



Provider Manual

▪ Kaiser Permanente Oregon Plus



Welcome To Kaiser Permanente

This section of the Provider Manual was created to help guide you and your staff in working with Kaiser Permanente's Oregon Plus Member eligibility and benefit determination policies and procedures. It provides a quick and easy resource with contact phone numbers, detailed processes and site lists for services related to Member eligibility and benefit determination. This Section also briefly describes our products.

If, at any time, you have a question or concern about the information outlined in this Section of the Provider Manual, you can reach our Member Services department by calling *503-813-2000* or *1-800-813-2000*.

Table of Contents

SECTION 11: KAISER PERMANENTE OREGON PLUS	3
11.1 INTRODUCTION.....	4
11.1.1 Manual Updates.....	4
11.1.2 Keep Us Informed.....	4
11.1.3 Interpretations Services.....	4
11.1.4 Americans with Disabilities Act.....	5
11.2 Key Contact List.....	5
11.3 Benefit Plans, Covered Benefits and Benefit Exclusions.....	6
11.4 Authorizations.....	10
11.5 Eligibility- Resources to Verify Eligibility.....	11
11.6 Member Rights and Responsibilities	13
11.7 Practitioner Responsibilities.....	15
11.7.1 Primary Care Practitioner Responsibilities.....	15
11.7.2 Specialist Responsibilities.....	16
11.7.3 Responsibilities Applicable to All Practitioners.....	16
11.7.4 Reporting Practice Changes.....	18
11.8 Practitioner Rights.....	21
11.8.1 Complaint and Patient Care Problem Resolution.....	21
11.8.2 Appeal Process.....	21
11.8.3 Peer Review Procedures.....	21
11.8.4 ENCC.....	21
11.9 Oregon Health Plan Patient Responsibility Waiver.....	23
11.10 Sterilization and Hysterectomy	24
11.11 Women’s Healthcare Services.....	24
11.12 Second Opinion.....	24

Section 11 Kaiser Permanente Oregon Plus

11.1 INTRODUCTION

Kaiser Permanente Oregon Plus designates Kaiser Permanente Health Plan coverage for members who receive medical assistance in the Oregon Health Plan. Kaiser Permanente contracts with the state's Division of Medical Assistance Programs (DMAP) to provide health services on a case-managed, prepaid, capitated basis to Oregon Health Plan (OHP) eligibles who are required to enroll in a prepaid health plan.

Kaiser Permanente Oregon Plus is available to Oregon Health Plan clients in Clackamas, Marion, Multnomah, and Polk 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 Kaiser Permanente Oregon Plus members.

11.1.1 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.

11.1.2 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 located in Section 2.

Kaiser Permanente's goal is to make this manual as helpful and easy to use as possible.

11.1.3 INTERPRETATION SERVICES

When providing services to an Oregon Health Plan 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. Kaiser Permanente has written information available in the prevalent non-English languages in each service area. Written materials are also available in alternative formats for members with special needs, such as visual limitations or limited

reading proficiency. Contact Member Services who can facilitate interpreter services or contact our Referrals Department at 503-813-4560 for help in arranging for an interpreter.

11.1.4 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.

11.2 KAISER PERMANENTE KEY CONTACT LIST

The following table lists departments and individuals that are able to assist you with questions regarding your association with Kaiser Permanente or providing services to Kaiser Permanente members. Please feel free to call them as the need may arise.

KAISER PERMANENTE NORTHWEST KEY CONTACT LIST

Type of Information or Inquiry	Contact(s)	Telephone/Fax
<p>Claims</p> <ul style="list-style-type: none"> • Claims - General • Claim payment status • Claims submission • Coordination of Benefits • Third Party Liability • Workers Compensation 	<p>Mailing Address Kaiser Permanente Building 500 NE Multnomah St. Suite 100 Portland, OR 97232</p>	<p>From Portland 503-813-2700 From all other area 1-800-813-2000</p>
<p>Member Services</p> <ul style="list-style-type: none"> • Eligibility Verification • Identification Cards (Member) • Special Member Services 		<p>From Portland 503-813-2000 From all other areas 1-800-813-2000</p>
<p>Provider Relations</p> <ul style="list-style-type: none"> • Contract issues and questions • Provider Orientation • Provider Manuals 	<p>Provider Contracting and Relations 500 NE Multnomah St. Suite 100 Portland, OR 97232</p>	<p>From Portland 503-813-3376 From all other areas 1-800-813-2000</p>
<ul style="list-style-type: none"> • Member Relations 		<p>From Portland 503-813-4480 From all other areas 1-800-813-2000</p>
<ul style="list-style-type: none"> • Exceptional Needs Care Coordinator 		<p>503-721-6435</p>

