

7. Member Rights and Responsibilities

KP recognizes that Members have both rights and responsibilities in the management of their health care.

Members have certain rights to which they are entitled when they interact with representatives of KP: Providers, and the employees of those Providers, as well as KP employees and physicians.

Members are also expected to be responsible for knowing about their health care needs and coverage. They are also responsible for maintaining appropriate attitudes and behavior when receiving health care as a Member.

This section addresses our Members' rights and responsibilities as well as their opportunities to address any situation where they may believe that they have not received appropriate services, care, or treatment.

7.1 Member Rights and Responsibilities Statement

KP has developed a statement of Member rights which includes a Member's right to participate in the Member's own medical care decisions. These decisions range from selecting a PCP to making informed decisions regarding recommended treatment plans. Providers and their staff are expected to accept and honor these Member Rights and Responsibilities.

The Member Rights and Responsibilities Statement also includes a Member's responsibility to understand the extent and limitations of their health care benefits, to follow established procedures for accessing care, to recognize the impact lifestyle has on physical condition, to provide accurate information to caregivers, and to follow agreed upon treatment plans.

Upon enrollment and annually thereafter, KP provides notification to each subscriber that a Member Rights and Responsibilities Statement is available which includes the following statements directed to Members:

Active communication between you and your physician as well as others on your health care team helps us to provide you with the most appropriate and effective care. We want to make sure you receive the information you need about your Health Plan, the people who provide your care, and the services available, including important preventive care guidelines. Having this information contributes to your being an active participant in your own medical care.

We also honor your right to privacy and believe in your right to considerate and respectful care.

This section details your rights and responsibilities as a Kaiser Permanente member and gives you information about member services, specialty referrals, privacy and confidentiality, and the dispute resolution process.

As an adult member, you exercise these rights yourself. If you are a minor or are unable to make decisions about your medical care, these rights will be exercised by the person with the legal responsibility to participate in making these decisions for you.

YOU HAVE THE RIGHT TO:

Receive information about Kaiser Permanente, our services, our practitioners and providers, and your rights and responsibilities.

We want you to participate in decisions about your medical care. You have the right and should expect to receive as much information as you need to help you make decisions. This includes information about:

- Kaiser Permanente
- The services we provide, including behavioral health services
- The names and professional status of the individuals who provide you with service or treatment
- The diagnosis of a medical condition, its recommended treatment, and alternative treatments
- The risks and benefits of recommended treatments
- Preventive care guidelines
- Ethical issues
- Complaint and grievance procedures

We will make this information as clear and understandable as possible. When needed, we will provide interpreter services at no cost to you.

Participate in a candid discussion of appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they're not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you don't agree with it or if it conflicts with your beliefs.

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender

expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Medical emergencies or other circumstances may limit your participation in a treatment decision. However, in general, you will not receive any medical treatment before you or your representative gives consent. You and, when appropriate, your family will be informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.

Participate with practitioners and providers in making decisions about your health care. You have the right to choose an adult representative, known as your agent, to make medical decisions for you if you are unable to do so and to express your wishes about your future care. Instructions may be expressed in advance directive documents such as an advance health care directive. See <http://www.kp.org/advancedirectives> for more information about advance directives.

For more information about these services and resources, please contact our Member Service Contact Center 24 hours a day, 7 days a week (closed holidays) at **1-800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711**.

Have ethical issues considered. You have the right to have ethical issues that may arise in connection with your health care considered by your health care team. Kaiser Permanente has a Bioethics/Ethics Committee at each of our medical centers to assist you in making important medical or ethical decisions.

Receive personal medical records. You have the right to review and receive copies of your medical records, subject to legal restrictions and any appropriate copying or retrieval charge(s). You can also designate someone to obtain your records on your behalf. Kaiser Permanente will not release your medical information without your written consent, except as required or permitted by law.

To review, receive, or release copies of your medical records, you'll need to complete and submit an appropriate written authorization or inspection request to our Medical Records Office at the facility where you get your care. They can provide you with these forms and tell you how to request your records. Visit <http://www.kp.org> to find addresses and phone numbers for these departments.

