Kaiser Permanente Affiliated Colorado Provider Manual

- **Provider Rights and Responsibilities**

Section 5: Provider Rights and Responsibilities

INTRODUCTION

You and your medical team are important to us. We value the care you give our Members and know you, like us, are committed to their good health. This section of the Provider Manual was created to help guide you and your staff in understanding your rights and responsibilities as our contracted Network Provider.

If, at any time, you have a question or concern about the information in this Provider Manual, you can reach our Provider Representative by calling 1-866-866-3951.

TABLE OF CONTENTS

SECTION 6: PROVIDER RIGHTS AND RESPONSIBILITIES

As a contracted Provider for Kaiser Permanente, you are responsible for understanding and complying with terms of your Agreement and this Provider Manual. If you have any questions regarding your rights and responsibilities under the Agreement and the Provider Manual, we encourage you to email your Provider Experience Consultant at NDPC-PEC-Cases@kp.org or by calling 1-866-866-3951 for clarification.

The Provider Manual is not intended to provide specific instructions on how to comply with these rights and responsibilities.

As a contracted Provider, you are responsible for the following:

- To verify eligibility of Kaiser Permanente Members prior to providing covered services.
- To provide medically necessary services to eligible Members.
- To verify whether a Member has other health care coverage for coordination of benefits.
- To refer Members, as needed, to other Participating Providers.
- To comply with Kaiser Permanente's referral and authorization requirements.
- To notify Kaiser Permanente of any potential inpatient discharge problems.
- To submit claims or encounter data to Kaiser Permanente on behalf of Kaiser Permanente Members.
- Please reference section 6.4 for notification of changes
- To provide health care services without discriminating on the basis of health status or any other unlawful category.
- To uphold all applicable responsibility outlined in Kaiser Permanente Member Rights and Responsibility Section in this Provider Manual.
- To maintain open communication with a Kaiser Permanente Member to discuss treatment needs and recommended alternatives, without regard to any covered benefit limitations or Kaiser Permanente administrative policies and procedures. Kaiser Permanente encourages open provider patient communication regarding appropriate treatment alternatives and does not restrict providers from discussing all medically necessary or appropriate care with a Kaiser Permanente Member.
- To provide all services in a culturally competent manner.

- To provide all covered services in a manner consistent with professionally recognized standards of health care.
- To assure that Members are informed of specific health care needs requiring follow-up and receive, as appropriate, training in self-care and other measures the Member may take to promote their own health.
- To participate in Kaiser Permanente Utilization Management and Quality Programs and Policy.
- To collect applicable Member Cost Shares including copayments, deductibles an d co-insurance from Kaiser Permanente Members as required by your Agreement.
- To comply with this Provider Manual and the terms of your Agreement.
- To cooperate with and participate in the Kaiser Permanente Member complaint and grievance process, as necessary.
- To secure authorization or referral from Member's PCP prior to providing any non-emergency services when applicable.
- To pursue improvement in patient safety including incorporating patient safety initiatives into daily activities.
- To ensure compliance with patient safety accreditation standards, legislation, and regulations.
- To be responsible for maintaining a complete medical record for patients who elect to receive their health care through your offices.
- To ensure the confidentiality of Kaiser Permanente Members' personal and medical information.
- To be responsible for the safeguarding of Kaiser Permanent Members' medical records and their information content against loss, defacement, tampering and from use by unauthorized agents.

6.1 PRIMARY CARE PROVIDERS' (PCP) RESPONSIBILITIES

All primary care physicians (PCPs) who have contracted with Kaiser Permanente are held to the same standards of care.

6.1.1 Qualifications

- Each PCP must be a family practitioner, internal medicine practitioner, pediatrician, or general practitioner.

- PCPs must complete the Kaiser Permanente credentialing process, including completion of a credentialing application, and supply copies of all applicable supporting documentation.
- All physicians in the practice must be participating with Kaiser Permanente, or in the process of becoming active. If all physicians in the practice are not participating, the practice may be terminated from the network.
- Appropriate licensure and malpractice insurance must be current and remain current throughout the duration of the agreement.

6.1.2 Scope of Services

- PCPs should provide care within the scope of their license and pursuant to applicable standards of care.
- Each PCP must designate, by age, those Members to whom the physician will provide care (i.e., pediatrics up to age 18, etc.).
- Offices must have a mechanism to notify Members if an allied health practitioner (i.e., PA, CNP, etc.) will provide care. PCPs are responsible for performing office visits during regular visit hours for the evaluation/management of medical conditions. Patient education functions may be delegated to appropriately trained staff under the PCP's supervision.
- The PCP may provide lab work that does not require CLIA certification (e.g., urinalysis by dipstick, blood sugar by dipstick, hemoglobin and/or hematocrit, stool occults blood, etc.).

