5.0 Member Rights, Complaints and Appeals/Grievances

5.1 Referring Members for Assistance

The Member Services Department has representatives to assist with calls for:

- General verification of member eligibility and enrollment
- Clarification of member benefits and coverage
- Information about member benefits while traveling out of the area
- Information about services available at Kaiser Permanente medical facilities
- Maps, driving directions, and other Kaiser Permanente literature
- Status or payment information related to a claim submission
- Information about or assistance with filing a Grievance, Appeal or Complaint
- Assistance with solving a problem
- Information about Participating Providers, and assistance with selecting or changing a primary care physician (PCP)
- Requests for replacement member identification card(s)
- Requests by a member to change the member's address or phone number

Kaiser Permanente Member Services representatives can be reached Monday – Friday between 7:30am and 9:00pm at ☎800-777-7902 (TTY – 711) except major holidays.

Representatives for Medicare members can be reached Monday – Sunday between 8:00am and 8:00pm at ☎888-777-5536 (TTY – 711).

5.2 Additional Resources for Providers

Kaiser Permanente Online Affiliate Portal
The Online Affiliate portal allows providers access to several time-saving self-service features.

External providers may be eligible to access the following information online:

- Patient eligibility, benefits, and demographics
- Referrals/authorizations
- Kaiser Permanente electronic medical records

Providers may be able to view and manage their organization's claims, through the following functions:

- Viewing and printing EOP's (Explanation of Payments)
- Viewing claim details (status, service date, billed amount, allowed amount, patient responsibility, etc.)
- Confirming payment information (check number, payment date, amount)
- Performing the following **"Take Action**" on a claim:
  - Submit a claim inquiry related to 'denied' or 'in progress' claims
  - Submit an inquiry related to a check payment, receive copy of a check or report a change of address for a specific claim.
  - Submit appeals or disputes – request a reconsideration of a payment
  - Respond to Kaiser Permanente request for information (RFI)

To enroll with Online Affiliate, navigate to kp.org/providers/mas and select **Online Provider Tools** from the Provider Resources menu.

Member Services: ☎ 800-777-7902 **Medicare Members: ☎ 888-777-5536**	**Provider Experience: ☎ 877-806-7470** **Fax ☎ 855-414-2623**
• Clarification of member benefits • Members presenting with no Kaiser Permanente identification card • Members terminated for greater than 90 days	• Contracted rate payment questions • Monthly reimbursement questions • Billing inquiries • Form requests

5.3 Selecting A Primary Care Physician

Enrollment forms request the designation of a PCP from the Health Plan's provider directory for each enrollee. Each covered family member may designate a different PCP.

An identification card is mailed to the member upon enrollment. Kaiser Permanente Participating Providers should verify eligibility for any member who has not yet received an identification card using the process described in Section 4.0.

5.4 Changing A Primary Care Physician

Members may change their PCP by selecting a new provider from the directory and contacting a Member Services representative with the new designation (See Section 5.1 for Member Services phone numbers). Changes received by the 20th of the month will be effective the first of the following month. Otherwise, the new selection will not be effective until the subsequent month. For example, a change made on or before April 20th would become effective on May 1; but a change made after the April 20th would not be effective until June 1.

When a PCP relocates or is no longer a Participating Provider, Kaiser Permanente sends a letter to all affected members explaining the change, when it will take place, and asking the member to select a new PCP.

Providers with questions about this process may contact the Provider Experience Department at ☎ 877-806-7470.

5.5 Member Rights and Responsibilities: Our Commitment to Each Other

Kaiser Permanente is committed to providing our members and their families with quality health care services. For your awareness, these are the rights and responsibilities we share with members in the delivery of their health care services.

MEMBER RIGHTS AND RESPONSIBILITIES

As a member of Kaiser Permanente, you have the right to:

1. **Receive information that empowers you to be involved in health care decision making. This includes your right to:**
   a. Actively participate in discussions and decisions regarding your health care options.
   b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are.
   c. Receive relevant information and education that helps promote your safety in the course of treatment.

d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.
e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time.
g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your authorized representative will be asked to provide written permission before your records are released, unless otherwise permitted by law.

