Provider Manual

- **Provider Rights and Responsibilities**

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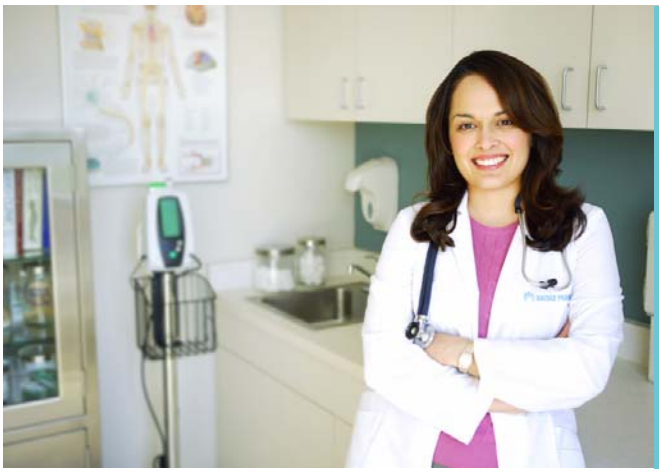

Welcome To Kaiser Permanente

This section of the Manual was created to help guide you and your staff in understanding your rights and responsibilities as our contracting Provider. If, at any time, you have a question or concern about the information in this Manual, you can reach our National Provider Contracting Department by calling 510-268-5448.

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Table of Contents

Section 6: Provider Rights and Responsibilities

As a contracting Provider for Kaiser Permanente, you are responsible for understanding and complying with terms of your Agreement and this Manual. If you have any questions regarding your rights and responsibilities under the Agreement and the Manual, we encourage you to call our National Provider Contracting Department at 510-268-5448 for clarification.

In addition to the obligations set forth in the Agreement Providers repsonbilities include, but are not limited to 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 coverage for coordination of benefits.
- 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.
- 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 the Kaiser Permanente Member Rights and Responsibility Section of this 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 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 Share including co-payments, deductibles and coinsurance from Kaiser Permanente Members as required by your Agreement.
- To comply with this 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.

6.1 Required Notices

6.1.1 Change of Information

In addition to what is set forth in the agreement, contracted providers are responsible for notifying Kaiser Permanente's National Transplant Network (NTN) promptly in writing 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 under 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 or 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 manner in which it provides Covered Services to Members.
- Illness or disability leads to a reduction in work hours or the need to close a transplant program, contracted providers must immediately notify the NTN Transplant Coordinator.
- 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 legal status, tax identification number, Medicare or Medicaid number, phone numbers or program office hours.

Provider shall use best efforts to notify Kaiser Permanente's NTN in writing at least thirty (30) days prior to a change in telephone numbers or program office hours and ninety (90) days prior to cessation or suspension of any Services. Verbal notification

must be followed by written/faxed documentation. Please mail or fax written notice, including the effective date of the change to:

National Transplant Network
Kaiser Permanente
1800 Harrison Street, 18th Floor
Oakland, CA 94612
Fax: 510-625-2899

6.1.2 Practitioner Retirement or Termination

If your program has a Practitioner who is retiring or leaving the practice, please mail written notice, including the effective date of the retirement or departure, thirty (30) days prior to the date the Practitioner is leaving to:

National Transplant Network
Kaiser Permanente
1800 Harrison Street, 18th Floor
Oakland, CA 94612
Fax: 510-625-2899

6.1.3 Contract Termination

Written notice is required to terminate the Agreement. The effective date of the termination is usually 90 days (unless otherwise specified in the Agreement) after the notice is received by Kaiser Permanente's National Transplant Network and National Provider Contracting Departments.

An NTN representative will contact the provider to review the termination process that may include transferring Members and their medical records to other Kaiser Permanente contracted centers.

The NTN will make every effort to notify all affected Members of the change in provider within 15 days notice of termination, so the Member can be assured of continuity of care and appropriate access of services.

The NTN will implement a transition plan to move those Members to other providers with minimal disruption to their medical treatment. In the event that the transition takes longer than the termination period, the provider remains obligated to care for the affected Member(s) per the terms of the Agreement.

6.1.4 Other Required Notices

You are required to give Kaiser Permanente notice of a variety of other events, including changes in your insurance and ownership, adverse actions involving your 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 manner in which notice should be provided.

6.1.5 Adding a New Practitioner

If Provider is adding a new Practitioner to the transplant program, please mail written notice, including the effective date of the retirement or departure, thirty (30) days prior to the date the Practitioner is leaving to:

National Transplant Network
Kaiser Permanente
1800 Harrison Street, 18th Floor
Oakland, CA 94612
Fax: 510-625-2899

6.1.6 Complaint and Patient Care Issues

Kaiser Permanente will make every effort to work with a Provider in the resolution of complaints they may have regarding administrative or contractual issues, or problems encountered while providing health care to Kaiser Permanente Members.