6.1.3 Appointment Access/Office Hours

- Provide, evaluate, triage, and arrange for a Member's care 24 hours a day, seven days a week, including evaluation of the need and consequent arrangement of appropriate specialty referral or consultation.
- Provide on-call coverage, 24 hours a day, seven days a week - Members are entitled to access their PCP, or his/her designee who must be a Kaiser Permanente contracted, credentialed provider, by telephone after regular office hours.

6.1.4 Covering Services

- PCPs are responsible for securing covering services from a physician who is contracted and credentialed with Kaiser Permanente.
- Covering Physician must have privileges at the same Kaiser Permanente contracted hospital as the PCP.

- Approval of coverage by a non-participating PCP is subject to Kaiser Permanente's sole discretion, and such approval must be in writing. Approved covering PCPs must abide by the responsibilities included in this Provider Manual.
- Payment to non-participating covering PCPs must be arranged by PCP.
- PCP will ensure covering physicians do not bill Members, except for applicable co-payments, co-insurance, and deductibles for any covered services.

6.1.5 Hospital Privileges

Referrals and Authorizations/Utilization Management:

- PCPs are responsible for complying with all referral and authorization requirements outlined in the "Utilization Management" chapter of this Provider Manual and are responsible for obtaining appropriate authorization for services on the Precertification list, available at http://providers.kaiserpermanente.org/html/cpp_cod/authorizationstoc.html
- PCPs must use participating vendors or provider may be liable for charges from non-participating vendors (i.e., laboratory, radiology vendors).
- Certain radiology procedures must have an authorization if not performed in a Kaiser Permanente medical office.
- PCPs should use KP Online-Affiliate to enter requests for authorization, enter referrals, as well as for verification of Members' benefits and eligibility.

6.1.6 Claims Submission

Providers should submit claims electronically. For details, see the "Billing and Payment" chapter of this Provider Manual.

6.1.7 Office Requirements

- Offices must have a sign containing the names of all the physicians practicing in the office.
- Offices must be readily accessible to all patients (with handicapped accessibility), including, but not limited to the entrance, parking, exam rooms, and bathroom facilities.
- Offices must be clean, presentable and have a professional appearance.
- Offices must provide clean, properly equipped patient toilet and hand washing facilities.
- Offices must have adequate waiting room space.
- Offices must have an adequate number of examination rooms which are clean, properly equipped, and provide privacy for the patient.
- Offices must have a non-smoking policy.
- Offices must have an assistant in the office during business hours.

- Offices must require a medical assistant to attend gynecological examinations unless the patient declines to allow such assistant to be present.
- Offices must collect all applicable co-pays, deductibles, or coinsurance.
- Offices must provide evidence that physicians have a copy of current licenses for all allied health practitioners (PAs, NPs etc.) practicing in the office, including state professional license, FDA and State Controlled Drug Substance, where applicable.
- Offices should keep on file and be able to produce any state required practice protocols or supervising agreements for allied health practitioners practicing in the office.
- If required, offices must pass a site evaluation, performed by a Provider Representative. Copies of the site evaluation are available in advance. A site visit may also be performed if a complaint is received.

6.1.8 Medical Record Standards

- PCPs must demonstrate at the time of application and throughout the term of the Agreement, that medical records are legible, reproducible, and otherwise meet applicable laws and standards for confidentiality, medical record keeping practices and that clinical documentation demonstrates comprehensive care.
- PCPs are responsible for ensuring the Member's medical record includes reports from referred and/or referring providers, discharge summaries, records of emergency care received and other information as Kaiser Permanente may require.
- For new Kaiser Permanente Members, PCPs are responsible for reviewing and determining which third party records are relevant to each patient's medical condition and treatment going forward.
- Each Member encounter must be documented in writing and signed or initialed by the PCP or as required by state law. Please include Member's name, date of birth and medical record number.
- PCPs must comply with the terms of the agreement regarding medical records and pursuant to Kaiser Permanente's medical record documentation standards. See Quality & Patient Safety Policy V-1 *"Medical Records Documentation Standards: Compliance and Intervention"*.
- Offices should have a mechanism to notify Members if an allied health practitioner (i.e., PA, NP, CNM, etc) will provide care.
- Participating PCPs will utilize the services of participating specialists.
- PCPs should review HEDIS information via KP Online and submit information needed to support HEDIS measures for the year.