Receive care with respect and recognition of your dignity. We respect your cultural, psychosocial, spiritual, and personal values; your beliefs; and your personal preferences.

Kaiser Permanente is committed to providing high-quality care for you and to building healthy, thriving communities. To help us get to know you and provide culturally competent care, we collect race, ethnicity, language preferences (spoken

and written) and religion data. This information can help us develop ways to improve care for our members and communities. This information is kept private and confidential and not used in underwriting, rate setting, or benefit determination. We believe that providing quality health care includes a full and open discussion regarding all aspects of medical care and want you to be satisfied with the health care you receive from Kaiser Permanente.

Use interpreter services. When you call or come in for an appointment or call for advice, we want to speak with you in the language you are most comfortable using. For more about our interpreter services, please refer to <http://info.kaiserpermanente.org/html/gethelp/california.html> or call our Member Services Contact Center at **1-800-464-4000** or **TTY: 711**.

Be assured of privacy and confidentiality. All Kaiser Permanente employees and physicians, as well as practitioners and providers with whom Kaiser Permanente contracts, are required to keep your protected health information (PHI) confidential. PHI is information that includes your name, Social Security number, or other information that reveals who you are, such as race, ethnicity, and language data. For example, your medical record is PHI because it includes your name and other identifiers.

Kaiser Permanente has strict policies and procedures regarding the collection, use, and disclosure of member PHI that includes the following:

- Kaiser Permanente’s routine uses and disclosures of PHI
- Use of authorizations
- Access to PHI
- Internal protection of oral, written, and electronic PHI across the organization
- Protection of information disclosed to Plan sponsors or employers

Please review the section titled “Privacy Practices” at <https://healthy.kaiserpermanente.org/privacy-practices>

For more information about your rights regarding PHI as well as our privacy practices, please refer to our Notice of Privacy Practices on our website <http://www.kp.org>, or call MSCC at **1-800-464-4000** or **TTY: 711**.

Participate in physician selection without interference. You have the right to select and change your personal physician within the Kaiser Permanente Medical Care Program without interference, subject to physician availability. To learn more about nurse practitioners, physician assistants, and selecting a primary care practitioner, please visit <http://www.kp.org> “Doctors and Locations”.

Receive a second opinion from an appropriately qualified medical practitioner. If you want a second opinion, you can either ask your Plan physician to help you arrange for one, or you can make an appointment with another Plan physician. Kaiser Foundation Health Plan, Inc., will cover a second opinion consultation from a non-Permanente Medical Group physician only if the care has been pre-authorized by a Permanente Medical Group. While it is your right to consult with a physician outside the Kaiser Permanente Medical Care Program without prior authorization, you will be responsible for any costs you incur.

Receive and use member satisfaction resources, including the right to voice complaints or make appeals about Kaiser Permanente or the care we provide. You have the right to resources such as patient assistance and member services, and the dispute-resolution process. These services are provided to help answer your questions and resolve problems.

A description of your dispute-resolution process is contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services Department or our Member Service Contact Center to request another copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy. When necessary, we will provide you with interpreter services, including Sign Language, at no cost to you.

For more information about our services and resources, please contact our Member Service Contact Center at **1-800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711**.

Make recommendations regarding Kaiser Permanente's member rights and responsibilities policies. If you have any comments about these policies, please contact our Member Services Contact Center at **1-800-464-4000** or **TTY: 711**.

YOU ARE RESPONSIBLE FOR THE FOLLOWING:

Knowing the extent and limitations of your health care benefits. A detailed explanation of your benefits is contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services Contact Center office to request another copy. If you receive your Kaiser Permanente coverage through your employer, you can also contact your employer for a current copy of your *Evidence of Coverage* booklet or *Certificate of Insurance*.

Notifying us if you are hospitalized in a non-Kaiser Permanente Hospital. If you are hospitalized in any hospital that is not a Plan Hospital, you are responsible for notifying us as soon as reasonably possible so we can monitor your care. You can contact us by calling the number on your Kaiser Permanente ID card.

Identifying yourself. You are responsible for carrying your KP identification (ID) card and photo identification with you at all times to use when appropriate, and for ensuring that no one else uses your ID card. If you let someone else use your card, we may keep your card and terminate your membership.

