Kaiser Permanente Northwest

2026 Quality Management and Utilization Management

Bulletin

April 2026

Dear community physicians, practitioners, and providers of care to members of Kaiser Permanente Health Plan of the Northwest,

The Northwest Permanente Medical Group (NWP) and Kaiser Foundation Health Plan of the Northwest (KFHPNW) are accountable to provide you with information and resources in the following areas of interest:

- Confidentiality.
- Member rights and responsibilities.
- Member-practitioner communication.
- Utilization management.
- Pharmaceutical management procedures.
- Quality management and improvement.

We hope you find the information in this bulletin helpful and appreciate your help sharing it with others at your practice site. Thank you for your attention to these policies and practices.

Sincerely,

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Confidentiality and protection of privacy policy

Kaiser Permanente employees and clinicians are required to maintain the confidentiality of member and patient information, whether oral, written or electronic. This obligation is addressed in policies and procedures and confidentiality notices and agreements. All practitioners with whom Kaiser Permanente contracts are subject to the Privacy and Security Program's confidentiality requirements. Kaiser Permanente has developed and distributed to members a Notice of Privacy Practices (NPP) describing members' privacy rights and Kaiser Permanente's obligation to protect their health information. The *Notice of Privacy Practices* is available online at **https://healthy.kaiserpermanente.org/oregon-washington/privacy-practices**.

As described in the NPP, Kaiser Permanente will not disclose protected health information without written authorization, except as required or permitted by law. If the member or patient is unable to provide authorization, his or her legally authorized representative may provide authorization for the disclosure of information on the member's or patient's behalf. Member or patient-identifiable protected health information may be shared with others including employers only with the member's or patient's permission or as otherwise required or permitted by law.

Members and patients have the right to see or receive copies of their own protected health information, and they have the right to authorize the disclosure of their own protected health information to others, or to request an accounting of certain disclosures of their protected health information, in accordance with applicable state and federal laws. Kaiser Permanente may collect, use, and share protected health information for treatment, payment, and healthcare operations and for other routine purposes as permitted by law, for example, for use in quality improvement activities.

Your rights and responsibilities

Oregon and Washington

Note: If you're a Washington State resident who lives outside the Vancouver/Longview area, learn about your rights and responsibilities by calling Member Services toll-free at **1-888-901-4636**.

About your rights and responsibilities

At Kaiser Permanente, we believe that maintaining good health is a very important part of your well-being. Providing the quality health care necessary to maintain your good health requires building a partnership between you and your health care professionals.

You need information to make appropriate decisions about your care and lifestyle choices. Your health care professionals need your involvement to ensure you receive appropriate and effective health care. Mutual respect and cooperation are essential to this partnership.

It is important for you to know what you can expect and what we need from you when you receive care at Kaiser Permanente.

Your rights

At Kaiser Permanente, you have the right to:

- **Receive information about Kaiser Permanente,** our services, our health care practitioners, and your rights and responsibilities.
- **Be treated with consideration, compassion, and respect taking into account your dignity and individuality, including privacy in treatment and care** without regard to your race, religion, ethnicity, color, national origin, cultural background, ancestry, language, gender, gender identity, gender expression, sex, sexual orientation, marital status, physical or mental disability, genetic information, age, or financial status.
- **Be supported in selecting and changing clinicians** and seeking a second opinion within our plan.
- **Participate with practitioners in making decisions about your health care.**
- **Receive full information about your care,** including a candid discussion of appropriate or medically necessary treatment options for your conditions; the benefits, risks and alternatives of recommended treatments or procedures regardless of cost or coverage; and realistic alternatives when hospital care is no longer appropriate. We'll provide information in a way you can understand and provide an interpreter if you need one.
- **Receive assistance when you face difficult medical ethics issues** by arranging consultations with members of our ethics services staff.
- **Be supported if you change your mind about any procedure,** refuse treatment or decline to participate in medical training programs or research projects, and inform you of the consequences of your refusal.
- **Be respected for your right to personal privacy** and your right to make decisions about your future.
- **Give instructions** about what is to be done if you are not able to make medical decisions for yourself. The legal documents that you can use to give your directions in advance are called "advance directives".
- **Timely access to your covered services and drugs.** As a plan member, you have the right to get appointments and covered services from our network of practitioners within a reasonable amount of time. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
- **Be transferred only when medically appropriate** and when the receiving facility is ready to accept you.
- **Receive the names,** professions, and educational backgrounds of the people treating you.
- **Expect that the confidentiality of all personal health information, communications, and records regarding your care are protected.** This information will not be released to any person or entity not affiliated with Kaiser Permanente without your prior authorization. We may make exceptions to this policy only when the release of information is authorized by law or when the information is to be used for quality improvement activities, bona fide research, or statistical reporting. You may review and obtain copies of your medical or dental records, unless restricted by law or when detrimental to your own well-being. If you think part of your medical record is incorrect, you may add a statement listing your objections and corrections.