6.2 SPECIALTY CARE PROVIDER RESPONSIBILITIES

- Provide consultation services when requested by Colorado Permanente Medical Group (CPMG) providers and participating PCPs and authorized by Kaiser Permanente.
- Provide all required professional services on a 24-hour basis for both outpatient and inpatient care when requested by the patient's PCP and authorized by Kaiser Permanente.
- Obtain required prior authorization from Kaiser Permanente and notify the PCP when any hospital or ancillary services by providers are requested by the specialist.
- Submit a report of findings to the patient's PCP promptly following diagnosis or treatment.
- Participating PCPs will utilize the services of participating specialists.

6.2.1 Qualifications

- Each specialist physician must be an MD, DO, or Podiatrist who dedicates a significant portion (usually greater than 50 percent of his or her professional services) to non-primary care delivery.
- Must complete the Kaiser Permanente delegated and facility credentialing process (as applicable), including completion of a credentialing application, and supply copies of all applicable supporting documentation.
- Appropriate licensure must be current and remain current throughout the duration of the agreement.
- All physicians in the practice must be participating with Kaiser Permanente, or in the process of becoming active. If all physicians in the practice are not participating, the practice may be terminated from the network.

6.2.2 Scope of Services

- Specialists should provide care within the scope of their license and pursuant to applicable standards of care.
- Specialists are responsible for communicating findings and recommended treatment to the Member's PCP in a timely manner.
- Offices should have a mechanism to notify Members if an allied health practitioner (i.e., PA, NP, CNM, etc.) will provide care.

6.2.3 Accessibility/Office Hours

- Specialists are responsible for performing office visits during regular visit hours for the evaluation/management of medical conditions. Patient education functions may be conducted by appropriately trained staff under the Kaiser Permanente contracted provider's supervision.

- Specialists must have on-call coverage, 24-hours a day, seven days a week. Members are entitled to access their specialty physician, or his/her designee who must be a Kaiser Permanente contracted and approved credentialed provider, by telephone after regular office hours. Specialists are responsible for having a reliable answering service or machine with beeping or paging system.
- Each specialist or their covering physician must respond to a Member within 30 minutes after notification of an urgent call.
- Specialists are responsible for making available at least an average of eight hours a week for scheduling office appointments, as applicable.
- Ob/Gyns shall make available at least an average of 20 hours a week over three days at all locations for scheduling appointments.
- If a specialist's office has more than one physical location contracted with Kaiser Permanente, then the specialist must have, at a minimum, eight hours of regularly scheduled office hours a week for patient treatment at each location.
- Each specialist must maintain the following standards for appointment access:
    - Emergency care: must be seen immediately or referred to ER, as appropriate.
    - Urgent complaint: same day, or within 24 hours of Member's request.
    - Primary Care: Routine 7 calendar days >=90%
    - Preventive Services: 30 calendar days >=90%
    - Prenatal Care: 7 calendar days >=90%
    - Specialty Care: Non-Urgent 30 calendar vedays >=90%
    - BH/MH/Substance Abuse: 7 calendar days >=90%
    - Regular or Routine Care: within 14 days of Member's request.
    - Preventive routine care: within 4 weeks of Member's request.

For Medicare Members, the minimum standards for appointment wait times for primary care and behavioral health service appointments are:

- Emergency or urgently needed services – immediately.
- Non-urgent/emergent, but enrollee requires medical attention – Seven (7) business days.
- Routine and Preventive care – 30 business days.

6.2.4 Covering Services

- Specialists are responsible for securing covering specialist services from a physician contracted and credentialed with Kaiser Permanente.
- For inpatient services, the covering physician must have privileges at the same Kaiser Permanente contracted facility as the specialist.
- Approval of coverage by a non-participating specialist physician is subject to Kaiser Permanente's sole discretion, and such approval must be in writing. Approved

covering specialists must abide by the responsibilities included in this Provider Manual.
- Payment to non-participating covering specialists must be arranged by the specialist.
- Specialist will ensure covering specialists do not bill Members, except for applicable co-payments, coinsurance, and deductibles for any covered services.

6.2.5 Hospital Privileges/Admissions

When applicable to relevant specialty, and based on the contractual obligation with Kaiser Permanente, specialists must have maintained hospital privileges with a contracted hospital for six months prior to application with Kaiser Permanente, unless specialist has more recently entered into clinical practice or completed their residency or fellowship training program. Hospital privileges must remain current and in good standing for the duration of the contractual relationship with Kaiser Permanente.
If the specialist provides specialty services at a contracted facility, the specialist must also meet any additional criteria applicable as set forth in the Participation Responsibilities for Facilities (below) for the duration of the terms of the contract.