Your Kaiser Permanente ID card is for identification only and does not give you rights to services or other benefits unless you are an eligible member of our Health Plan. Anyone who is not a member will be billed for any services we provide.

Keeping appointments. You are responsible for promptly canceling any appointment that you do not need or are unable to keep.

Supplying information (to the extent possible) **that Kaiser Permanente and our practitioners and providers need in order to provide you with care.** You are responsible for providing the most accurate information about your medical condition and history, as you understand it. Report any unexpected changes in your health to your physician or medical practitioner.

Understanding your health problems and participating in developing mutually agreed treatment goals to the highest degree possible. You are responsible for telling your physician or medical practitioner if you don't clearly understand your treatment plan or what is expected of you. You are also responsible for telling your physician or medical practitioner if you believe you cannot follow through with your treatment plan.

Following the plans and instructions for care you have agreed on with your practitioners. You are responsible for following the plans and instructions that you have agreed to with your physician or medical practitioner.

Recognizing 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—poor choices such as smoking or choosing to ignore medical advice or positive choices such as exercising and eating healthy foods.

Being considerate of others. You are responsible for treating physicians, health care professionals, and your fellow Kaiser Permanente members with courtesy and consideration. You are also responsible for showing respect for the property of others and of Kaiser Permanente.

Fulfilling financial obligations. You are responsible for paying on time any money owed to Kaiser Permanente.

Knowing about and using the member satisfaction resources available to you, including the dispute-resolution process.

For more about the dispute resolution process, see <http://www.kp.org>. A description of your dispute-resolution process is also contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact our Member Services Contact Center to request a copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy of your *Evidence of Coverage* booklet or *Certificate of Insurance*. Our Member Services Contact Center can also give you information about the various resources available to you and about Kaiser Permanente's policies and procedures. If you have any recommendations or comments about these policies, please contact our Member Services Contact Center 24 hours a day, 7 days a week (closed holidays) at **1-800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711**.

7.2 Non-Compliance with Member Rights and Responsibilities

Failure to act in a way that is consistent with the Member Rights and Responsibilities Statement can result in action against the Member, the Provider, or KP, as appropriate.

7.2.1 Members

In the event a Member has a complaint or grievance, the Member is instructed on <http://www.kp.org> and their EOC, or *Certificate of Insurance*, to discuss the situation with the Member Services Contact Center. Members can file a grievance for any issue, including complaints against the Provider and/or the Provider's staff. Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.

Although the Member should contact the Member Services Contact Center about a grievance, you may be approached directly by the Member. If you do receive a complaint from or on behalf of a Member which, in your reasonable judgment, is not resolvable within 2 Business Days, you must notify Provider Services as soon as possible.

KP's grievance forms for Medicare and non-Medicare Members can be downloaded at: <http://providers.kp.org/nca/grievances.html>.

7.2.2 Providers

If a Member fails to meet an obligation as outlined in the Member Rights and Responsibilities Statement and you have attempted to resolve the issue, please contact the Member Services Contact Center (MSCC).

You should advise a KP Threat Management office if a Member performs any of the following acts. Please see Section 2.4 for General Information phone numbers of local KP facilities.

- Displays disruptive behavior or is not able to develop a positive provider/patient relationship
- Unreasonably and persistently refuses to follow your instructions/ recommendations to the extent that you believe it is jeopardizing the patient's health
- Commits a belligerent act or threatens bodily harm to physicians, physician staff, hospital personnel, and/or home health/hospice/SNF staff
- Purposely conceals or misrepresents medical history or treatment
- Uses documents with your signature without proper authorization or forges/falsifies your name to documents, including prescriptions
- Allows someone to misrepresent the Member as a KFHP Member

KP reserves the right at its discretion to:

- Conduct informal mediation to resolve a relationship issue
- Move the Member to another provider
- Pursue termination of the individual's membership or take other appropriate action, as allowed under that Member's specific EOC and applicable law

7.3 Health Care Decision-Making

KP and contracted hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for Members' medical needs. KP does not compensate anyone for denying coverage or services, nor does KP use financial incentives to encourage denials. In order to maintain and improve the health of Members, all Providers should be especially vigilant in identifying any potential underutilization of care or service.

