Kern Family Health Care™

Provider Manual

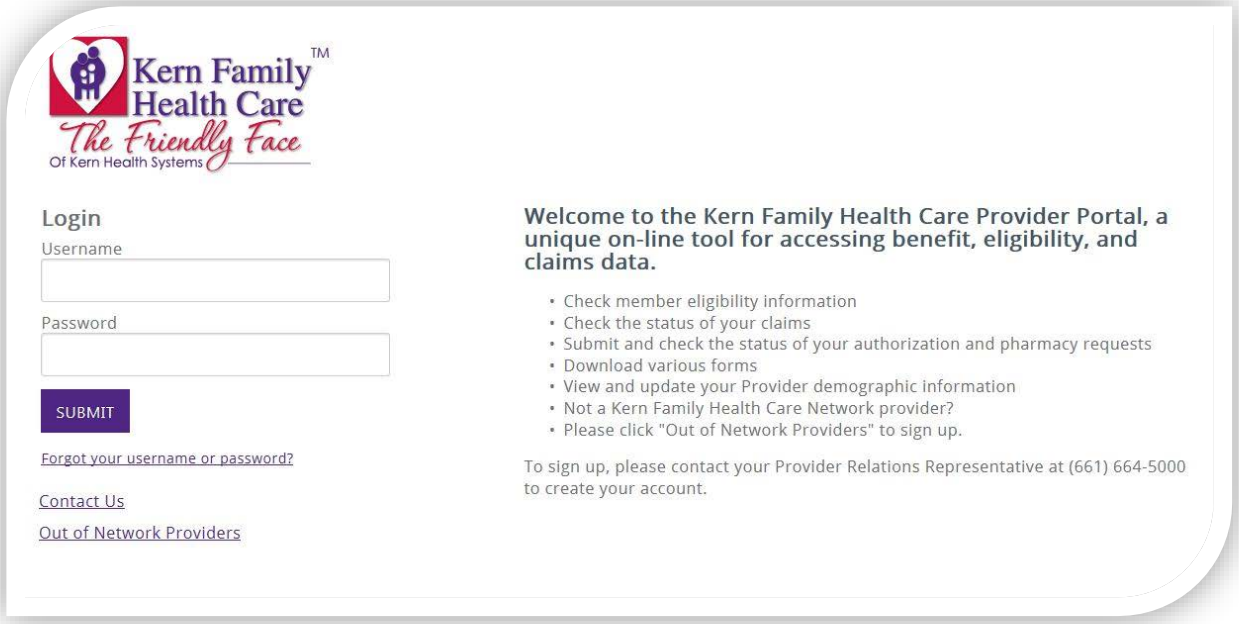
2019

This manual is revised periodically. For the most recent version, please visit the KFHC website at: kernfamilyhealthcare.com or **call the Provider Relations Department at (661) 632-1590 or (800) 391-2000. Providers can select option 5**, a silent prompt created for Providers to bypass other queues.

TABLE OF CONTENTS

QUICK REFERENCE

Visit our website to access the KFHC Provider Portal, search for a network provider, view and download KFHC Policies and Procedures, and many other helpful resources are available at [www.kernfamilyhealthcare.com.](http://www.kernfamilyhealthcare.com)



KEY CONTACTS

Department	Contact Information
KFHC Member Services	661-632-1590 (Bakersfield), 1-800-391-2000 (outside of Bakersfield). **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.
KFHC Administrative Office	5701 Truxtun Avenue, Suite 201 Bakersfield, CA 93309 Walk-in access for Members, Monday – Friday, 8:00 am-5:00 pm. 9700 Stockdale Hwy Bakersfield, CA 93311 Monday – Friday, 8:00 am - 5:00 pm
KFHC Advice Nurse Line	800-391-2000 Available 24 hours a day, 7 days a week
Claims	**Submit electronic claims to any of the following:** • Change Health • Relay Health • Office Ally • SSI Group Use KHS Payor ID: 77039 **Paper Claims:** Kern Health Systems P.O. Box 25003 Bakersfield, CA 93311
KFHC Transportation Department	661-632-1590 (Bakersfield), 800-391-2000 (outside of Bakersfield), choose option 3. Available 24 hours a day, 7 days a week for urgent or after hours assistance. Transportation should be requested at least 5 days in advance.
Interpreting Services Language Line In-Person interpreting	661-632-1590 (Bakersfield), 800-391-2000 (outside of Bakersfield)

KEY CONTACTS

Department	Contact Information
Verify Eligibility	• KFHC Provider Portal • KFHC DIVA (661) 664-5185 • AEVS 800-456-2387 • KFHC Member Services Dept. 661-632-1590 (Bakersfield), 800-391-2000 (outside of Bakersfield) 800-391-2000, **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.
California Relay Services	Call 800-735-2922, if you **do not** have a TTY device in your office or call 800-735-2929 if you **do** have a TTY device in your office.
Denti-Cal	800-322-6284, denti-cal.ca.gov
California Children's Services (CCS)	661-868-0504, fax 661-868-0280 Kern County Public Health Services Dept. 2nd Floor, Bakersfield, CA 93306 kernpublichealth.com
Behavioral Health & Recovery Services (BHRS)	Mental Health Administration 661-868-6600 Non-crisis Adult Care 661-868-8080 Crisis Line Toll Free 800-991-5272 Crisis Line 661-868-8000 kernbhrs.org
Vision Services Plan (VSP)	800-877-7195 www.vsp.com
Submit Authorizations	• KFHC Provider Portal • Written requests: Utilization Department / Kern Health Systems 9700 Stockdale Hwy, Bakersfield, CA 93311 (mailing will delay process due to postal delivery time, using the Provider Portal is highly recommended)

SECTION 1: INTRODUCTION

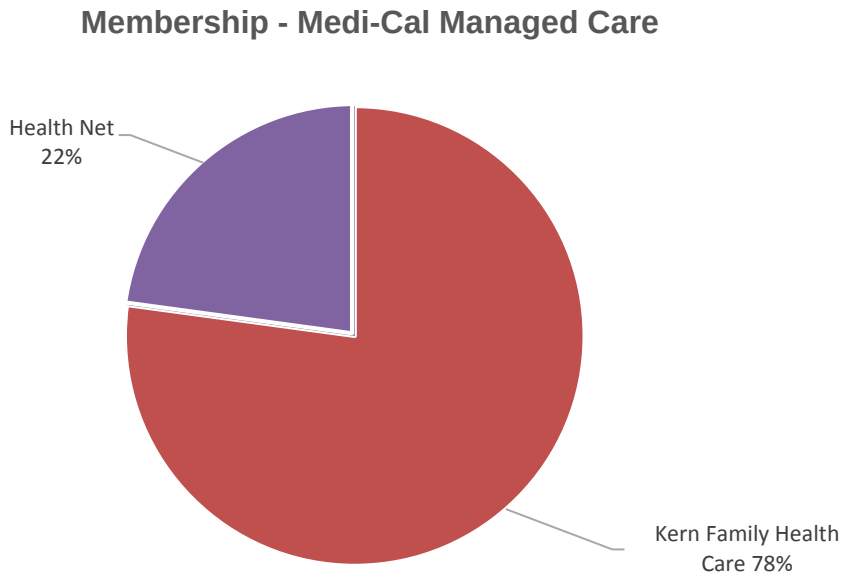
About Kern Health Systems

Kern Health Systems (KHS) was established by the Kern County Board of Supervisors in April 1993 as the County's Local Initiative. In Kern County, Medi-Cal is operated through a Two-Plan Model consisting of a "local initiative" health plan and a commercial plan. Kern Health Systems (KHS) is the local initiative managed care plan in Kern County. Currently, Health Net is the commercial plan.

KHS is a Knox-Keene licensed Health Plan and is regulated by the California Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and as well as the federal government's Centers for Medicare and Medicaid Services (CMS).

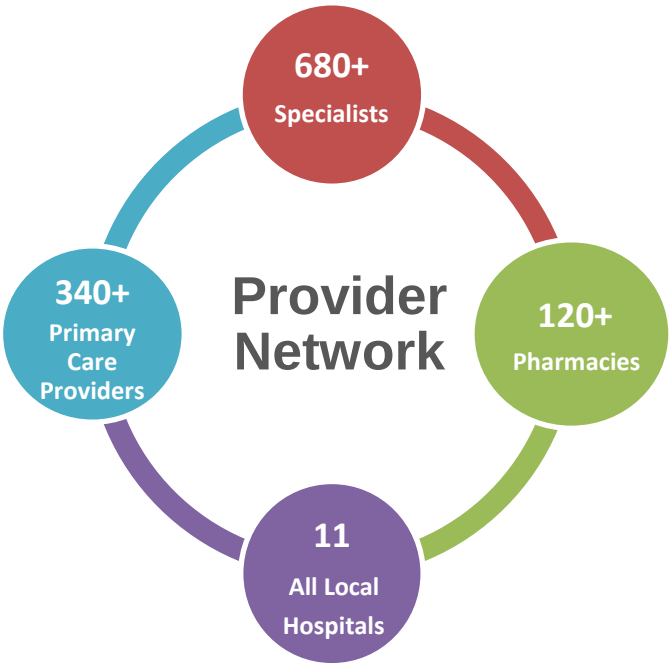
Member Distribution

As of October 2018, 321,970 Medi-Cal members were distributed amongst the two Kern County Medi-Cal managed care plans (Kern Family Health Care and Health Net). Of those members, 251,099 (78%) were enrolled in Kern Family Health Care, and 70,871 (22%) in Health Net.



KFHC Provider Network

KFHC Members have access to a compressive network of providers that includes primary care providers, specialists, pharmacies, hospitals, and urgent care facilities.



KFHC Provider Network as of December 2018

Our Mission

Kern Health Systems is dedicated to improving the health status of our members through an integrated managed health care delivery system for Kern County.

KFHC Employee Code of Conduct

The Code of Conduct articulates the standards of behavior that each employee is expected to observe while performing their jobs.

Governing Board & Committees

The KHS Board of Directors are appointed by the Kern County Board of Supervisors it includes physicians, safety-net providers, hospitals, pharmacies and community representatives. For more information regarding the Board & Committees or to view past agendas, visit www.kernfamilyhealthcare.com. The following is a list and description of the KHS Advisory Committees:

Finance Committee

The Finance Committee reviews, approves, and makes recommendations to KHS' Board of Directors on all financial and contractual matters that are presented by KHS' staff in support of administrative and management operations. It ensures KHS' financial stability by providing oversight on its budget.

Physician Advisory Committee (PAC)

The PAC serves as an advisor to the Board of Directors on health care issues, peer review, provider discipline and credentialing/re-credentialing decisions. This PAC is responsible for reviewing provider grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee.

Quality Improvement / Utilization Management Committee (QI/UM)

The QI/UM Committee oversees all covered health care services delivered to members by systematic methods that develop, implement, assess and improve the integrated health delivery systems of KHS.

Pharmacy & Therapeutic Committee (P&T)

The P & T Committee monitors the KFHC Formulary, oversees medication prescribing practices by providers, assesses usage patterns by members and assists with study design and clinical guidelines development. The committee is composed of Physician and Pharmacist providers as well as internal staff. If you would like to serve on the committee, please contact the Director of Pharmacy or Medical Director.

Public Policy / Community Advisory Committee (PP/CAC)

Provides a mechanism for structured input from KFHC members regarding how our operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages.

Intent of the Provider Manual

Our provider network is a critical component in serving our mission. We want this manual to be a useful guide which will offer a general overview of information, tools, and guidance needed for you and your staff to facilitate care and services for KFHC Members. If you have any questions, need assistance, or have suggestions for improving the manual, please contact the Provider Relations Department at (800) 391-2000. **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.

If the terms of your Agreement differ from the information in this Provider Manual, the Agreement will supersede. In addition, if there are conflicts between the Manual and current State or federal laws and regulations governing the provision of health care services, those laws and regulations will supersede this Manual.

How to Use the Provider Manual

Providers can search particular topics by reviewing the table of contents or by using the Adobe/PDF search function. To obtain a copy in other formats, call our Provider Relations Department at (800) 391-2000. For more detailed information, please refer to Kern Health System policies, procedures located at www.kernfamilyhealthcare.com, if you do not have internet access a hard copy will be provided.

Search tip: To search for a specific topic, hit Ctrl + F on your keyboard to activate the "Find" function, if you are using a PC. If you are using a Mac, hit Command + F.

SECTION 2: ELIGIBILITY

Individuals who wish to enroll in KFHC must have been determined eligible for the Medi-Cal program through the Kern County Department of Human Services, or the Social Security Administration.