6.2.6 Referrals and Authorizations/Utilization Management

- Specialists are responsible for complying with all referral and authorization requirements outlined in the "Utilization Management" chapter of this Provider Manual, and are responsible for obtaining appropriate authorization for services on the Prior Authorization List available at: http://providers.kaiserpermanente.org/html/cpp_cod/authorizationstoc.html
- Specialists must use participating vendors, or they may be liable for charges from non-participating vendors (i.e., laboratory, radiology vendors).
- Certain radiology procedures must have an authorization if not performed in a Kaiser Permanente medical office.
- Specialists are requested to use KP Online-Affiliate to enter requests for authorization, enter referrals, as well as for verification of Members' benefits and eligibility.
- Specialists are responsible for obtaining authorizations, verifying the necessary authorizations are valid, and verifying Member eligibility and benefits in advance, prior to seeing the Member.
    - For Commercial <embers, the provider must check eligibility within 2 days prior to providing service to maintain the right to receive payment should the Member have been terminated prior to service.

6.2.7 Claims Submission

Providers are requested to submit claims electronically. For details, see the "Billing and Payment" chapter of this Provider Manual.

6.2.8 Office Requirements

- Offices should have a sign containing the names of all the physicians practicing at the office.
- Offices should be readily accessible to all patients (with handicapped accessibility), including but not limited to the entrance, exam rooms, parking and bathroom facilities.
- Offices should be clean, presentable and have a professional appearance.
- Offices should provide clean, properly equipped hand washing and toilet facilities for Members.
- Offices should have adequate waiting room space.
- Offices should have an adequate number of exam rooms that are clean, properly equipped, and provide privacy for the patient.
- Offices should have a non-smoking policy.
- Offices should have an assistant on the premises during scheduled office hours.
- Offices should require a medical assistant to attend specialized (i.e., gynecological) examinations unless the patient declines to allow such assistant to be present.
- Offices must collect all applicable co-pays, deductibles, or coinsurance.
- Offices must provide evidence that physicians have a copy of current licenses for all allied health practitioners (PAs, NPs etc.) practicing in the office, including state professional license, FDA and State Controlled Drug Substance, where applicable.
- Offices should keep on file and be able to produce any state required practice protocols or supervising agreements for allied health practitioners practicing in the office.
- If required, offices must pass a site evaluation, performed by a Provider Representative. Copies of the site evaluation are available in advance. A site visit may also be performed if a complaint is received.

6.2.9 Medical Record Standard

- Specialists must demonstrate at the time of application and throughout the term of the Agreement, that medical records are legible, reproducible, and otherwise meet Kaiser Permanente's standards for confidentiality, medical record keeping practices, and that clinical documentation demonstrates comprehensive care.
- Members' medical records should include reports from referred and/or referring providers, discharge summaries, records of emergency care received and other information as Kaiser Permanente may require.
- Each Member encounter must be documented in writing and signed or initialed by the specialist or as required by State law. Please include Member's name, date of birth and medical record number.

- Specialists must comply with the terms of the agreement regarding medical records and pursuant to Kaiser Permanente's medical record documentation standards. See Quality & Patient Safety Policy V-1 *"Medical Records Documentation Standards: Compliance and Intervention"*.
- Specialists should review HEDIS information via KP Online-Affiliate, and submit information needed to support HEDIS measures for the year.
- Specialists are required to submit consultation reports to Kaiser Permanente within 30 days. Please continue to use the specific fax number your office was given.

6.3. HOSPITAL AND FACILITY RESPONSIBILITIES

All hospitals and ancillary facilities that have contracted with Kaiser Permanente are held to the same standards of care.

- Hospitals and facilities are responsible for providing hospital or ancillary services, per the contractual agreement with Kaiser Permanente.
- Hospitals and facilities are responsible for cooperation and compliance with Kaiser Permanente Utilization Management and Quality & Patient Safety programs.
- Hospitals and Facilities are responsible for accurate registration and verification of identity through driver's license or state ID and the Kaiser Permanente ID card.
- Hospitals and Facilities are responsible for obtaining appropriate authorization for services on the Prior Authorization List, available at http://providers.kaiserpermanente.org/html/cpp_cod/authorizationstoc.html on the provider Web site (also contained in Secction 4 of this Provider Manual).
- Hospitals and Facilities must collect all applicable co-pays, deductibles, or coinsurance.
- Hospitals and Facilities are responsible for determining primary and secondary carriers for Members, for the purpose of coordination of benefits for Members.
- Hospitals must submit claims electronically.
- Hospitals and Facilities are responsible for maintaining appropriate licensure, insurance, and accreditation as appropriate and specified in the contracted terms, and per NCQA, CMS, and state and Federal guidelines.
- Hospitals are responsible for ensuring hospital-based physicians (emergency medicine, radiologists, pathologists) are credentialed.
- All facilities should review HEDIS information via KP Online-Affiliate, and submit information needed to support HEDIS measures for the year.
- Hospitals are required to submit discharge summaries to Kaiser Permanente. Please continue to use the specific fax number your facility was given.

