# Kaiser Permanente Northwest Medicaid Provider Manual 2024

## Medicaid Programs

This provider manual is updated regularly by our provider relations representatives in collaboration with contract managers, other Kaiser Permanente departments, and informed by local market Plan partner(s) and/or State regulatory agencies. Its intent is to provide our network providers/vendors with useful information on accessing the Kaiser Permanente system and to share Kaiser Permanente's expectations of network providers.

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# Section 14:Kaiser Permanente Medicaid Programs

## 14.1 Oregon Health Plan

The Oregon Health Plan (OHP) is the State of Oregon assistance program that provides Medicaid covered services in the State of Oregon as well as health care benefits for other qualified individuals eligible for OHP. The eligibility effective date for an OHP recipients is retroactive to the recipient's application date. OHP recipients are eligible for OHP for 12 months and must reapply at the end of each 12-month period. Children 0-5 have continuous coverage until age 6. If recipients do no reapply before their eligibility ends, their OHP eligibility may terminate until the reapply.

### 14.1.2 Applying for the Oregon Health Plan

Application for eligibility is coordinated by the Oregon Health Authority (OHA) offices. People may also apply directly at oregonhealthcare.gov or through the OHP Application Center by calling toll-free 800-359-9517. Eligibility screeners at federally funded health centers in Oregon are available to help with the application process and answer questions. You can also get help from local OHP Application Assisters using the following link: Find Local Community Partners.

### 14.1.3 Health Plan Enrollment

Kaiser Permanente participates in a variety of different Coordinated Care Organizations (CCOs). To CCO members, the appearance is one of Kaiser Permanente being a "partner." All material they will receive is branded per their respective CCO.

The following are a list of CCOs that Kaiser Permanente participates in:

Health Share of Oregon

PacificSource Community Solutions Marion/Polk County

PacificSource Community Solutions Lane County

When applying for OHP, recipients may choose an available CCO in their area. Those who do not are appointed randomly to their CCO by OHA.

OHA enrolls OHP recipients shortly after they become eligible for OHP. Recipients can be enrolled with their health plan on the first day of the month or on any Monday.

Counties have either mandatory Managed Care Organization (MCO) or CCO enrollment, with some exceptions, or voluntary enrollment with a health plan.

If an OHP recipient is not enrolled in a CCO, he/she receives services through the fee-for-service Medicaid program. The fee-for-service program is managed by OHA. Claims for these members must be submitted to OHA for processing.

### 14.1.4 Verifying Eligibility – no "believe me" policy for Medicaid

Only services rendered to eligible members will be reimbursed. Thus, it is the provider's responsibility to verify patient's eligibility on the date of service. Failure to do so can result in

denial of payment. To check patients' eligibility use OneHealthPort or please contact the Kaiser Permanente's eligibility verification line at 503-813-2000 or 1-800-813-2000.

### 14.1.5 Provider Enrollment

Licensed Providers and Healthcare Professionals in the State of Oregon who serve OHP enrollees must comply with all Oregon statutes and regulations for provisions of Medicaid services. For information on how to enroll, providers can call the OHA at 1-800-336-6016 (option 6), or they can find information on the OHA website at the following link: https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx. In addition, participating providers must abide by the following Oregon Administrative Rules (OARs):

- OHP Administrative Rule Books
- CCO Administrative Rulebook
- OHP General Rules
- **Oregon Administrative Rule** 410-120-1260 Provider Enrollment

### 14.1.6 Provider Enrollment Information Changes and Renewal

For information update such as contact information, taxonomy information, licensure and more, fill out the Provider Update Form OHP 3035. Updates must be submitted to OHP within 30 days of changes. Fax the completed forms to 503-378-3074.

Renewed licenses should be faxed to Provider Enrollment at 503-947-1177. For additional questions please call Provider Enrollment at 800-336-6016 (option 6) or email: provider.enrollment@dhsoha.state.or.us.

### 14.1.7 Qualified Medicare Beneficiaries (QMB) and Balance Billing

The QMB program is a Medicaid program that assists Medicare members in paying for their medical care. You may bill QMB members for services that Medicaid and Medicare Part A or B do not cover, if the client understands that they are not covered. Refer to the "Services that are Limited or Not Covered by OHP" section above.

Federal Law prohibits providers from balance billing Medicaid members and QMBs for services that are covered. Please refer to the Social Security Act and the OHP Do's and Don'ts for additional details.

### 14.1.8 Member Rights and Responsibilities

Providers must abide by the Oregon Health Plan Member Rights and Responsibilities and the Kaiser Permanente Member Rights and Responsibilities.

Members receive their rights and responsibilities statement in their Plan Partner member handbook at onboarding and with each subsequent revision of the handbook. It is also made available online. New and existing providers can review the members' rights and responsibilities statement in the members' respective CCO handbook or online. Providers are required to ensure

members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language, and ability to understand.

