Kaiser Permanente Colorado Provider Manual

- **Member Rights and Responsibilities**

Member Rights and Responsibilities

Our Members' health is important to us and we strive to meet their health care and wellness needs whatever they may be. This section of the Provider Manual was created to help guide you and your staff in understanding the rights and responsibilities of Kaiser Permanente Members. If, at any time, you have a question or concern about the information in this Provider Manual, you can reach our Provider Representatives by calling 1-866-866-3951.

KAISER PERMANENTE®

Table of Contents

Section 7: Member Rights and Responsibilities

7.1 Member Rights and Responsibilities

Our Members have certain rights and responsibilities that all network providers should be familiar with to ensure consistent and coordinated care. The following text is taken from the Member Rights and Responsibilities Statement and should help you better understand our approach to partnering with them in every stage of their health.

We are partners in your health care. Your participation in your health care decisions and your willingness to communicate with your doctor and other health professionals help us in providing you with appropriate and effective health care. We want to make sure you receive the information you need to make decisions about your health care. We also want to make sure your rights to privacy and to considerate and respectful care are honored.

As a Member of Kaiser Permanente, you have the right to receive information about your rights and responsibilities and to make recommendations about our Member rights and responsibilities policies.

You* have the right to:

- **Participate in your health care.** This includes the right to receive the information that you need to accept or refuse a recommended treatment. Emergencies or other circumstances occasionally may limit your participation in a treatment decision. In general, however, you will not receive medical treatment before you or your legal representative give consent. You have the right to be informed and to decide if you want to participate in any care or treatment that is considered educational research or human experimentation.
- **Express your wishes concerning future care.** You have the right to choose a person to make medical decisions for you and to express your choices about your future care if you are unable to do so yourself. These choices can be expressed in documents, such as a durable power of attorney for health care, a living will, or a CPR directive. Inform your family and your doctor of your wishes and give them copies of documents that describe your wishes concerning future care.
- **Receive the medical information you need to participate in your health care.** This information includes the diagnosis, if any, of a health complaint, the recommended treatment, alternative treatments, and the risks and benefits of the recommended treatment. We will make this information as clear as possible to help you understand it. You are entitled to an interpreter if you need one. You also

have the right to review and receive copies of your medical records, unless the law restricts our ability to make them available. You have the right to participate in making decisions involving ethical issues that may arise during the provision of your care.

- **Receive information about the outcomes of care you have received**, **including unanticipated outcomes.** When appropriate, family Members or others you have designated will receive such information.

- **Receive information about Kaiser Permanente as an organization, its practitioners, providers, services, and the people who provide your health care**. You are entitled to know the name and professional status of the individuals who provide your service or treatment.

- **Receive considerate, respectful care.** We respect your personal preferences and values.

- **Receive care that is free from restraint or seclusion.** We will not use restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.

- **Have a candid discussion of appropriate or medically necessary treatment options for your condition(s).** You have the right to this discussion, regardless of cost or benefit coverage.

- **Have impartial access to treatment.** You have the right to all medically indicated treatment that is a covered benefit, regardless of your race, religion, sex, sexual orientation, national origin, cultural background, disability, or financial status.

- **Be assured of privacy and confidentiality.** You have the right to be treated with respect and dignity. We will honor your right for privacy and will endeavor not to release your medical information without your authorization, except as required or permitted by law.

- **Have a safe, secure, clean, and accessible environment.**

- **Choose your physician.** You have the right to select and to change physicians within the Kaiser Permanente Health Plan. You have the right to a second opinion by a Kaiser Permanente physician. You have the right to consult with a non-Kaiser Permanente physician at your expense.

- **Know and use Member satisfaction resources.** You have the right to know about resources such as patient assistance, Member service, and grievance and appeals committees, which can help you answer questions and resolve problems. You have the right to make complaints and appeals about

Kaiser Permanente or the care we provide without concern that your care will be affected. Your Membership benefits booklet (*Evidence of Coverage* or *Membership Agreement*) describes procedures to make formal complaints. We welcome your suggestions and questions about Kaiser Permanente, our services, our health professionals, and your rights and responsibilities.