6.4. EVENTS THAT REQUIRE NOTIFICATION

6.4.1 Closing and Opening Provider Panels

If you intend to close your practice to new patients, you are required to provide Kaiser Permanente written notice *30* days prior to the effective date.

Verification of your provider's open or closed panel status can be done through the quarterly attestation verification communication or by completing the Practitioner Adds-Changes-Terms Template as found on the Provider Portal and submit to KPCO-PDM@kp.org.

6.4.2 Change of Information

Providers must notify Kaiser Permanente promptly by email to KPCO-PDM@kp.org of any of the following events:

- Any license, certification, accreditation, or clinical privilege of a Practitioner or Facility providing Covered Services is revoked, suspended, restricted, expired, or not renewed.
- Provider, a Practitioner or Facility is subject to sanction or is debarred, excluded, or suspended from any Federal program including Medicare or Medicaid.
- There is any formal report submitted to the medical board (or similar practitioner board) or licensing agency of any state or U.S. territory, or the National Practitioner.
- Data Bank of adverse credentialing or peer review action regarding Provider, a Practitioner, or a Facility.
- There is any material change in the credentialing or privileging status of Provider, a Practitioner, or a Facility.
- There is any incident that may affect any license, certification, privileges, or accreditation held by Provider, Practitioner, or any Facility.
- Any change in Provider's operations (including termination, suspension, or interruption of any Services) that will materially affect the way it provides Covered Services to Member.
- Any unusual occurrence that affects any Member receiving Covered Services and that is required to be reported to any governmental or regulatory body or to an accreditation organization.
- Any change in the Practice / Contract Legal Entity's ownership; name change; billing TIN or NPI change; service, billing, or notice address change.
- Updates to locations where practitioners are linked for directory display and Member appointments. Since this information is subject to regulatory auditing, immediate notification of these roster changes is imperative.

- Any change of the Practitioner's name; Medicare or Medicaid number or enrollment status; degree change; or location providing services.
- Any change of appointment phone numbers or referral fax numbers for each practice location and/or facility location.
- Any change of Contracting Contact; Practitioner Credentialing Contact; Facility Credentialing Contact; and/or Quarterly Attestation Recipient.
- Any other event or circumstance that materially impairs Provider's ability to provide Covered Services to Members as required by the Provider Manual (including Provider's inability to provide covered services at a Facility at which KP expects Provider to provide Covered Services).

Access the Provider Demographics page at http://kp.org/providers for templates and instructions to submit updates.

*Note that a W9 is ***required*** to update the Contract Legal Entity or dba name, the TIN, and the billing (remittance) address.

6.4.3 Adding a New Practitioner

If your office/facility is adding a physician or other professional practitioner to your practice, ~~please~~ fill out the appropriate provider demographic template found on the Community Provider Portal (CPP)* and email or fax the template and written notice, including the effective date of the change, at least 90 days in advance to allow time for enrollment and credentialling processes.

- For Professional and Facility demographic updates email KPCO-PDM@kp.org or send via secure fax to 877-580-0632.

*Provider Demographic templates may be found at:
http://providers.kaiserpermanente.org/html/cpp_cod/providerdemographics.html

Please Note: *Practitioners* **may not** see Kaiser Permanente Members or bill for services until they have successfully completed the credentialing process.

Facility Credentialing or when Credentialing is Not Required: Please notify KPCO-PDM@kp.org prior to rendering services to update Kaiser Permanente's systems accordingly. ***Please note: Do not see Kaiser Permanente Members or bill for services until KP has been notified.***

Providers with delegated Credentialing agreements: The delegated entity must notify KPCO-PDM@kp.org of the addition of a credentialed physician or professional practitioner as soon as possible, but not greater than fifteen (15) days after the credentialing approval date.

Please note: Failure to notify KP within fifteen (15) days of the credentialing approval date will result in denial of claims for all dates of service through the date KP receives notification.

6.4.4 Adding a New Practitioner

If your office has a physician or other professional practitioner leaving your practice, please notify KPCO-PDM@kp.org.

6.4.5 Quarterly Attestations

All Providers will receive attestation rosters quarterly. The data must be validated for accuracy and responses sent to KPCO-PDM@kp.org within 15 days. Notifying KP Provider Data Management of updates to the attestation recipient email address as it occurs is critical to this process.

6.4.6 Other Required Notices

Providers shall use best efforts to notify Kaiser Permanente in writing at least 90 days prior to cessation or suspension of any services.

Providers are required to give Kaiser Permanente notice of a variety of other events, including changes in insurance and ownership, adverse actions involving Practitioners' licenses, participation in Medicare, and other occurrences that may affect the provision of services under your Agreement. Your Agreement describes the required notices, and the way notices should be provided.