**Members' rights**

- You have the right to be treated like this:
- Be treated with dignity, respect, and consideration for your privacy.
- Be treated by providers the same as other people seeking health care.
- Have a stable relationship with a care team that is responsible for managing your overall care.

**Have the right to:**

- Not have people hold you down or keep you away from others as a way to:
  - Make you do something you don't want to do
  - Make caring for you easier for your providers
  - Punish you for something you said or did

**Have the right to get this information:**

- Materials explained in a way and in a language you can understand.
- Materials that tell you about CCOs and how to use the health care system. (The Member Handbook is one good source for this.)
  - HealthShare 2024 Member Handbook
  - PacficSource Community Solutions Member Handbook
- Written materials that tell you your rights, responsibilities, benefits, how to get services, and what to do in an emergency. (The Member Handbook is one good source for this.)
- The information specified in 42 CFR § 438.10(f)(2)-(3) and 42 CFR § 438.10(g), if applicable, within thirty (30) days after Plan receives notice of the Member's Enrollment from OHA within the time period required by Medicare. Plan shall notify all Members of their right to request and obtain the information described in this section at least once a year.
  - In instances where Plan's Members have obtained an MA or Dual Special Needs Plan through one of Plan's Affiliates, Plan may choose to send integrated Medicare and Medicaid materials such as a Medicare/Medicaid summary of benefits and
- Information about your condition, what is covered, and what is not covered, so you can make good decisions about your treatment. You can ask for this information in a language and a format that works for you.
- A health record that keeps track of your conditions, the services you get, and referrals.

- Have access to your health records.
- Share your health records with a provider.

- Written notice of a denial or change in a benefit before it happens. You might not get a notice if it isn't required by federal or state rules.
- Written notice about providers who are no longer in-network.
- Notification in a timely manner if an appointment is cancelled.

**Have the right to get this care:**

- Care and services that put you at the center. Get care that gives you choice, independence, and dignity. This care will be based on your health needs and meet standards of practice.
- Services that consider your cultural and language needs and are close to where you live. If available, you can get services in nontraditional settings.
- Care coordination, community-based care, and help with care transitions in a way that works with your culture and language. This will help keep you out of a hospital or facility.
- Services that are needed to know what health condition you have.
- Help to use the health care system. Get the cultural and language support you need. This could be:
    - Certified or qualified health care interpreters.
    - Certified traditional health workers.
    - Community health workers.
    - Peer wellness specialists.
    - Peer support specialists.
    - Doulas.
    - Personal health navigators.
- Help from CCO staff who are fully trained on CCO policies and procedures.
- Covered preventive services.
- Urgent and emergency services 24 hours a day, 7 days a week without approval or permission
    - Referrals to specialty providers for covered coordinated services that are needed based on your health.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

**Have the right to do these things:**

- Choose your providers and to change those choices.
- Have a friend, family member, or helper come to your appointments.
- Be actively involved in making your treatment plan.
- Agree to or refuse services. Know what might happen based on your decision. A court-ordered service cannot be refused.
- Refer yourself to behavioral health or family planning services without permission from a provider.
- Make a statement of wishes for treatment. This means your wishes to accept or refuse medical, surgical, or behavioral health treatment. It also means the right to make directives and give powers of attorney for health care, listed in ORS 127.
- Make a complaint or ask for an appeal. Get a response from Kaiser Permanente when you do this.
- Ask the state to review if you don't agree with Kaiser Permanente's decision. This is called a hearing.
- Get free certified or qualified health care interpreters for all non-English languages and sign language.

**Responsibilities as an OHP member**

**Members must treat others this way:**

- Treat Kaiser Permanente staff, providers, and others with respect.
- Be honest with your providers so they can give you the best care.

**Members must tell OHP this information:**

Call OHP at 800-699-9075 (TTY 711) when you:

- Move or change your mailing address.
- If any family moves in or out of your home.
- Change your phone number.
- Become pregnant and when you give birth.
- Have other insurance.

**Members must help with their care in these ways:**

- Choose or help choose your primary care provider or clinic.
- Get yearly checkups, wellness visits, and preventive care to keep you healthy.
- Be on time for appointments. If you will be late, call ahead or cancel your appointment if you can't make it.