- **Review, amend, and correct your medical records** as needed**.**

- **Child Health Plan Plus (CHP+) Members** have additional rights, as described by 42CFR438.100(b)(2) and the CHP+ contract. The full list of rights as documented in the CHP+ EOC and the CHP+ Member Rights Policy are given below:

    - be treated with respect for your personal dignity and the need for privacy.
    - get information in a way that is easy for you to understand, like plain language, large print, another language, or through a TTY/TDY phone line.
    - talk about Medically Necessary treatment options for your condition, regardless of cost or benefit coverage, with the information presented in a way that you can understand.
    - be a part of deciding what is best to do for your health care.
    - refuse recommended medical treatment or procedures.
    - be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
    - get a copy of your or your minor child's(ren's) medical records and request corrections.
    - obtain healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.
    - exercise these rights without any adverse effect on the way you are treated.

You* are responsible to:

- **Know the extent and limitations of your health care benefits.** An explanation of these is contained in your Evidence of Coverage or Membership Agreement.

- **Identify yourself.** You are responsible for your membership card, for using the card only as appropriate, and for ensuring that other people do not use your card. Misuse of membership cards may constitute grounds for termination of membership.

- **Keep appointments.** You are responsible for promptly canceling any appointment that you do not need or cannot keep.

- **Provide accurate and complete information.** You are responsible for providing accurate information about your present and past medical conditions, as you understand them. You should report unexpected changes in your condition to your doctor.

- **Understand your health problems.** Participate in developing mutually agreed upon treatment goals to the degree possible.

- **Follow the treatment plan on which you and your health care professional agree.** You should inform your doctor if you do not clearly understand your treatment plan and what is expected of you. If you believe you cannot follow through with your treatment, you are responsible for telling your doctor.

- **Recognize the effect of your lifestyle on your health.** Your health depends not only on care provided by Kaiser Permanente, but also on the decisions you make in your daily life, such as smoking or ignoring care recommendations.

- **Be considerate of others.** You should be considerate of health professionals and other patients. Disruptive, unruly, or abusive conduct may constitute grounds for termination of membership. You should also respect the property of other people and of Kaiser Permanente.

- **Fulfill financial obligations.** You are responsible for paying on time any money you owe Kaiser Permanente. Nonpayment of amounts owed may constitute grounds for termination of membership for some plans.

*You or your guardian, next of kin, or a legally authorized responsible person.

Department	Contact information	Quick Reference to Administrative Operations
Provider Contracting and Provider Representatives	8:00am-5:00pm MST Monday - Friday Toll-free 1-866-866-3951	• Provider demographic updates such as tax ID change, address change, addition of providers, termination of providers • Provider education and training • Contract questions
Member Services Department	8:00am-6:00pm MST for information on Non-Medicare Members Monday – Friday 8:00am-8:00pm MST for information on Medicare Members 7 days a week Member Relations P.O. Box 378066 Denver, CO 80237-8066 Non-Medicare 1-800-632-9700 Medicare Toll-free 1-800-476-2167 711 TTY for the deaf, hard of hearing or speech impaired	• General enrollment questions • Eligibility and benefit verification • Co-pay, deductible and coinsurance information • Documents, Reports and facilitates Member complaints • Interactive Voice Response System • Billing Inquiries • Claims related issues • Interpretive Services
Fully Insured Claims Department	8:00am-5:00pm MST Monday – Friday 303-338-3600 or toll-free 1-800-382-4661 711 TTY for the deaf, hard of hearing or speech impaired Claims Submittal: Kaiser Foundation Health Plan of Colorado PO Box 373150 Denver, CO 80237-3150 (For POS/Added Choice Members – use PO Box 370897) Denver, CO 80237	• General Billing procedures • Claims submissions • Claims status • Statements of Remittance • Provider Adjustments • Reconsiderations and Appeals • Interpretive Services