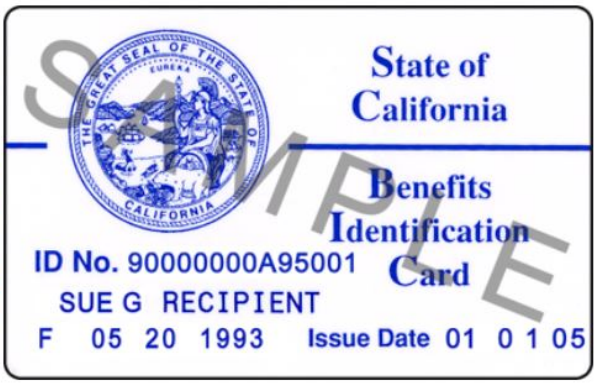
Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a member's eligibility must be verified *before delivery of services* and that the KFHC Member Identification (ID card) *alone* is not a guarantee of eligibility.

The state of California issues a plastic Medi-Cal ID card known as the Benefits Identification Card, or BIC. The BIC shows the member's name, date of birth, 14-digit identification number and the card issue date.

The Kern County Department of Human Services may issue a temporary, emergency "paper card" when the Member cannot wait for the state to issue the BIC.

The new "Poppy" BIC design will be provided to newly eligible recipients and recipients requesting replacement cards. Providers are responsible for verifying the recipient is eligible for services and is the recipient to whom the card was issued Both BIC designs should be accepted by providers.

"Poppy" design



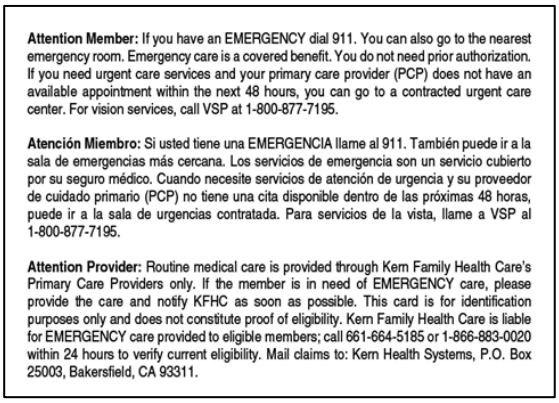
"Blue and White" design

KFHC Member Identification Card

KFHC issues all new Members an Identification Card that must be presented to Providers at the time Covered Services are requested. Please note that the KFHC ID card alone should not be considered verification of Member eligibility. The KFHC ID card is issued for identification purposes only and does not guarantee eligibility. KFHC issues an ID card to Members, an example of which is shown below.

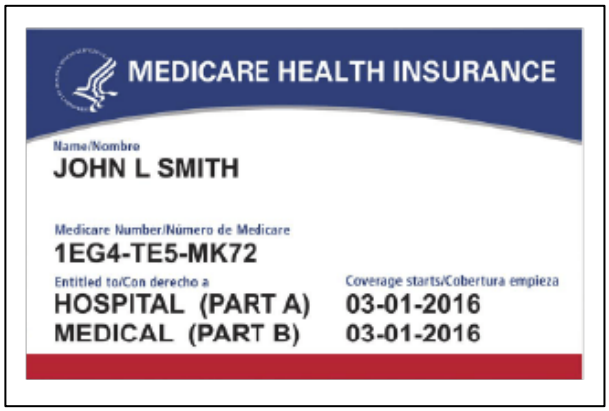
Front KFHC Member Card

Back KFHC Member Card



New Medicare Card

Medicare will be issuing new Medicare cards between April 2018 and April 2019. The new Medicare card has a new Medicare number unique to each beneficiary. Medicare is removing Social Security Numbers from Medicare cards to protect beneficiaries from possible identity theft. For more information visit www.medicare.gov



Verifying Member Eligibility

All providers should verify eligibility on the date that the service is rendered. A Referral or Authorization is also not sufficient to guarantee that the patient is eligible on the date of service.

KFHC Provider Portal

KFHC offers providers access to an interactive online portal with the capability to:

- Verify Member eligibility
- Check status of claims
- Submit and check status of authorization and pharmacy requests
- Download various forms
- View and update provider demographic information.

To access the online portal Providers can contact the Provider Relations Department at 661-664-5000 (in Bakersfield) or 1-800-391-2000 (outside of Bakersfield). **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.

Automated Eligibility Verification System (AEVS)

AEVS, the State Medi-Cal automated eligibility verification system, is a tool that is available 24/7 to verify a Member's eligibility. To use AEVS please call (800) 456-2387 and have your Provider Identification Number (PIN) ready. A confirmation number will be provided which should be maintained to document the verification of eligibility.

KFHC DIVA Automated Eligibility Line

DIVA is another automated tool that is available 24/7 to verify a Member's eligibility. To use DIVA, please call (661) 664-5185 and provide the Member's KFHC identification number or Medi-Cal identification number. A confirmation number will be provided which should be maintained to document the verification of eligibility.

KFHC Member Services Department

Eligibility can also be verified by calling the KFHC Member Services Department. Representatives are available to assist with eligibility verification inquiries Monday through Friday from 8:00 a.m. to 5:00 p.m. To contact the Member Services Department, call (800) 391-2000. **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.

Primary Care Provider (PCP) Assignment

PCPs are the primary provider of covered services for Members so they play a central role in coordinating care. For this reason, the selection or assignment of each Member to a PCP is of critical importance.

PCP Selection & Change

Members can find available PCP's using the KFHC Provider Directory or the online "Find a Provider" search tool located on the kernfamilyhealthcare.com home page. Members can change their PCP by logging onto the Member Portal located at kernfamilyhealthcare.com or by downloading the free KFHC mobile application, LiNK. Members can also make a PCP change by calling Member Services at 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield)

Clinic Assignment

Every Medi-Cal enrollee has a right by law to access medical services through a Federally Qualified Health Center (FQHC). If a member chooses a FQHC, it must be contracted with KFHC. The enrollee may either choose a FQHC provider or a FQHC clinic.

PCP Auto Assignment

KFHC will encourage new Members to select a Primary Care Provider (PCP) within **30 calendar days of enrollment**. If KFHC does not receive a PCP selection for a new Medi-Cal member one will be assigned by KFHC through a default, automatic method of assignment. Every effort will be made to provide new members the opportunity to change a PCP assignment provided through the automatic assignment process to the PCP of their choice. This process will take no more than 30 days from the effective date of enrollment.

All members for whom KFHC chooses and assigns a PCP will be notified of the assignment within **seven calendar days** of the assignment.

To allow better access to care, Members can change their PCP at any time via Member Portal, KFHC Mobile Link App or by calling the Member Services Department.

For more information, see KHS Policy & Procedures: 5.06-P Assignment of Primary Care Provider

Member Disenrollment

Disenrollment of Medi-Cal members is processed by Health Care Options, an enrollment contractor approved by the California Department of Health Care Services (DHCS). KFHC does not enroll or disenroll members. Members requesting disenrollment or information about the disenrollment process are immediately referred to the enrollment contractor, Health Care Options.

For cases requiring mandatory disenrollment, KFHC may request the disenrollment of a Member under specific guidelines set by DHCS such as: Out of Area, Incarceration, Long Term Care, Transplant, etc. Please note that final disenrollment decisions are handled entirely by DHCS.

SECTION 3: UTILIZATION MANAGEMENT PROGRAM

KFHC Utilization Management Department (UM), policies and procedures support the provision of quality health care services. The goal of UM is to provide Members with the right care, in the right venue, within the most appropriate timeframe. The key objective of the Program is to improve access to care, maintain the highest quality, and create healthy outcomes while providing the most cost effective care possible.

Preventative Care Services

PCPs are required to ensure that all age and risk appropriate preventive services are provided to assigned members. Members may schedule an appointment for preventive care (including an Initial Health Assessment) by calling their PCP. When a request is made for CHDP services (Child Health and Disability Prevention), an appointment should be offered for the member to be examined within 2 weeks of the request. If the member cannot be seen within the two week timeframe because the member refused offered appointments, refusal should be documented. If the member encounters difficulty in scheduling an appointment, he/she may call KFHC Member Services at 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield) for assistance.

Initial Health Assessment (IHA)

The Department of Health Care Services (DHCS) requires that each PCP complete an Initial Health Assessment (IHA) for all Medi-Cal members. The IHA is a comprehensive assessment that is completed during the member's initial visit(s) with his or her primary care provider, or mid-level providers that are qualified to perform patient history and physicals. The purpose of the IHA is to assess and set the baseline for managing the acute, chronic and preventive health needs of the member.

All new KFHC Members must receive an Individual Health Assessment. For Medi-Cal members this must be complete within **120 days** of enrollment. During audits, a PCP's compliance with this standard will be assessed and is part of the yearly performance incentive.

At a minimum, an IHA must include the following: comprehensive history, preventive services, comprehensive physical and mental status exam, diagnoses and plan of care, and Individual Health Education Behavioral Assessment (IHEBA) using the Staying Healthy Assessment (SHA) or other state-approved tool.

Exemption of the IHA Requirement

If any member—including emancipated minors, or a member's parent or guardian—refuses an IHA, this should be documented in the member's medical record with a statement signed by the member. IHAs do not need to be performed if both of the following conditions are satisfied:

A. The member's medical record contains complete information, updated within the previous 12 months, consistent with the KFHC assessment requirements for the member's age group and gender

B. Based upon review of the prior medical record, the provider reviews and signs off in the medical record that the patient is current.

Scheduling IHAs

As PCPs receive their assigned patient panels, the Providers' offices should contact members to schedule an IHA to be performed within the time limit. If the provider/staff is unable to contact the member, he/she should contact the KFHC Member Services Department for assistance.

In these cases, KFHC Member Services staff initiates attempts to contact the member via telephone and/or letter and coordinates with the PCP's office in an effort to secure a timely appointment. Contact attempts and results are documented by both the PCP and KFHC Member Services staff.

Staying Healthy Assessments

The initial Staying Healthy Assessment should be performed during the IHA thereafter, the PCP must re-administer the Staying Healthy Assessment at the appropriate age intervals. DHCS requires PCPs to administer an Individual Health Education Behavioral Assessment (IHEBA) as part of the IHA for new Members and for subsequent well care visits for current Members. Forms are available on the KFHC website www.kernfamilyhealthcare.com under the "For Providers" tab as well as the DHCS website dhcs.ca.gov. PCP's may also contact KFHC Provider Relations for technical assistance on using the form.

If an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.).

For more information see KHS Policy and Procedure: 3.05-P Preventative Medical Care

Referral Process

A routine request by the PCP for referral authorization is initiated by submitting a Referral/ Prior Authorization Form via the KFHC Provider Portal. The request must include pertinent medical records, diagnoses and treatment codes, and member data which support the referral and will assist the specialty provider in the assessment and delivery of services.

The signature of the referring PCP must appear on the Referral/Prior Authorization Form. A signature stamp is acceptable if KFHC is in receipt of certification that the PCP authorizes the use of such a signature stamp.

Prescribing physicians may request authorization by completing the Prior Authorization Request (PAR) form, attaching clinical documentation to support the request, and submitting it by one of the following ways:

- KFHC Provider Portal, www.kernfamilyhealthcare.com
- Utilization Management Department Fax: (661) 664-5190
- Mail:
  Utilization Management Department
  Kern Health Systems
  9700 Stockdale Hwy, Bakersfield, CA 93311
  (mailing will delay process due to postal delivery time)

Provider and Member Notification

Results of the utilization review for non-urgent referrals are communicated by Utilization Management Staff (UM), to the Provider and Member as outlined in the following table. Notification to provider is provided via facsimile.

Result of Review	Provider Notice	Member Notice
Approved	**Referring**: Approved *Referral/Prior Authorization Form* (within 24 hours of the decision). **Specialist:** Approved *Referral/Prior Authorization Form* and any pertinent medical records and diagnostics (within 24 hours of the decision). **OR** **Hospital:** *Hospital Notification Letter* (within 24 hours of the decision).	Notice of Referral Approval (within 48 hours of the decision).
Deferred	**Referring:** Copy of Notice of Action Letter and the *Referral/Prior Authorization Form (*within 24 hours of the decision) **OR** **Hospital:** Requests for hospital services are not deferred.	Notice of Action Documents (within 2 business days of the decision). Documents include all of the following: • *Notice of Action - Delay* letter • *Your rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.

Result of Review	Provider Notice	Member Notice
Modified (Initial request for a service or treatment)	**Referring:** Copy of Notice of Action Letter and modified *Referral/ Prior Authorization Form* (within 24 hours of the agreement). **Specialist:** *Modified Referral/Prior Authorization Form* and any pertinent medical records and diagnostics (within 24 hours of the agreement).	Notice of Action Documents, (within 2 business days of the decision). Documents include all of the following: • *Notice of Action – Modify* • *Your rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.
Terminated or Reduced (Subsequent request for a continuing service or treatment that was previously approved)	**Treating:** Copy of Notice of Action Letter sent to the member (within 24 hours of the decision).	Notice of Action Documents, (within 2 business days of the decision and at least 10 days before the date of action unless falls under exceptions listed in KFHC Policy 3.22-P. Documents include all of the following: • *Notice of Action – Terminate* • *Your rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.