11.3 Benefit Plans

Kaiser Permanente Oregon Plus Benefit Coverage for 2008:

	KP is Prepaid to Provide All These Services	Part of FFS Medicaid Program (ALL providers bill OHP directly for these services.)	Provided by Others Under Their Own Capitated Contract w/ OHP
PROFESSIONAL			
• Abortion		X	
• Office Visits	X		
• Emergency Room	X		
• Chemical Dependency	X		
• SNF visits/oversight	X		
• MH			X
OUTPATIENT FACILITY			
• Laboratory	X		
• Diagnostic Imaging	X		
• Emergency Room	X		
• Chemical Dependency	X		
• Abortion		X	
• Mental Health			X
• DME/Prosth/Supplies	X		
• PT/OT/Speech	X		
INPATIENT FACILITY			
• Acute hospitalization (if admitted through ER, then ER facility cost becomes part of INPT claim)		X	
• CD Residential		X	
• Abortion		X	
• Mental Health			X
• Acute Detox			X
• SNF up to 20 Days	X		

	KP is Prepaid to Provide All These Services	Part of FFS Medicaid Program (ALL providers bill OHP directly for these services.)	Provided by Others Under Their Own Capitated Contract w/ OHP
HOME HEALTH/HOME IV	X		
HOSPICE	X		
*PHARMACY *Prescription drugs and drug classes covered by Medicare D for fully dual eligible clients are not a covered service."			
<ul style="list-style-type: none"> • Generic/Brand <u>except</u> category 7&11 drugs 	X		
<ul style="list-style-type: none"> • Category 7&11 Generic/Brand (\$2/\$3 copay) 		X	
<ul style="list-style-type: none"> • Methadone 	X		
<ul style="list-style-type: none"> • SNF Patients 	X		
<ul style="list-style-type: none"> • 3-day emergency supply 	X		

AMBULANCE			
<ul style="list-style-type: none"> • Emergency transport 	X		
<ul style="list-style-type: none"> • Non-emergency transport <p>This service cannot be arranged through Kaiser Permanente. Please call the DMAP transportation brokers listed below. DMAP Medical Transport (503) 802-8700 Portland area- Tri Met Ride Service at (503) 802-8725 Salem Area- Trip Link at (503) 315-5520</p>			X
VISION			
<ul style="list-style-type: none"> • Exams (adults \geq 21: No limit if medically indicated but refraction only exams limited to 1/24 months. Child: No limit even on refraction only.) 	X		
<ul style="list-style-type: none"> • Hardware (adults \geq 21: 1 pair frames&lenses or 2 pairs of contacts every 24 months. Child: limit on pairs of glasses.) 	X		
HEARING AIDE			
<ul style="list-style-type: none"> • Adult: 2 aides every 5 years. Child: 2 aides 	X		

every 3 years.			
• Covered up to supplier's price to carrier	X		
DENTAL			X

Mental Health Counseling

The following organizations provide mental health counseling services to Kaiser Permanente Oregon Plus members:

Clackamas County Mental Health

503-742-5300

Mid-Valley Behavioral Care Network

503-585-4991

Verity Integrated Behavioral Healthcare Systems

(Multnomah County Behavioral Health)

503-988-3999

Dental care

The following organizations provide dental care services to Kaiser Permanente Oregon Plus members:

Capitol Dental Care

503-585-5205

Hayden Family Dentistry Group

541-242-8929

Managed Dental Health Care of Oregon

1-800-538-9604

Multicare Dental

(Multnomah County Health Department)

