. and 6 p.m., Monday through Friday, in the Portland area 503-813-2000, and from all other areas 1-800-813-2000.

Basic Health's telephone eligibility/enrollment system is automated. The automated system will give you eligibility information on a Basic Health Plus member as of the previous day.

HEALTH RECORD NUMBER

When new members enroll in the Kaiser Permanente Health Plan, a unique Health Record Number (HRN) is assigned to each applicant and each of his/her dependents. The HRN is used by Kaiser Permanente to identify the member in the various computer databases. It is also listed on the member identification card.

If a member leaves the Kaiser Permanente Health Plan and re-enters at a later date, s(he) retains the same HRN although employer and other information may change. The HRN enables medical records/history to be tracked for all periods of enrollment.

Note: The Health Record Number should be used as the "Patient ID" when submitting claims or encounter data.

12.10 PRACTITIONER RIGHTS

Complaint And Patient Care Problem Resolution

Kaiser Permanente will make every effort to assist a practitioner in the resolution of complaints they may have regarding administrative or contractual issues, or problems encountered while providing health care to Kaiser Permanente members.

The first step in resolving these issues is to contact the Kaiser Permanente Provider Relations Department at the telephone number listed on the Key Contact List on page 3. The Provider Relations representative will instruct the practitioner on the appropriate course of action or procedures that must be followed for resolving the issue.

Appeal Processes

Appeal processes to decisions made with respect to administrative and clinical issues are available to both members and practitioners. When practitioners and members are notified that a decision, which may generate an appeal, has been made, the process for submitting an appeal is included in the notification letter.

The grievance and appeal process for Kaiser Permanente Basic Health Plus members is outlined in the attached DSHS Member Satisfaction Procedure, and also in the Kaiser Permanente Basic Health Plus Member Handbook, pages 21-25. These members have specific grievance and appeal rights as per 42 CFR 438.414 and 42 CFR 438.10(g)(1).

Peer Review Procedures

During the quality management processes, practitioners are monitored for:

- Quality Indicators
- Under/over utilization of medical services
- Member access to care
- Member complaints of both administrative and quality of care issues
- Compliance with Kaiser Permanente policies and procedures

In any of these situations, when Kaiser Permanente feels a practitioner's performance may adversely affect the care provided to members, they may take corrective actions which could range from provider education, implementation of corrective action plans and monitoring performance, or termination from the Kaiser Permanente Network.

If a practitioner is subject to any disciplinary actions, they have the right to request a review of the action through the Kaiser Permanente Peer Review Procedure.

12.11 ADDITIONAL PRACTITIONER RESPONSIBILITIES

12.11.1 Primary Care Practitioner Responsibilities

The primary care practitioner (PCP) is responsible for providing primary care services and managing all health care services needed by the Kaiser Permanente members assigned to them. Maintaining an overall picture of a member's health and coordinating all care provided is key to helping that member stay healthy while effectively managing appropriate use of health care resources.

When providing primary health care services and coordination of care, the PCP must:

- Provide for all primary health care services that do not require specialized care, such as routine preventive health screenings and physical examinations, routine immunizations, routine/urgent/emergent office visits for illnesses or injuries, medical management of chronic conditions not requiring a specialist, and hospital medical visits. This includes the provision, coordination and supervision of healthcare to meet the needs of each Basic Health Plus enrollee.
- Obtain all required preauthorizations and refer the member to affiliated Kaiser Permanente specialists and ancillary providers for medically necessary diagnosis or treatment.
- Assure members understand the scope of specialty or ancillary services which have been authorized and how/where the member should access the care.
- Communicate a member's medical condition, treatment plans, and approved authorizations for services with appropriate specialists and other providers.
- Admit members as needed to Kaiser Permanente Network hospitals, rehabilitation facilities, skilled nursing facilities, or outpatient surgical facilities.

12.11.2 SPECIALIST RESPONSIBILITIES

When a member has been referred to a specialist, s(he) is responsible for diagnosing that member's medical condition and managing treatment of the condition until it has been resolved or the specialist's services are no longer medically necessary. The scope of the services rendered are limited to those related to the medical condition or problem for which the member was referred by primary care practitioner and medically necessary services related directly to the condition/problem.

