

SECTION 6

MEMBER RIGHTS AND RESPONSIBILITIES

6.0 INTRODUCTION

Kaiser Permanente recognizes that its members have both rights and responsibilities in the management of their health care. Individuals enrolled in Kaiser Permanente Health Plans have certain rights that are protected during their encounters with Kaiser Permanente representatives who consist of participating providers, contracted providers, and their employees, as well as Kaiser Permanente employees. By the same token, members are expected to assume responsibility for their knowledge, attitudes, and behavior related to the health care services they receive while enrolled in a Kaiser Permanente Health Plan.

This section addresses a member's rights and responsibilities, in addition to avenues available to remedy any situation the member believes they have not received appropriate services, care, or treatment.

6.1 MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

Kaiser Permanente has developed a statement which addresses a member's right to participate in their medical care decisions which range from selecting a primary care provider to being provided with all information needed to making decisions regarding recommended treatment plans.

This statement also addresses their responsibilities which include understanding the extent and limitations of their health care benefits, following established procedures for accessing care, recognizing the impact their lifestyle has on their physical conditions, providing accurate information to their caregivers, and following agreed treatment plans.

Kaiser Permanente provides each member with the Member Rights and Responsibilities Statement upon enrollment in the Health Plan. A copy of the statement is included in the Kaiser Permanente Rights and Responsibilities Handbook, the Disclosure Form and Evidence of Coverage booklet, the Healthwise Handbook, and in New Member materials. Members may call their local DME department (if applicable) or Member Services to obtain additional copies of the information listed above. Please refer to the "Key Contacts" section of this Provider Manual for telephone numbers.

Kaiser Permanente members have the right to:

- Receive care with dignity and respect. The right to be treated fairly, with respect and consideration, without regard to race, religion, gender, sexual orientation national origin, cultural background, disability, age or financial status
- Be supported in choosing and changing providers and seeking a second opinion within the plan
- Receive information about policies, services, facilities, benefits and care in a way they can understand. Be provided an interpreter if needed. Make recommendations regarding our policies (including member rights and responsibilities) and services
- Consult with our ethics service staff when facing difficult medical ethics issues

- Be supported if they change their mind about any procedure, refuse treatment, and be informed of the consequences of their decision
- Receive information regarding Kaiser Permanente and its services
- File a complaint, grievance or appeal about Kaiser Permanente's policies, or the care or services provided and expect an appropriate, confidential and timely response
- Receive information regarding charges and payment methods
- Have a safe, secure, clean and accessible health care environment
- Express their wishes concerning their care
- Receive information about the people who provide their care
- Participate in a candid discussion of all available treatment options
- Have impartial access to treatment
- Be assured of privacy and confidentiality
- Receive information and education they need to participate in their health care to ensure a safe course of treatment. This information includes the diagnosis of a health complaint, the recommended treatment, alternative treatments and the risk and benefits of the recommended treatment.

Kaiser Permanente members are responsible for:

- Reading their Disclosure Form & Evidence of Coverage booklet so that they know the extent as well as exclusions of their coverage
- Identifying themselves to providers
- Keeping appointments
- Understanding their health problems and participating in developing mutually agreed upon treatment goals to the degree possible
- Helping Kaiser Permanente to provide them with the best possible care by sharing with their physician or health care provider, past medical history
- Following the treatment plan agreed upon and to advise the provider of any disagreements with provider recommendations
- Fulfilling financial obligations to Kaiser Permanente and any provider that has been authorized to render services to the member by Kaiser Permanente
- Inform their provider if they are satisfied or dissatisfied with any aspect of their care
- Recognize the effects of their daily lifestyle on their health
- Being considerate of others

Providers and their staff are expected to review and abide by this statement. Should the provider have any questions regarding its contents, they should contact the Management department at the phone number found in the "Key Contacts" section of this Provider Manual.

6.2 NON-COMPLIANCE WITH MEMBER RIGHTS AND RESPONSIBILITIES

Failure to meet the requirements of Kaiser Permanente's Rights and Responsibilities Statement may result in action against the member, provider, or Kaiser Permanente, as appropriate.