6.5. CALLING COVERAGE PROVIDERS

Call Coverage Providers must adhere to Sections 6.1 and 6.2 of this Provider Manual.

6.6. TYPES OF DISPUTES, REQUIREMENT AND SUBMISSION TIME PERIODS

6.6.1 Types of Disputes – Definitions

Provider Reconsideration / Appeal

A provider is challenging the initial organization determination by the plan.

- For claims for Medicare Members: Applies only to non-contracted providers*
- Claim denied 100%
- Partially paid claims with Post Stabilization (CRD12) denials
- Partially paid claims with Not Authorized (AUDxx) denials
- Partially paid claims with denials assigning financial responsibility to the Member (Not copay/coinsurance/deductible)

*Note – for claims for Medicare Members:

Per CMS Guidelines: Provider Disputes involving payment amounts are governed by the dispute resolution provisions in the provider contract. Thus, a reconsideration / appeal request cannot be filed for fully and partially paid claims by contracted providers.

Provider Dispute
A provider is challenging the initial organization determination by the plan.

- Contracted providers – Medicare and non-Medicare
- Non-Contracted providers – non-Medicare
- Includes any other determination not defined as a reconsideration (above)

6.6.2 Provider Disputes – Timely Submission

Provider Claims Dispute

- In writing
- Within 90 calendar days of the last plan determination
- Failure to request the dispute within 90 days shall result in the appeal request being denied

6.6.3 Provider Reconsiderations/Appeals - Timely Submission

Provider Reconsideration / Appeal

- In writing
- Must be filed within 60 calendar days from the date of the notice of the initial determination
- Waiver of Liability (WOL) must be filed with the appeal
- Failure to request the reconsideration within 60 days or no WOL will result in a dismissal

6.6.4 Submission Instructions

Online Submission of Claims, Disputes, Appeals and Supporting Claim Documents:
Kaiser Permanente has launched a new capability to allow providers that use Online Affiliate to submit the following information electronically:

- Claim appeal/dispute requests.
- Respond directly to Kaiser Permanente's Requests for Information (RFI).
- Proactively upload claim-related documents/attachments.

Please begin submitting claims disputes, appeals, and requests for information electronically!

To begin submitting electronically, please visit providers.kaiserpermanente.org/cod and locate **Online Affiliate** from the left side menu bar.

6.6.5 Provider Claims Disputes – Decision

Denial Upheld: The Provider will be notified in writing by the Kaiser Permanente Provider Disputes department within 45 calendar days of receipt and the plan will forward the case, including the rationale for the decision.

Denial Overturned: The Provider will be notified in writing within 45 calendar days of the outcome of the claims dispute including the rationale for the new determination along with a description of the payment. The provider will also be notified through the standard claims adjudication process via an Explanation of Payment (EOP).

6.6.6 Provider Reconsiderations/Appeal – Decision

Denial Upheld: The Provider will be notified in writing by the Kaiser Permanente Provider Appeals department within 60 calendar days of receipt.

For claims for Medicare Members (applicable to non-contracted providers only), the plan will forward the case to the Medicare Independent Review Entity (IRE), Maximus, as per established CMS procedures.

Denial Overturned: The Provider will be notified in writing within 60 calendar days of the appeal's outcome, including the rationale for the new determination and a payment description. The provider will also be notified through the standard claims adjudication process via an Explanation of Payment (EOP).

6.7. PROVIDER RIGHTS AND RESPONSIBILITIES/MEDICARE ADVANTAGE

Adherence to Appeals Procedures (same as under Member Rights) Compliance with Laws and Regulations:

Practitioners and providers and subcontractors must agree to comply with all rules and regulations applicable to Federal contracts. These include all laws and regulations applicable to Federal contracts, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of Federal funds. You must comply with Federal criminal law, the False Claims Act (31 U.S.C. 3729 et.Seq.) and the anti-kickback statue (section 1128B(b) of the Act). This also includes the general rules that might apply, and the policies, procedures and manual provisions, as well as other program requirements, issued by CMS. These also include Kaiser Permanente's policies and procedures.

6.7.1 Compliance with Policies and Programs

All practitioners and providers must comply with the medical policy, quality assurance program and medical management program. This includes reviewing and participating in the programs as required.

6.7.2 DOI Regulation 4-2-80 - - Diversity and Cultural Competency Training Tools

If you have not completed your required Diversity and Cultural Competency Training for this year, you can find the Kaiser Permanente Diversity, Equity, and Inclusion Tool Kit here: Diversity Equity Inclusion Toolkit

Once training has been completed for your group, please answer the following questions, and send your responses to your Provider Experience Consultant.