- **Receive a response in an appropriate, confidential, and timely manner** to any concerns you have about your care or services provided, without sanction or reprisal. Membership Services will inform you of member satisfaction procedures and resources available to assist you.
- **Be informed of business relationships** between your Health Plan and others – health care practitioners, educational institutions, insurer – that may influence your treatment and care.
- **Receive information about charges and payment methods.** We will provide an itemized statement of non-covered services upon request, for an additional service charge.
- **Voice your complaints freely** without fear of discrimination or retaliation. If you are not satisfied with how your complaint was handled, you may have us reconsider your complaint.
- **Make recommendations** regarding Kaiser Permanente's Member Rights and Responsibilities policy.

Your responsibilities

At Kaiser Permanente, you have the responsibility to:

- **Follow the treatment plan agreed on by you and your health care practitioner.** You have a responsibility to inform your health care practitioner if you do not understand or cannot follow through with your treatment and to let your health care practitioner know if changes need to be made.
- **Improve the quality and safety of your care** by providing accurate and complete information about your medical history, medications, and any changes in your condition.
- **Understand your health problems** and participate in developing mutually agreed upon treatment goals, to the extent possible. Ask questions if you do not understand any aspect of your medical or dental condition or treatment.
- **Be aware of the daily lifestyle decisions** that affect your health, and that the choices you make can reduce the risks to your health and the health of your family.
- **Tell your health care team** if you are satisfied or dissatisfied with any aspect of your care.
- **Provide your family, health care practitioner, and hospital** with a copy of any advance directive you wish Kaiser Permanente to follow, should you be unable to make your own decisions.
- **Treat your health care team with consideration and respect.**
- **Treat other patients with consideration and respect.** When you are in the hospital, avoid having the volume on television sets too loud, having too many visitors, or holding loud conversations that may disturb other patients.
- **Comply with the no-smoking, no-weapons, and visiting-hours policies.**
- **Be familiar with your health care benefits.**
- **Tell us if you have any other health insurance coverage** or prescription drug coverage in addition to our plan. Please call Member Services to let us know.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. If your coverage is through your employer, it is important that the change of address is also reported to your employer.
- **Have your membership ID card handy** when you call for an appointment or advice, or when you come in for care.
- **Notify Kaiser Permanente** in advance if you will be late for, or have to cancel, an appointment.
- **Pay your bills on time** and pay your copayments when you come in for care.

Member-practitioner communication

A basic value of Kaiser Permanente is that members and patients are to be treated fairly, with consideration, compassion and respect taking into account their dignity and individuality, including privacy in treatment and care without regard to their race, religion, ethnicity, color, national origin, cultural background, ancestry, language, gender, gender identity, gender expression, sex, sexual orientation, marital status, physical or mental disability, genetic information, age, or financial status. We believe quality health care includes a full and open discussion with each patient regarding all aspects of medical care and treatment alternatives without regard to benefit coverage limitations. We maintain confidentiality consistent with the policies set forth by Kaiser Permanente. Conforming to our long-standing values, KPNW allows open practitioner-patient communication regarding appropriate treatment alternatives, allows member's participation in their treatment plan, and does not penalize practitioners for discussing medically necessary or appropriate care.