KP encourages open Provider-patient communication regarding available treatment alternatives. We do not penalize Providers for discussing all available care options with our Members.

Our Members have the right to choose among treatment or service options, regardless of benefit coverage limitations. Providers are expected to inform our Members of appropriate care options, even when one or more of the options are not covered benefits under the Member's benefit plan. If the Provider and the patient decide upon a course of treatment that is not covered in the Member's EOC, the Member must be advised they are responsible for the cost of that care.

If the Member is dissatisfied with this arrangement, the Member should be advised to contact MSCC for an explanation of the Member's benefit plan. If the Member persists in requesting non-covered services and the Provider is willing to provide such service, the

Provider should make payment arrangements with the Member in advance of any non-emergent treatment to be provided.

KP's UM program and procedures are:

- Based on objective guidelines adopted by KP
- Used to determine appropriateness and indication of care
- Designed to establish whether services provided or to be provided are covered under a Member's benefit plan

Please refer to Section 4 and Section 9 of this Provider Manual for more details.

The ultimate decision on whether to proceed with treatment rests with the Provider and the Member.

7.4 Advance Directives

An Advance Directive is a written instruction recognized under California and/or federal law, such as a living will or a Durable Power of Attorney for Health Care. An Advance Directive allows Members to appoint a representative to make personal health care decisions on their behalf. A Member's representative must be at least 18 years old. The Member's representative is referred to as a Health Care Agent. To avoid potential conflicts of interest, neither Kaiser Permanente Medical Care Program (KPMCP) personnel nor physicians may serve as witnesses for a Member's Advance Directive.

KP requires that all Providers comply with the federal Patient Self-Determination Act of 1990, which mandates that a patient must have the opportunity to participate in determining the course of their medical care, even when the patient is unable to speak for themselves. The federal law applies to emancipated minors but does not apply to all other minors. Providers must also comply with California's Health Care Decisions law and any other California State Laws concerning Advance Health Care Directives.

To ensure compliance with governing law, the existence of any Advance Directive must be documented in a prominent place in the medical record. An institutional Provider is required to provide written information regarding Advance Directives to all Members admitted to the facility and provide staff and patient education regarding Advance Directives.

Members should be encouraged to provide copies of their completed Advance Directives to all Providers of their medical care. Members should also be informed that they can register their Advance Directive with California Secretary of State's Office. The State will provide the Member with a Registry Card that the Member can carry with them.

If a Member who is a patient wishes to execute or modify an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss

the decision with the Member. The attending physician must document any changes to an Advance Directive in the Member's medical record.

An Advance Directive may be revoked by the Member at any time, orally or in writing if the Member is capable of doing so. Upon divorce, if the spouse was designated as the surrogate decision-maker, by law, the chosen agent is invalidated unless the patient specifically states to the contrary in their Advance Directive. If a Member has more than one written Advance Directive, then the most recently executed document should be recognized. Please note, revoked forms should not be discarded but remain a part of the Member's Medical Record.

Members are provided with information regarding Advance Directives in the Evidence of Coverage and the website at <https://healthy.kaiserpermanente.org/northern-california/health-wellness/life-care-plan> Members may also contact MSCC regarding Advance Directives for an informational brochure and appropriate forms.

7.4.1 Physician Orders for Life Sustaining Treatment (POLST)

A POLST form is a document that is completed with the Member's input (or that of their decision maker) and is signed by their physician. It documents the Member's choices about resuscitation, medical interventions, use of antibiotics, and use of artificially administered fluids and nutrition.

POLST is a physician's order form that outlines a plan of care that reflects the Member's wishes concerning end-of life care. It is voluntary and is intended only for people who are seriously ill. It can be revoked by the Member at any time. This form can assist physicians, nurses, health care facilities, and emergency personnel in honoring the Member's wishes for life-sustaining treatment.

The POLST form complements the advance directive and is not intended to replace that document. Information on the POLST form will be incorporated into the medical record when presented to the individual's Provider.

For more information on POLST, visit <http://www.capolst.org>.

