

Chapter 8: Dispute Resolution

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How to File an Appeal

Standard Appeal

If we deny your request for coverage as a result of our UM review or payment of a benefit claim, you have the right to file an appeal to ask that we reconsider our decision. Generally, we'll issue a written notice that tells you the specific reasons why we denied coverage or payment for the item or service. The notice will describe your appeal rights and how to file an appeal. You must submit your appeal within 180 days of the date of our denial notice.

You may appoint someone to file the appeal on your behalf. If you choose to appoint a representative, you must name this person in writing and state that they may file the appeal on your behalf. Both you and your representative must sign this statement, unless the person is your attorney. When necessary, your representative will have access to medical information about you that relates to the request. If you prefer, you may call Member Services at 1-800-966-5955 to request an *Appointment of Representative* form.

You may file your appeal by mailing or delivering your request to:

Kaiser Foundation Health Plan, Inc.
Attn: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813

Include in your appeal your name, the patient's name and Kaiser Permanente medical record number, the date, the nature of our decision that you're appealing, and all comments, documents, and other information you want us to consider regarding your appeal. Fax your appeal to **808-432-5260** or file it by electronic mail at **KPHawaii.Appeals@kp.org**. If you have questions about the appeals process, you may call Member Services. Our phone numbers are listed at the back of this guide.

Standard appeals must be filed on weekdays during office hours, from 7 a.m. to 7 p.m. The receipt date for appeals filed after office hours or on weekends will be the next business day.

When received, your appeal will be prepared for an internal review. Appeal reviews will consider all information you submit (whether or not that information was submitted with your initial request for payment or coverage), will be decided by a different reviewer than the person who denied your initial request, and will not give deference to the initial decision you're appealing. When you appeal, you may give testimony in writing or by telephone. Please call Member Services to get information about giving testimony by phone. If we consider, rely upon or generate any new or additional evidence in our appeal review, or if our appeal decision is based on a new or additional coverage rationale, we will provide you, free of charge, such evidence or coverage rationale as soon as possible and give you a reasonable opportunity to respond before our decision is due. If you do not respond before we must make our decision, our decision will be based on the information that we have on hand. If we continue to deny your request after our appeal is completed, our written notice to you will include the specific reasons for the decision and refer to the specific plan provisions on which our decision was made. If you are not satisfied with our decision, you may request external review as noted in this guide.

Appeals related to claims for payment (post-service requests) filed by members on employer group plans will be processed through two internal levels of review. When received, your post-service appeal will be prepared for a first-level review. Generally, we will provide you with our written decision within 30 calendar days. If you are not satisfied with the first-level decision, you may request a second-level review by our Regional Appeals Committee within 60 days of the date of the first-level decision letter. We'll acknowledge receipt of your second-level appeal and provide you with our written decision within 30 calendar days of our receipt of the request. Appeals filed by members on non-group or individual plans (Obtained ON or OFF the Marketplace) will be completed through a single level review and decisions communicated in writing within 60 calendar days of receipt of the appeal.

You may request a free copy of all documents and information relevant to your initial claim and appeal; any rule, guideline, or protocol we relied upon in denying the service or supply you requested; and the identity of any experts whose advice was obtained by us in connection with our denial of your request. You can request the information by calling Member Services. Our phone numbers are listed in the back of this guide.

You also have the right to request the diagnosis and treatment codes and their meanings that are the subject of your claim. You can request this information by calling Claims Administration Member Services at **1-877-875-3805**.

When a health plan like Kaiser Permanente issues an adverse benefit determination, the federal Affordable Care Act requires the health plan to notify recipients of their right to request language assistance to understand the denial notice and their appeal rights. The law also requires health plans to notify recipients of the right to request translation of the denial notice. Language assistance is available in languages mandated by the federal Affordable Care Act:

Para obtener asistencia en Español, llame al 808-432-5955 ó 1-800-966-5955.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 808-432-5955 o di kaya'y 1-800-966-5955.