KPNW Pharmacy Program

The KPNW Regional Formulary and Therapeutics Committee (RFTC) oversees the management of the formulary in conjunction with Regional Pharmacy Services. This group reviews and maintains pharmaceutical management procedures and formulary determinations on an ongoing basis. The RFTC uses the formulary system and evidence-based decision making to determine which medications will be made available for practitioners to order for patients.

The Formulary

The Formulary is intended to enhance the quality of patient care by ensuring that available drugs meet established quality standards by providing information for safe and effective use and by limiting the availability of drugs that are unsafe, less effective, and ineffective or have high potential for toxicity or abuse.

Formulary drugs are drugs and biologic agents that have been reviewed by the RFTC and placed on the Formulary. Non-formulary drugs are drugs which have not yet been reviewed or which were reviewed but not accepted for inclusion in the Formulary.

The Formulary is available to all clinicians and Health Plan staff via the internal KPNW Pharmacy Department website. All members and contract practitioners can access the Formulary via the **kp.org** website: **https://healthy.kaiserpermanente.org/oregon-washington/health-wellness/drug-formulary**.

Individuals without Internet access may request print copies by contacting Pharmacy Services at 503-261-7900, toll free at 1-888-572-7231.

All KPNW Physicians and Allied Health practitioners who are licensed to prescribe pharmaceuticals in the state of Oregon or Washington may prescribe Formulary drugs within KP formulary specifications (including criteria, prescribing restrictions and quantity limits).

The RFTC reviews medications for addition to or deletion from the formulary on a monthly basis. Any practitioner or member may request that a drug or dosage form be added to or deleted from the formulary.

Practitioners may do so by completing a Drug Formulary Change Request form by contacting Pharmacy Services via phone at 503-261-7900, toll free at 1-888-572-7231.

Members requesting a formulary change will be directed to the Member Relations Department to submit a formal request that will be reviewed through the medical necessity determination process and, if approved, through the RFTC review process.

Drug selection decisions are made primarily based on safety and effectiveness. Safety and effectiveness are determined by a thorough review of pertinent medical evidence, incorporating expert opinion and relevant findings from appropriate external organizations. After safety and effectiveness are investigated, cost is considered.

Non-formulary exception process

Drugs not on the KPNW Formulary are considered non-formulary, and are not covered by the drug plan, unless the prescribing clinician has determined the non-formulary medication to be medically necessary. [See UM Policy 13a for more information on the exception process]. The Non-Formulary Drug review process does not apply to drugs used for indications excluded by contract, or drugs used for non-covered services.

http://providers.kaiserpermanente.org/html/cpp_knw/pharmacypolicies.html

Generic substitution

As drugs become available in generic form, they are reviewed by Pharmacy Services based on bioequivalence data provided by the Food and Drug Administration (FDA). Members demanding branded products for which there is a generic option will pay the retail cost of the drug unless medically necessary as determined through the criteria-based prescribing review process. Pharmacists administer generic substitution as outlined in the Oregon and Washington State Boards of Pharmacy Laws.

Therapeutic Substitution

Therapeutic Substitution (TS) drugs produce essentially the same therapeutic outcome and have similar toxicity profiles. Usually these drugs are within the same pharmacological class or are different dosage forms of the same drug (i.e. tablet for capsule or half-tablet for full tablet of lesser strength). TSs are restricted to the list approved by the RFTC and updated annually. An annual TS List authorization signed and approved by the practitioner authorizes the pharmacist to perform therapeutic interchange for medications on the TS List.