503-988-3711

ODS Community Health

1-800-852-5195

Willamette Dental Group

1-800-460-7644

Kaiser Permanente Oregon Plus Excluded Benefits for 2008:

Administrative Exams	Not Covered
Circumcision- newborn or adult	Not Covered
Cosmetic- Primary purpose to improve appearance	Not Covered
Experimental Investigational Treatment	Not Covered
Fertility Treatment	Not Covered
Immunizations for Travel	Not Covered
Medical Care While Patient Incarcerated	Not Covered
Pain Center Eval and Treat	Not Covered
Plasma Infusions for Multiple Sclerosis	Not Covered
Radial Keratotomy	Not Covered
School-Based Health Services	Not Covered
Services/items for Patient Convenience	Not Covered
Treatment of sexual performance/impotence	Not Covered
Whole Blood Products	Not Covered

11.4 Authorizations

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 the Kaiser Permanente, he or she may make a referral to an outside provider.

ROUTINE REFERRAL SERVICES

The Kaiser Permanente referral center and Membership 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 an Oregon Health Plan recipient. Kaiser Permanente provides outpatient medical services for this patient. Only services that are included on the enclosed authorization will be reimbursed. Inpatient services are not covered through Kaiser Permanente and must be preauthorized through the Division of Medical Assistance Program.”

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.

11.5 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 Kaiser Permanente Health Plan.

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 the Division of Medical Assistance Programs (DMAP) for Kaiser Permanente Oregon Plus Members. Contact DMAP at 1-800-522-2508.

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

Kaiser Permanente
Oregon Plus
Providers must verify member's eligibility with OMAP before each visit.

Health record number: _____ Gender: _____

 **KAISER PERMANENTE.**

Northwest Region

**In a medical emergency call 911
or go to the nearest emergency facility.**

Advice and information on getting nonemergency care are available 24 hours a day. Call your medical office during business hours. After hours, call Membership Services and select the option for the advice nurse.

Membership Services: 1-800-813-2000
Portland: 503-813-2000
TTY: 1-800-735-2900

Language interpretation services: 1-800-324-8010

If you are hospitalized outside the Kaiser Permanente network, you must notify us as soon as possible. Call 503-571-4540 or, toll free, 1-877-813-5993.

This card is for identification only and is not transferable. To be entitled to coverage, the cardholder must be a member complying with all provisions of the service agreement.

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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. (503) 813-2000.

DMAP's telephone eligibility system is referred to as the Automated Information System (AIS). AIS is a computer system that keeps information about a person's eligibility for services covered by the Division of Medical Assistance Programs (DMAP). You may call AIS at 1-800-522-2508. Lines are open Monday through Saturday 3am to midnight and Sunday from 6am to 7pm.

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.

11.6 Member Rights and Responsibilities

Kaiser Permanente Oregon Plus members have certain rights and responsibilities. Contracted providers must comply with any applicable Federal and State laws that pertain to member rights and take these rights into account when furnishing services to members (42 CFR 438.100 (a) (2)). Member rights and responsibilities are also listed in the Kaiser Permanente Oregon Plus Member Handbook on pages 21-24.

Contracted Providers shall guarantee each Kaiser Permanent Oregon Plus member the following rights:

- To be treated with dignity and respect.
- To be treated by health care providers the same as other people seeking benefits to which they are entitled.
- To choose a primary care provider or primary medical office, and to change if they would like.
- To refer him/herself directly to mental health, chemical dependency, or family planning. The member does not need a referral from their Kaiser Permanente primary care provider for these services.
- To have a friend, family member, or advocate present during appointments and at other times, as needed, within clinical guidelines.
- To be actively involved in the development of their own treatment plan.
- To be given information about his/her conditions and about services that are covered and not covered under his/her plan, so that they can make informed decisions about their treatment.
- To consent to treatment or to refuse services. To be told what can occur because of their decision, except for services ordered by a court.
- To receive written materials describing their rights, responsibilities, benefits available, how to access services, and what to do in an emergency.
- To have written materials explained to them so that they can understand them.
- To receive services that are necessary and reasonable for the provider to diagnose what is causing their symptoms.
- To receive services that are covered under the Oregon Health Plan, that meet generally accepted standards of practice, and are medically appropriate.
- To obtain covered preventive services.