Denied (Included those carve out services that are denied as not covered by KFHC)	**Referring:** Copy of Notice of Action Letter (within 24 hours of the decision). **OR** **Hospital:** *Hospital Notification Letter* (within 24 hours of the decision).	Notice of Action Documents, (within 2 business days of the decision). Documents include all of the following: • *Notice of Action – Denial* • *Your rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.

Denials

Only the Chief Medical Officer, Medical Director or Associate Medical Director may deny an authorization request based on medical necessity within the DHCS timelines of 1-5 days for routine requests. Reasons for possible denial include:

A. Not a covered benefit
B. Not medically necessary
C. Member not eligible
D. Continue conservative management
E. Services should be provided by a PCP
F. Experimental or investigational treatment
G. Member made unauthorized self-referral to provider
H. Services covered CCS (California Children's Services)
I. Inappropriate setting
J. Covered by hospice

Urgent Referrals

A Provider may submit an urgent referral request via KFHC Provider Portal. After-hour urgent authorizations may be obtained by telephone from the 24-Hour on call nurse or administrator at KFHC.

Hospital/Facility Authorization
All Providers must request authorization for scheduled hospital/facility admission from KFHC Utilization Management Department. Admissions will be to contracted facilities unless an exception occurs and the KFHC UM Department has granted special authorization.

Lab, X-Ray and Assistant Services
Routine lab and x-ray services do not require pre-authorization, but must be directed to KFHC contracted providers. Non-emergent specialty x-ray procedures require pre-authorization. Contracted providers must be utilized for all non-emergent lab and imaging procedures. Please reference Prior Authorization list located on www.kernfamilyhealthcare.com.

Covered Services That Do NOT Need Prior Authorization / Referral

Unless specifically excluded, all services must be authorized by KFHC in accordance with KFHC referral policies and procedures. The following services do not require prior authorization:

- Family Planning - Members may access Family Planning Services by self-referral to an appropriate qualified practitioner/provider such as: FQHC, Federally Funded Family Planning Clinic and Public Health Clinic.
- Primary care from a KFHC contracted Primary Care Provider
- Dental – Providers are expected to refer to Denti-Cal.
- Hospice – Outpatient services.
- Basic prenatal care - Members may self-refer to a KFHC contracted OB/GYN or family practice physician.
- Vision - PCP or member may initiate a referral to VSP contracting optometrists.
- Mental Health - Referrals for mental health services may be generated by self-referral, provider of care, KFHC Case Managers, school systems, or employers.
- Abortion - Prior authorization is not required unless inpatient hospitalization for the performance of the abortion is requested.
- Gynecology (OB/GYN) - Members may self-refer to any contracted OB/GYN specialist.

The Prior Authorization Form and supporting documentation may be required for KFHC tracking purposes.

Specialists Requiring Prior Authorization:

- Audiology
- Dermatology
- Endocrinology
- Home Health
- Neurology
- Orthopedic
- Pain Management
- Phys Med/ Rehab
- Plastic Surgery
- Podiatry
- Rheumatology
- Vascular/Plastic Surgery

A current list of specialists that require prior authorizations and Current Procedural Terminology (CPT) Codes can be found on the www.kernfamilyhealthcare.com website.

Obtaining a Second Opinion

Requests for second opinions may be initiated by the Member or Provider and should document the initial opinion and the person requesting the second opinion. All requests for second opinions are reviewed by the KFHC Chief Medical Officer or their designee. Authorization or denial of the second opinion is accomplished within 72 hours of KFHC' receipt of the request.

For more information see KHS Policy and Procedure: 3.05-P Preventative Medical Care, 3.09-P Second Opinions, 3.22-P Referral and Authorization Process.

California Children Services (CCS)

CCS is a statewide program managed by the Department of Health Care Services (DHCS) and is administered in Kern County by the Kern County Public Health Services Department. The CCS program requires authorization for health care services related to children under the age of 21 with a CCS-eligible medical condition. These services are not covered by KFHC therefore KFHC does not give prior authorization for payment of services related to CCS eligible conditions. Authorization for such services must be received from the CCS program.

CCS eligible conditions are those physically handicapped conditions defined in Title 22, California Code of Regulations (CCR) §41515.1. The following are examples of CCS-eligible conditions include, but are not limited to:

- Cystic fibrosis
- Hemophilia
- Cerebral palsy
- Heart disease
- Cancer
- Traumatic injuries
- Infectious diseases producing major sequelae

For an overview of the CCS program, please visit the California Department of Health Care Services (DHCS) website by clicking here: California Children's Services, or the local office visit the Kern County Public Health Services Department website by clicking here: Kern County CCS

Providers are responsible for identifying members with CCS eligible conditions and for making prompt referrals of such members to the local CCS program and to KFHC. Providers must notify the KFHC Utilization Management Department of members with a potential CCS condition via a Referral/Prior-Authorization Form.

Referrals to CCS are also accepted from any source, health professionals, parents, legal guardians, school nurses, KFHC, etc. Members may also self-refer. Once a member is accepted by the CCS program, KFHC Case Management continues to work with CCS to coordinate care. CCS referrals are tracked by the KFHC UM Department to ensure follow through of services to members.

CCS Referral Process

Referral of CCS eligible conditions by a KFHC contracted Provider involves notification of both CCS and KFHC. Referrals to the local CCS program may be initiated via telephone, same-day mail, or fax to:

California Children's Services
1800 Mt. Vernon Avenue, 2nd Floor
Bakersfield, CA 93306-3302

Phone: 661-868-0531
Fax: 661-868-0268

The initial referral should be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the CCS Program.

For more information see KHS Policy and Procedure: 3.16-P California Children's Services (CCS)

Case Management

The Case Management Department Staff, consisting of Registered Nurses, Master Social Workers, and Certified Medical Assistants, manage a complex population who are identified by a predictive modeler as those most likely to be admitted to the hospital in the next six months. These are members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Referrals to Case Management

Referrals may also originate from other sources including, but not limited to, self-referral, caregiver, PCPs or Specialists, discharge planners at medical facilities, and internal departments at Kern Health Systems such as Utilization Management, Disease Management Health Education, and Member Services.

Care Plans

Care Plans are created for these members following an assessment, and communicated to the PCP for collaboration. Care Coordination planning is implemented, there is follow up, assistance with transitions of care, and efficient communication post transition to prevent readmission and maintain progress. The eventual goal of Case Management services is for the member to achieve self-management and discharge from the program. The Case Management Department helps members maintain optimum health and/or improved functional capability, educate members regarding their health and reinforce the PCP prescribed treatment plan. These efforts are anticipated to decrease costs and improve quality through focusing on the delivery of care at the appropriate time and in the appropriate setting.

Palliative Care

Palliative Care services must receive prior authorization from KFHC. Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The Palliative Care benefit will connect members with a palliative care team trained to focus on symptom management and who understand advance care planning and end of life complexities.

Eligible Members

Members eligible for Palliative Care are expected to have one (1) year or less life expectancy, be in the advanced stage of illness, have received appropriate patient-desired medical therapy, or for whom patient desired medical therapy is no longer effective, and have started to access the hospital or emergency department as a means to manage late stage illness. Members should also have one or more of the following disease-specific eligibility criteria:

- Congestive heart failure (CHF): hospitalized due to CHF as primary diagnosis (no further invasive interventions planned) OR NYHA III or higher AND EF <30% or significant comorbidities
- Chronic obstructive pulmonary disease (COPD): FEV1<35% predicted and 24 hour and O2 requirement less than 3L/min OR 24 hour O2 requirement >3L/min
- Advanced cancer: any stage III or IV solid organ cancer, leukemia or lymphoma AND Karnofsky Performance Scale score < 70 OR treatment failure of 2 lines of chemotherapy
- Liver disease: evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices OR evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

Palliative Care Services

Eligible palliative care services include advanced care planning, palliative assessment and consultation with a palliative care team, care coordination, pain and symptom management, and mental health and medical social services for counseling and support. Providers interested in learning more regarding the criteria for providing palliative care services, please contact the KFHC Providers Relations Department. For additional information regarding this new benefit, please refer to the DHCS All Plan Letter 17-015: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-015.pdf

Emergency and Urgent Care Services

Emergency services **do not** require prior authorization. Emergency services are covered services required by a member as the result of a medical condition that manifests as the onset of symptoms (including pain) so severe that a prudent layperson would expect the absence of immediate medical attention to:

- Place the health of the member in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.
- Induce an “active labor” in a pregnant woman requiring emergency delivery to avoid threat to the health and safety of either mother or child.

Post Stabilization Care

When the treating physician believes additional health care services are needed before a member can be safely discharged or transferred after stabilization of an emergency condition, the treating physician should contact our UM Department as soon as possible to request prior authorization. We respond within 30 minutes of receiving the request for a pre-approval for post stabilization/maintenance medical care; if no response is received, the physician may deem the request to be pre-approved/authorized.

KFHC covers all medically necessary, approved health care services to maintain the member’s stabilized condition until the member is discharged or transferred.

Urgent Care Services

Urgent care services **do not** require prior authorization. Urgently needed services are covered services provided when the member is temporarily absent from a service area or when, as a result of an unforeseen illness or injury, medical services are required without delay and the services could not be obtained reasonably through a normal appointment with a contracted provider. Contracted Urgent Care facilities can be found in the KFHC Provider Directory or by using the Find a Provider search tool on our website, www.kernfamilyhealthcare.com.

Advice Nurse Line

Members can call the KFHC Advice Nurse Line at (661) 632-1590 or 1-800-391-2000 to get medical advice via telephone when their doctor’s office is closed or can’t be reached.

Community Based Adult Services (CBAS)

The primary objectives of the program are to restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities, age 18 or older; and delay or prevent inappropriate or personally undesirable institutionalization as well as foster a partnership with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence.

Each participant shall receive ALL of the following basic CBAS benefits as bundled services on each day of attendance at the CBAS center:

a) Professional nursing services;
b) Social Services and/or personal care services;
c) Family and/or caregiver training and support
d) Therapeutic activities; and
e) One meal offered daily.

Additional services, not covered as part of the bundled services, will be coordinated by KFHC as specified in the member's Individual Plan of Care (IPC) as unbundled services when deemed medically necessary:

a) Physical therapy
b) Occupational therapy
c) Speech and language pathology services
d) Behavioral/Mental Health services
e) Registered Dietician/Nutrition services
f) Transportation to/from CBAS center and participant's place of residence

Mental Health Services

KFHC will cover outpatient mental health services that are within the scope of practice of Primary Care Providers or when performed for mild to moderate mental health conditions on an outpatient basis by a licensed mental health provider. Members who need specialty mental health services are referred to and are provided mental health services by an appropriate Medi-Cal Fee-For-Service (FFS) mental health provider or the Kern County Behavioral and Recovery Services (KCBRS) for Serious Emotional Disturbances.

Mental Health Parity

The KFHC Utilization Management Department (UM) collaborates with the KCBRS in the delivery of mental and physical health services to KFHC members. KFHC's UM Program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements.

Mental Health Benefits

PCP's will identify the need for a mental health screening and refer to a specialist within the contracted network. Upon assessment, the mental health specialist can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to the Mental Health Plan (MHP) for a Specialty Mental Health Services (SMHS) assessment. When a member's condition improves under SMHS and the mental health providers in the plan and the County System of care coordinate care, the member may return to the mental health provider within the KFHC network.

All eligible Medi-Cal HMO Members with a mental health diagnosis and with mild or moderate impairment receive the following mental health benefits administered through KFHC:

1. Individual and group mental health evaluation and treatment (psychotherapy)
2. Psychological testing when clinically indicated to evaluate a mental health condition
3. Psychiatric consultation
4. Outpatient services for the purposes of monitoring drug therapy
5. Outpatient laboratory, supplies and supplements-
6. Drugs (excluding anti-psychotic drugs which are covered by Medi-Cal Fee-For-Service)

For more information see KHS Policy and Procedure: 3.14-P Mental Health Services

Behavioral Health

BHT/BIS are defined as professional services and treatment programs, including but not limited to Applied Behavioral Analysis (ABA) and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with or without the diagnosis of Autism Spectrum Disorder.

The Centers for Medicare and Medicaid Services (CMS) requires that all children receive EPSDT screenings designed to identify health and developmental issues as early as possible. All children enrolled in Medi-Cal must be screened at regular intervals per recommendations for preventive pediatric health care developed by the American Academy of Pediatrics "Bright Futures" guidelines. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay.

To be eligible for BHT/BIS, the member must meet all of the following coverage criteria:

1. Be under 21 years of age.
2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT/BIS is medically necessary.
3. Be medically stable.
4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

KFHC is responsible for coordinating the provision of services with the other entities to ensure that KFHC and the other entities are not providing duplicative services.