Prescribing Criteria/Step Therapy

The RFTC has approved prescribing criteria to apply to selected medications. Medications classified as criteria-based/step therapy are usually second or third line medications for the treatment of a specific disease state. The RFTC uses both internal and external resources, including Specialty Department input, Food and Drug Administration recommendations and clinical trials published in the medical literature to guide them in the creation of prescribing criteria. [See UM Policy 13e for more information on criteria-based/step therapy].

https://healthy.kaiserpermanente.org/oregon-washington/community-providers

Quantities

Standard prescription quantities are as defined by the drug benefit: a 30-day supply or unit of use per copayment or coinsurance at the clinic level, or a 90 day supply of maintenance medication for two (2) copayments from the mail order pharmacy as defined by the plan.

The 30/30 Benefit list places dispense quantity limitations on medications with a high potential for waste or diversion. Medications on this list, whether formulary or non-formulary, will be limited to no more than a 30-day supply at one time, even if the member's drug benefit would normally provide a greater supply.

The Quantity Limit list limits included medications to a maximum quantity per days supply indicated. The limits help minimize the number of units (tablets, capsules, etc.) that members need to take and is beneficial for both the individual member and KP's affordability mission.

There are no limits on the number of prescriptions which may be prescribed per member, or number of refills other than those delineated by state and federal laws or per RFTC recognized therapeutic guidelines established by the FDA.

More information/Contacting Pharmacy Services

For more information about the KPNW formulary process or other pharmaceutical management policies and procedures – including criteria-based consultation prescribing, copayment requirements, and any other restrictions and/or limitations – or to obtain a copy of the KPNW drug formulary, contact Pharmacy Services at **503-261-7900**, toll free at **1-888-572-7231.**

Access to care decisions and availability of utilization management criteria and guidelines

As a practitioner of service to KPNW members, you may be aware that Kaiser Foundation Health Plan of the Northwest (KFHPNW) and Northwest Permanente Medical Group (NWP) have jointly established the Utilization Management (UM) Program. This program is designed to monitor, evaluate, and guide decisions the quality and cost of health care services delivered to all KPNW members.

The goal of the UM Program is to ensure that care is delivered to KP members with consistent quality, safety, and efficiency, regardless of the location or service practitioner. Within the UM Program, specially trained and designated staff conduct selected pre-service, concurrent, and retrospective review activities; monitor compliance with guidelines; and screen cases through the use of published and organizationally-developed criteria. NWP physicians with expertise in utilization and quality activities consult with the UM staff as needed. The regional medical director of Utilization Management has direct responsibility for implementation of the UM Program and provides oversight of day-to-day activities.

As a practitioner who may order medical items and services for Kaiser Permanente members, you and your patient are affected by decisions made through the application of utilization management review processes. Because of this involvement, it is important for you to have information about the UM Program that includes how decisions are made, how criteria are used to guide determinations of medical necessity, how to obtain a copy of specific criteria used, and how to contact appropriate staff regarding UM issues. The following information may be helpful.

UM decision making

The physicians and other health care staff of KPNW make medical necessity decisions based on the appropriateness of care and services for patients' medical needs and existence of coverage. KPNW does not compensate practitioners or other individuals responsible for utilization management decision making for issuing denials of coverage or service nor are decisions about hiring, pay, promotions, or termination of employment based on the likelihood that denials will be supported. No financial incentives exist that encourage decisions that result in denials or underutilization of coverage or service at KPNW. In order to maintain and improve the health of our members, all practitioners and health care staff should be especially vigilant in identifying any potential underutilization of care or service.

UM criteria

KPNW physicians are involved in developing criteria used to guide UM decisions and ensuring the criteria used are applied consistently in decisions to approve or deny services. Criteria are objective and based on medical evidence. Criteria and guidelines are used in conjunction with clinical judgment and case-specific consideration. Availability of services in the local delivery system and individual member needs (like age, co-morbidities, complications, psychosocial and cultural issues, home environment, patient safety, and community resources) are considered when making UM decisions. When applicable, clinical criteria or guidelines are referenced to guide UM decision making. The criteria used in the utilization management process are available to all practitioners. You can find this information by visiting kp.org, navigating to Forms & Publications, and selecting Clinical Review. If preferred, you can also request a copy by contacting the Referral Coordinator at 503-813-4560.