- Bring your medical ID cards to appointments. Tell the office that you have OHP and any other health insurance. Let them know if you were hurt in an accident.
- Help your provider make your treatment plan. Follow the treatment plan and actively take part in your care.
- Follow directions from your providers or ask for another option.
- If you don't understand, ask questions about conditions, treatments, and other issues related to care.
- Use information you get from providers and care teams to help you make informed decisions about your treatment.
- Use your primary care provider for tests and other care needs, unless it's an emergency.
- Use in-network specialists or work with your provider for approval if you want or need to see someone who doesn't work with Kaiser Permanente.
- Use urgent or emergent services appropriately. Tell your primary care provider within 72 hours if you do use these services.
- Help providers get your health records. You may have to sign a form for this.
- Tell Kaiser Permanente if you have any issues or complaints or need help.
- Pay for services that are not covered by OHP.
- If you get money because of an injury, help Kaiser Permanente get paid for services we gave you because of that injury.

Reference: Oregon Administrative Rule (OAR) 410-141-3590- MCE Member Relations: Member Rights and Responsibilities

Free to ask the Oregon Health Authority Ombudsperson for help with problems at: 503-947-2346 or toll free 877-642-0450, TTY 711.

### 14.1.9 Nondiscrimination Statement

Kaiser does not Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

Kaiser does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment

Kaiser must follow state and federal civil rights laws. We cannot treat people unfairly in any of our programs or activities because of a person’s:

Age

Color

Disability

Gender identity

Marital status

National origin

Race

Religion

Sex

Sexual orientation

Health Status and need for services

Everyone has a right to enter, exit, and use buildings and services. They also have the right to get information in a way they understand. This includes receiving written material in other formats that work for you (large print, audio, Braille, etc.) If you don't speak English, this also includes free interpretation services and written information/material in the language you speak. Kaiser will make reasonable changes to policies, practices, and procedures by talking with you about your needs.

To report concerns, get help filing a grievance, or to get more information, please contact our Member Services at 503-813-2000..

Members have a right to file a complaint with the Oregon Health Authority (OHA) Office of Civil Rights. Contact that office in one of these ways:

Web: www.oregon.gov/OHA/EI

Email: OHA.PublicCivilRights@odhsoha.oregon.gov Phone: (844) 882-7889, 711 TTY

Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750, Portland, OR 97204

Members also have a right to file a complaint with the Bureau of Labor and Industries Civil Rights Division. Contact that office in one of these ways:

Phone: (971) 673-0764

Email: boli_help@boli.oregon.gov

Mail: Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St., Suite 1045, Portland, OR 97232

Members also have a right to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR). Contact that office one of these ways: Web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Email: OCRComplaint@hhs.gov

Phone: Toll free (800) 368-1019, (800) 537-7697 (TDD)

Mail: Office for Civil Rights, 200 Independence Ave SW Room 509F HHH Bldg Washington DC 20201

### 14.1.10 Equal Access to Facilities, Services and Programs

Kaiser Permanente is committed to providing equal access to its facilities, services and programs to all individuals, including those with disabilities. Equal Access to KP Facilities, Services, and Programs. Actions KP takes to provide equal access to its facilities, services, and programs to all individuals, including those with disabilities, include but are not limited to the following:

Kaiser Permanente constructs and maintains Kaiser Permanente Facilities so that they are accessible to and usable by individuals with disabilities. These features include but are not limited to: entrances, paths of travel, rest rooms, elevators, drinking fountains, parking, etc. Kaiser Permanente provides each facility with an accessibility checklist to ensure compliance with ADA accessibility requirements

### 14.1.11 Member appeals and grievance rights

An enrollee has the right to file a grievance, appeal or request a contested case hearing.

**Timing**

1. A member may file a grievance at any time. The CCO will notify the member, within 5 business days from the date of the receipt of the grievance, of one of the following: (a) A decision on the grievance has been made and what the decision is; or (b) That there will be a delay in the contractor's decision, of up to 30 days. The written notice will specify why the additional time is necessary. Member and provider may file complaint with the CCO, or the state.
2. If the CCO denies, stops or reduces a medical service a provider has ordered, the CCO will mail the enrollee a Notice of Adverse Benefit Determination (NOABD) letter explaining why the decision was made. If the member or provider disagrees with the decision, they may file an appeal within 60 days from the date of the NOABD. The member will receive a Notice of Appeal Resolution (NOAR) letter within 16 days with the CCO's decision.
3. If the CCO fails to adhere to the required time frames for processing standard/extended appeals, the member is deemed to have exhausted the CCO's appeal process and my initiate a contested case hearing.
4. If the decision is upheld, the member can file a contested case hearing request with CCO or OHA, no later than 120 days from the date of the Notice of Appeal Resolution (NOAR). Or, if the CCO fails to adhere to the notice and timing requirements, OHA may deem that the CCO appeals process is exhausted.