2. **Receive information about Kaiser Permanente and your plan. This includes your right to:**
   a. Receive information in languages other than English, in large print or other alternative formats.
   b. Receive the information you need to choose or change your Primary Care Physician, including the name, professional level, and credentials of the doctors assisting or treating you.
   c. Receive information about Kaiser Permanente, our services, our practitioners and providers, and the rights and responsibilities you have as a member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies.
   d. Receive information about financial arrangements with physicians that could affect the use of services you might need.
   e. Receive emergency services or Part D drug when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
   f. Receive covered urgently needed services when traveling outside Kaiser Permanente's service area.
   g. Receive information about what services are covered and what you will have to pay and to examine an explanation of any bills for services that are not covered.
   h. File a complaint, grievance or appeal about Kaiser Permanente, Part D drug or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.

3. **Receive professional care and service. This includes your right to:**
   a. See plan providers, get covered health care services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.
   b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.
   c. Be treated with respect and dignity.

d. Request that a staff member be present as a chaperone during medical appointments or tests.
e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status including any mental or physical disability you may have.
f. Request interpreter services in your primary language at no charge.
g. Receive health care in facilities that are environmentally safe and accessible to all.

As a member of Kaiser Permanente, you have the responsibility to:

1. **Promote your own good health:**
   a. Be active in your health care and engage in healthy habits.
   b. Select a Primary Care Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Physician.
   c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.
   d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals.
   e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.
   f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.
   g. Schedule the health care appointments your physician or health care professional recommends.
   h. Keep scheduled appointments or cancel appointments with as much notice as possible.
   i. Inform us if you no longer live or work within the plan service area.

2. **Know and understand your plan and benefits:**
   a. Read about your health care benefits and become familiar with them. Detailed information about your plan, benefits and covered services is available in your Evidence of Coverage. Call us when you have questions or concerns.
   b. Pay your plan premiums and bring payment with you when your visit requires a copayment, coinsurance or deductible.
   c. Let us know if you have any questions, concerns, problems or suggestions.
   d. Inform us if you have any other health insurance or prescription drug coverage.
   e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our plan.

3. **Promote respect and safety for others:**
   a. Extend the same courtesy and respect to others that you expect when seeking health care services.
   b. Assure a safe environment for other members, staff, and physicians by not threatening or harming others.

EQUITY, INCLUSION, DIVERSITY

Members have the right to free language services for health care needs. We provide free language services including:

- **24-hour access to an interpreter.** When members call to make an appointment or talk to their personal physician, if needed, we will connect them to a telephonic interpreter.

- **Translation services.** Some member materials are available in the member's preferred language.
- **Bilingual physicians and staff**. In some medical centers and facilities, we have bilingual physicians and staff to assist members with their health care needs. They can call Member Services or search online in the medical staff directory at **kaiserpermanente.org**.
- **Braille or large print**. Blind or vision impaired members can request documents in Braille or large print or in audio format.
- **Telecommunications Relay Service (TRS)**: If members are deaf, hard of hearing, or speech impaired, we have the Telecommunications Relay Service (TRS) access numbers that they can use to make an appointment or talk with an advice nurse or member services representative or with you.
- **Sign language interpreter services**. These services are available for appointments. In general, advance notice of two or three business days is required to arrange for a sign language interpreter; availability cannot be guaranteed without sufficient notice.
- **Video Remote Interpretation (VRI).** Video Remote Interpreting (VRI) provides on-demand access to American Sign Language & Spoken Language interpretation services at medical centers for members. It meets the need in the care experience of walk-in deaf patient and those in need of urgent care.
- **Educational materials**. Health education materials can be made available in languages other than English by request. To access Spanish language information and many educational resources go to **kp.org/espanol** or **kp.org** to access La Guía en Español (the Guide in Spanish). Members can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in La Guía en Español.
- **Prescription labels**. Upon request, the KPMAS pharmacist can provide prescription labels in Spanish for most medications filled at the Kaiser Permanente Pharmacy.

At Kaiser Permanente, we are committed to providing quality health care to our members regardless of their race, ethnic background or language preference. Efforts are being made to collect race, ethnicity and language data through our electronic medical record system, HealthConnect®. We believe that by understanding our members' cultural and language preferences, we can more easily customize our care delivery and Health Plan services to meet our members' specific needs.

Currently, when visiting a medical center, members should be asked for their demographic information. It is entirely the member's choice whether to provide us with demographic information. The information is confidential and will be used only to improve the quality of care. The information will also enable us to respond to required reporting regulations that ensure nondiscrimination in the delivery of health care.