7.5 Member Grievance Process

Members are assured a fair and equitable process for addressing their complaints, grievances and appeals ("grievances") against Providers, their staff, and KP employees. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the Member and the organization, including you, our Provider. Members are notified of the processes available for resolving grievances in their *Evidence of Coverage* and on <http://www.kp.org>.

A Member grievance may relate to dissatisfaction with quality of care, access to services, Provider or staff attitude, operational policies and procedures, benefits, eligibility and

requests for services and care they believe are available under their coverage. Valid Member complaints and grievances against a Provider are included in the Provider's quality file at KP and reviewed as part of the recredentialing process. Grievances are tracked and trended on an ongoing basis to identify potential problems with a Provider or with our own policies and procedures.

The grievance information provided in this Provider Manual is a general overview and is not all inclusive. There are variations to the Member's rights and remedies depending on the membership type (e.g., Medicare, Medi-Cal, etc.), Therefore, Members should be referred to MSCC or to their *Evidence of Coverage* brochure for more information.

7.5.1 Provider Participation in Member Grievance Resolution

The established procedures for resolving Member grievances may require the Provider's participation under certain circumstances. KP will advise you of any involvement required or information that must be provided. Grievances about clinical issues will be reviewed by at least one practitioner provided by KP and practicing in the same or a similar specialty that typically manages the related medical condition, procedure or treatment who was not previously involved in the patient's care. As a result of this review, you may be asked as part of the investigation to respond by email or by an Investigative Review Form to MSCC with your clinical opinion regarding the Member's concern or request.

7.5.2 Member Grievance Resolution Procedure

One of the rights that Members are apprised of on <http://www.kp.org> is that they have the right to participate in a candid discussion with the Provider of all available options regardless of cost or benefit coverage. Members are told, "You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they're not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you do not agree with it or if it conflicts with your beliefs."

If the issue cannot be resolved this way, we encourage the Member to contact a Patient Assistance Coordinator or a Member Services representative at the local KP facility (see also MSCC contact information in Section 2.1). If the Provider presents a grievance on behalf of a Member, and the issue is felt to be of an emergent nature, one that could seriously jeopardize the Member's life, health, or ability to regain maximum function, the Provider or the Member may contact the Expedited Review Unit (ERU) through the Member Service Contact Center to request a review.

7.5.3 Processes for Grievance Resolution

If the problem is not amenable to immediate resolution at the point of service, the Member may submit a grievance through any of the following methods:

- in person to a Patient Assistance Coordinator or Member Services Representative in the Member Services Department at the local KP facility
- via our website at <http://www.kp.org>
- by calling the Member Service Contact Center at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711**
- by completing a Grievance Form or writing a letter and mailing it to a Member Services office at a Plan Facility (member can refer to <http://www.kp.org> for addresses)

Our representatives will advise the Member about the resolution process and ensure that the appropriate parties review the complaint.

Sample Medicare and Non-Medicare Grievance Forms can be found at the end of this section.

Grievances reviewed through the standard process are generally acknowledged within 5 Calendar Days, and resolved as quickly as the member's health requires, but no longer than regulatory timeframes. Depending on the issue and the applicable regulatory requirements, the resolution time frame is generally within 14-30 days.

NOTE: For expedited processing, see Section 7.5.3.2.

7.5.3.1 Quality of Care Grievances

Members' grievances which contain potential quality of care concerns are forwarded by Member Services to the Member Services Clinical Consultants for case review. Clinical Consultants will forward cases to the responsible Quality departments as appropriate.

For Medicare members, the written response to a quality of care grievance will inform the Member of the right to file the quality of care complaint with the Quality Improvement Organization (QIO). The QIO is an organization comprised of practicing doctors and other health care experts under contract with the federal government to monitor and improve the care given to Medicare members. In California, the QIO is Livanta.

7.5.3.2 Expedited Review

A Member who believes that their health status would be seriously jeopardized by submitting an issue through the standard process may request an expedited review.