Contacting a UM physician reviewer

A physician is required to review all services and items denied based upon medical necessity criteria or clinical judgment. A physician reviewer is available to discuss these denial decisions upon request. The information needed to contact a physician reviewer is documented in the requesting practitioner's written denial notice.

It's also possible to obtain the information needed to contact a reviewing physician and/or to get information related to UM issues by contacting Membership Services, Monday through Friday, between 8 a.m. and 6 p.m. In the Portland area, call **503-813-2000**. From all other areas, call **1-800-813-2000**. For TTY, call **1-800-735-2900**. You can also email Membership Services 24 hours a day, 7 days a week, by logging onto **kp.org**. A representative will make every attempt to respond to your inquiry the next business day.

To check on the status of a referral to an external practitioner, please contact the Regional Referral Center, Monday through Friday, between 8 a.m. and 5 p.m., by calling **503-813-4560**.

KPNW Patient Safety Program

Patient safety — defined as the freedom from unnecessary risk of harm associated with health care — is an integral component of Kaiser Permanente's philosophy to provide quality health care that our members can trust. Kaiser Permanente Northwest Region (KPNW) incorporates patient safety into the everyday workings of the organization, guided by three principles:

- Patient safety comes first.
- Patient safety is every patient's right.
- Patient safety is every individual's responsibility.

Patient safety is a key part of our health care delivery system, and it continues to be an important component of all our quality improvement programs. The program is designed to create and support a work environment that puts our members' safety first. It includes developing and implementing appropriate systems, tools, and training guides to assist practitioners, managers, supervisors, and frontline staff in their work of providing safe and effective care for our members. We promote the Institute of Medicine's six dimensions of quality: safe, timely, effective, efficient, equitable, and patient-centered care.

KPNW and its network of practitioners, managers, employees, and affiliates are responsible for patient safety. This responsibility guides individuals and health care teams in achieving excellent performance in safe and effective healthcare delivery.

The Kaiser Permanente vision is to be the safest system in which to receive and provide healthcare. To achieve this vision, our strategy is based upon our Safety Management System which focuses on the Reliability of the people and systems within; Accountability of our leaders, physicians, practitioners, and employees to provide an environment of transparency and safety; and Resilience of individuals and the organization to recover from setbacks, adapt well to change and make improvements leading to safer systems of care.