Behavioral Treatment Plan

BHT/BIS is provided under a behavioral treatment plan that has measurable goals over a specific timeline for the particular member being treated, and that has been developed by a BHT/BIS Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT/BIS Provider. The behavioral treatment plan may be adjusted if medically necessary. BHT/BIS may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

For more information see KHS Policy and Procedure: 3.72-P Behavioral Health Therapy and Behavioral Intervention Services

KERN CARE - HEALTH HOME PROGRAM

The Department of Health Care Services (DHCS), released APL18-012 on June 28, 2018, for Health Home Program (HHP) Requirements, along with the HHP Program Guide. The HHP is a free and voluntary program that is available to all eligible KFHC members. The KFHC Health Home Program, Kern Care is a physician-led intensive case management program that uses an interdisciplinary team to address the member's physical, behavioral and social needs. This team includes a Physician, NP, social worker, case manager, care coordinator, Pharmacist, and support staff all in one location.

Member Eligibility

Member eligibility is determined by the Department of Health Services (DHCS) as follows:

1. Has a chronic condition in at least one of the following categories:
   - At least two of the following: Chronic Obstructive Pulmonary Disease, Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Chronic Renal (kidney) Disease, Dementia, Substance Use Disorders; **OR**
   - Hypertension and one of the following: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure; **OR**
   - One of the following: Major Depression Disorders, Bipolar Disorder, Psychotic Disorders (including Schizophrenia); **OR**
   - Asthma

2. In addition, the member must also have (1) of the following:
   - Has at least 3 or more of the HHP chronic conditions; ***OR***
   - At least one inpatient stay in the last year **OR**
   - Either 3 ER visits in the past 12 months **OR**
   - Chronic homelessness

HHP Core Services

There are six core services provided in the Health Home Program which include:

- Care Management – Developing and updating an individualized Health Action Plan (HAP) to guide each member with needed services and care.
- Care Coordination – Implementation of the members HAP with coordinating care and connection for health and community services.

- Health Promotion – Educating patients about and supporting them in health behaviors.
- Transitional Care – Facilitating care transitions between the hospital, nursing homes, other treatment facilities additional criteria and home.
- Member and Family Support - Supporting the self-management and decision making efforts of patients and their family or support team.
- Referral to Community and Social Support – Connecting patients to community and social services, including housing, as needed.

If you would like more information regarding the Kern Care Program, you can call 1-844-597-5342 or go to http://www.dhcs.ca.gov and search for Health Home Program to view the program guide and information.

SECTION 4: CLAIMS SUBMISSION

Claim Requirements

The KFHC claims editing software program ensures all claims received comply with Medi-Cal billing guidelines. Claims submitted incorrectly will be denied. Providers must ensure their billing processes are following Medi-Cal guidelines. The Medi-Cal Provider Manual is available online at www.medi-cal.gov.

Advantages of Electronic Claims Submission

The quickest and most efficient way to file claims is electronically. If your office is not currently submitting claims electronically, we encourage you to do so. All electronic transactions with KFHC must be HIPAA compliant. To submit claims electronically an account must be established with our vendors Change Healthcare, Relay Health, Office Ally and SSI Group. For assistance in submitting electronic claims, contact the KFHC Provider Relations Department.

Submitting claims electronically has substantial benefits including:

- **Expedited claims processing:** Electronic submission allows KFHC to begin adjudicating claims faster than if the claim is submitted by paper.
- **Faster Claims Submission Confirmation:** An electronic acknowledgement of the receipt of electronic claims is sent to Provider within **2 working days** of the date of receipt.
- **Cost effectiveness:** Electronic submission eliminates the cost of purchasing billing forms, envelopes and postage.

Claims Submissions

Claims can be submitted in either paper form or electronically. The standard forms accepted are CMS-1500 and CMS-1450 (UB04). KFHC is able to acknowledge the receipt of **electronic** claims within **two (2) working days** and is able to acknowledge receipt of **paper** claims within fifteen **(15) working Days. However, if submitted electronically, rejections are identified by the clearinghouse within two (2) business days.**

Important Billing Tips

- Before filing a claim, be sure to verify the Member's eligibility.
- File claims electronically if at all possible.
- Be sure covered services requiring prior authorization have received prior authorization. A list of Prior Authorization Status for CPT Codes is available at kernfamilyhealthcare.com.
- File claims within the required timely filing requirements.
- Avoid using members Social Security Numbers (SSN) on claims.
- Use Member Client Identification Number (CIN) or the Member ID Number.
- Hospitals, long term care facilities, licensed primary care clinics and emergency medical transportation are excluded from the SSN billing restriction. However, these excluded entities are required to make a good faith effort to obtain the member's CIN information for billing purposes.
- A valid 10-digit NPI must be entered in the billing provider field on the paper claim form or electronic claim submission.
- National Drug Code (NDC) numbers are required for certain medical supplies.

Our vendors for electronic claims submission are Change Healthcare, Relay Health, Office Ally, and SSI Group. Information on where to file claims is indicated below:

Electronic Claims	**Paper Claims for KFHC**	**Claims Disputes**
Clearinghouses include: • Change Healthcare • Relay Health • Office Ally • SSI Group KHS Payor ID: 77039	Attn: Claims Department Kern Family Health Care PO Box 25003 Bakersfield, CA 93311 *Do not hand-deliver or mail claims to the KFHC physical address.	Attn: Claims Department Kern Family Health Care 9700 Stockdale Highway Bakersfield, CA 93311 * Must be submitted using a *Provider Claims Dispute Resolution Request* form

Coordination of Benefits (COB)

State and federal laws require Providers to bill other health insurers prior to billing KFHC. Providers should attempt to be reimbursed for services from any other health insurance program for which the patient is eligible (including Medicare) before submitting a claim to KFHC. Upon receipt of a denial or partial payment from the Members other health insurance, the Provider should submit the claim along with documentation of denial or payment from the primary carrier.

Reporting Provider-Preventable Conditions (PPC)

Provider Preventable Conditions (PPCs) are either Health Care-Acquired Conditions (HCACs) or Other Provider-Preventable Conditions (OPPCs) as defined under Title 42 of the Code of Federal Regulations (CFR) sections 438.3(g), 434.6(a)(12)(i), and 447.26447.26. Providers must report PPCs to the Department of Health Care Services (DHCS) via the PPC secure online portal. Providers are also required to send KFHC a copy of PPCs submitted to DHCS. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of beneficiary information. KFHC will not reimburse providers for PPC-related health care services.

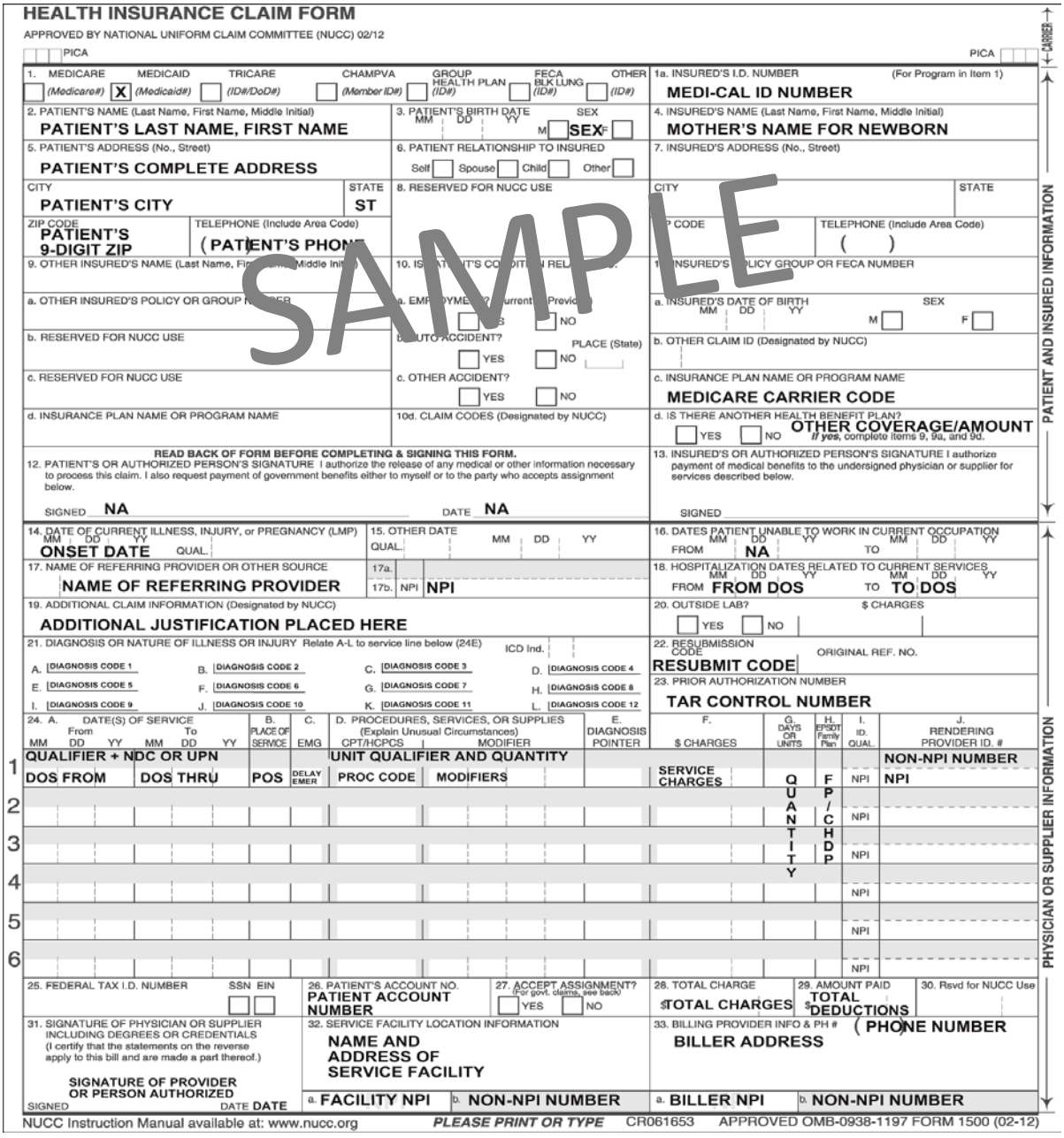
For more information visit http://www.dhcs.ca.gov/individauls/Pages/AI_PPC.aspx

Providers can send copies of their PPC submissions by mail, fax or by secure email to:

Kern Health Systems
9700 Stockdale Highway
Bakersfield, CA 93311
Attn: Compliance Director
Fax: (661) 664-5420
PPCreports@khs-net.com

Sample CMS 1500 Form

The CMS 1500 form should be used by physicians, laboratories, and allied health professionals to submit claims for medical services. Durable medical equipment and blood products should also be billed using this form. Pharmacies may also use this form to bill for supplies not billable through the on-line pharmacy claims processing service. Providers should follow the Medi-Cal instructions for completing the CMS 1500 Form, located on the www.cms.gov website.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDI-CAL ID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PATIENT'S LAST NAME, FIRST NAME

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F: SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MOTHER'S NAME FOR NEWBORN

5. PATIENT'S ADDRESS (No., Street): PATIENT'S COMPLETE ADDRESS

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: PATIENT'S CITY | STATE: ST

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: PATIENT'S 9-DIGIT ZIP | TELEPHONE (Include Area Code): (PATIENT'S PHONE

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE CARRIER CODE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO: OTHER COVERAGE/AMOUNT (If yes, complete items 9, 9a, and 9d.)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: NA | DATE: NA

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: ONSET DATE | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM NA TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NAME OF REFERRING PROVIDER

17a.