We are seeking support from our practitioners and providers to assist us with the member demographic data collection initiative. We would appreciate your support with the data collection by asking that you and your staff check the member's medical record to ensure the member demographic data is being captured. If the data is not captured, please take the time to collect this data from the member. The amount of time needed to collect this data is minimal and only needs to be collected once. Recommendation for best practices for collecting data is during the rooming procedure.

In conclusion, research has shown that medical treatment is more effective when the patient's race, ethnicity and primary language are considered.

To access organization wide population data on language and race, please access the reports via our Community Provider Portal at www.providers.kp.org/mas under *News and announcements*.

To obtain your practice level data on language and race, please email the Provider Experience Department at provider.relations@kp.org.

For additional language resources, providers may request services from the following:

- Virginia
  - Virginia Department for the Deaf and Hard of Hearing: www.vddhh.org/interpreters.htm
  - The Blue Ridge Area Health Education Center: www.brahec.jmu.edu/services.html
  - Commonwealth Catholic Charities: www.cccofva.org/interpreter-services
- Washington, D.C.
  - U.S. Department of Health & Human Services: www.hhs.gov/civil-rights/for-individuals/special-topics/hospitals-effective-communication/limited-english-proficiency/index.html
- Phone Interpretation
  - United Language Group: www.unitedlanguagegroup.com/
  - Language Line Solutions: www.languageline.com/
- Sign Language
  - Sign Language U.S.A.: www.signlanguageusa.com/
- Document Translation
  - UNO Translations and Communications: www.unotranslations.com/
  - Akorbi: akorbi.com/
  - Avantpage: avantpage.com/

5.6 Member Grievances (Complaints) and Appeals

All members have the right to make an inquiry, and/or initiate a complaint or appeal with Kaiser Permanente. A member may contact us directly or have their authorized representative such as a family member act on their behalf. Authorization forms for members to appoint an authorized representative can be found at Forms and Publications | Kaiser Permanente. As a Participating Provider, you have the right to make an inquiry and/or file a grievance (complaint) or appeal on behalf of a member with their written permission/authorization. In some cases, Health Care Professionals caring for Medicare patients may file a pre-service initial determination request or appeal without additional authorization documentation.

Our Member Services Department is available to assist members or their authorized representative (including a Provider acting on behalf of a member) with:

- Questions about health care services
- Providing Kaiser Permanente with feedback about a positive care experience
- Concerns about member treatment or how they have been treated
- Concerns with a decision made by Health Plan; or if you disagree with decision made about the member's care
- Questions or concerns regarding a claim or bill received by the member for health care services

A member or their authorized representative may initiate an inquiry or grievance (complaint) telephonically by calling ☎ 800-777-7902 (TTY – 711) Monday – Friday from 7:30am to 9:00pm except major holidays.

Medicare members or their authorized representatives should call ☎ 888-777-5536 (TTY – 711) Monday – Sunday from 8:00am – 8:00pm.

A member or their authorized representative also has the option to initiate an inquiry, grievance (complaint), or appeal in person at a Kaiser Permanente Medical Center. Written inquiries, grievances (complaints), or appeals can also be sent to the following address:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Rd., NE
Atlanta, GA 30305
Fax: ☎ 404-949-5001

All grievances (complaints) are investigated and handled by our Member Service Representatives through coordination with the appropriate departments. Our Member Services Representatives will do their best to resolve issues or concerns at the time of initial contact. If the issue cannot be immediately resolved, it will be handled within (30) thirty calendar days.

All compliments are shared with appropriate staff and departments.

Members and/or their authorized representative (such as a Participating Provider acting on their behalf) have the right to file an appeal when they disagree with Health Plan's decision to deny or authorize a reduced amount for medical services including the reduction, or premature discontinuation of a previously authorized ongoing course of treatment. Any provider will not be penalized in any way by Kaiser Permanente for assisting a member with filing an appeal and/or acting on a member's behalf.

Appeals for non-urgent services or claim payments must be filed in writing. A member or their authorized representative may send a written appeal to:

Kaiser Permanente
Attn: Member Relations
Nine Piedmont Center
3495 Piedmont Rd., NE
Atlanta, GA 30305
Fax: ☎ 404-949-5001

A written appeal letter should include:

- The member's name
- Kaiser Permanente Medical record number

- Description of the services (or claims) that were denied
- The reason that Health Plan should authorize the service or pay the claim
- A copy of the denial notice that was received and a copy of the billing statement in dispute, if applicable

For an appeal request related to a medical necessity determination and/or related to a health care service that has initially been determined by Health Plan to be experimental/investigational services, please see additional details under Utilization Management Section 9.21 – Denials and Appeals

Expedited Appeal

An expedited appeal is available for medically urgent situations and should be requested if the member or their authorized representative feels that the regular period of time to review your request could endanger the life or health of the member.