➤ **Members**

- In the event a member believes their member's rights have not been upheld, they are instructed in the Member Handbook to discuss the situation with the provider.
- If the member is not comfortable discussing concerns or the member believes the provider cannot resolve the issue to the member's satisfaction, the member may contact Member Services directly to file a complaint against the provider and/or staff.
- Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.
- If a provider receives a complaint from or on behalf of a Kaiser Permanente member which, within their reasonable judgment, is not resolved within two working days, they should notify National Provider Contracting and Strategy Management department at the phone number included in the "Key Contacts" section of this Provider Manual.

➤ **Providers**

If a member fails to meet his/her obligations as outlined in Kaiser Permanente's Rights and Responsibilities Statement and the provider has attempted to resolve the issue, they should contact the local DME department (if applicable) or Member Services. Please refer to the "Key Contacts" section of this Provider Manual for telephone numbers.

Providers should advise Member Services if a member:

- Displays disruptive behavior or is not able to develop a provider/member relationship
- Unreasonably and persistently refuses to follow provider's instructions to the extent that the member's health is considered jeopardized
- Commits belligerent acts or threatens bodily harm to providers and/or staff
- Purposely conceals or misrepresents their medical history or treatment in order to subvert proper treatment planning
- Uses documents with the provider's signature without proper authorization or forges/falsifies a provider's name to documents
- Allows someone to misrepresent him/herself as a Kaiser Permanente member

➤ **Kaiser Permanente reserves the right to**

- Conduct informal mediation to resolve a relationship issue
- Move the member to another provider
- Pursue termination of the member's coverage with the Health Plan, as allowed by the applicable Member "Disclosure Form and Evidence of Coverage."

6.3 ACCESS TO CARE DECISIONS

Kaiser Permanente and affiliated hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for member's clinical needs. Kaiser Permanente does not compensate anyone for denying coverage or service, and Kaiser Permanente does not use financial incentives to encourage denials. In order to maintain and improve the health of the member, all providers should be especially vigilant in identifying any potential under utilization of care or service.

Kaiser Permanente allows open provider-member communication regarding appropriate treatment alternatives without penalizing providers for discussing medically necessary or appropriate care for members. Kaiser Permanente members have the right to choose treatment or service options regardless of benefit coverage limitations. Providers are encouraged to communicate appropriate treatment options, even when the options are not covered by the member's benefit plan. If the provider and the member decide upon a course of treatment that is not covered under the member's Health Plan, the member should be advised to contact Member Services for an explanation of his/her benefits plan. If the member persists in requesting non-covered services, the provider should make payment arrangements with the member in advance of any treatment provided. Kaiser Permanente's Utilization Management program and procedures are:

- To establish whether services are covered under the member's benefit plan
- Based on objective guidelines adopted by Kaiser Permanente, and
- Used to determine medical necessity and appropriateness of care

The decision to proceed with treatment rests with the provider and the member.

6.4 MEMBER COMPLAINT AND GRIEVANCE PROCESS

Kaiser Permanente members are assured a fair and equitable process for reviewing their complaints against contracted providers, their office staff, and Kaiser Permanente employees. This review process is designed to evaluate contributing factors and arrive at a solution that will strive to be mutually satisfactory to the member and Kaiser Permanente. Members are notified of the processes available for resolving complaints in the "Disclosure Form & Evidence of Coverage" booklet, the "Healthwise Handbook", the "Member Rights and Responsibilities" handbook, as well as New Member materials. Complaints and Grievances may be initiated by the member, the member's authorized representative or a contracted provider acting on behalf of a member. A member's complaint may relate to quality of care, access to services, provider or Kaiser Permanente staff attitude, operational policies and procedures, benefits, eligibility, or related issues. When filing a complaint, a member may seek reimbursement of outside costs, an explanation, or an apology. The member may also seek reimbursement, payment, or other resolution, which may exceed the limits of Kaiser Permanente's contractual obligations.

Valid member complaints and grievances against a provider are included in the provider's quality file at Kaiser Permanente. Complaints and grievances are tracked and trended on an on-going basis to identify potential problems with a provider or Kaiser Permanente policies and procedures.

6.5 PROVIDER PARTICIPATION IN MEMBER COMPLAINT RESOLUTION

The established procedures for resolving members' complaints may require the provider's participation. Kaiser Permanente will advise the provider of the involvement required or information that must be provided. The provider will also be informed of how the complaint is resolved and what recourse the provider may have should a decision be made against the provider. For additional information regarding the provider appeal process, the provider should refer to the "Provider Rights and Responsibilities" section of this Provider Manual.