如果需要中文的帮助, 请拨打?个号码 808-432-5955 或者 1-800-966-5955。

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 808-432-5955 doodaii 1-800-966-5955.

Expedited Appeal

You may ask that we make an expedited decision on your appeal. The expedited procedure applies to denied requests for services or supplies that you have not yet received or are currently receiving that are being reduced or terminated. It does not apply to denied requests for payment for services or supplies that you have already received. We'll make an expedited decision in less than 72 hours if we find, or if your Physician states, that reviewing your appeal under the 30-day process would seriously jeopardize your life or health, seriously affect your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. Our decision may take longer if we have to wait for information from you or medical records about your case, but we must make a decision within 72 hours of our receipt of such additional information.

You or your Physician may request an expedited appeal anytime by calling toll free **1-866-233-2851**, or by faxing, writing, or delivering your request to the same address and phone numbers listed for standard appeals. If we determine that your request does not meet the criteria for an expedited appeal, we'll automatically review your written appeal under the 30-day process.

Different procedures apply to the following plans: Kaiser Permanente Senior Advantage, Kaiser Permanente QUEST Integration, the Federal Employees Health Benefits Program, and Kaiser Permanente Individuals and Families. Members on these plans should consult their respective Evidence of Coverage or brochure for a description of the claims and appeals procedures that apply to them.

External Appeal with an Independent Review Organization

Once you've exhausted your internal appeal rights and we've continued to deny coverage or payment as stated in any final adverse benefit determination (ABD) notice that you receive from us, you can request an external appeal with an independent review organization (IRO) for our final adverse benefit determination that

- relies on medical judgment (including but not limited to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered service),
- concludes that the requested care or service is experimental or investigational,
- concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits,
- involves consideration of whether We are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130), or
- involves a decision related to rescission of your coverage.

If our appeal decision to deny your request for coverage or payment does not involve medical judgment or medical information, then your request is not eligible for external review.

An IRO is independent from Kaiser Permanente and has the authority to overturn our denial of coverage or payment. The IRO that is responsible for conducting your external appeal is based on your KP plan.

Our appeal notice will contain information about the IRO that applies to you and instructions on filing an external appeal with the IRO. You may also be able to simultaneously request external review as permitted under federal law in connection with an expedited internal appeal.

You, your appointed representative, or treating provider (in the case of an expedited review) may file the request for external review by the Hawaii Insurance Commissioner. Requests for external review must be submitted to the commissioner within 130 days of receipt of Kaiser Permanente's final adverse decision. Requests for external review may be filed at the address below or by facsimile to **808-587-5379**. You can reach the Health Insurance Branch of the Hawaii Insurance Division by calling **808-586-2804**.

State of Hawaii DCCA
Insurance Division - External Appeals
335 Merchant St., 2nd Fl.
Honolulu, HI 96813

If the request is determined eligible for external review, the commissioner will assign the case to an IRO approved by the Insurance Division within three business days. Once assigned, the IRO will notify you and Kaiser Permanente within five business days that the external appeal has been opened for review. We must submit to the IRO within five business days of our receipt of the notice from the IRO all the documents and information that we considered during our internal review of your request. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the notice from the IRO.

The IRO will perform the external review by considering the information noted above and the terms of your Kaiser Permanente plan as well as your medical records, any recommendations from your attending health care professional, additional consulting reports from appropriate health care professionals, the medical necessity statute defined under Hawaii law (Hawaii Revised Statutes Chapter 432E-1), the most appropriate practice guidelines, any applicable clinical review criteria developed and used by Kaiser Permanente, and the opinion of the IRO's clinical reviewer. The IRO will not be bound by our initial and appeal adverse decisions in deciding your external appeal. The IRO will send you its decision in writing within 45 days of receiving your external review request. In the event the IRO reverses our adverse decision, we must immediately cover or pay for the service or item that you are requesting.