- To have access to urgent and emergency care services 24 hours a day, seven days a week.
- To receive referrals to specialists for medically appropriate services that are covered by their health plan.
- To have their records maintained, including documentation of their conditions, the services they have received, and the referrals they have been given.
- To have access to their records unless laws do not allow it.
- To transfer a copy of their clinical record to another provider.
- To prepare a statement of their wishes for treatment, including their right to accept or refuse medical, surgical, alcohol, drug, or mental health treatment. To prepare and sign legal directives and powers of attorney for health care established under Oregon and federal law.
- To receive a notice in writing before a service is denied or a benefit or service level is changed, unless federal or state regulations do not require such a notice.
- To know how to make a complaint, grievance, or appeal to their health plan and to receive a response.
- To request an administrative hearing with the Department of Human Services (DHS).
- To receive interpreter services as covered under Oregon law.
- To receive a notice in a timely manner if their appointment has to be cancelled.

Kaiser Permanente Oregon Plus members have the following responsibilities:

- To choose a health plan and a primary care provider or medical office or help with their assignment to one.
- To treat Kaiser Permanente administrative staff and providers with respect.
- To be on time for appointments made with providers.
- To call in advance if they need to cancel an appointment or if they expect to be late.
- To seek health exams and preventive services regularly from their primary care provider or medical office.
- To use their primary care provider or medical office to diagnose and provide their care except in an emergency.
- To ask their primary care provider or Kaiser Permanente medical office for a referral before they go to a specialist unless self-referral to the specialist is allowed.
- To use urgent and emergency care when it is appropriate. To notify Kaiser Permanente within 72 hours when they have had emergency care.
- To give accurate information that will be put into their medical record.
- To help their provider or medical office get their records from other providers. They may have to sign a release of information.
- To ask questions when they do not understand conditions, treatments, and other issues related to their care.
- To use information to make informed decisions about treatment before they receive it.

- To help their primary care provider create their treatment plan.
- To follow prescribed treatment plans they and their provider have agreed to.
- To tell the provider that their care is covered under the Oregon Health Plan before services are received and to show their primary care provider or Kaiser Permanente staff their DMAP Medical Care Identification form if they are asked for it.
- To tell their DHS case worker when they change their address or phone number.
- To tell their DHS case worker if they become pregnant and to notify their DHS case worker of the birth of their child.
- To tell their DHS case worker if any family members move into or out of their household.
- To tell their DHS case worker if they have any other insurance.
- To pay for services they request that are not covered under the Oregon Health Plan.
- To pay their monthly OHP premium on time if so required.
- To help Kaiser Permanente try to get payment from any third party resources available (for example, someone who has injured them in an accident). Also, to pay Kaiser Permanente the amount of benefits Kaiser Permanente has paid to treat their injury if they have received a payment from a claim for that injury.
- To let Kaiser Permanente know about any issues, complaints, or grievances they have.
- To sign an authorization for release of medical information in a timely manner so that their DHS case worker and /or Kaiser Permanente can get information that they need to respond to a request for an administrative hearing.

11.7 Practitioner Responsibilities

11.7.1 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.

- 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.

11.7.2 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 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.

11.7.3 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 Member Rights & Responsibilities Statement when providing care to members.

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 DMAP members.

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.

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.

11.7.4 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 Kaiser Permanente'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.

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.

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.

11.8 PRACTITIONER RIGHTS

11.8.1 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 in Section 2. The Provider Relations representative will instruct the practitioner on the appropriate course of action or procedures that must be followed for resolving the issue.

11.8.2 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.

11.8.3 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.

Please refer to the other sections of your Kaiser Permanente Provider Manual for additional information regarding situations that may lead to required corrective actions or contract termination.

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.

11.8.4 Exceptional Needs Care Coordination

Oregon Health Plan requires that a case management nurse is available to help and support OHP members. OHP calls this nurse an "Exceptional Needs Care Coordinator" or "ENCC."