6.6 MEMBER COMPLAINT AND GRIEVANCE RESOLUTION PROCEDURE

If a member has a question or concern about medical services, Kaiser Permanente encourages the member to resolve the issue directly with the provider. If the issue cannot be resolved in this manner, the member or their authorized representative is encouraged to contact a Member Assistance Coordinator or the Member Service Department at the local Kaiser Permanente facility. The member or their authorized representative is also provided the telephone number to the Member Service Call Centers for assistance if the member or provider believes that the issue is urgent in nature, the member, their authorized representative, or provider may call the Expedited Review and Appeal Department. More information regarding Expedited Review may be found in the Utilization Management section of this Provider Manual.

6.7 COMPLAINT PROCEDURES

If the problem/issue is not amenable to immediate resolution at the point of service, the member has three options. These are:

- File a formal complaint with the Member Assistance Coordinator
- File a formal complaint with local Member Service Department
- Contact the Member Service Call Center. This may be done verbally or in writing

Receipt of the complaint will be acknowledged within five (5) business days. Resolution should be received within thirty (30) days of receipt of the complaint. Resolution will be in written form. If the member is not satisfied with the resolution, he/she should be advised of their appeal rights.

6.8 GRIEVANCE PROCEDURES

If a member's request for resolution is monetary in nature, he/she should be advised to contact the Member Service Department at the local Kaiser Permanente facility or to contact the Member Service Call Center to file a formal grievance. This may be done verbally or in writing. The issue will be researched and presented to the Medical Center Member/Member Grievance Committee and a decision will be rendered within thirty (30) days. Decision will be in written form. If the member is not satisfied with the response, he/she may request an appeal. Decisions on appeals will be rendered within forty-five (45) days. The member retains the right to make a brief (fifteen minute) presentation to the initial Member Grievance Committee and to the Appeals Committee.

6.9 APPEALS

Appeals Link Site:

[Claims | National Contracting | Kaiser Permanente](#)

All Kaiser Permanente members have the right to appeal claims denied for payment or requests for services or supplies that have been denied. An appeal may be initiated by the

member; the member's authorized representative or a contracted provider acting on behalf of a member. This includes requests related to medical necessity as well as requests related to coverage denials.

A reconsideration request or appeal should include the following information when Customer Service is contacted to initiate the appeal:

- Name and identification number of the member involved
- Name of the member's provider
- Service that was denied authorization

Kaiser Permanente processes appeals within the time frames established under federal and state law.

If an appeal based on medical necessity or appropriateness is upheld by Kaiser Permanente independent external review may also be available.

Members are made aware of their right to appeal through various Kaiser Permanente member communications. The member appeals process is also outlined in the member's Evidence of Coverage, which is mailed to the member on an annual basis. If Kaiser Permanente denies a service based on medical necessity and/or lack of benefits, the member is notified of the appeals process in the written denial notice.

In the event that the denial is related to services already rendered, as in the case of a denial of claims payment, the member is notified of the appeals process on the back of the Explanation of Benefits.

6.10 72 HOUR EXPEDITED REVIEW AND APPEAL

Members and providers who believe that the member's health status would be seriously jeopardized by submitting a complaint through the standard processes (i.e. waiting 30 days for a response), may contact the Clinical Review Department to request a 72 Hour Expedited Review.

If the issue is accepted for processing through this procedure, the member will receive a response within 72 hours. If it is determined that there is no serious threat the issue will be referred to the local facility for processing by standard timeframes. If the issue is denied for the initial 72-hour Expedited Review, and expedited appeal process is available. Upon receipt of all necessary information, Kaiser Permanente must make a determination on the appeal as expeditiously as required by the member's medical condition, not to exceed 72 hours.

6.11 DEMAND FOR ARBITRATION

A member may file a demand for arbitration after he/she has received the appeal decision or at any earlier step in the process. For more information on arbitration procedures, advise the member or their authorized representative to contact the local facility Member Services department.

NOTE: The complaint and appeals information provided may not address the rights and remedies of each category of member, for example, Medicare, Medicaid (Medi-Cal in California), as well as members who are employed and/or retired from the state or the Federal Government may have different rights and remedies. Members in these categories should be directed to contact Member Services for applicable grievance and appeal provisions, or they may refer to their “Disclosure Form and Evidence of Coverage” brochure for more information.

For all member assistance regarding the above processes, the provider should refer the member to the regional Member Services department at the telephone number listed in the “Key Contacts” section of this Provider Manual.