17b. NPI: NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM FROM DOS TO TO DOS

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ADDITIONAL JUSTIFICATION PLACED HERE

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. DIAGNOSIS CODE 1 | B. DIAGNOSIS CODE 2 | C. DIAGNOSIS CODE 3 | D. DIAGNOSIS CODE 4

E. DIAGNOSIS CODE 5 | F. DIAGNOSIS CODE 6 | G. DIAGNOSIS CODE 7 | H. DIAGNOSIS CODE 8

I. DIAGNOSIS CODE 9 | J. DIAGNOSIS CODE 10 | K. DIAGNOSIS CODE 11 | L. DIAGNOSIS CODE 12

22. RESUBMISSION CODE: RESUBMIT CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: TAR CONTROL NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 QUALIFIER + NDC OR UPN / DOS FROM / DOS THRU	POS	DELAY EMER	UNIT QUALIFIER AND QUANTITY / PROC CODE / MODIFIERS		SERVICE CHARGES	QUANTITY	F P/C H D P	NPI	NON-NPI NUMBER / NPI
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: PATIENT ACCOUNT NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $TOTAL CHARGES

29. AMOUNT PAID: $TOTAL DEDUCTIONS

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED

SIGNED | DATE DATE

32. SERVICE FACILITY LOCATION INFORMATION: NAME AND ADDRESS OF SERVICE FACILITY

a. FACILITY NPI | b. NON-NPI NUMBER

33. BILLING PROVIDER INFO & PH #: BILLER ADDRESS (PHONE NUMBER

a. BILLER NPI | b. NON-NPI NUMBER

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

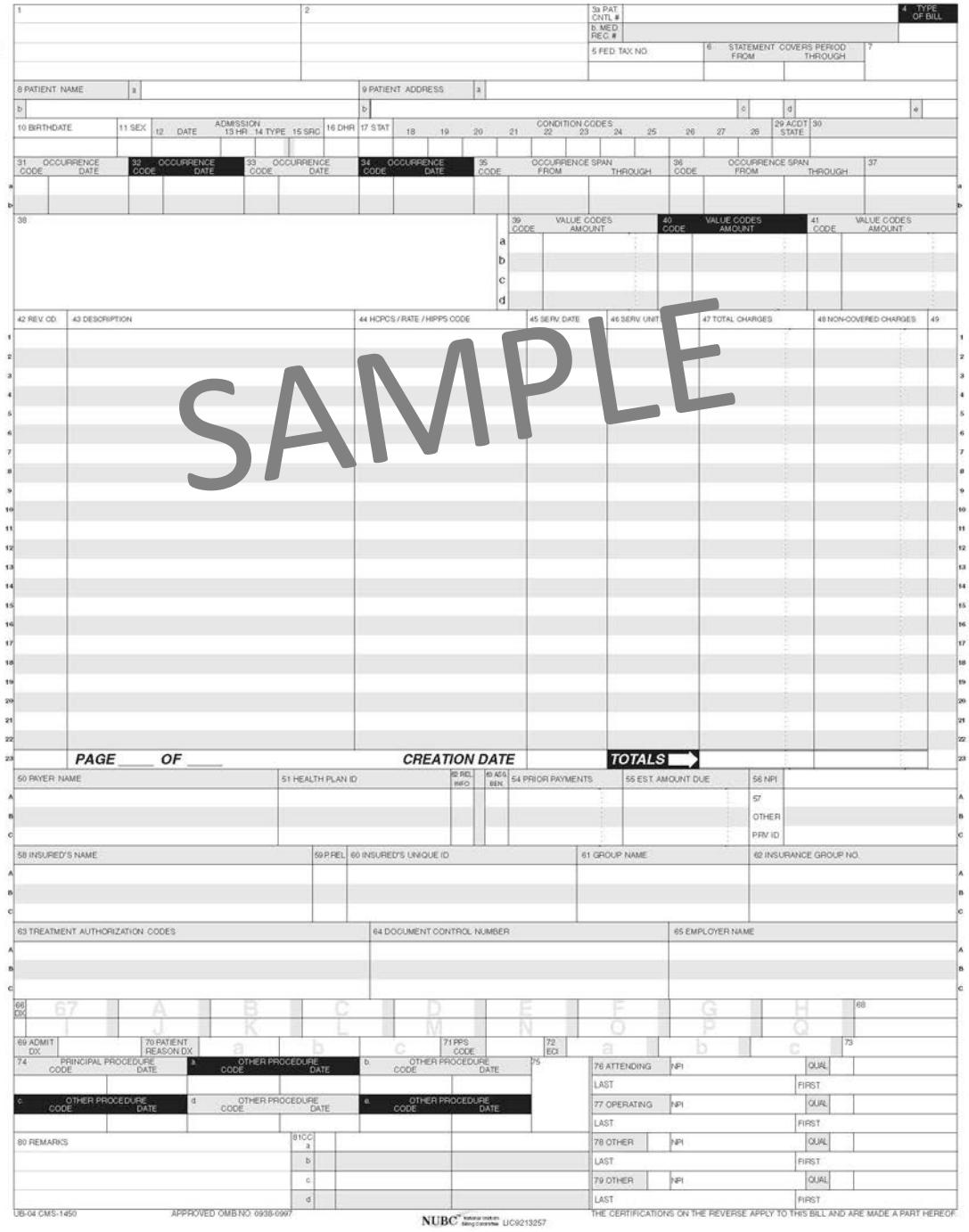
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Sample UB-04 (CMS-1450) Form

The UB-04 (CMS 1450) form should be used to submit claims for inpatient Hospital accommodations and ancillary charges and for hospital outpatient services. Providers should follow the Medi-Cal instructions for completing the UB-04 (CMS 1450) Form, located on the www.cms.gov website.



Claims for Contracted Providers

In order to receive full compensation, contracted providers should submit to a complete, written bill for all covered services rendered within **one hundred and eighty (180) calendar days** following the provision of the covered services.

Claims received after **180 calendar days** following the provision of the covered services are denied with the following exceptions:

A. Other Primary Insurance: Claims submitted within 90 calendar days of the date of the primary carrier's Explanation of Benefits (EOB).

B. California Children's Services: Claims must be submitted within 90 calendar days of the CCS denial letter.

Claims Payment or Denial Timeframes

KFHC will reimburse 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities, within 30 calendar days of the date of receipt. KFHC will reimburse each completed claim, or portion thereof, as soon as possible, but no later than 45 working days after the date of receipt of the complete claim. In accordance with State regulations, interest will be paid on clean claims not paid within 45 working days of receipt.

Claims Reimbursement

Claims for Providers will be reimbursed according to the terms specified in the Provider's Agreement. Claims for non-contracted providers will be adjudicated primarily in accordance with Medi-Cal guidelines and fee schedules. When no fee schedule exists, KFHC reasonable and customary rates will apply.

Claims Overpayment

When recovery for an overpayment is pursued, KFHC sends a refund request letter to the provider. Within thirty (30) working days of receipt of the letter, the Provider must submit to KFHC either a complete refund of the overpayment or a provider dispute.

KFHC shall require contracted providers to report to KFHC when it has received an overpayment, to return the overpayment to KFHC within sixty (60) calendar days after the date on which the overpayment was identified, and to notify KFHC in writing of the reason for the overpayment.

Providers shall submit the overpayment and written reason to the KFHC Claims Department at the following address:

Claims Department
Kern Health Systems
PO Box 25003
Bakersfield, CA 93311

Claims Payment Disputes

A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted, or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Disputes must be submitted within 365 calendar days of the date of KFHC' action, or in the case of inaction, 365 calendar days after the time for contesting/denying claims has expired. Disputes that are returned for additional information must be resubmitted to KFHC within 30 working days of the date of receipt.

Disputes should be mailed to the following address:

Claims Department
Kern Family Health Care
9700 Stockdale
Bakersfield, Ca 93311

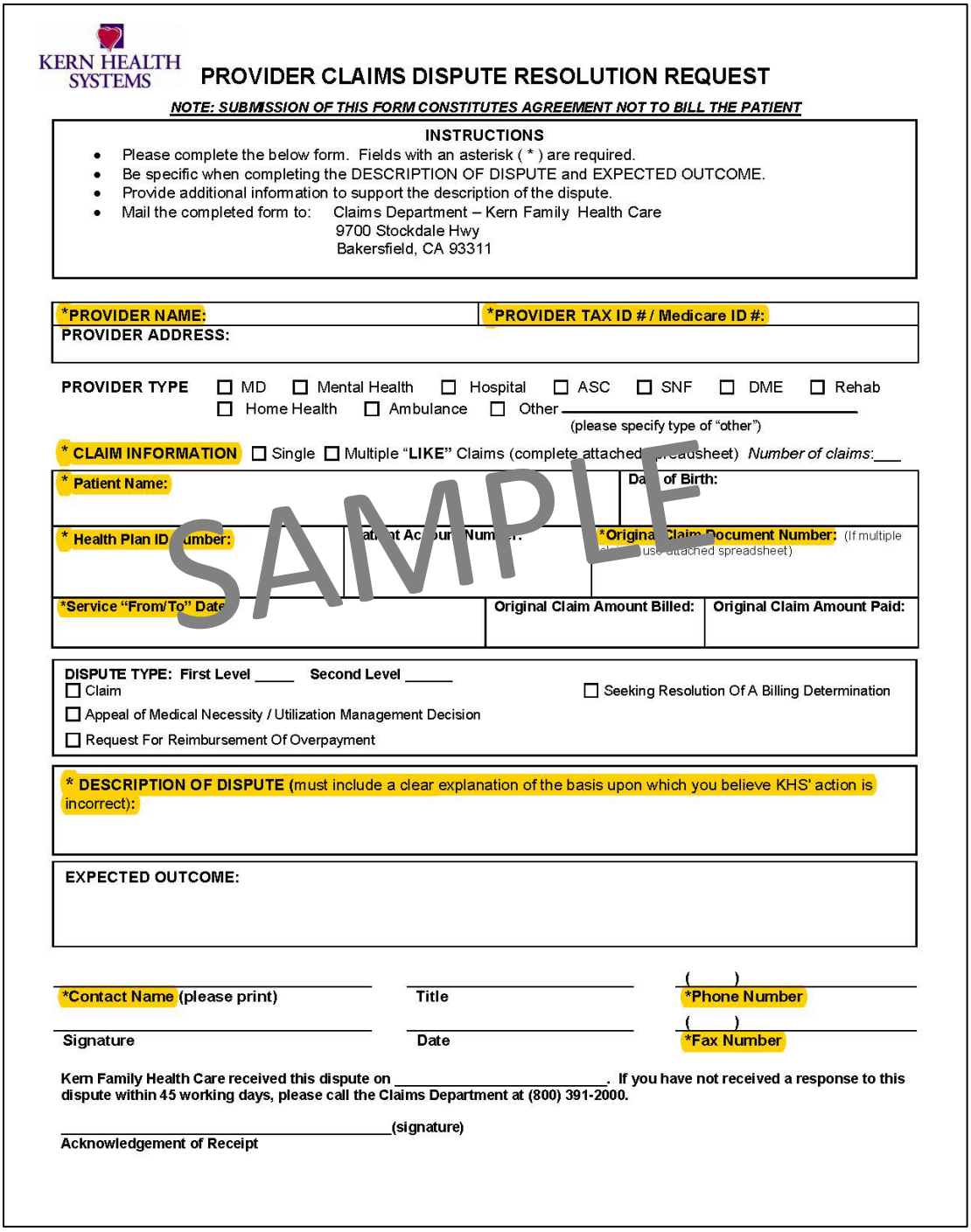
An acknowledgement letter is submitted to the Provider within **15 working days** of the receipt date, and resolved within **45 working days** of the receipt date of the dispute. Providers can make inquiries regarding disputes by calling the KFHC Claims Department.

Prior to submitting a claims dispute, KFHC encourages Providers to call the KFHC Claims Department to discuss the claim at 661-632-1590 (Bakersfield), 1-800-391-2000 (outside of Bakersfield), dial 5 to bypass other queues. Many times we can resolve the issue without the need of a claims dispute, saving both the Provider and KFHC time and effort.

For further instructions on how to submit a Provider Claims Dispute Resolution Request, please see Policy 13.05-P located on the KFHC website, www.kernfamilyhealthcare.com.

Sample Provider Claims Dispute Resolution Request Form

Claims Disputes must contain the information highlighted below. Disputes that do not contain all the necessary information are returned to the Provider. Supporting documentation must also accompany all disputes. Visit www.kernfamilyhealthcare.com to download the Provider Claims Dispute Form.



KERN HEALTH SYSTEMS

PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- Mail the completed form to: Claims Department – Kern Family Health Care
  9700 Stockdale Hwy
  Bakersfield, CA 93311

***PROVIDER NAME:** | ***PROVIDER TAX ID # / Medicare ID #:**

PROVIDER ADDRESS:

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "other")

*** CLAIM INFORMATION** ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims:*___

*** Patient Name:** | **Date of Birth:**

*** Health Plan ID Number:** | **Patient Account Number:** | ***Original Claim Document Number:** (If multiple claims use attached spreadsheet)

***Service "From/To" Date** | **Original Claim Amount Billed:** | **Original Claim Amount Paid:**

DISPUTE TYPE: First Level _____ Second Level _____

☐ Claim
☐ Seeking Resolution Of A Billing Determination
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment

*** DESCRIPTION OF DISPUTE** (must include a clear explanation of the basis upon which you believe KHS' action is incorrect):

EXPECTED OUTCOME:

***Contact Name** (please print) | **Title** | **(____) *Phone Number**

Signature | **Date** | **(____) *Fax Number**

Kern Family Health Care received this dispute on _____. If you have not received a response to this dispute within 45 working days, please call the Claims Department at (800) 391-2000.