Expedited External Appeal

Expedited review may be requested from the commissioner by you, your authorized representative, or health care provider if processing under the standard timeframe would result in serious jeopardy to your life or health, seriously affect your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. Expedited review may also be requested from the commissioner if your appeal involves admission to a facility for health care services, the availability of care or a continued stay at a facility for health care services, or a health care service that you are receiving during an Emergency visit before you are discharged from the

facility where the Emergency services are being obtained. If your request qualifies for expedited processing at the time you receive our initial ABD or file your internal appeal, you have the right to simultaneously request expedited review with the commissioner. The expedited process does not apply to services or items that you have already received.

If the request is determined eligible for expedited external review, the commissioner will immediately assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that we considered during our internal review of your request.

The IRO will perform the external review by considering the same types of information as noted earlier under the standard process. The IRO will not be bound by our initial and appeal adverse decisions in deciding your external expedited appeal. The IRO will notify you of its decision as expeditiously as your medical condition or the circumstances require, but in no event more than 72 hours of its receipt of your eligible expedited request. If its decision was provided verbally at first, then the IRO must send written confirmation within 48 hours of its verbal notice. In the event the IRO reverses our adverse decision, we must immediately cover or pay for the service or item that you are requesting.

External Review Requests for Experimental or Investigational Services or Treatments

Additional procedures apply to a request involving an experimental or investigational service or treatment. You or your authorized representative may make an oral request for expedited review if your treating physician certifies in writing that the service or treatment you are requesting would be significantly less effective if it was not initiated promptly. This certification must be filed promptly with the commissioner following your oral request for review. If you or your authorized representative request expedited review in writing rather than orally, you must include your treating Physician's written certification with the written request. If your request is determined eligible for expedited review, the commissioner must immediately assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that we considered during our internal review of your request.

Within three business days after being assigned to perform the external review, the IRO will select one or more clinical reviewers who are experts in the treatment of the condition and knowledgeable about the service or treatment that is the subject of the request. Each clinical reviewer must provide an opinion regarding whether the service or treatment should be covered. This opinion must be provided to the IRO orally or in writing as expeditiously as your condition requires but in no event more than five calendar days after the reviewer was selected. If the opinion was provided orally, then the reviewer must provide a written report to the IRO within 48 hours following the date the oral opinion was provided. The IRO must provide you, your authorized representative, and Kaiser Permanente with its decision either orally or in writing within 48 hours after it receives the opinion. If its decision was provided orally, then the IRO must send its decision in writing within 48 hours of the oral notice. If a majority of the clinical reviewers recommend that the service or treatment should be covered, then the IRO must reverse Kaiser Permanente's adverse decision. If a majority of the reviewers recommend that

the service or treatment should not be covered, then the IRO will make a decision to uphold Kaiser Permanente's adverse decision. If the reviewers are evenly split as to whether the service or treatment should be covered, then the IRO must obtain the opinion of another clinical reviewer. The processing timeframes are not extended if the IRO needs to obtain the opinion of an additional reviewer.

For non-expedited requests involving an experimental or investigational service or treatment that are determined eligible for external review, the commissioner has three business days after the eligibility decision was made to assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must submit to the IRO within five business days of our receipt of the name of the IRO all the documents and information that we considered during our internal review of your request. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the Insurance Division's notice that your case was assigned to an IRO. The IRO must select one or more clinical reviewers within three business days after it was assigned to perform the external review. Each reviewer must provide its opinion to the IRO in writing within 20 days of the date the IRO was assigned to perform the review. The IRO must then provide its written decision to you, your authorized representative, and Kaiser Permanente within 20 days after the opinions were received. The IRO must decide to reverse or uphold Kaiser Permanente's adverse decision in the same manner discussed earlier based on a majority of the clinical reviewers' recommendations.