The Expedited Review Unit (ERU) handles Part C organization determinations and redeterminations meeting the expedited review criteria. The Part D Unit (PDU) addresses expedited Part D coverage determinations and redeterminations. Part C or D payment issues or post-service may not be expedited. When a Member's expedited Part C case or Part D case is received by Member Services, it is the responsibility of the program representative to screen the request to immediately identify whether the request meets the established qualifying criteria for expedited review. Requests that meet these criteria are immediately referred to the ERU or PDU for review.

The ERU and PDU physicians determine if the request meets the criterion for expedited review, which includes screening against regulatory requirements. If a Plan or non-Plan Physician states that an expedited review is required for reasons of clinical urgency, an expedited review will be automatically granted.

Requests meeting expedited criteria are reviewed by a designated ERU/PDU physician in consultation, as needed, with the appropriate specialist(s). If the physicians deny the request, in whole or in part, the Member is informed of the reason for the denial and given information for the next steps to take to have the determination reconsidered.

The Member will be notified of the expedited decision verbally and in writing, as quickly as the member's health requires but no later than the required expedited timeframes – generally within 72 hours.

Requests that do not meet the qualifying criteria for expedited review will be processed in accordance with standard review timeframes.

7.5.3.3 Instructions for Filing a Grievance

The following instructions are to be included with any Grievance Form supplied by Providers to our Members. Providers may reproduce this page and the forms immediately following for that purpose.

HOW TO FILE A GRIEVANCE

KP is committed to providing Members with quality care and with a timely response to their concerns. Members can discuss their concerns with our Member Services representatives at most Plan Facilities, or they can call the MSCC.

Members can file a grievance for any issue. Their grievance must explain the issue, such as the reasons why they believe a decision was in error or why they are dissatisfied about Services they received. Members must submit their grievance orally or in writing within 60 Calendar Days (Medicare) or 180 Calendar Days (Commercial) of the date of the incident that caused their dissatisfaction, or without time limitation (Medi-Cal) as follows:

- To a Member Services representative at their local Member Services Department at a Plan Facility (Member should refer to <http://www.kp.org> for locations), or by calling our Member Service Contact Center:


English: **1-800-464-4000**
Spanish: **1-800-788-0616**
Chinese dialects: **1-800-757-7585**
TTY: **711**

- Through our website at: **<http://www.kp.org>**

We will acknowledge receipt of a Member's grievance after receiving it and provide a resolution as soon as their health requires but no later than regulatory time frames allow, which is generally within 14-30 Calendar Days. If we do not approve a Member's request, we will tell them the reason and inform them about additional dispute resolution options.

NOTE: If we resolve a Member's issue by the end of the next business day after we receive their grievance and Member Services representative notifies them orally about our decision, we will not send them a written decision unless their grievance involves a quality of care issue, breach of privacy, Hospital grievances, coverage dispute, a dispute about whether a service is medically necessary, an experimental or investigational treatment, or those grievances for which they request a written response.

Sample Grievance Form—Medicare

 KAISER PERMANENTE		Grievance/Appeal FORM - Medicare		California	
Member/Patient Name:			Medical Record Number:		
Address		Street		City	
				Zip Code	
Daytime Telephone Number:		Alternate Telephone Number:		Birth Date:	
Name of Person Filing <i>(If different than above, a Statement of Authorized Representative form will be mailed to the member for completion):</i>			Relationship:		Daytime Telephone Number:
Department/Location and Medical Facility where issue occurred:				Date Issue Occurred:	
Please describe the nature of the issue <i>(attach additional sheets if needed):</i>					
Please explain how you have tried to resolve this issue.					
What would you consider a proper solution to this issue?					
Signature:				Date:	
<i>For Program Representative Use Only</i>					
Name of Program Representative:			Facility:		Date Received:
<input type="checkbox"/> Medicare Grievance	<input type="checkbox"/> Part D Drug Coverage Determination	<input type="checkbox"/> Part D Drug Redetermination	<input type="checkbox"/> Medicare Organization Determination	<input type="checkbox"/> Medicare Reconsideration	<input type="checkbox"/> Medi-Medi <input type="checkbox"/> Fed-Med <input type="checkbox"/> PERS-Med
<i>You will be advised of any additional procedural and appeal rights to which you are entitled as we move forward with your issue.</i>					