What will the ENCC do?

1. Contact new members who are part of Medicaid's Aged, Blind and Disabled program and Old Age Assistance program to:
 - Help them to select a PCP.
 - Assess them for current medical problems to get them transitioned over to KP clinicians without a break in care.
 - Assess them for psychosocial issues that may need coordination with Kaiser Permanente's Social Work Department or their OHP Case Worker.

2. The ENCC will accept OHP member referrals from KP clinicians and medical office staff to provide case management or coordination services.

What sort of issues would be reasons to refer a KP Oregon Plus member to the ENCC?

1. Coordination of care with OHP providers of mental health and dental services.

2. Assist the KP Social Work Department and OHP Case Worker in coordinating external resources.

3. Repeated missed appointments - the ENCC will evaluate the reason and try to assist the patient to obtain care.

4. Disruptive or abusive patients - the ENCC will coordinate with our KP Social Work Department, the OHP Case Worker and possibly the OHP Mental Health plan to help manage the patient or if that is not possible, to get them removed from our panel.

5. Case Management for OHP patients with complex medical conditions.

How can you refer members to the ENCC?

- By the ENCC phone line and voice mailbox (503)721-6435.

11.9

**OREGON HEALTH PLAN
PATIENT RESPONSIBILITY WAIVER**

The following services are not covered benefits under the Oregon Health Plan:

Medical and/or surgical services

Condition/Diagnosis

I, _____
 (Patient name and OHP Identification number)

Understand that the services listed above, for the condition listed above, are not covered for payment by Kaiser Permanente (Health Plan Name) or the Division of Medical Assistance Programs under the Oregon Health Plan. If I or my dependent chooses to obtain the services listed above on this date, I agree to be personally responsible for paying the financial charges for these services. The estimated amount that I may be responsible for is \$ _____, not to exceed \$ _____.

PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

WITNESS DATE

* If you have Medicare, you may have additional appeal rights. Contact _____ (Health Plan Name) Customer Service at _____ (Phone Number) for further information.

11.10 Sterilizations and Hysterectomies

Sterilizations are a Covered Service only when they meet the federally mandated criteria in 42 CFR 441.250 to 441.259. A signed DMAP consent form is required in accordance with OAR 410-130-0580 unless the Circuit Court of the DMAP member's county has issued a Sterilization Order. This form must be signed 30 days prior to the sterilization and must be submitted to the state after the sterilization procedure. DMAP Member Representatives are not allowed to give consent for sterilizations.

The Consent to Sterilization form (DMAP 742) can be found at:

<http://209.85.173.104/search?q=cache:fP0RHVF6WGwJ:dhsforms.hr.state.or.us/Forms/Served/OE0742.pdf+Omap+742&hl=en&ct=clnk&cd=1&gl=us>

Hysterectomies are a Covered Services according to the criteria in 42 CFR 441.255 to 441.256 only when provided for medical reasons unrelated to sterilization. All hysterectomies, except radical hysterectomies, require prior authorization. All provisions regarding informed consent must be met when performing a hysterectomy. The DMAP Hysterectomy Consent form (DMAP741) is required unless: 1) The DMAP Member was already sterile prior to the procedure, in which case the performing or attending physician must certify in writing that the DMAP Member was already sterile and state the cause of the sterility; or 2) The procedure was performed in a life-threatening emergency situation, in which case the performing or attending physician must certify in writing prior consent by the DMAP Member was not possible and state the nature of the life-threatening emergency circumstances. Do not use the Consent to Sterilization form (DMAP 742) for hysterectomies.

11.11 Women's Health Care Services

Female DMAP Members must be provided with direct access to women's health specialists within the Participating Provider Panel for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the DMAP Member's designated PCP if the designated PCP is not a women's health specialist.

11.12 Second Opinion

DMAP Members are entitled to a second opinion from a qualified Participating Provider. If a qualified Participating Provider cannot be arranged, then it may be arranged for the DMAP Member to obtain the second opinion from a Non-Participating Provider, at no cost to the DMAP Member.