Procedures Applicable to All Requests for External Review

The IRO's decision is binding on you and Kaiser Permanente except for any additional remedies that may be available to you or Kaiser Permanente under applicable federal or state law. You or your authorized representative may not file a subsequent request for external review involving the same adverse decision for which you already received an external decision.

When filing any request for external review, you must include a copy of Kaiser Permanente's final ABD with your request, unless you are seeking simultaneous expedited external review, or we have substantially failed to comply with our internal appeals procedures. You or your authorized representative will also be required to authorize the release of your medical records that need to be reviewed for the external appeal, as well as provide written disclosure that permits the commissioner to perform a conflict of interest evaluation as part of the selection process for an appropriate IRO. You can find forms that meet each requirement on our website at **kp.org** or by calling Member Services at the phone number listed in the back of this guide. Lastly, a \$15 filing fee must be included with the external appeal request. The filing fee will be refunded if Kaiser Permanente's adverse determination is reversed through the external review or the commissioner waives the fee because it poses an undue hardship on you. Your request will be considered incomplete and the external review delayed if you do not submit all the required information with the request.

When you submit a request for external review, the commissioner will inform Kaiser Permanente about your request. We will be responsible for notifying the commissioner and you or your authorized representative in writing whether the request is complete and eligible for external review. If we believe

your request is not eligible for external review, you may file an appeal with the commissioner. Our notice of ineligibility will include information on requesting this appeal.

You must exhaust Kaiser Permanente's internal claims and appeals process before you may request external review, except when external review is permitted to occur simultaneously for requests that qualify for expedited review, or we have failed to comply with applicable claims and appeals requirements under federal or state law. You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures and external review. If you are enrolled through a plan that is subject to ERISA, you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-3272**. Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

Different procedures apply to the following plans: Kaiser Permanente Senior Advantage, Kaiser Permanente QUEST Integration, and the Federal Employees Health Benefits Program. Members on these plans should consult their respective Evidence of Coverage or brochure for a description of the independent external review procedures that apply to them.

Binding Arbitration

Except as provided in this chapter or by applicable law, any and all claims, disputes, or causes of action arising out of or related to this EOC, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this EOC, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;

On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this EOC, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):

- Kaiser Foundation Health Plan, Inc.,
- Kaiser Foundation Hospitals,
- Hawaii Permanente Medical Group, Inc.,
- The Permanente Federation, LLC,
- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this EOC, the following claims shall not be subject to mandatory arbitration:

- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services (such as temporary restraining orders, and emergency court orders).
- claims that may not be subject to binding arbitration under applicable federal or state law;
- for Medicare members, claims subject to the Medicare appeals process.

Initiating Arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration Proceedings

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than \$25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The

arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for:

- production of documents that are relevant and material,
- taking of brief depositions of treating Physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
- independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.

Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this EOC or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.

The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial.

With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, *9 U.S.C. Chapter 1*.

General Provisions

All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is

deemed to prohibit any term in this EOC in any particular case, then such term(s) shall be severable in that case and the remainder of this EOC shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this EOC shall supersede those in any prior EOC.

Arbitration confidentiality

Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special Claims

Medical Malpractice Claims

Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the “Initiating arbitration” section.

Benefit Claims

If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party’s claim is frivolous. If the Member Party has any questions about the Member Party’s plan, the Member Party should contact Health Plan at 1-800-966-5955.

Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the “Initiating Arbitration” section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to this “Dispute Resolution” section.

External Appeal of Internal Review Decisions

If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this EOC.

In addition to the arbitration procedures set forth in this EOC which may be elected by the Member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for

Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in the "Appeals" section of this EOC.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

Senior Advantage Member Claims

Complaints and appeals procedures for Senior Advantage Members are described in the Kaiser Permanente Senior Advantage Evidence of Coverage (EOC). The arbitration provisions of this EOC apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this EOC, irrespective of the legal theory upon which the claim is asserted.