Culturally Sensitive and Anti – Bias Questions

- Have your providers and front office staff gone through Culturally Sensitive, Anti-Bias, Health Equity, or any similar training during the previous calendar year?
- Type of Training? (Cultural Competency, Anti-Bias, Structural Racism, Racial Justice, Health Equity, Allyship, or Other)
- Training provided by? (i.e. HR department, outside consulting group, Youtube, etc.)
- Course duration (minutes, hours, or days)
- # Of licensed providers at the practice
- # Of licensed providers who have completed training
- # Of Front Office Staff at the practice
- # Of Front Office Staff that have completed training
- Date Completed
- Was Certificate or CME awarded? (Y or N)

Third-Party Payers, including Kaiser Permanente, will be collecting this data on a yearly basis.

If you have questions about Regulation 4-2-80, please reference link below, OR reach out to your Provider Experience Consultant (PEC) at 1-866-866-3951 or by email at NDPC-PEC-Cases@kp.org.

https://doi.colorado.gov/announcements/notice-of-adoption-amended-regulations-4-2-73-and-5-2-12-and-new-regulation-4-2-80

6.7.3 Continuation of Services after Termination

Practitioners and providers acknowledge that they will continue to provide benefits to Members if Kaiser Permanente goes bankrupt, cannot pay its debts, or terminates its contract with CMS or another provider.

Practitioners and providers must continue to serve the Member until the end of the month in which CMS makes its last payment to Kaiser Permanente for the Member. If the Member is hospitalized when the contract is terminated, the obligation to provide services continues until discharge.

6.7.4 Cooperate with Independent Quality Review

Quality Review is an essential part of Kaiser Permanente's arrangement with CMS. Since medical care is subject to quality review and are obligated to participate in any quality review function Kaiser Permanente designates.

6.7.5 Cultural Competency

Practitioners and providers must ensure that services are provided in a culturally competent manner to all Members. Kaiser Permanente expects providers to provide health care that is sensitive to the needs and health status of different population groups, which includes Members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical and mental disabilities. Kaiser Permanente has a Diversity Department that can assist with questions Providers may have regarding this matter.

6.7.6 Delegation

If Kaiser Permanente has delegated any core activity or function (as defined by CMS) to a contracted practitioner, the activity or function must be monitored and overseen by Kaiser Permanente.

To the extent that any practitioner or provider has been delegated any activities or functions which are the responsibility of Kaiser Permanente, the provider or practitioner will make periodic and other reports as reasonably required by Kaiser Permanente. In its agreements with practitioners and providers, Kaiser Permanente will specify the delegated activities and reporting responsibilities, termination procedures should the affiliated practitioner not perform function(s) as required, and Kaiser Permanente's right and responsibility to perform ongoing monitoring.

6.7.7 Disclosure of Quality and Performance Indicators

Kaiser Permanente conducts ongoing studies and surveys of Member satisfaction and health outcomes. The provider must participate in these studies and surveys as requested by Kaiser Permanente pursuant to CMS standards.

6.7.8 Follow Up Care and Training in Self Care

Contracted providers must ensure Members receive the information they need to participate fully in their own care, including information on such subjects as: self-care,

medication management, use of medical equipment, potential complications and when these should be reported to providers, and scheduling of follow up services.

6.7.9 Adherence to CMS Marketing Provisions

All forms of written or electronic marketing materials for potential and current Members must be reviewed and approved by Kaiser Permanente Medicare Compliance and/or CMS before they are sent.

Marketing materials include materials used to promote Kaiser Permanente or Kaiser Permanente Senior Advantage, inform Medicare Members and beneficiaries about enrollment, explain coverage of benefits and plan rules, and explain coverage of Medicare services. Materials will usually be developed, produced, and disseminated by Kaiser Permanente. If practitioners and providers or provider groups develop their own informational materials intended to inform their Medicare patients about Kaiser Permanente Senior Advantage or its services, such materials must be submitted to Kaiser Permanente Medicare Compliance for review and approval. Marketing materials developed by practitioners and providers that are intended for Senior Advantage Members or other Medicare beneficiaries require Kaiser Permanente Medicare Compliance and/or CMS approval.

6.7.10 No Recourse Against Members

CMS requires Medicare Advantage Members be protected from incurring financial liability for charges that are the obligation of Kaiser Foundation Health Plan of Colorado. Senior Advantage Members are liable only for cost-sharing amounts that are specified in the Member's Evidence of Coverage.

