Kaiser Permanente PPO Colorado Provider Manual

- **Member Rights and Responsibilities**

Section 7: Member Rights and Responsibilities

INTRODUCTION

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.

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SECTION 7: MEMBER RIGHTS AND RESPONSIBILITIES

7.1 MEMBER AND RESPONSIBILITIES

7.1.1 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 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 Services and Member Relations 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 and appeals. 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**.**

7.1.2 Child Health Plan Pus (CHP+) Members

- **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.*

7.1.3 Key Contacts

Department	Contact Information	Quick Reference to Administrative Operations
AffiliateLink	Online at: Kaiser Permanente Sign On (kp.org) or Contact your Provider Representative at (866) 866-3951	• Patient Demographics • Member Eligibility and Benefits Verification • Claims Data • Clinical Data

		• EMR Real-Time Referral /Authorization Inquiry
Claims Department	• 8 a.m.-5 p.m., MST • Monday-Friday • 303-338-3600 or 1-800-382-4661 • TTY for the deaf, hard of hearing or speech impaired 711 Claims Submittal: • Claims Administration PO Box 373150, Denver, CO 80237 KPIC – Self-funded Claims • Administration PO Box 30547, Salt Lake City, UT 84130-0547 EDI Payor ID #94320 • 1-866-213-3062 8 a.m.-5 p.m., MST - Monday – Friday	• General billing procedures • Claims submissions • Claims status • Statements of Remittance • Provider Adjustments • Reconsiderations and Appeals • Interpreter Services
Member Relations	P.O. Box 278066, Denver, CO 80237-8066	Grievances and Appeals
Member Services Contact Center	• 8 a.m.-5 p.m., MST for information on Non-Medicare members • Monday – Friday • 8 a.m.-8 p.m., MST for information on Medicare members • 7 days a week • 2500 South Havana, Aurora, CO 80014 • Non-Medicare 303-338-3800 or toll-free 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 • Copay, deductible and coinsurance information • Documents, Reports and facilitates member complaints • Billing inquiries • Claims related issues Interpreter Services

Department	Contact information	Quick Reference to Administrative Operations
Provider Contracting and Provider Relations	• 8 a.m.-5 p.m., MST • Monday – Friday • Toll-free 1-866-866-3951	• Provider education and training • Contract questions • General Operational questions
Provider Demographics	KPCO-PDM@kp.org	• Demographic updates such as: • Practitioner updates including adding, terming, licensing, panels • Location updates including address, phone, fax and practitioner linking • Billing updates including address (with W9), TIN, NPI
Referrals/ Utilization Management Department	Colorado Region • 1-877-895-2705	• Pre-Service Authorization Requests • Hospital Concurrent Authorization Requests
Self-funded Provider Portal	http://kpclaimservices.com	• Patient Demographics • Member Eligibility and Benefits Verification • Claims Data

7.2 MEMBER GRIEVANCE (I.E. COMPLAINTS) 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:
    - Self-funded members: 1-877-883-6698
    - Medicare Advantage Members at 1-800-476-2167
    - TTY for all areas: 711

7.2.2 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. Members can file a grievance in the following ways:

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

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

- We respond in writing to written grievances as expeditiously as the Member's health requires, but no longer than 3 calendar days from receipt.

7.2.3 When KP Receives a Grievance from a CHP+ Member

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

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

- 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 and if an extension is in the Members best interest. 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 as soon as the problem is resolved, or before the extension period ends, whichever is sooner. 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 with filing 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 or toll-free at 1-800-632-9700 for more information.

7.3.1 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 oral or written complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. Grievances may include a member's complaint or dispute of an involuntary disenrollment initiated by the Plan.
- **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 Grievance may be defined as follows: Any complaint or dispute, other than a coverage determination, or an LEP determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item. Every complaint must be handled under the appropriate process i.e., grievance or appeal.

7.3.2 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.

7.3.3 Appeal

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

7.3.4 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 the 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)

7.3.5 Commercial and KPIC VSL Appeals (Group Plans Only)

A request for Health Plan review of an Adverse Benefit Determination (ABD) from the Health Plan's first-level Appeal, which is only available to members covered under a Commercial or KPIC group health plan. The Health Plan will reevaluate ABD from a first-level Commercial/KPIC Appeal, the findings upon which it was based, and any other evidence submitted or obtained. VSL Appeals are limited to appeal requests where the request was denied as not medically necessary, or if a medical service was denied as a benefit excluded by the Plan, and the member/advocate is able to provide evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit. 6.2.1.6.5.

- **Self-Funded VSL Appeals:** A request for the KFHP review of a Pre-Service or Post-Service Adverse Benefit Determination (ABD) from the Health Plan's first level Appeal, which is only available to members covered under a qualifying Self-Funded health plan. The Health Plan will re-evaluate ABD from a first level appeal, the findings upon which it was based, and any other evidence submitted or obtained.

- **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.

7.4 ADDITIONAL INFORMATION RELATED TO CHP+ MEMBER APPEALS AND RIGHT TO REQUEST AN EXTERNAL REVIEW

7.4.1 CHP+ Appeals

The 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).

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

The Health Plan's decision on the appeal will be in writing and will be available in English. The Member may request that the 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.

7.4.2 How to start CHP+ Appeals

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 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.

- We can extend the review time up to fourteen (14) calendar days if you or the DCR ask us to. We can also extend the time if more information is needed, and the delay is in your best interest. We will send you a letter within two (2) calendar days if we need more time to decide. We will let you know our decision as soon as possible and before the extension 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.

7.4.3 Expedited (Rush) CHP+ Appeals

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 will 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:

- Member name and medical record number;
- Member's medical condition or relevant symptoms;
- Specific services that are being requested;
- All the reasons the Member disagrees with Health Plan's decision; and

- All supporting documents.

For expedited appeals, the Member or the DCR or the Health Plan can request an extension if additional information is needed, and the extension is in the Member's best interest. The 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 as quickly as possible and before the extra time ends and notify you about our decision in writing and make reasonable efforts to provide oral notification.

The Health Plan shall provide written notice of the disposition of the Appeals process, which shall include the results and data of the Appeal resolution. If the decision is not wholly in the Member's favor, the letter will also include: The Member's right to request a State Review and information on how the Member can request a State Review.

If the Health Plan does not adhere to the notice and timing requirements regarding the Member's appeal, the Member may request a State Review.

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.

7.4.4 Member Request for State Review

The Member, or the DCR, or the representative of a deceased member's estate, 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 of the Health Plan's decision.

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

For further explanation, refer to:
https://hcpf.colorado.gov/appeals#HowToAskForAFormalHearing

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