**Filing procedures/requirements**

1. A member, their provider, or member representative with written consent, may file a grievance, a CCO level appeal, and may request a contested case hearing.
2. A member may file a grievance, either orally or in writing, with OHA or the CCO (i.e., Plan Partner).
3. A provider acting on behalf of the member, and with the member's written consent, may file an appeal, either orally or in writing.
4. If the member and their provider believe that the member has an urgent medical problem that cannot wait for a regular appeal, an expedited appeal can be requested. Members should include a statement from their provider or ask the provider to call the CCO to explain why it is urgent. If the CCO agrees that it is urgent, a decision will be made in 72 hours.

5. The CCO can assist the enrollee with filing grievances and appeals.
6. A contested case hearing can be requested by submitting FORM MSC 0443. This form will be included with the NOAR or may be requested by calling the CCO or OHA.
7. Include as parties to the contested case hearing: The member and the representative, CCO and the legal representative of a deceased member's estate.
8. A member, or provider, who believes that taking the time for a standard resolution of a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function may request an expedited contested case hearing.

A member has the right to request continuation of benefits that the CCO seeks to reduce or terminate during an appeal or state fair hearing filing.

**Timing**

Request must be made within 10 days after the date of the Notice of Adverse Benefit Determination (NOABD), or the intended effective date of the Action proposed in the notice.

The CCO shall continue the member's benefits if:

1. The member or member's representative files the appeal or administrative hearing request in a timely fashion;
2. The appeal or administrative hearing request involves the termination, suspension or reduction of a previously authorized service;
3. The services were ordered by an authorized provider;
4. The period covered by the original authorization has not expired;
   AND
5. The member files for continuation of benefits in a timely manner.

If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal is in process, the benefits must be continued until one of the following occurs:

1. The member withdraws the appeal or contested case hearing;
2. The member does not request a contested case hearing within 10 days from when the CCO mails the Notice of Appeal Resolution (NOAR) to the member's appeal;
3. A contested case hearing decision adverse to the member is made;
4. OHA issues an appeal decision adverse to the member;
5. The authorization expires or authorization service limits are met.

If the final resolution of the appeal or contested case hearing is adverse to the member (upholds the CCO's original decision), the CCO may recover from the member the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section. Notification of updates to these procedures and timeframes will be provided within five (5) Business Days after approval of such updates by OHA.

### 14.1.12 PCP Assignment and Selection

Use our doctor and location search to:

- Learn about each practitioner's gender, certifications, specialties, languages spoken, interests, and more
- Select a personal physician. Members can use the online tool Help with finding doctors and locations for help.

In some areas, members may not be able to choose your doctor online. Don't worry — just call your local Member Services or Physician Selection Services, and a service specialist will help the member make your choice.

If members don't choose a personal physician, we may help by selecting one. If the member wants to make a switch, they can change their doctor at any time and for any reason.

### 14.1.13 Member Complaints

Kaiser members have the right to file complaints in accordance with Oregon Administrative Rules (OAR) and Centers for Medicare and Medicaid Services (CMS) guidelines. Kaiser encourages members and providers to resolve complaints, problems, and concerns directly with those involved. However, Kaiser provides formal procedures for addressing complaints and problems when they cannot be resolved otherwise.

If they are not resolved, OHP members have the right to request a hearing by OHA through its hearing process. Members may call Member Relations to file their complaint.

Providers may not discourage any member from using any aspect of the grievance and appeal system, nor is the following acceptable behavior from providers:

a. Encourage any member to withdraw a grievance, appeal, or contested case hearing request already filed.
b. Us the filing or resolution of a grievance, appeal, or contested case hearing request as a reason to retaliate against a member or as a basis for requesting member disenrollment.
c. Take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal.

Violation of these provisions may cause corrective action to be taken.

**Resolving Complaints at Kaiser**

All Grievances and Appeals will be resolved by the Program representative as expeditiously as the member's health requires either verbally or in writing, as allowed/required by state and federal regulations. The timeframe for resolution will in no event exceed that which is required by state and federal regulations. *(in accordance with policy NW.MR.009)*

**Oregon Health Plan Complaint Forms**

If a Kaiser OHP member is uncomfortable contacting Kaiser, they may submit a complaint to the OHA using Oregon Health Plan Complaint Form 3001 or contact the OHP Client Services Unit at 800-273-0557 (TTY 711).

**Restraint and Seclusion**

In compliance with federal and state law, Kaiser recognizes that each member has the right to be free from any form of restraint or seclusion as means of coercion, discipline, convenience or retaliation.

**Restraint** is:

- Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely.
  OR
- A drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom or movement, which is not a standard treatment or dosage.

**Seclusion** is the involuntary confinement of a patient in an area or room from which the patient is physically prevented from leaving.

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, clinic staff or others from harm. They type of restraint or seclusion used must be the least restrictive e intervention that will be effective to protect the member, clinic staff and others from harm. In addition, the nature of the restraint or seclusion must take into consideration the age, medical and emotional state of the member. Undre no circumstance may a patient be secluded for more than one hour.