6.7.11 Notice and Hearing Rights

If Kaiser Permanente suspends or terminates an agreement for services, its written notice of such suspension or termination will be provided to the party with whom Kaiser Permanente has the contract. If the contract is with an individual affiliated provider, Kaiser Permanente will provide the practitioner or provider with the notice of hearing rights as required by the Medicare Advantage statues, rules, and regulations. If a contract is with a practitioner or provider group or organization, the group or organization must give each affected physician who is entitled to notice and a hearing under the Medicare Advantage Program, written notice of such suspension or termination. The notice shall include notice of the right to appeal, the process, and timing of such appeal and reference Kaiser Permanente's notice and hearing procedures. Any such right of appeal will not delay the date of suspension or termination. Right of appeal and hearing are only available to individual physicians.

6.7.12 Notice of Termination of Practitioners

Kaiser Permanente has procedures in place to notify all affected Members of a

practitioner's termination from the network. Such terminated practitioners may only communicate with Members in accord with Kaiser Permanente policies and procedures.

Furthermore, terminated practitioners must provide Kaiser Permanente with the information needed to meet its notice obligations. Kaiser Permanente is required to make a good faith effort to notify affected Members within 30 calendar days of the date when the notice of termination was provided.

6.7.13 Payment and Incentive Arrangements

Payment arrangements between Kaiser Permanente and its practitioners and providers must be specified in all contracts. These provisions apply to all levels of contracting, and it is important that this requirement be included at each level of the contracting process. Note that no contract provision can create an incentive to reduce or limit services to a specific Member.

6.7.14 Professionally Recognized Standards of Health Care

Services to Members must be provided in a manner consistent with professionally recognized standards of care.

6.7.15 Prohibiting Against Contracting with Excluded Individuals and Entities and Opt Out Providers

Kaiser Permanente is prohibited from employing or contracting with practitioners and providers excluded from participation in any Federal health care program, including Medicare. Affiliated practitioners and providers are also prohibited from employing or contracting with such providers. In addition, Kaiser Permanente may not contract with practitioners and providers who treat Kaiser Permanente Medicare Advantage Members unless they participate in Medicare. Such practitioners and providers must certify to Kaiser Permanente that their contractors are eligible to participate in Medicare. Contracts are terminable for these reasons.

6.7.16 Prompt Payment

The amount of payment and the period in which payment should be made must be set forth in the contract. Any subcontracts that you have with practitioners or providers to provide services to Senior Advantage Members must likewise contain a prompt payment provision.

6.7.17 Terminations without Cause

To ensure stability and continuity in services for Senior Advantage Members, CMS requires that Medicare Advantage organizations like Kaiser Permanente and its practitioners and

providers provide each other with at least 60 days written notice before terminating a contract without cause.

6.7.18 Medicaid and CHP+ Providers

Federal regulations established by the Centers for Medicare & Medicaid Services (CMS) require enhanced screening for all existing (and newly enrolling) providers who render services under a state Medicaid plan or waiver. These regulations are designed to increase compliance and quality of care and to reduce fraud. All providers, medical or nonmedical, who are enrolled with and bill Medicaid for services must be screened under rule CCR 2505-10 8.100 by enrolling. In addition, providers that provide services through Managed Care Organizations (MCOs), including Child Health Plan *Plus* (CHP+) and Regional Accountable Entities (RAEs), need to enroll as a Colorado Medicaid Provider. The validity and currency of all provider licenses to perform any service must be screened. Providers complete the enhanced screening requirements during Medicaid enrollment as under rule 10 CCR 2505-10 8.125.

Kaiser Permanente must verify whether a provider, supplier or facility is actively enrolled in Health First Colorado (Colorado's Medicaid Program) on the date(s) of service and is eligible to receive payment for CHP+ members prior to paying any CHP+ claim for covered services. Kaiser Permanente will deny a CHP+ claim submitted for processing if an NPI listed on the claim is not actively enrolled with Health First Colorado on the date(s) of service.

To enroll as a Colorado Medicaid provider, revalidate or correct the NPI with Health First Colorado visit the Provider Enrollment website at https://hcpf.colorado.gov/provider-enrollment.

For Provider Enrollment assistance, contact the Health First Colorado Provider Services Call Center at 1-844-235-2387, Monday – Friday 7:00 a.m. - 5:00 p.m. MT with questions about enrollment and revalidation.

Providers are encouraged to check the status of all provider NPIs listed on a claim to confirm active enrollment as billing, servicing, ordering, prescribing, referring or attending providers as of the date(s) of service. A request for a retroactive enrollment effective date may be necessary if the NPI was not actively enrolled with Health First Colorado on the service date(s). Organization Health Care Providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled. Note that Child Health Plan Plus (CHP+) and Health First Colorado providers must revalidate in Health First Colorado at least every five (5) years to continue as a provider. Providers are encouraged to check revalidation dates in addition to enrollment to avoid lapses. The revalidation schedule is available on the Department's provider webpage under "Revalidation Wave Schedule." https://hcpf.colorado.gov/revalidation