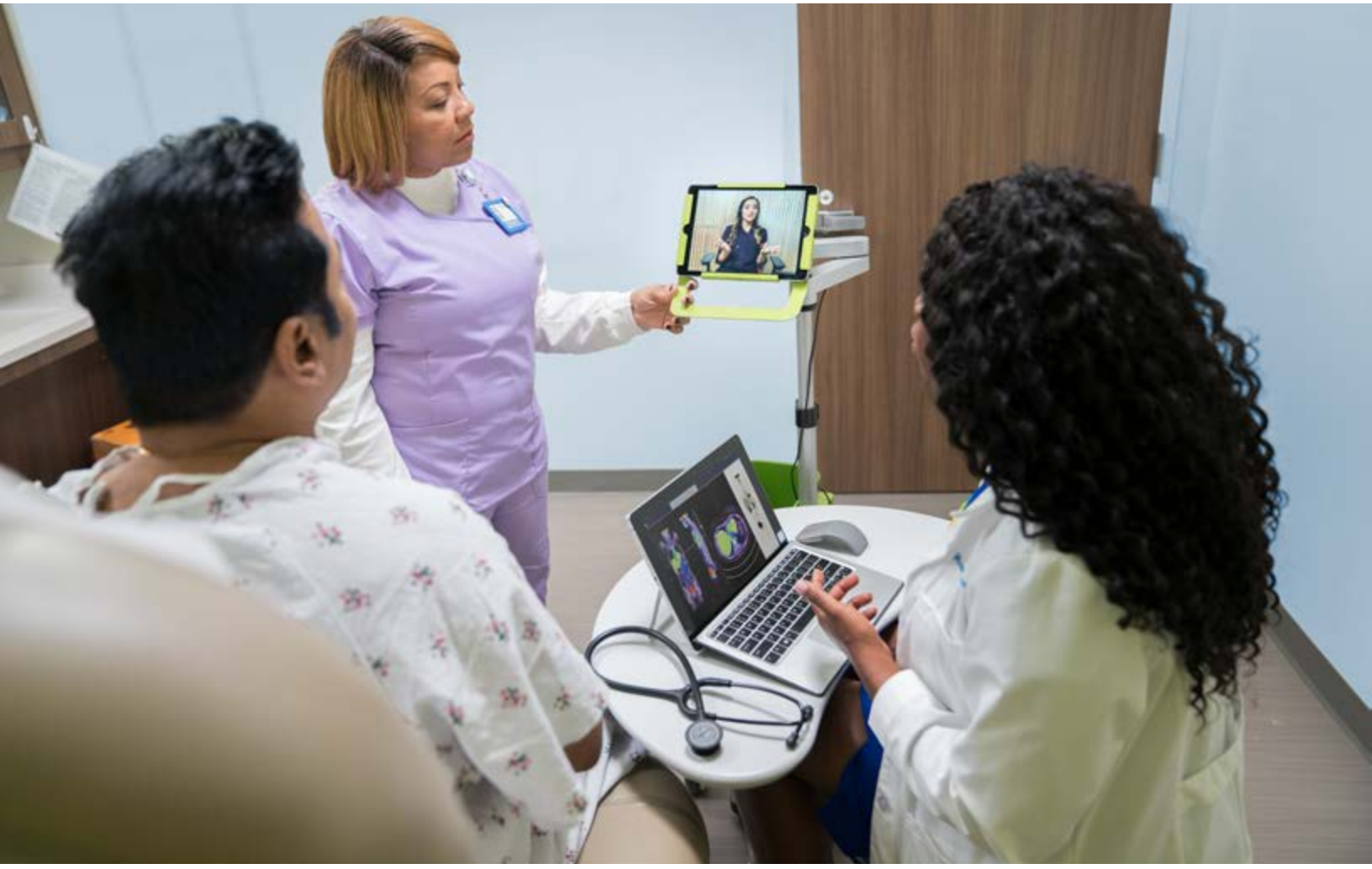
We have several systems interventions in place aimed at improving our culture of safety and reducing the possibility of error. Some include:

- A regional-wide focus on a culture of safety that promotes, enhances, and sustains safety as a focus within the organizational culture to include a reporting culture and a learning culture, supported by a Just Culture which identifies system and process failures while supporting individual accountability. With the outcome that everyone has a safety mindset, using and supporting safe practices everywhere at KP so that there is no patient harm.

- Areas of focus:
  - **Medication reconciliation** through our **Transition in Care** that ensures medications prescribed in the clinic and hospital settings are reconciled at each care transition to what the patient should be taking.
  - **Medication adherence** which supports medication management and medication compliance for the patient.
  - **High Alert Medication Safety Program** that identifies certain high-risk medications which carry a greater risk of harm due to nature of the medication and the route administered. This program ensures a set of safe medication management practices are in place prior to administering these medications.
  - **The use of Kaiser Permanente's electronic medical record system** (KP HealthConnect) as a tool to trap potential errors that may otherwise affect patients. In addition, through KP HealthConnect, a "patient support tool" aids practitioners and health care teams in the identification of care gaps that may need to be addressed among the patients in the care team's panels.
  - **Surgical/procedural safety program.**
  - **A Regional Simulation Center team** that supports clinical staff in reinforcing safe and effective patient care practices.
  - **Adherence to accreditation standards** including but not limited to, the Joint Commission, DNV (Det Norske Veritas), AAAHC (Accreditation Association for Ambulatory Health Care), CMS, and state, in our hospitals and clinic setting where applicable, with attention to encouraging patients' active involvement in their own care as a patient safety strategy.
  - **Continued participation in the Oregon Patient Safety Commission.**
  - **Focus on the prevention** of serious adverse reportable events (SRAEs) and hospital acquired conditions (HACs).