In providing specialty care, the practitioner must:

- Verify that the PCP has preauthorized services being requested and the member is still eligible for coverage under the Kaiser Permanente Health Plan.
- Deliver all authorized medical health care services related to the member's medical condition as defined by the authorization.
- Deliver all medical health care services available to members through self-referral benefits.
- Determine when the member may require the services of other specialists or ancillary providers for further diagnosis or specialized treatment, or if the member requires admission to a hospital, rehabilitation facilities, skilled nursing facilities, or outpatient surgical facilities.
- Provide verbal or written consult reports to the member's PCP for review and inclusion in the member's primary care medical record.

12.11.3 RESPONSIBILITIES APPLICABLE TO ALL CONTRACTED PRACTITIONERS

Follow Kaiser Permanente's administrative policies and procedures, and clinical guidelines when providing or managing health care services within the scope of a member's benefit plan.

Uphold all applicable responsibilities outlined in the Kaiser Permanente Basic Health Plus Enrollee Rights & Responsibilities Statement when providing care to Basic Health Plus members. The Enrollee Rights and Responsibility Statement is listed on pages 8-10, and is also outlined in the Kaiser Permanente Basic Health Plus Member Handbook, pages 18-20.

Maintain open communications with a member to discuss treatment needs and recommended alternatives, regardless of benefit limitations or Kaiser Permanente administrative policies and procedures. This includes not initiating contact or marketing independently to potential Basic Health Plus members. All enrollee information and marketing materials are developed at the 6th grade reading level and shall have the prior written approval of Kaiser Permanente.

Provide for timely transfer of member medical records if a member selects a new primary care practitioner, or if the practitioner's participation in the Kaiser Permanente Network terminates.

Obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCS 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and State and Federal Medicaid rules concerning advance directives (WAC 388-501-0125 and 42 CFR 438.6(m)); and when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

Participate in Kaiser Permanente Utilization Management and Quality Improvement Programs. Kaiser Permanente Utilization Management and Quality Improvement Programs are designed to identify opportunities for improving health care provided to members and the related outcomes. These programs may be related to complaint or grievance resolution, disease management, preventive health, or clinical studies. Kaiser Permanente will communicate the programs and extent of practitioner participation through updates to the provider manual, practitioner newsletters, and special mailings. Practitioner participation is critical to the successful outcomes of these programs. Participation may include:

Working with Kaiser Permanente and patients with specific medical conditions to implement disease management programs which can improve the health and lifestyle of participating patients.

Providing access to Kaiser Permanente member medical records:

During the recredentialing process and biennial medical record reviews to determine compliance with Kaiser Permanente medical recordkeeping standards.

During referral authorization, case management, and/or grievance and appeal resolution processes to determine the medical necessity of medical services and coordination of care.

To assess medical care rendered and their outcomes for the purposes of clinical or preventive health studies, and to evaluate overall quality of care.

During the resolution of member complaints and grievances related to health care services.

Responding to surveys to assess practitioner satisfaction with Kaiser Permanente and identify opportunities for improvement.

Serving on a Quality or Utilization Management Committees, or acting as a specialist consultant in the utilization management or peer review processes.

12.11.4 REPORTING PRACTICE CHANGES

Contracted practitioners in the Kaiser Permanente Affiliated Network are responsible for notifying the Provider Relations Department of any changes that would affect member access.

Practice changes that must be reported are:

PRACTICE RELOCATIONS WITHIN THE DIVISION'S GEOGRAPHIC SERVICE AREA
Notify Kaiser Permanente's Provider Relations Department at least 30 days prior to relocation in order to allow for the transition of members to other practitioners.

If the practitioner relocating to a new site provides primary care, OB/GYN or high volume specialty services, Kaiser Permanente will conduct a medical record and office site review prior to allowing members to be seen at that site.