_____(signature)
Acknowledgement of Receipt

SAMPLE

For more information see KHS Policy and Procedure:

6.01-P Claims Submission and Reimbursement
6.08-P Coordination of Benefits
13.02-P Pharmacy Claims Submission and Reimbursement
13.05-P Disputes Regarding Pharmacy Claims

SECTION 5: ACCESSIBILITY STANDARDS – TIMELY ACCESS

Appointment Waiting Time and Scheduling

KFHC adheres to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). These standards are to ensure Medi-Cal beneficiaries are offered appointments for care within a time period appropriate for their condition. Members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent appointment for services that do not require prior authorization	Within 48 hours of a request
Urgent appointment for services that do require prior authorization	Within 96 hours of a request
Primary Care routine and follow-up	Within 10 business days of a request
Specialist	Within 15 business days of a request
Mental Health	Must offer the appointment within 10 business days of request
Ancillary services such as x-rays, lab tests, and physical therapy	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

Telephone Accessibility

Providers and administrative personnel must maintain a reasonable level of telephone accessibility to KFHC members. At minimum, the following response times are required:

Nature of Telephone Call	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 9-1-1 or (661) 868-8000
Urgent medical	30 Minutes
Non-urgent medical	By close of following business day
Non-urgent mental health	By close of following business day
Administrative	By close of following business day

Provider offices must provide procedures to enable patient access to emergency services 24 hours per day, seven days per week. Patients must be able to call the office number for information regarding physician availability, on call provisions or emergency services. An answering machine or service must be made available after normal business hours with direction in non-emergency and emergency situations.

Office Waiting Time – Maximum

Service	Urgent	Routine
Primary Care Services (including OB/GYN)	1 hour	1 hour
Specialty Care Services	1 hour	1 hour
Diagnostic Testing	1 hour	1 hour
Mental Health Services	1 hour	1 hour
Ancillary Providers	1 hour	1 hour

Physicians are not held to the office waiting time standards for unscheduled non-emergent walk-in patients.

Monitoring Access Standards

KFHC will monitor all network Providers using the following sources to study and assure compliance with access standards:

A. Quarterly Appointment Availability Survey
B. Quarterly After-hours Call Survey
C. Access Grievance Review
D. Annual Appointment Availability Survey
E. Provider and Member Satisfaction Survey

For more information see KHS Policy and Procedure: 4.30-P Accessibility Standards-Timely Access

Transportation Services

KFHC has contracted with American Logistics Company (ALC), a national passenger transportation management company, who will manage the scheduling component of Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. Transportation provided via ambulance and air will still require prior authorization through the current KFHC prior authorization process.

NMT (Non-Medical Transportation)

NMT services are a covered benefit for all KFHC eligible members to obtain medically necessary KFHC or Medi-Cal covered services. NMT does not include transport of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who require to be transported by ambulance. NMT services will be provided at the least costly method that meets the member's needs. Methods of NMT include:

- Public Transit Systems via bus pass
- Private Conveyance via Lyft or Taxi
- Greyhound Transportation for long distance appointments where Lyft is unavailable
- Mileage Reimbursement will be no less than the current Internal Revenue Service (IRS) rate for medical purposes.

NEMT (Non-Emergency Medical Transportation)

NEMT includes transportation by ambulance, wheelchair vans, and gurney vans to or from KFHC covered services and can be used when:

- Medically needed
- A member cannot use a bus, taxi, car or van to get to their appointment because they require assistance to travel
- Is requested by a treating physician

NEMT via gurney or wheelchair vans, prior authorization will not be required. Providers will be required to complete a Physician Certification Statement (PCS) form prior to the member receiving NEMT services.

Scheduling Transportation

Members and Providers can call our Transportation Department, Monday through Friday, from 7:00 am to 6:00 pm, at 661-632-1590 or 1-800-391-2000 and choose, option #3. The Transportation Department is available 24 hours a day, 7 days a week for urgent or after hours assistance. **For more information, see KHS Policy & Procedures: 3.25-P Prior Auth Services and Procedures, 3.50-P Medical Transportation Services**

Sample Physician Certification Statement (PCS) Form

The PCS form is available on the KFHC Provider Portal and on our website at [www.kernfamilyhealthcare.com, under the "For Providers" tab.](http://www.kernfamilyhealthcare.com)

Kern Family Health Care™
The Friendly Face
Of Kern Health Systems

PHYSICIAN CERTIFICATION STATEMENT (PCS)
NON-EMERGENCY MEDICAL TRANSPORT

Fax completed form to: 661-473-7631

Please read the instructions before completing this form

1. Transport/ Start Date:	This PCS form is for non-emergency medical transportation services and is effective for 12 months from the start/approval date for repetitive transports or for a single prescheduled or unscheduled transportation to medical services and/or a medical facility.

2. Patient Information:

First Name:	Middle Initial:	Last Name:	Date of Birth:
CIN:		Member ID:	Preferred Language:
Diagnosis:		Functional Limitation (to support prescribed modality):	

3. Non-Medical Transportation (NMT) does not require Referral Authorization

NMT is public or private transportation. This benefit does not require PCS form submission. Members may call 1-800-391-2000 and press option #3 to request transportation assistance. For requests on behalf of the member, please choose **ONE** of these modalities.

Public/Private Transportation ☐	Member has a transportation need with no medical or physical limitations and is able to use the public transit/bus system	**Curb to Curb** ☐	Member has a transportation need, is able to walk short distances

4. Non-Emergency Medical Transportation (NEMT) that do not require Referral Authorization

The following modalities are **medically necessary** and authorized with the completion of this form and DO NOT require KFHC review. Select **ONE** appropriate modality according to the patient's transportation need.

a. Litter/Gurney Van ☐	Member requires transport in a gurney and must remain in prone or supine position during transport	**b. Wheelchair Van** ☐	For a member who: • Require transport in a wheelchair OR • Is incapable of sitting in public or private transportation for the duration of transport OR • Requires assistance to and from their residence, the vehicle, and place of treatment

5. Other NEMT Transportation that requires Referral Authorization

Ambulance and Air Transportation modalities DO require KFHC referral submission to Utilization Management for review. Follow the KHS Prior Authorization review process.

CERTIFICATION:

I certify that the above information is true and correct based on my evaluation of this patient. I represent that I have personal knowledge of the patient's condition at the time of completion of this certificate. I understand that non-emergency medical transportation is available to obtain Medi-Cal covered services when the patient's medical/ physical condition does not allow them to travel by bus, passenger car, taxicab or other forms of public or private conveyance.

Staff/Physician Name: (PRINT)	Date:
Staff/Physician Signature:	NPI:
Phone Number:	Fax Number:

SECTION 6: CULTURAL & LINGUISTIC SERVICES

Kern Family Health Care (KFHC) will provide equal access to health services for Limited English Proficient (LEP), vision and hearing impaired members by providing appropriate interpreter services.

The following Language assistance services are available at no cost to Members and Providers:

- Interpreter support during medical appointments via LanguageLine
- In-person interpreter support during medical appointments
- Sign language interpreters via LifeSigns
- Services for the hearing or speech impaired via California Relay Services
- Member informing materials in alternative formats (i.e., large print, audio, and Braille)

Interpreter Access to Members

Interpreters must be made available as needed by face to face or via telephone with physicians, physician extenders, registered nurses, or other personnel who provide medical or health care advice to members. Interpreter services must be also be available at all pharmacy sites.

Discourage the Use of Family Members as Interpreters

Family members, friends, and especially minors are discouraged from performing interpretive services for KFHC Plan members. The use of family or friends may jeopardize the quality and/or accuracy of information that is relayed to the member and may also present a hardship if the family member or friend must deliver confidential information.

Telephone Interpreting Services

During KFHC Office Hours: Providers and Members may contact the KFHC Member Services Department for an interpreter that is on staff or a Member Services Representative will connect the Provider or Member with LanguageLine Solutions- a translating service available with over 240 language options.

After KFHC Office Hours: Providers and Members are connected to LanguageLine Solutions via the KFHC Nurse Advice Line which is available by calling (661) 632-1590 (Bakersfield) or (800) 391-2000 (out of Bakersfield).

In-person Interpreter Services

Members or providers may also request in-person interpreting services for a medical appointment. Providers can contact the KFHC Member Services Department to schedule an in-person interpreter. KFHC will send either a qualified KFHC interpreter or a qualified contracted interpreter to the provider's office. Future appointments, if necessary, should be scheduled to include a KFHC staff member/interpreter or contracted interpreter.

After regular business hours, one-on-one interpreting services are provided by KFHC contracted Hospitals/Urgent Care Facilities from a pool of their employees that are interpreters.

Medical Record Documentation

All providers are required to document the member's language in the medical record. Requests or refusals for interpreter services by members must also be indicated in the member's medical record.

Provider Requirements

Providers are required to report their language capabilities as well as languages spoken by their staff. The information provided is included in the Provider Directory and the KFHC website to assist Members in selecting the best Provider for their needs.

Cultural & Linguistic Resources & Training

To assist KFHC Providers in better communicating with patients that are limited in their English proficiency (LEP), the following resources available on www.kernfamilyhealthcare.com .

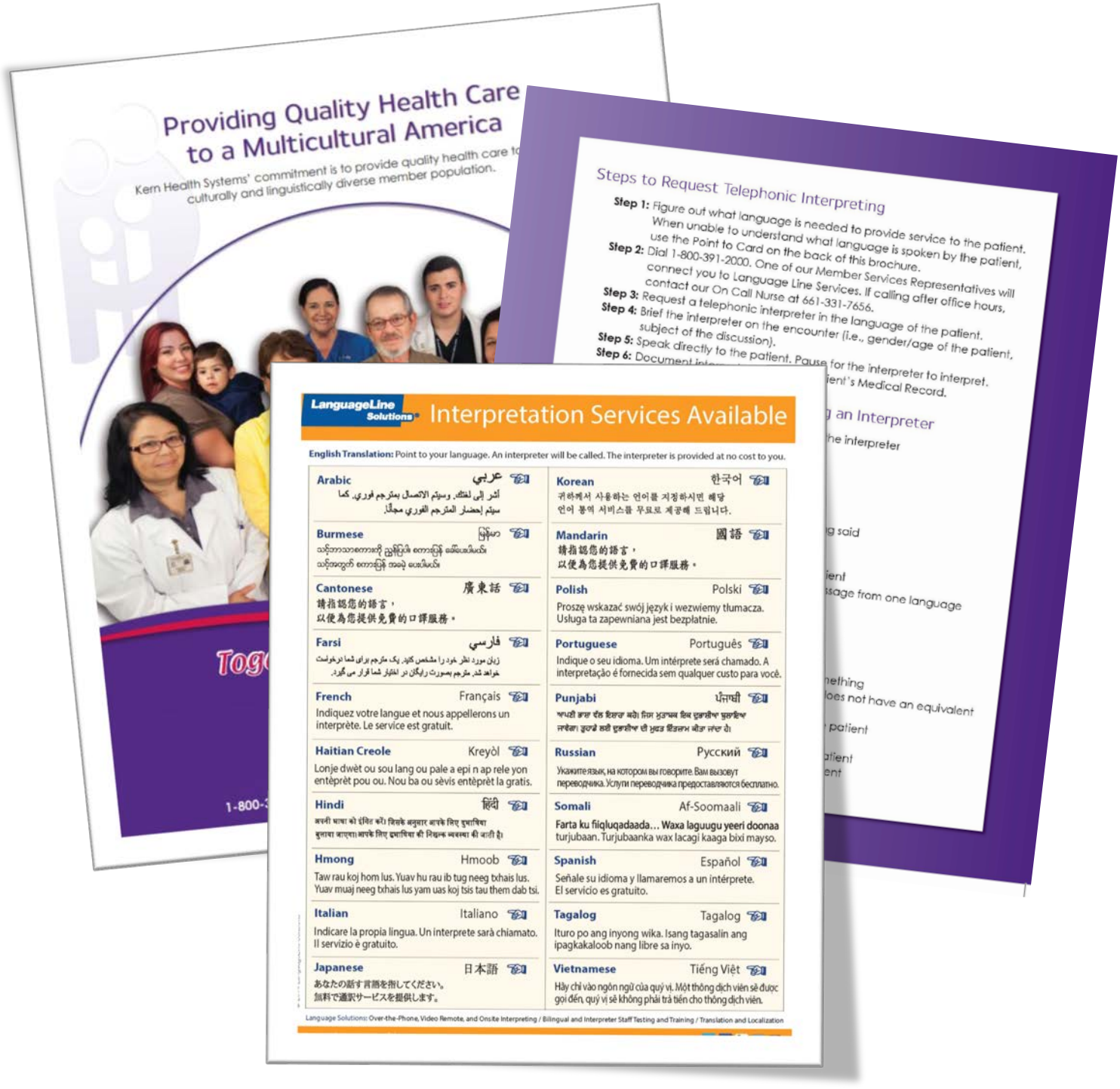
- Training: “Limited English Speaking Patients: How We Can Help You Meet Their Linguistic Needs” is available to all KFHC contracted providers
- Brochure: “Providing Quality Health Care to a Multicultural America”: Valuable information for health care providers and staff on how to effectively communicate with culturally and linguistically diverse members. Also included are steps and tips on how to request and use telephonic interpreters.
- Poster: Highlights how important it is to meet the needs of LEP patients and provides important steps to follow in doing so.
- Desktop displays: LanguageLine point to language ID display
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations: The material tool kit was produced by a nation-wide team of health care professionals. The material will provide resources to address specific operational needs that often arise because of changing service requirements and legal mandates.
- Online Courses:
  HRSA: Effective Communication Tools for Healthcare Professionals
  Addressing Health Literacy, Cultural Competency, and Limited English Proficiency

For more information or to schedule a training session, please contact Cynthia Cardona, Cultural & Linguistic Administrative & Support Supervisor at (661) 617-2498, cynthia.cardona@khs.net.com.