The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by this policy, the provider policy and in accordance with state law. In addition, the use of restraint or seclusion must be in accordance with the order of a physician or other licensed health care professional who is responsible for the care of the patient.

### 14.1.14 Services that are Limited or Not Covered by OHP

Participating Providers can access the Prioritized List of Health Services provided by OHP to stay informed about the services that are covered by the plan. Simply click on "Current Prioritized List". A list of Past Prioritized Lists and Pending prioritized lists are also available online for access.

All actively enrolled OHP members assigned to Kaiser Permanente are not liable for any cost sharing for OHP-covered services.

You must contact Kaiser Permanente Regional Referral Center at 503-813-4560 and get referral authorization before services are rendered or determine whether a service requires prior authorization. Failure to do this may result in denial of payment. Prior written authorization ensures that only necessary and benefit-covered services are provided and that you, in turn, are paid for those services. Authorization is provided with the use of the Prior Authorization Request form.

Most services require prior authorization. To verify benefit coverage for prior authorization, contact Member Services at 503-813-2000. *(refer to Section 4 of the Provider Manual for further information)*

As a contracted provider, you're expected to provide timely feedback to Kaiser Permanente on the outcome of consultations, plans of care, and further testing and follow-up.

Kaiser Permanente provides diagnostic, imaging, and lab testing for members at Kaiser Permanente medical facilities, so please direct members to one of these facilities. For a current list of plan facilities, go to kp.org or call the Kaiser Permanente Member Services Department, Monday through Friday, 8:00 a.m. to 5 p.m., 1-800-813-2000, to request a Kaiser Permanente Medical Facility Directory.

Kaiser Permanente will pay for covered health care services only when Kaiser Permanente Referral and Authorization requirements are met.

Members must be informed of non-covered services prior to service delivery. Members who choose to receive non-covered services by OHP must be given a service cost estimate and must complete and sign the "OHP Client Agreement to Pay for Health Services" form (OHP 3165).

### 14.1.15 Services covered by the Oregon Health Plan (OHP)

**Prioritized List of Health Services**

OHP covers a comprehensive set of medical services defined by a list of close to 700 diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Services Commission. This list is called the Prioritized List of Health Services. The state legislature determines funding levels for OHP benefits.

To determine if a service is covered by OHP, check the prioritized list on the MMIS portal which may be found at the following link: *or-medicaid.gov/ProdPortal/*

Diagnosis and treatment pairs that are above the line are covered by OHP and Kaiser. Diagnosis and treatment pairs that fall below the line are not covered benefits of either.

OHP or Kaiser. Services below the line generally include conditions that improve by themselves, conditions for which no effective treatments are available or cosmetic treatments.

The list can also be accessed by calling OHA Provider Services at 800-336-6016. If a service is not covered by OHP and a provider decides that treatment is essential, an authorization request may be submitted with relevant documentation to the Regional Referral Center.

Requests for non-covered services are denied automatically if additional information is not included with an authorization request.

**Medicaid Services and/or items Covered by Kaiser Permanente**

- Primary care and preventive services
- Specialty services
- Emergency and Post Stabilization services
    - Emergency services are a physical, mental or oral/dental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, rather than a Health Care Professional, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman

or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

- **Post-stabilization services:** services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under some circumstances to improve or resolve the condition. [1]

- Maternity care
- Family planning
- Gender affirmative care
- Abortion (voluntary pregnancy termination)
- Inpatient hospital and extended care (hospice and skilled nursing facility)
- Prescriptions
- Laboratory and X-ray
- Durable medical equipment and supplies
- Home health
- Physical, occupational and speech therapy
- Ambulance transportation
- Vision services
- Sterilizations & hysterectomies
- Health Related Social Needs Benefits
- *Mental health services
- *Substance use disorder services

**Please note*: *For additional details related to Behavioral Health services and or Substance use disorder services, please refer to our metro area behavioral health providers page at careoregon.org/bhproviders*

### 14.1.16 Language Access

All providers must make interpreting services available to Kaiser members.

Services must be available during and after hours for consultation and provision of care. While interpreting services can be scheduled with short notice, to ensure coverage, please schedule as soon as a member makes an appointment.

Interpreting services should be performed by certified and qualified interpreters. The interpreters may be on staff or scheduled through a Kaiser approved vendor. They may operate on site, over the phone or via computer screen. Interpreting should not be provided by a member of the patient's family. Members should never be asked to bring their own interpreter.

Kaiser's interpretive services cover the following occurrences:

- Onsite medical, dental or behavioral health appointments
- Scheduling or rescheduling appointments
- Appointment reminders
- Appointment follow-ups
- Relaying test results
- Registration for procedures/admissions

Use only our approved vendors.