Providers should contact a Transplant Coordinator from the referring Kaiser Permanente Hub (see Key Contact Section of this Manual) for assistance in resolving administrative and patient related issues. Some examples of administrative issues include clarification of the authorization or referral process.

For assistance in resolving contractual issues, the provider is advised to contact the National Provider Contracting Department at 510-268-5448.

6.2 Types of Disputes, Requirements and Submission Time Periods

Kaiser Permanente provides all Providers with a dispute resolution mechanism under which you may submit all disputes regarding claims, billing determinations, or other

contract issues. We will handle disputes and this dispute resolution mechanism in accordance with your Agreement and the applicable law.

If you disagree with the handling of a claim, you should first call the Member Service Department in the Member's health plan region (see Key Contacts Section of this Manual) to inquire about the claim. In most cases, Member Services should be able to answer and resolve any issues you may have. If resubmission or reconsideration is necessary please send in the information and make sure you stamp or write resubmission or reconsideration on the claim form.

Timely Submission of Provider Request for Reconsideration

When a Provider disagrees with a claim determination, a request for reconsideration on the claim must be forwarded in writing to Kaiser Permanente within 60 days from the date of the Explanation of Payment (EOP) (*See Section 5.42 in the Billing and Payment Section of this Manual*). Provider's failure to submit written requests for reconsideration within 60 days shall result in the request being denied by Kaiser Permanente with no further action being allowed by the Provider.

6.2.1 Requirements

If your Provider Appeals Notice does not contain all of the applicable information listed below, Kaiser Permanente may return the Provider Appeals Notice to you and we will identify in writing the missing information necessary to resolve the dispute. If you want to continue the dispute, you must submit an amended Provider Dispute Notice within 60 business days after the date that you received your Provider Dispute Notice back from Kaiser Permanente. Your Provider Appeals Notice must contain at least the information listed below, as applicable to your dispute.

- Provider name and contact information
- If the dispute concerns a claim or a request for reimbursement of any overpayment of a claim, a clear identification of the disputed item using the same number assigned to the original claim, the date of service and a clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.
- If the dispute is not about a claim, a clear explanation of the issue and your position on the issue.
- If the dispute involves a Member or a group of Members, the name and Medical Record Number(s) of the Member(s), a clear explanation of the disputed item, including the date of service and your position about the item.
- If you are submitting a batch of disputes, they must be substantially similar, and you must have a numbering system that identifies each dispute contained in the bundled notice.

6.2.2 Who is Authorized to Submit Provider Appeals

A Provider Appeals Notice may be submitted by you or by your authorized representative (for example, a billing service, a collection agency, or an attorney) approved by you to perform this function.

If your authorized representative submits your Provider Appeals Notice, that representative will be required to provide confirmation that an executed business associate agreement that complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is in place between you and the representative.

6.2.3 Where to Send Provider Appeals

The Provider Appeals Committee in the Kaiser Permanente health plan region reviews written appeals submitted by contracted providers regarding claims payment or denial. The Committee reviews appeals submitted for provider liability issues only. The Provider Appeals Committee reviews the circumstances and determines the disposition of the following types of appeals:

- Timely filing
- Other carrier
- No referral or Authorization
- Date of Authorization Different than Date of Service
- Contract Dispute
- Coding Issues
- Other

Providers should submit written appeals along with supporting documentation, within 60 calendar days from the statement of remittance to Kaiser Permanente Provider Appeals Department in the Member's home region.

You will be notified in writing by the Kaiser Permanente Appeals Unit regarding the decision to uphold a denial. The letter will contain the rationale for the decision. For payment appeal, if the Member may potentially be held financially liable, the Member will also receive a copy of the letter and instructions on any further appeal rights.

If the denial is overturned, you will be notified in writing on the outcome of the appeal and action taken by Kaiser Permanente Appeals Unit, e.g. payment processes or referral/authorization approved.

All provider disputes must be submitted to the address specified in the initial denial letter/notification by the Provider or designee if related to the claim, or to the notification address identified in the Agreement for contract related issues.

6.2.5 Dispute Submission Timeline

Providers should submit your request for appeal in writing, along with supporting documentation, within 60 calendar days of the EOP to the Claims Department responsible for payment of the Member's claims.

Kaiser Permanente will notify you in writing of the outcome of your payment dispute request within 45 working days following Kaiser Permanente's receipt of all necessary information.

6.2.6 Provider Adjustments

Requests for adjustments to claims payments must be made as follows:

- Request for claims adjustments must be made within 30 days of the original Explanation of Benefits (EOB).
- Request for adjustments to claim involving coordination with federally funded health benefit plans, including Medicare and Medicaid, must be made with 36 months of the date of service.

Adjustment initiation process can be started by calling the Member Services Department, see Key Contact Section of this Manual.