For more information see KHS Policy and Procedure: 3.71-P Linguistic Services, 4.01-P Credentialing

Cultural & Linguistic Provider Materials

Visit www.kernfamilyhealthcare.com to download Cultural & Linguistics Resources for your office.



SECTION 7: PHARMACY SERVICES

KFHC Pharmacy Network

The KFHC Pharmacy Network includes most retail and community pharmacies in Kern County and surrounding areas. Members should fill prescriptions at network pharmacies. A list of network pharmacies can be found at www.kernfamilyhealthcare.com using the Find a Provider search tool or by downloading the Provider Directory.

Pharmacy & Therapeutics Advisory (P&T) Committee

The P&T Committee monitors the KFHC Drug Formulary, oversees medication rescribing practices by Providers, assesses usage patterns by Members and assists with study design and clinical guidelines development, which also include safety, efficacy, and cost-effectiveness. The committee is composed of Physician and Pharmacist Providers as well as internal staff.

Pharmacy Resources

Providers can locate additional information on KFHC pharmacy policies and procedures as well as pharmacy forms at www.kernfamilyhealthcare.com under For Providers. To locate prior authorization criteria and other drug limits/restrictions, Providers should access the KFHC Formulary on the website which is also located under Pharmacy Resources.

KFHC Drug Formulary

The KFHC Drug Formulary is a list of preferred generic and brand-name medications in various therapeutic classes that are covered pharmacy benefits for our Members. edications listed in the Drug Formulary may be subject to certain restrictions such as quantity limits, step therapy, age limit, or other requirements. Providers can visit www.kernfamilyhealthcare.com to download a PDF version or utilize the KFHC online Pharmacy Drug Search tool. A printed version is distributed yearly at time of publication, please contact the Provider Relations Department for more information.

Formulary Updates / Provider Bulletins

Provider Bulletins are valuable updates, information, and action requests. Bulletins are distributed on an as-needed basis primarily to provide timely notification of new plan information, including drug formulary changes, as well as changes in regulations relating to Medi-Cal Managed Care. Bulletins are faxed and posted online at kernfamilyhealthcare.com.

Non-Formulary Drug Request

A prior authorization can be submitted when a drug is not listed on the formulary, or does not meet step therapy restriction, quantity limit, or duration of therapy limits (as listed on the formulary). These non-formulary drug requests can be made electronically via the KFHC Provider Portal, which is the preferred method, or on a Prescription Drug Prior Authorization also known as a TAR. Prior authorization requests are reviewed seven days a week, year round. Decisions are replied to within 24 hours to the requested submitter.

If Provider is unable to submit the request online, the Prescription Drug Prior Authorization form can be mailed or faxed to:

KFHC Pharmacy Department
9700 Stockdale Highway
Bakersfield, CA 93311
Fax: (661) 664-5191

To constitute a prior authorization request, all of the following information must be provided:

- Member name
- CIN number
- Diagnosis with brief history
- Reason for request including formulary medication failures
- Drug name, strength, directions, and National Drug Code
- Prescriber's name

Emergency Dispensing

During weekends, holidays, and non-business hours a pharmacy may choose to dispense enough medication (72 hours supply maximum) as an emergency supply to the member until the next working day, at the dispensing pharmacist's discretion according to pharmacy policy and procedures. If the medication is not on the Plan Formulary, a request must be submitted to payment processing stating the emergency and medication dispensed. TAR approval is not needed for reimbursement before dispensing of 72 hour emergency supply of non-Formulary drugs.

Sample Medications

Providers are discouraged from providing samples; however, if samples are given to the member, the entire course of therapy must be covered by the samples in accordance with Policy 2.24, Pharmaceutical Guidelines. Medications provided as samples do not establish continuity precedent, and therefore, do not obligate coverage by KFHC.

Billing Procedures

Pharmacy claims should be billed through the processes stipulated in the provider contract. Retail pharmacy claims billed to the PBM will follow the current standard NCPDP format. BIN, PCN and Member ID are outlined in the front (Preface) of the Formulary. Physician Administered Drugs (PAD), will follow the requirements of billing medical claims.

KFHC is payer of last resort. Any other source of other health care (OHC) is required to be billed ahead of KFHC in accordance to the provider contract.

Where applicable, 340B claims are required to be identified. For NCPDP claims, a value of 20 should be used in the Submission Clarification Code field. For PAD claims, the UD modifier should be used to indicate the status.

Pharmacy Claims Submission

Electronic billing is the preferred method of billing for medications and related materials. Claims are adjudicated electronically through KFHC's Pharmacy Benefit Manager (PBM), Argus Health Systems Inc. Electronic claims should be submitted to Argus Health Systems. Manual claims should be mailed to the Kern Family Health Care address below:

Pharmacy Claim Type	Address	Required Format
Electronic	Argus Health Systems Inc. BIN 600248 PCN 04970000	NCPDP D.0
Manual	Claims Department Kern Family Health Care 9700 Stockdale Highway Bakersfield, CA 93311	Pharmacy/Medical Supplies Claim Form (State of California of Health Services 30-1C)
Medicare co-insurance	Claims Department Kern Family Health Care 9700 Stockdale Highway Bakersfield, CA 93311	CMS 1500 form

Pharmacy Disputes

Providers are encouraged, but not required, to first utilize the dispute process through the KFHC Pharmacy Benefit Manager (PBM) before submitting a dispute to KFHC. Pharmacy Disputes should be mailed or faxed to the following:

Pharmacy Department
Kern Family Health Care
9700 Stockdale Highway
Bakersfield, CA 93311
Fax: 661-664-5191

Pharmacy disputes must be submitted using a Provider Pharmacy Claims Dispute Resolution Request form.

For more information see KHS Policy and Procedure:

2.24-P Pharmaceutical Guidelines
13.01-P Drug Utilization and Non-Formulary
13.02-P Pharmacy Claims Submission and Reimbursement
13.05-P Disputes Regarding Pharmacy Claims

SECTION 8: GRIEVANCE AND APPEAL PROCESS

KFHC responds promptly to complaints from either a Provider or a Member. Two types of formal complaints may be submitted by or on behalf of a Member are: Grievance and an Appeal.

A **Grievance** means a member's written or oral expression of dissatisfaction, regarding KFHC and/or a network Provider, including quality of care concerns and shall include a complaint, dispute, and request for reconsideration or appeal made by a Member or the member's representative. There is no time frame or deadline for a Member to file a grievance.

An **Appeal** pertains to an Adverse Benefit Determination, a formal request for KFHC to reconsider a determination (e.g., denial, deferral or modification of a decision about health care coverage). An appeal may be filed to request reconsideration of a proposed resolution of a reported grievance. The Member has 60 calendar days from the date on the Notice of Adverse Benefit Determination (NOA) to file an appeal.

Filing a Member Grievance or Appeal

A grievance from a Member or a member's representative may be submitted either in person, verbally or in writing in following ways:

- Online via KFHC website: kernfamilyhealthcare.com or Member Portal
- Contact Member Services at 661-632-1590 (Bakersfield), 1-800-391-2000 (outside of Bakersfield). Monday-Friday: 8:00 am-5:00 pm.
- By mail or in-person:

  KFHC Member Services Department
  5701 Truxtun Avenue, Suite 201
  Bakersfield, CA 93309

Routine Grievances

If possible, the grievance is resolved over the phone before the close of the next business day. An acknowledgement is mailed to the member within 5 calendar days of receipt of the grievance. The grievance is reviewed by the *Grievance Review Team*, and a resolution is provided to the member within 30 calendar days of receipt.

Urgent/Expedited Grievances

If a grievance qualifies as an "urgent grievance", the Member is notified immediately of the classification and of their right to notify the Department of Managed Health Care (DMHC) of the grievance. Consideration is given to the member's medical condition when determining response time for urgent grievances. In such cases KFHC will attempt to inform the Member as soon as possible. An acknowledgement is mailed to the Member within 3 calendar days.

Grievances Filed in a Provider's Office

If a Member requests to file a grievance in the provider's office, the Provider must supply the member with a *Member Report of Complaint/Grievance* form and provide the following options:

A. Member can call the KFHC Member Services Department at 661-632-1590 or 1-800-391-2000 from Provider's office to file a grievance verbally for assistance regarding complaint/grievance form.

B. The Member may submit the grievance in writing using the *Member Report of Complaint/Grievance* form. Providers are required to make forms and assistance readily available in accordance with California Code of Regulations, Title 28 §1300.68 (b)(7). Providers are also required to email or fax the form to KFHC on the day of receipt to grievance@khs-net.com or send via fax to 661-664-5179. The forms are available in English and Spanish.

A member who files a grievance may not be discriminated against, and cannot be dis-enrolled from the provider's office or facility in retaliation of filing a grievance. As part of KFHC investigation process, the provider will be required to respond in writing to the complaint and provide medical records if applicable.

Provider Cooperation

Providers are contractually obligated to submit medical records and, if requested, a written response to the KFHC Grievance Coordinator within ten (10) business days of the date of their receipt of the request or if otherwise specified in the request. Providers who do not comply with contract requirements may be subject to disciplinary action.

Routine Member Appeal

All routine appeals are reviewed by the KFHC Grievance Review Team and are resolved within 30 calendar days of receipt by the plan. An acknowledgement is mailed within 5 calendar days of receipt of the appeal. A Provider may submit an appeal on behalf of a Member. All pertinent supporting documentation must be provided to KFHC within the appeal. The Member or Provider, as appropriate, are notified in writing of the appeal resolution.

If the appeal is overturned and approved, KFHC must notify the member within 72 hours from the date and time of the decision. A written notice will be mailed to the member, member's representative and/or provider. Unfavorable determinations are submitted to the member, member's representative and/or provider in writing with further rights, including the right to request a State Fair Hearing. Medi-Cal members are also advised of their right to seek assistance from the Ombudsman Program.

Expedited Appeals

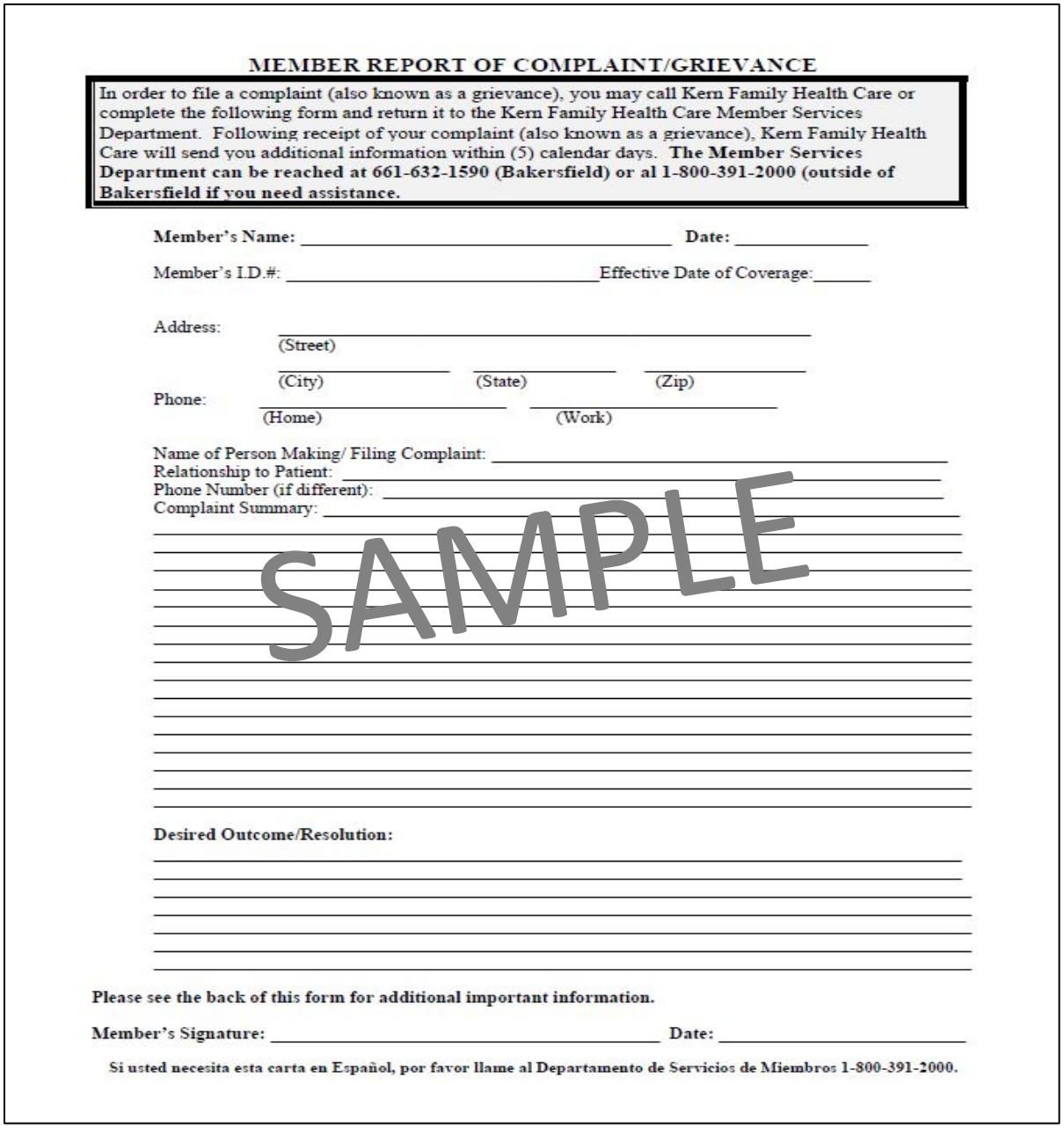
If an expedited appeal is requested and the expedited criteria is met, the Member will receive verbal notification of the resolution within 72 hours, and a written notice will be mailed within **three (3) calendar days.**

When requesting an appeal on behalf of a Member, Provider must gain the Member's written consent before filing the appeal.