Kaiser pays for interpreting services so that members can access their covered health care services and benefits. We have contractual arrangements with approved vendors. Please use them when serving our members. (Be sure to verify that your patient is covered by the Oregon Health Plan.)

To schedule services through Kaiser's contracted vendors, visit our NW Interpreter and Translation Services website.

### 14.1.17 Electronic member communications

Members have access to MyKP and can receive communications through the app or via text if they opt in to receive text messages. Kaiser may use electronic communications for purposes described only if:

- The recipient has requested or approved electronic transmittal;
- The identical information is available in written, hard copy format upon request;
- The information does not constitute a direct notice related to an Adverse Benefit Determination or any portion of the Grievance, Appeal, Contested Case Hearing or any other Member rights or Member protection process;
- Language and alternative format accommodations are available; and
- All HIPAA requirements are satisfied with respect to personal health information

### 14.1.18 Not charging members a cancellation or urgent appointment fees

Medicaid members cannot be held financially liable for missed and cancelled appointments, as well as fees for emergent or urgent appointments in accordance with 42 CFR § 447.50 through 42 CFR § 447.90 and the applicable Oregon Administrative Rules.

### 14.1.19 Right to Second Opinion

OHP members have the right to seek a second opinion at no additional cost to them. Members can request the name of another expert from their current provider, or if they don't feel comfortable asking their doctor, they can contact Member Relations at 800-813-2000, their local medical society, or the nearest university hospital. If a member chooses an out-of-network provider, they will need an authorization prior service being rendered.

### 14.1.20 Access to Care Standards

Oregon Health Plan members shall be seen, treated, or referred as within the following timeframes:

- Emergency Care-Immediately or referred to an emergency department depending on the member's condition.
- Urgent care-Within 72 hours or as indicated in initial screening, in accordance with OAR 410- 141-3515 section 14(b) and OAR 410-141-3840.
- Well care-Within 4 weeks or within the community standard. Non-Urgent behavioral health treatment within 2 weeks from date of request.

Specialty Care Providers' Responsibilities for Kaiser Permanente's Access to Care Standards. Also see section 6.2 of this manual.

- Emergency care: patient must be seen immediately or referred to ER, as appropriate.
- Urgent complaint: same day care, or within 24 hours of member's request
- Regular or routine care: within 14 days of member's request
- Preventive routine care: within four (4) weeks of member's request

Dental Care access standards outlined in the Dental Provider Manual, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services, including for dental health, the member is seen, treated, or referred within the following timeframes:

- Emergency dental care: Seen or treated within twenty-four (24) hours.
- Urgent dental care:
    - Within one (1) week or as indicated in the initial screening for pregnant individuals
    - Within two (2) weeks or as indicated in the initial screening for children or non-pregnant individuals
- Routine dental care:
    - Within four (4) weeks, unless there is a documented special clinical reason that makes a period of longer than 4 weeks appropriate for pregnant individuals.
    - Within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than 8 weeks appropriate for children or non-pregnant individuals.

Behavioral Health and Substance Use Disorder access standards can be found in Health Share of Oregon's provider manual and PacificSource Health Plans provider manual.

### 14.1.21 Family Planning Services- OAR 410-130-0585

Interrupted pregnancy/abortions procedures can be performed at Kaiser Permanente but payment for the service is billed to OHP. In general, OHP covers both elective and therapeutic abortions. However, coverage would ultimately depend on the member's OHP benefit package as well as the diagnosis code and treatment code pairings to determine if the service is covered per the OHP Prioritized List. In addition, the following services are covered without a referral:

- Annual exams

- Contraceptive education and counseling to address reproductive health issues
- Laboratory tests
- Radiology services
- Medical and surgical procedures, including tubal ligations and vasectomies
- Pharmaceutical supplies and devices.

Family Planning Services must be billed using the appropriate diagnosis code with modifier -FP. This applies to:

- Annual Family Planning Visits
- Comprehensive Contraceptive Counseling
- Contraceptive Supplies
- Family Planning Methods

### 14.1.22 Sterilizations & Hysterectomies

**Requirements**

Oregon law requires that informed consent be obtained from any individual wanting voluntary sterilization (tubal ligation or vasectomy) or a hysterectomy.

It is prohibited to use state or federal money to pay for voluntary sterilizations or hysterectomies that are performed without the proper informed consent. Therefore, Kaiser cannot reimburse providers for these procedures without proof of informed consent. A Consent to Sterilization form must be completed and available in the members health record. For more information about claims for these procedures, please see the "*Section 5 Billing and Payment*" section.

**Voluntary Sterilization**

For a tubal ligation or vasectomy, the patient must sign the Consent to Sterilization form (available in both English and Spanish) at least 30 days, but not more than 180 days, prior to the sterilization procedure.