Department	Contact information	Quick Reference to Administrative Operations
KPIC Self-funded Claims Department	5:00am-7:00pm MST Monday – Friday 866-213-3062 Claims Submittal: Kaiser Permanente Insurance Company P.O. Box 30547 Salt Lake City, UT 84130-0547 EDI Payor ID #94320	• General Billing procedures • Claims submissions • Claims status • Statements of Remittance
Referrals Department	8:00am-5:00pm MST Monday – Friday Colorado Region 1-877-895-2705	• Pre-Service Authorization Requests • Hospital Concurrent Authorization Requests
AffiliateLink	Online at: http://www.providers.kaiserpermanente.org/cod/index.html or Contact your Provider Representative at 1-866-866-3951	• Patient Demographics, Eligibility and Benefit Verification • Real-Time Referral /Authorization Inquiry • Online References for your KP Business Needs
KPIC Self-funded Provider Portal	http://kpclaimservices.com	• Patient Demographics, Eligibility and Benefit Verification • Claim Status • Statements of Remittance

7.2 Member Grievance (i.e. Complaint) and Appeal Process

7.2.1 Customer Satisfaction Procedure

If Members are not satisfied with the services they receive, they may file a grievance. Member can file a grievance in the following ways:

- Send written complaint to the Kaiser Permanente Member Relations; or
- Telephone Member Services:
    - Non-Medicare Members: 1-800-632-9700
    - Medicare Advantage Members at 1-800-476-2167
    - TTY for all areas: 711

When KP Receives a Grievance

1. A Member Relations representative reviews the grievance and conducts a thorough investigation, verifying all the relevant facts.

2. The Member Relations representative or a physician or health plan representative evaluates the facts and makes a recommendation for corrective action, if appropriate.

3. We respond in writing to written grievances as expeditiously as the Member's health requires, but no longer than 30 calendar days from receipt. We respond orally or in writing to oral grievances as expeditiously as the Member's health requires, but no longer than 30 calendar days from receipt. *Please see Grievance process for CHP+ Members below.*

CHP+ Grievances:

If CHP+ Members are not satisfied with the services they receive, they may file a grievance. There is no time limit to file a Complaint. Member can file a grievance in the following ways:

- Send written complaint to the Kaiser Permanente Member Relations; or
- Request to meet with a Member Relations representative at the Health Plan Administrative Offices; or
- File a complaint over the telephone with Member Services:
    - Denver/Boulder area at 303-338-3800
    - TTY for all areas: 711

When KP Receives a Grievance

1. A Member Relations representative reviews the grievance and conducts a thorough investigation, verifying all the relevant facts.

2. The Member Relations representative or a physician or health plan representative evaluates the facts and makes a recommendation for corrective action, if appropriate.

3. We will send the Member a letter acknowledging that we have received the grievance within 2 business days and we will resolve CHP+ Member complaints within 15 business days.

CHP+ Members can ask for more time to resolve their problem and we can ask for more time, up to 14 calendar days, if more information is needed. We will send CHP+ Members a letter within 2 calendar days if we need more time to solve the problem and will send another letter when the problem is resolved. The Member has the right to submit a complaint if they disagree with our decision to extend the grievance timeline.

With the Member's written permission, a representative can assist a CHP+ member file a grievance. We can also help Members complete forms, answer questions, or help give you no-cost language services or auxiliary aids. Call Member Service at 303-338-3800 for more information.

7.2.2 Definitions

Grievance:

- **Commercial, KPIC, FEHBP, and Self-Funded**: An expression of dissatisfaction about care or service and/or a care/service related request for which the Member or his/her duly authorized representative seeks provision of or reimbursement for services or supplies, or other financial resolution, that does not constitute an initial request for covered services (Initial Determination review process), and that does not include a request for medical care or covered services, regardless of how that dissatisfaction is submitted to the Health Plan.
- **CHP+**: Grievance (also known as a complaint): A formal expression of dissatisfaction about any matter. Grievances may include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect a Member's rights regardless of whether remedial action is requested. A grievance can include a Member's right to dispute an extension of time proposed by Kaiser Permanente to make an authorization decision.
- **Medicare Part C:** Any expression of dissatisfaction to the health plan, provider, facility or QIO by a Member made orally or in writing. This can include concerns about the operations of providers, insurers, or health plan such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to Members, the claims regarding the right of the Member to receive services

or receive payment for services previously rendered. It also includes the health plan's refusal to provide services the Member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance or appeal process.

- **Medicare Part D:** A Part D complaint may involve a grievance, coverage determination or both. If an enrollee addresses two or more issues in one complaint, each issue should be processed separately and simultaneously (to the extent possible) under the proper procedure. A Part D complaint also may involve a low-income subsidy (LIS) or late enrollment penalty (LEP) determination. Every complaint must be handled under the appropriate process i.e., grievance or appeal.