NCQA accreditation

Since 1995, the National Committee for Quality Assurance (NCQA) has accredited Kaiser Foundation Health Plan of the Northwest (KFHPNW). NCQA is a private, nonprofit organization dedicated to improving health care quality. NCQA accreditation helps health plans demonstrate their commitment to quality improvement and value, meet regulatory requirements, and distinguish themselves from the competition. KPNW's last accreditation survey was in April of 2025. Our Medicare HMO and Commercial HMO both received accredited designations. This means we met or exceeded strict evaluation requirements in the areas of preventive measures, access and service, utilization management, physician credentialing, and quality. The next NCQA survey will be in 2028. More about KPNW quality and performance is available online at **kp.org/quality**.



KPNW Quality Program

Kaiser Permanente Northwest's Quality Program seeks to improve the quality of both clinical care and services provided to the approximately 600,000 members it serves in Northwest Oregon and Southwest Washington. To that end, the program encompasses an extensive array of activities in collaboration with Kaiser Foundation Health Plan of Northwest (KFHP-NW), Northwest Permanente, P.C. (NWP), Kaiser Foundation Hospitals (KFH) and its contracted practitioners.

Quality assessment and improvement is accomplished through a systematic, integrated approach to evaluation, planning, design, and implementation of the Quality Strategy. It involves routine monitoring of performance on access, service, clinical quality and patient safety measures; communicating with medical offices and practitioners about performance and opportunities; identifying improvement initiatives and complying with applicable regulatory and accrediting requirements.

More information about the Quality Program including the Quality Program Description, Annual Evaluation, and Work Plan can be obtained by contacting the Regional Quality Department at 503-813-3810.

KPNW disease management programs

Disease Management aims to measurably reduce the complications with selected chronic diseases and to enhance patients' health and quality of life through a coordinated set of evidence-based interventions. KPNW offers disease management programs to target individuals with a specific disease such as diabetes, cardiovascular disease and congestive heart failure. Interventions for each program are based on risk stratification. Patients enrolled in any of the disease management programs receive education and self-care tools to help better manage their conditions, some may also receive case management services depending on need.

Members are identified for participation in the respective disease management program through methods such as claims and practitioners referrals. Eligible members are enrolled in these programs using an opt-out method and added to the disease management registries of the respective programs. We want you to be aware of these services so that you can integrate them with your clinical practice and facilitate member participation.

To refer a member or find out more about any of the disease management programs, case management, or other population care initiatives, contact Clinical Quality Support Services toll free at 855-517-8382.

Members may be dis-enrolled upon their request or the request of their primary care clinician by contacting Clinical Quality Support Services.

Complex case management

Our regional team of Complex Case Managers is available to assist with your complex, chronic medical patients. Complex Case Management is for members who may have experience a critical event or diagnosis, are medically complex or resource intensive and need help navigating the system. The program has been designed to meet NCQA accreditation standards and to support Kaiser Members for anywhere from nine to eighteen months. Members enrolled in the Program set their own goals and work intensively with a Case Manager to make progress toward improved health and functional capability.

If you have a patient that meets criteria outlined below and might benefit from the program, you can refer them. A Complex Case Management Coordinator will review referrals for appropriateness. If the patient meets established criteria the Coordinator will reach out to the member to offer enrollment in the program. If your patient needs urgent or immediate assistance, this would not be the appropriate referral.