Exceptions:

- In case of premature delivery, the sterilization may be performed fewer than 30 days but more than 72 hours after the date that the member signs the consent form. The member's expected date of delivery must be entered.
- In case of emergency abdominal surgery, the sterilization may be performed fewer than 30 days but more than 72 hours after the date of the individual's signature on the consent form. The circumstances of the emergency must be described.

The person obtaining the consent must sign and date the form. The date should be the date the patient signs or after. It cannot be on the date of service or later. The person obtaining consent must provide the address of the facility where consent was obtained.

If an interpreter assists the patient in completing the form, the interpreter must also sign and date the form.

The physician must sign and date the form either on or after the date the sterilization was performed.

Fully and accurately completed consent forms, including the physician's signature, should be submitted with all sterilization claims. Incomplete forms are invalid and will be returned to the provider for correction.

**Hysterectomies**

Hysterectomies performed for the sole purpose of sterilization are not a covered benefit.

Patients who are not already sterile must sign the Hysterectomy Consent form (available in both English and Spanish).

Physicians must complete Part I including the portion "medical reasons for recommending a hysterectomy for this patient." Kaiser will return the form to the provider if this portion is omitted.

Patients who are already sterile are not required to sign a consent form. In these cases, the physician must complete Part II including cause and date (if known) of sterility, e.g. "tubal ligation 1992."

In cases of life-threatening emergency when consent cannot be obtained, the physician must complete Part II including the nature of the emergency that made prior acknowledgement impossible.

### 14.1.23 Advance Directives

Physicians, Nurse Practitioners, Physician Assistants and Their Designated Staff at all KPNW Facilities.

Inform patients of their right to make healthcare decisions in advance and provide patients with an Advance Healthcare Directive (AHCD).

Upon routine medical care as an outpatient.

Prior to the date of a procedure planned at an ASC.

Upon admission to either KSMC or KWMC.

Send a copy of completed Advance Directive or paper POLST forms to Medical Records department for:

Scanning in the patient's medical record.

Faxing Oregon POLST forms to Oregon POLST registry

Note in the medical record any revocation of an Advance Directive or POLST.

Upon determining that a patient lacks decision-making capacity or has recovered decision-making capacity shall promptly record such determination in the medical record and communicate them to the HCR.

Kaiser informs members of changes in state law regarding advance directive as soon as possible, but no later than 90 days following the changes in law.

Members and patients are not required to complete an advance directive or POLST to be covered by Health Plan benefits or to receive services at any Kaiser Permanente facility.

Review the medical record and as appropriate contact the Oregon State POLST Registry prior to treatment of an incapacitated patient to determine if a prior POLST form exists.

Individual health care practice may be influenced by personal ethical and religious beliefs. In some situations, a practitioner may object to providing a medically recognized legal health care service desired by a patient. Examples of situations include but are not limited to: Withholding or withdrawing life sustaining treatment, Physician assisted suicide.

The attending physician or healthcare facility shall promptly notify the Health Care Representative (HCR) if, for any reason they are unable to or unwilling to carry out the wishes of the HCR. In this event, the attending physician must make reasonable efforts to transfer the patient's care to another physician and continue care until at transfer can be arranged. (ORS 127.625).

### 14.1.24 Compliance *(reference section 8 of the Provider Manual)*

**Fraud, Waste and Abuse**

Kaiser Permanente will investigate allegations of provider fraud, waste, or abuse related to services provided to members and, when appropriate, take corrective action, including but not limited to civil or criminal action. The Federal False Claims Act and similar state laws are designed to reduce fraud, waste, and abuse by allowing citizens to sue on behalf of the government to recover fraudulently obtained funds (i.e., "whistleblower" or "qui tam" actions). KP personnel may not be threatened, harassed, or in any way discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

### 14.1.24 Practice Guidelines

Practice Guidelines are kept and disseminated through the KPNW Intranet portal in the Clinical Library to all providers and, upon request, to members, and potential members.

## 14.2 Washington State Medicaid Apple Health

Apple Health is the Medicaid Program in Washington State administered by the Health Care Authority (HCA). The program provides health care services to low-income individuals and families. Interested individuals should visit www.wahealthplanfinder.org to check for eligibility. Clients can receive healthcare services through enrollment in a Managed Care Organization (MCO) plan like Molina or on a fee for service basis. At the time of enrollment, members assigned to Molina can choose Kaiser Permanente Northwest as their provider. Kaiser Permanente Northwest provides services in both Clark and Cowlitz counties.