Initial Determination Review Process:

- A methodology to review an initial request for a benefit from a Member or their duly authorized representative to render an initial Plan decision regarding the request for covered services.

Appeal:

- **Commercial, FEHBP, and KPIC**: A Member or his/her duly authorized representative's request for Health Plan review of an initial Adverse Benefit Determination.

CHP+: A request for review of an adverse benefit determination, by a CHP+ Member or Provider acting on the Member's behalf. An adverse benefit determination is:

- When we deny or limit a type or level of service you requested.
- When we reduce, suspend or stop a service that was previously approved.
- When we deny payment for any part of a service.
- When we do not provide or authorize (approve) services in a timely manner required by the state.
- When we do not act within timelines required by the state to resolve complaints and appeals, and provide notifications to you.
- When we deny your request to dispute your financial liability (your Copayment)

- **Medicare Part C:** Any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service for services, decisions not to provide or pay for services that the enrollee believes may be covered by the health plan. These procedures include reconsiderations by the health plan, and if necessary, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, review by the Medicare Appeals Council (MAC) and judicial reviews.
- **Medicare Part D**: Any of the procedures that deal with the review of adverse coverage determinations made by the Part D plan on the benefits under a Part D plan the enrollee believes he or she is entitled to receive, including delay in providing, or approving drug coverage (when a delay would adversely

affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage, as defined in section 4223.566(b). These procedures include redeterminations by the Part D plan sponsor, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, review by the Medicare Appeals Council (MAC), and judicial reviews.

7.3 Additional Information Related to CHP+ Member Appeals and Right to Request an External Review

7.3.1 CHP+ Appeals

Health Plan will send the Member a Notice of Adverse Benefit Determination ("NABD") letter when:

- We deny or limit a type or level of service you requested.
- We reduce, suspend or stop a service that was previously approved.
- We deny payment for any part of a service.
- We do not provide or authorize (approve) services in a timely manner required by the state.
- We do not act within timelines required by the state to resolve complaints and appeals and provide notifications to you.
- We deny your request to dispute your financial liability (your Copayment).

This letter will tell the Member how to file an Appeal if you do not agree with the decision.

Health Plan's decision on the appeal will be in writing and will be available in English. The Member may request that Health Plan provide the Notice of Adverse Benefit Determination in non-English languages or ask us for assistance if needing oral translations services. To request assistance, the Member should call Member Services.

The amount of time the Member has to file an appeal is 60 calendar days.

Appeals may be filed by the Member or by a Designated Client Representative (DCR). A DCR is someone the member chooses to talk on their behalf. A DCR can be a provider, an advocate, a lawyer, a family Member, a representative of a deceased member's estate, or any other person the Member chooses to appoint. As a provider you may file an appeal as the Member's DCR. If a Member asks you to be a DCR, the Member must sign a form designating you as the DCR, giving your name, address and phone number. A DCR can also be the legal representative of a deceased Member's estate. To request a DCR form, please contact the n Appeals Program at (303) 344-7933 or toll free at 1-888-370-9858 or TTY 711, or by fax at 1-866-466-4042.

To start the appeal process, the Member or the DCR must contact the Member Appeals Program.

To start the appeal of an action, the Member or the DCR can call the Member Appeals Program at (303) 344-7933 or toll free at 1-888-370-9858 or TTY 711 or fax the request to 1-866-466-4042 or write the Member Appeals Program.

- If writing a letter, please mail to: Member Appeals Program, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066 Denver Colorado 80237-8066.The Member or the DCR should send the Member Appeals Program all information that supports the Member's opinion that the Health Plan's decision is not correct. The letter should include the following information:
  i. Member name and medical record number;
  ii. Member's medical condition or relevant symptoms;
  iii. Specific services that the Member is requesting;
  iv. All the reasons the Member has for disagreeing with Health Plan's decision; and
  v. All supporting documents.