Below are the inclusion/exclusion criteria for Complex Case Management Program. When referring, please specific the focus/reason the patient is being referred, along with a corresponding diagnosis.

Inclusion criteria

Patient is a member of Kaiser Health Plan, 18 years of age or older, and meets **ONE** of the following characteristics:

1. **Frequent hospitalizations:** Greater than or equal to three visits in a six-month period
2. **One or more inpatient admissions:** With discharge to skilled nursing facility in the past six-months
3. **Frequent urgent care visits:** Greater than or equal to three visits in a six-month period
4. **Frequent ED visits:** Greater than or equal to three visits in a six-month period

Additional consideration is made for members who may not exactly meet the criteria listed above, however demonstrate a need for stabilization to avoid further utilization of hospital or clinic services.

Exclusion criteria

1. No active coverage plan with Kaiser Permanente.
2. Pregnancy if needs are primarily related to the current pregnancy and if established with obstetrics.
3. Had successful, closed case management episode within the last 6 months and no change in condition.
4. Have been unable to reach or have declined case management within the last 3 months.
5. Active chemical abuse/substance abuse where the member has not adhered to their care plan.
6. Mental health disorders without Medical Dx, or without the ability to engage in CCM activities.
7. When telephonic case management is not possible.
8. Well-managed by a case management program such as: Oncology, Hospice/Palliative Care, GLTC, or other disease management programs.

Clinical practice guidelines

KPNW supports the development and use of evidence-based clinical practice guidelines and practice resources to aid clinicians and members in the selection of the best prevention, screening, diagnostic, and treatment options. The best options are those that are backed by high-quality evidence, provide net clinical benefit (the balance between benefits and harms), respect members values and preferences, and use resources equitably and efficiently.

The KP Guidelines are informational and not a substitute for reasonable exercise of independent clinical judgement. Each patient's needs are considered on an individual basis when rendering treatment plans. Recommendations are designed to apply to populations, not individuals.

For more information on clinical practice guidelines and practice resources, contact the Guidelines and Evidence-Based Medicine Department via the information below:

- Frank Y. Chen, MD, Director | **Frank.Y.Chen@kp.org** | 503-813-2663
- Kelly S. Staten, Senior Program Manager – Medical Ethics & Clinical Guidelines | **Kelly.S.Staten@kp.org** | 503-457-3120

Resources are accessible via KP login and via intranet.

Grievances and appeals

Member complaints, grievances, and appeals

If members are dissatisfied with their care, they are encouraged to discuss this with their practitioner as soon as possible. For other problems with care or service, they are asked to speak with a facility administrator. Members may also contact the Member Services Call Center (at 503-813-2000 in Portland and 1-800-813-2000 in all other areas) to voice complaints. Member Services representatives will advise members about our resolution process and ensure the appropriate parties review the member's complaint. Every attempt is made to resolve the concern promptly. Members or the member's authorized representative may file a written grievance if not satisfied with our response. They may appeal to have a complaint, grievance or adverse determination reviewed again. Members are notified of these processes in their Explanation of Coverage or Benefit Booklet, distributed annually.

Expedited reviews

Initial requests, grievances, and appeals are expedited according to the clinical urgency of the situation. Requests will also be expedited if a physician states a need based on the member's medical condition.

Independent medical review

If the appeal process within Kaiser Permanente has been exhausted, an appeal may be eligible for an independent review. If the member's case qualifies for an independent medical review, medical experts not affiliated with Kaiser Permanente will conduct the review. There is no charge to the member for this review, and Kaiser Permanente will honor the decision made by the Independent Review Organization (IRO). When an appeal is denied, the independent review process is outlined in the member's appeal denial letter.

Contacting Member Services by phone

503-813-2000 in Portland and 1-800-813-2000 in all other areas.

Contacting Member Services in writing

Attn: Member Services
Kaiser Permanente
500 NE Multnomah St., Ste. 100
Portland, OR 97232