### 14.2.1 Provider Enrollment

Licensed providers and healthcare professionals in the states of Washington and Oregon can apply to become a Medicaid Provider with Apple Health. Complete an application online on the ProviderOne website and choose your enrollment type as a "healthcare professional practicing under a group or facility". Once your application has been submitted for review, please fax supporting documents as needed along with the cover sheet to 1-866-668-1214 or Mail to:

Provider Enrollment

PO Box 45562, Olympia, WA 98504-5562

### 14.2.2 Checking Eligibility

It is the provider's responsibility to check a client's eligibility and coverage prior to providing services. Failure to do so may result in claim(s) denial. If a client chooses to receive a service that is not covered by Molina Healthcare, the provider may be able to bill them. Member's must be assigned to Kaiser Permanente Northwest region. Prior to the delivery of non-covered or authorized services please have the patient sign the Agreement to Pay for Healthcare Services form 13-879.

You can verify member's eligibility and assigned provider by:

- Contacting the Kaiser Permanente's eligibility verification line at 503-813-2000 or 1-800-813-2000
- Molina Healthcare WebPortal
- ProviderOne

### 14.2.3 Balance Billing

Balance billing a Medicaid Member for covered services is prohibited by law. Providers cannot bill Molina Members for covered benefits. As a provider you are responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Members cannot be liable for any sums owed by Molina to the Provider. Please refer to WAC 182-502-0160.

Members cannot be held financially liable for missed and cancelled appointments or rescheduling fees. Only distinct Medicaid services are billable.

### 14.2.4 Services that are Limited or Not Covered by Molina– Clark and Cowlitz Counties

Please refer to the Molina Healthcare of Washington (MHW) Benefits Index as a guide for covered services that are medically necessary.

### 14.2.5 Member Rights and Responsibilities

Providers must abide by the Molina Healthcare of Washington and the Kaiser Permanente Member Rights and Responsibilities.

### 14.2.6 Rights to Second Opinion

Molina members are eligible to receive a second medical/surgical opinion about their health care or condition. Second opinion consultations by in-network providers do not require prior approval. For non-participating providers, review and approval will be required by Molina Healthcare.

## 14.3 THE FOLLOWING SECTIONS APPLY TO BOTH WASHINGTON MEDICAID AND OREGON HEALH PLAN

### 14.3.1 Provider's Contracted with Kaiser Permanente who are not enrolled with OHP and/or Apple Health

The individual providers and the billing providers will need to enroll directly through the State.

### 14.3.2 National Provider Identifier (NPI)

A valid (NPI) is required for all licensed providers at time of enrollment for Oregon Health Plan and Molina Health Care of Washington. Providers cannot be enrolled without a valid NPI number. To apply, visit the National Plan and Provider Enumeration System (NPPES) or call the NPI toll-free number at 800-465-3203. It is also suggested that providers keep their information on NPPES up-to-day to avoid any delays with the State provider enrollment process.

### 14.3.3 Referrals

For specialty care services, a referral must be submitted by the Primary Care Provider (PCP). The following does not require a referral if the patient is being seen by an in-network provider:

- Help to stop smoking
- Help with addiction to alcohol or drugs (substance use disorder services)
- Mental health services
- Reproductive services (contraceptives, vasectomies, tubal ligations, abortions

Please contact the Kaiser Permanente Regional Referral Center at 503-813-4560 to obtain referral authorizations. Please refer to section 4.2 in the provider manual for additional details.

### 14.3.4 Prior Authorization (PA)

Some services require prior authorization prior to the delivery of care. To determine whether a prior authorization is required for services please contact Member Services at 503-813-2000. Please refer to section 4.2 in the provider manual for additional details.

### 14.3.5 Claims payment and timely filing

Kaiser Permanente has established a set of policies and procedures to ensure accurate and timely processing of claims received. Claims can be submitted by mail or electronically. Electronic submissions are highly encouraged. Please refer to section 5 in the Kaiser Permanente Provider manual for additional details in regards to claim submissions, appeals and denials.

**NOTE:** The rendering, attending, prescribing, and billing provider NPIs reflected on the claim **must be enrolled** as a participating provider with OHP through the Oregon Health Authority. Kaiser Permanente will be unable to pay claims for OHP covered services if these NPIs are not actively enrolled with the OHP on the date of service. We can pay a claim in question after enrolling with OHP, if the claim is an otherwise a clean claim. This will require resubmitting the claim once enrolled with OHP with an effective date that covers the date of service. Please refer to section **14.1.5- Provider Enrollment.**

For information on how to enroll, providers can call the OHA at 1-800-336-6016 (option 6), or they can find information on the OHA website at the following link: https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx.

### 14.3.6 Office of the Inspector General Exclusions or Disbarment

Please refer to sub-section 8.5 in the Kaiser Permanente Manual.

### 14.3.7 Fraud Waste & Abuse (FWA)

Please refer to sub-section 8.5 in the Kaiser Permanente Manual.

Please refer to the Kaiser Permanente Principles of Responsibility for more information about our Guiding Principles.