To request an expedited appeal, a member or provider should contact the following:

Member Services (Mon. – Fri. 7:30am – 9:00pm):	☎ 800-777-7902
Medicare Member Services (Mon.– Sun. 8:00am – 8:00pm)	☎ 888-777-5536
TTY for the hearing impaired:	☎ 711
Fax:	☎ 404-949-5001

After business hours, for medically urgent situations, call:

☎ 703-359-7878 – Advice Line

☎ 800-777-7904 or ☎ 800-700-4901 (TTY – 711), toll-free outside the Washington metro calling area.

Once the expedited appeal is submitted with all the necessary information to review the case, a decision will be made within the regulatory required timeframe for an expedited appeal, based on the member's contract.

If for some reason the initial request does not qualify as an expedited appeal, the request will follow the timeframe for a standard appeal.

Please refer members to their Evidence of Coverage (EOC) for detailed information on procedures for sharing compliments, grievances (complaints) and for filing an appeal.

Exception to these appeal processes – denials for not medically necessary or as experimental/investigational services are processed under the Utilization Management Denials and Appeals described in Section 9. Medicare appeals (initial determination denial) are also processed under Utilization Management for medical indication.

Other Assistance Available to Members

Kaiser Permanente is committed to ensuring that member concerns are fairly and properly heard and resolved. After exhausting the internal grievance and appeal rights process, if a member continues to have concerns about their health care that they believe Health Plan has not satisfactorily addressed, the member has the right to request an independent review. Under State or Federal requirements, members may have the right to request a standard or expedited independent review before completing Kaiser Permanente's internal process, or at the same time as the internal process if certain criteria are met. For Medicare members, internal review (coverage, organization determination, and appeal) is completed prior to IRE (external) review. Members may file a quality of care complaint with the Quality Organization at the same time as Kaiser Permanente is reviewing the complaint (grievance).

Requests for independent review may be submitted to one of the following agencies. Please refer members to their Evidence of Coverage (EOC) for specific details on when an independent review can be requested without first exhausting the internal process and for details on which of the following agencies to contact.

In Maryland

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place
Baltimore, MD 21202
☎ 410-528-1840
☎ 877-261-8807 (toll-free out-of-area)
☎ 410-576-6571 (fax)
www.oag.state.md.us (email address)
Web: www.marylandattorneygeneral.gov

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202-2272
☎ 410-468-2000
☎ 800-492-6116 (toll-free)
☎ 410-468-2270 or 410-468-2260 (fax)
Web: www.mdinsurance.state.md.us

In Virginia

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
☎ 877-310-6560 (toll-free out of area)
☎ 804-371-9032 (Richmond metropolitan area)
ombudsman@scc.state.va.us (e-mail address)
Web: https://scc.virginia.gov/pages/Office-of-the-Managed-Care-Ombudsman

State Corporation Commission
Bureau of Insurance Life and Health Division
P.O. Box 1157
Richmond, VA 21218
☎ 804-371-9691
☎ 877-310-6560 (toll-free)
Web:
https://scc.virginia.gov/pages/Consumers

In the District of Columbia

District of Columbia Department of
Healthcare Finance
441 4th Street, NW, 900S,
Washington, DC 20001
Phone: ☎ 202-442-5988
Fax: ☎ 202-442-4790
Web: www.healthcareobmudsman.dc.gov

For Federal Employees

United States Office of Personnel Management
Insurance Services Programs
Health Insurance Group 3
1900 E St. NW
Washington, DC 20415-3630
☎ 202-606-0755
Web: www.opm.gov

For Medicare Members with Quality of Care Concerns or Who Want Immediate Peer Review of a Hospital Discharge:

Members may contact Livanta, the designated Quality Improvement Organization contracted by The Centers for Medicare and Medicaid Services (CMS) at the following address:

Livanta
BFCC-QIO Program
10820 Guilford Road, Suite 202

Annapolis Junction, MD 20701-1105
☎ 888-396-4646 (Toll-free)
Monday – Friday 9:00am – 5:00pm
Weekends/Holidays 11:00am – 3:00pm
 888-985-2660 (TTY)