Revised: 07.01.17

Sample Grievance Form—Non-Medicare

 COMPLAINT OR BENEFIT CLAIM/REQUEST FORM - Non-Medicare California		
Member/Patient Name:		Medical Record Number:
Address	Street	City Zip Code
Daytime Telephone Number:	Alternate Telephone Number:	Birth Date:
Name of Person Filing <i>(If different than above, a Statement of Authorized Representative form will be mailed to the member for completion):</i>		Relationship: Daytime Telephone Number:
Department/Location and Medical Facility where issue occurred:		Date Issue Occurred:
Please describe the nature of the issue <i>(attach additional sheets if needed):</i>		
Please explain how you have tried to resolve this issue.		
What would you consider a proper solution to this issue?		
Signature:		Date:
<i>For Program Representative Use Only</i>		
Name of Program Representative:	Facility:	Date Received:
Department of Managed Health Care Complaint Process* The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone Kaiser Foundation Health Plan at 1 (800) 464-4000 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.dmhca.gov has complaint forms, IMR application forms and instructions online. <small>*Not available to Medi-Cal members in Cal Optima, Gold Coast Health Plan, and Partnership HealthPlan of California.</small>		

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

DO NOT FILE IN PATIENT CHART

Please mail this form to the P.O. Boxes listed above for processing. If you prefer, you may file a grievance online at kaiserpermanente.org, in person at your local Member Service office or by phone by calling **(800) 464-4000**.

CGA: Grievance Form, Non-Medicare (English)
 Revised 12-13-2019

7.5.4 Department of Managed Health Care Complaint Process—Non-Medicare

The DMHC is responsible for regulating health care service plans. If a Member has a grievance against KP, the Member should notify Kaiser Foundation Health Plan at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711** to lodge the grievance with MSCC. The Member will have the opportunity to seek resolution of the problem using KP’s grievance process. If the Member is not satisfied with the outcome of the grievance process, or if the grievance has remained unresolved for more than 30 Calendar Days, the Member may contact the DMHC for assistance. The DMHC will determine whether the Member is eligible to participate in the Independent Medical Review Program, described below.

7.5.4.1 Independent Medical Review Program Availability—Non-Medicare

California law requires health plans to offer an independent medical review program to Members who have been denied services because the services were deemed not medically necessary or considered experimental or investigational. This includes denial of emergency and urgent care services from non-KP providers. The Independent Medical Review Program (“IMR”) is administered by the California DMHC. If the DMHC determines that the Member’s case qualifies for an IMR, medical experts not affiliated with KP will conduct the review. KP will honor the DMHC decision.

A Member may qualify for IMR if the issue has been denied or is unresolved after 30 Calendar Days, or 3 Calendar Days for requests that meet expedited review criteria, if KP:

- Denies, changes, or delays a service or treatment because the plan determines it is not medically necessary
- Will not cover an experimental or investigational treatment for a serious medical condition
- Will not pay for emergency or urgent medical services that you have already received

Members can request an IMR by completing an IMR Application Form, which comes with a grievance resolution letter. Along with the Application, Members should attach copies of letters or other documents about the treatment or service that KP denied. Members can Mail or fax the form and any attachments to:

Department of Managed Health Care
980 9th Street Suite 500
Sacramento CA 95814-2725
Help Center FAX: **(916) 255-5241**

The numbers to the DMHC are: **(888) 466-2219** and **(877) 688-9891** (TDD). The DMHC web address is <http://www.dmhc.ca.gov>.

7.5.5 Demand for Arbitration

Under certain circumstances, a Member may file a demand for arbitration after receiving an appeal decision, or at any earlier step in the process. For more information on arbitration procedures, please advise the Member to contact the Member Services Department at the local KP facility or contact MSCC at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711**.

NOTE: The complaint and appeals information provided in this Provider Manual may not address the rights and remedies of every category of Member, for example, Medicare, Medi-Cal, as well as Members employed/retired from the State of California and/or the Federal Government, each of whom may have different rights and remedies. Members in these categories should be directed to contact MSCC for applicable grievance and appeal provisions, or they may refer to their Evidence of Coverage brochure for more information.