PRIMARY CARE PRACTITIONERS (PCPS)
Kaiser Permanente has developed standards regarding geographic access for members to their PCPs. Changes in practice locations may affect accessibility by members, particularly if the practitioner moves to a location beyond the geographic access standard. In those situations, members will be given the opportunity to select a new PCP. Kaiser Permanente will notify PCPs of any enrollment changes resulting from relocation.

SPECIALISTS
Specialists must also notify Kaiser Permanente of any changes in relocation in order for members to be provided with the most current information and referrals for specialty services to be made within a reasonable geographic distance from the member.

ADDING NEW PRACTICE SITES
Notify Kaiser Permanente's Provider Relations Department at least 30 days prior to opening an additional practice site.

Before members can be seen at a new site where primary care, OB/GYN or high volume specialty services are provided, Kaiser Permanente will conduct a medical records and office site review. Please refer to Section 9, Medical Record and Office Site Reviews, for additional information regarding the review process.

PRACTICE CAPACITY LIMITS AND REOPENING

Notify Kaiser Permanente's Provider Relations Department at least 30 days prior to closing the practitioner's practice to new patients.

Since patient volumes fluctuate, also notify Provider Relations immediately when the practitioner is accepting new patients again.

Please refer to Section 5, "Member Access to Care" for additional information regarding panel closures.

12.11.5 VOLUNTARY TERMINATIONS

Mail and fax notification to the Provider Relations Department no less than 90 days prior to the date the practitioner will terminate their agreement with Kaiser Permanente.

A Provider Relations representative will contact the practitioner to review the termination process that includes transferring members and their medical records to other contracted practitioners.

Advise the Provider Relations Representative of any members who are in the course of treatment. Kaiser Permanente will implement a transition plan to move those members to other practitioners with as little disruption as possible to their medical treatment.

> Kaiser Permanente will notify all affected members of the change in practitioners so the member can be assured of continuity of care and appropriate access to services.
>
> > ***Note:* If a practitioner must terminate their contract due to circumstances beyond their control, Provider Relations should be notified as soon as possible in order to begin the immediate transition of members as described above.**

12.11.6 PROHIBITION ON ENROLLEE CHARGES FOR COVERED SERVICES

Basic Health Plus Medicaid enrollees are protected from payment for covered services in a manner compliant and consistent with SSA 1932(b)(6), SSA 1128B(d)(1) and WAC 388-502-0160 that limits the billing of Medicaid enrollees both within and outside the network for covered services.

12.11.7 CARE OUTSIDE THE SERVICE AREA

Services must be covered for Basic Health Plus enrollees temporarily outside of the service area or who have moved to another service area but are still enrolled with KFHP Basic Health Plus. This includes services that are neither emergent nor urgent but are medically necessary and cannot reasonably wait until enrollee's return to the service area. This does not include non-symptomatic services (i.e. preventive care) outside the

service area. Pre-authorization for such services may be requested as long as the wait times specified in Appointment Standards are not exceeded.

12.11.8 CONTRACTUALLY REQUIRED APPOINTMENT STANDARDS

Providers are required to comply with appointment standards that are no longer than the following:

Non-symptomatic (i.e. preventive care) office visits shall be available from the enrollee's PCP or an alternative practitioner within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or children and adult immunizations.

Non-urgent, symptomatic (i.e., routine care) office visit shall be available from the enrollee's PCP or an alternative practitioner within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

Urgent, symptomatic office visits shall be available within 48 hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

Emergency medical care shall be available 24 hours per day, seven days per week.

12.11.9 FRAUD AND ABUSE

Providers must comply with KFHP's DSHS approved fraud and abuse policies and procedures (attached).

12.11.10 DSHS MEMBER SATISFACTION PROCEDURE (BASIC HEALTH PLUS ENROLLEE GRIEVANCE AND APPEALS PROCESS)

The grievance and appeal process for Kaiser Permanente Basic Health Plus members is outlined in the attached DSHS Member Satisfaction Procedure, and also in the Kaiser Permanente Basic Health Plus Member Handbook, pages 21-25. These members have specific grievance and appeal rights as per 42 CFR 438.414 and 42 CFR 438.10(g)(1).