- After receiving the phone call or letter, Health Plan will mail a letter to the Member or DCR within two (2) business days. This letter will acknowledge receipt of the request for an appeal.

  i. The Member or the DCR can provide information giving the Member's reasons as to why the Health Plan should change the adverse benefit determination decision. The Member or the DCR can also give us any information or records that they think would support their appeal, ask questions, and ask for the criteria or information used by Health Plan to make the decision. The Member or the DCR can look at Health Plan's medical records and other information related to the appeal by contacting Health Plan's **Member Services. Member Services** will provide copies of these documents without cost to the Member or the DCR.

- Within 10 working days, we will send the Member a letter with our decision on the appeal.

- If the Member or the DCR requests an extension or if additional information is needed from the service provider, Health Plan will send the Member a letter within two (2) calendar days indicating the review is being extended for no more than fourteen (14) calendar days. We will resolve the Appeal before the extra time ends.

- The Member or the DCR can request a "rush" or expedited appeal if the Member is in the hospital or feels that waiting for a regular appeal would threaten his/her life or health. *(See below for more information on expedited appeals).* An appeal for when we deny payment for any part of a service is not considered serious or life threatening. Therefore, these types of appeals are not rushed or expedited.

Expedited (Rush) Appeals can be requested by the Member or the DCR if the Member believes that waiting the usual amount of time for a decision would seriously affect his/her life, health or ability to maintain or regain maximum function. The Health Plan can also decide on its own that the appeal should be expedited.

For a rush appeal, a decision would be made within 72 hours; Since there is a short amount of time to make a rush decision, the Member or the DCR has a short amount of time to look at Health Plan's records and a short amount of time to give information in person or in writing. The information the Member needs to provide includes:

i. Member name and medical record number;
ii. Member's medical condition or relevant symptoms;
iii. Specific services that are being requested;
iv. All the reasons the Member disagrees with Health Plan's decision; and
v. All supporting documents.

For expedited appeals, if the Member of the DCR requests an extension, or if additional information is needed from the service provider, Health Plan will send the Member a letter within two (2) calendar days indicating the review is being extended for no more than fourteen (14) calendar days. We will resolve the Appeal before the extra time ends.

If the Member or DCR does not agree with our decision on the Appeal, they have the right to request a State Review.

Call Member Services at **303-338-3800** if you have any questions. Please let us know if you need help with no-cost language services or auxiliary aids.

7.3.2 CHP+ Member Request for State Review

The Member has the right to an external review. A State Review means that a State Administrative Law Judge (ALJ) will review Health Plan's decision. The Member, DCR, or the representative of a deceased Member's estate, may ask for a State Review (or State Fair Hearing) if the Member is not satisfied with Health Plan's decision about the appeal. The Member or the DCR need to ask for a State Review within 120 calendar days from the date they received the letter with our decision on the Appeal.

If the Member or the DCR want to ask for a State Review, the Member or the DCR may call or write to:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203
Phone: (303) 866-2000
Fax: (303) 866-5909

The written request should include: · The Member's name and address;

- A copy of the initial denial;
- A copy of our appeal decision; and
- Reason(s) for the appeal.

The Office of Administrative Courts will send the Member a letter explaining the State Review process and will set a date for the hearing. The Member can speak for themself at a State Review or can have a DCR or representative of a deceased Member's estate speak. The ALJ will review Health Plan's decision. Then the ALJ will make a decision. It could take up to 90 days for the judge to decide the case and the judge's decision is final.

If the Member or DCR want the Office of Administrative Courts to make a fast decision because the time it takes to have a State Review would put the Member's life, health or ability to function fully in danger, the Member or DCR can contact the Office of Administrative Courts and ask for an expedited (fast) State Review. The Office of Administrative Courts must make a decision no later than 72 hours after receiving your request.

The Member can have their DCR help them with this process. We can give you no-cost language services or auxiliary aids, contact: **Member Services**, Kaiser Foundation Health Plan of Colorado, **2500 South Havana Street, Aurora CO 80014-1622**, telephone **303-338-3800** or toll free at **1-800-632-9700** or **TTY 711** or fax the request to **303-338-3220**.

If the Member requests a State Review and would like to have someone act for them, he/she may appoint someone. The Non-Attorney Authorization form can be found using the link below, then click Health First Colorado Non-Attorney Authorization to open the form: https://www.colorado.gov/pacific/oac/oac-form-links