For more information see KHS Policy and Procedure: 5.01-P KHS Member Grievance Process

Member Report of Complaint/Grievance

Members are encouraged but not required to submit their grievance in writing using the Member Report of Complaint/Grievance form. The Complaint/Grievance is available on the KFHC's website at kernfamilyhealthcare.com. An Online Grievance Form is also available on the KFHC website. Member Services staff can assist with filling out the form. This form is also available in Spanish.



MEMBER REPORT OF COMPLAINT/GRIEVANCE

In order to file a complaint (also known as a grievance), you may call Kern Family Health Care or complete the following form and return it to the Kern Family Health Care Member Services Department. Following receipt of your complaint (also known as a grievance), Kern Family Health Care will send you additional information within (5) calendar days. **The Member Services Department can be reached at 661-632-1590 (Bakersfield) or al 1-800-391-2000 (outside of Bakersfield if you need assistance.**

Member's Name: _____ **Date:** _____

Member's I.D.#: _____Effective Date of Coverage:_____

Address: _____
(Street)

_____ _____ _____
(City) (State) (Zip)

Phone: _____ _____
(Home) (Work)

Name of Person Making/ Filing Complaint: _____
Relationship to Patient: _____
Phone Number (if different): _____
Complaint Summary: _____

SAMPLE

Desired Outcome/Resolution:

Please see the back of this form for additional important information.

Member's Signature: _____ **Date:** _____

Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros 1-800-391-2000.

SECTION 9: PROVIDER SERVICES

New Provider In-Service

Provider orientations (In-Service) will be conducted for all contracted providers and their staff within **ten days** of becoming active with KFHC's provider network. If an unexpected emergency occurs and the provider is unable to complete the training within the ten day timeframe, the contract effective date will be postponed. Therefore the contracted provider is made aware that they may not provide services to Plan members, until the provider completes training.

Provider Directory Updates

KFHC is required to provide accurate information regarding their Provider Network. Contracted providers are responsible to ensure KFHC has accurate directory information for their office. In addition, KFHC asks all contracted providers to attest to the accuracy of their reported provider directory information in accordance with the frequency and time frames defined in Health and Safety Code section 1367.27 (SB-137).

To update your provider directory information you may:

- Make updates via KFHC Provider Portal
- Contact your Provider Relations Representative
- Contact the KFHC Member Services Department, 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield)
- Email: ProviderDirectoryFeedback@khs-net.com

Providers can direct members or prospective members' questions or comments regarding directory inaccuracies to the Member Services Department at 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield).

In addition to contacting KFHC, Providers may also direct the member or a prospective member to the California Department of Managed Health Care at **1-888-466-2219** to report any inaccuracy with the KFHC Provider Directory.

Provider Bulletin

Provider Bulletins are valuable updates, information, and action requests. Bulletins are distributed on an as-needed basis primarily to provide timely notification of new plan information, including changes in regulations relating to Medi-Cal Managed Care. Bulletins are faxed and posted online at kernfamilyhealthcare.com.

Provider Portal

The KFHC Provider Portal (Provider Connection) is one of the most beneficial resources to help with:

- **Verify member eligibility**: Providers can verify eligibility by KFHC ID number, CIN, member's name, and date of birth.
- **Check claim status**: Providers can review submitted claims and determine payment status.
- **Online Authorizations**: Providers can submit authorization requests electronically as well as check status of submitted referrals.
- **TAR:** Providers can submit electronic TAR's and check status of submitted requests.
- **Other resources available:** monthly membership lists, download various forms, P4P scoreboard, etc.
- **View and update** your Provider demographic information.

To obtain access to the KFHC Provider Portal, please contact your office designated admin user. If you are unsure who your admin user is, please contact your Provider Relations Representative or the Provider Relations Department at (661) 632-1590.

Resources available on KFHC Website

The policies, procedures, forms and documents referenced in this manual can also be found at **www.kernfamilyhealthcare.com** under the For Providers tab. The For Provider section is the hub of information for providers, including the latest bulletins, regulatory updates, and training opportunities.

For more information see KHS Policy and Procedure: 4.23-P Provider Education

SECTION 10: HEALTH EDUCATION

Members will receive health education services at no charge as part of preventive and primary health care visits. To facilitate this process, Providers are required to utilize the "Staying Healthy" assessment form, (see Section 3 in this manual and KFHC Policy and Procedure 3.05-P: Preventative Medical Care. Health Education promotes healthy living, improving health outcomes, reducing risks of disease and empowering members to be active participants in their health care.

The goal is to help Members be engaged and informed so they can be active participants in their care and the care of their children. The services below are provided in English and Spanish.

- Weight Management
- Diabetes Care
- Smoking Cessation
- Nutrition Counseling
- Asthma Management
- Prenatal Care and more

KFHC Health Education Workshops

Health Education Workshops are hosted by our Member Health Educators and are free to anyone interested. Workshop dates and times are posted on the KFHC Calendar of Events located on kernfamilyhealthcare.com or facebook.com/KernFamilyHealthCare.
Workshop topics include:

- Healthy Eating and Active Lifestyle Workshop
- Breathe Well Asthma Workshop
- Intro to Gardening
- Rethink Your Drink

To learn more about workshop dates, times and locations or how to refer patients, call 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) and ask for our Health Education Department.

Health Education Referrals

Health education services are available by referral from KFHC staff, member, or by provider. Upon receipt of a health education referral, health education staff will contact the member to assess their interest in participating in health education services. Transportation and interpreter services are provided accordingly. The best available health education resource is then identified for the member.

Health Education Materials

KFHC has developed health education brochures addressing important health issues facing our local community. These materials are provided at no cost to Providers and Members. Contact your Provider Relations Representative for more information on how you can receive health education brochures for your office. Click on the topics below to view each brochure. Brochures are also available in Spanish.

Control Asthma

Control COPD

Control High Blood Pressure

Diabetes Control

Taking Care of Yourself & Your Baby

Growing Up Healthy Series

Eat Healthy

Exercise

Not Sure It's an Emergency?

Urgent Care

KFHC takes into account the specific needs of Seniors and Persons with Disabilities (SPD). Upon request by the SPD member, family caregiver or Provider, KFHC provides educational materials in alternative formats such as Braille, large print, audio, or other appropriate methods. The Health Education Department will handle requests for health educational material in alternative formats.

Health Education Resources

Health Education services are also provided to Members through:

- KFHC 24-Hour Nurse Advice Line – In addition to Nurse Advice services, the Health Information Library has an audio library with hundreds of health topics recorded in English and Spanish.
- *Family Health, a* quarterly newsletter that is mailed to KFHC Members which includes health education and local resources. View current and past newsletters at kernfamilyhealthcare.com
- Community Events & Health Fairs – KFHC participates in health fairs and community events to promote personal health awareness and preventive health care to Members and the community. View a list of community events at kernfamilyhealthcare.com or facebook.com/KernFamilyHealthCare

Health Education Service Providers

The HE department offers the following types of services through community partnerships:

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Small Steps to a Healthier Weight (English only)
- Individual Nutrition Counseling

Community Wellness Program (CWP):

- In-home or group setting for Asthma, Diabetes, Nutrition or Stroke Prevention Education
- Freedom from Smoking Program

Clínica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

- Telephone Smoking Cessation Counseling

For more information see KHS Policy and Procedure: 3.05-P Preventative Medical Care

Member Incentives

KFHC offers three wellness based incentives and one chronic condition based incentive for members.

Initial Health Assessment (IHA) – Newly enrolled members who complete the IHA visit within 120 days of enrollment are eligible to receive a $10.00 Walmart gift card.

Pregnancy – Members who complete at 1st trimester prenatal visit and prenatal incentive form will be eligible to receive a $30.00 Target gift card, if the prenatal visit occurs during the 1st Trimester. Member who complete a postpartum care visit with their doctor (21-56 days after delivery) will be eligible to receive a $30.00 Target gift card.

Well Child – Members ages 12 -23 months who complete their annual well child visit are eligible to receive a $25 Target gift card.

Multi-Medication – Members on multiple medications would benefit from a pill box. KFHC Disease and Case Management Departments identify and mail this incentive to members.

SECTION 11: DISEASE MANAGEMENT

The Disease Management Department performs assessments, coordinates care, monitors and evaluates medical services for members with an emphasis on quality of care, continuity of services, and cost-effectiveness. The two program areas of the Disease Management Department are Diabetes and Hypertension and Asthma. The goals of disease management are to improve health outcomes for members by augmenting and helping support the work of its primary care providers in managing chronic conditions. The available programs include:

Diabetes Management and Hypertension

KFHC provides coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable the member to properly use covered equipment, supplies, and medications, and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the member's Primary Care Provider. Training shall include guidance that will enable members and their families to gain an understanding of the diabetic disease process and the daily management of diabetic therapy, to avoid frequent hospitalizations and complications.

Asthma Management

KFHC provides coverage for asthma education, including education to enable a member to properly use inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters.

Members can access disease management programs through:

- Self-referral by calling KFHC's Member Services Department at 1-800-391-2000
- KFHC interdepartmental referrals
- PCP referral

For more information see KHS Policy and Procedure: 2.35-P Disease Management

SECTION 12: MEMBER RIGHTS & RESPONSIBILITIES

KFHC Members have specific rights and responsibilities outlined under Title 22, California Code of Regulations Section 72527. KFHC provides this information to members in the Member Handbook (Evidence of Coverage, EOC), member newsletter, on KFHC's website, and upon request.

Members have the right to all of the following:

A. To be treated with respect, giving due consideration to their right to privacy and the need to maintain confidentiality of the member's medical information

B. To be provided with information about the organization and its services

C. To be able to choose a PCP within the KFHC provider network

D. To participate in decision making regarding their own health care, including the right to refuse treatment

E. To voice grievances, either verbally or in writing, about the organization or the care received

F. To receive oral interpretation services for their language

G. To formulate advance directives

H. To have access to Family Planning Services, Federally Qualified Health Centers (FQHCs), Indian Health Service Facilities, Sexually Transmitted Disease (STD) services, and Emergency Services outside the KFHC network pursuant to the federal law

I. To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible

J. To have access to, and where legally appropriate, receive copies of, amend or correct their medical record

K. To disenroll upon request

L. To access minor consent services

M. To receive written member informing materials in alternative formats, including Braille, large size print, and audio format upon request

N. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

O. To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

P. Freedom to exercise these rights without adversely affecting how they are treated by KFHC, providers, or the State.

Q. To receive upon request a statement describing KFHC policies and procedures for preserving the confidentiality of medical information.

Members also have the following responsibilities:

A. To cooperate with their health care practitioners/providers.

B. To provide, to the extent possible, accurate information needed by professional staff who are caring for them.

C. To follow instructions and guidelines given by those providing health care services.

D. To keep appointments which they or their practitioner have made.

Member Handbook / Evidence of Coverage (EOC)

A Member Handbook also known as EOC, is sent to members upon enrollment and annually thereafter. The EOC provides members with a description of the scope of covered services and information about how to access such services under KFHC's Medi-Cal plan. The EOC is available electronically online at www.kernfamilyhealthcare.com under the "For Members" tab or in hard-copy by calling our Provider Relations Department at 661-632-1590 (Bakersfield) or toll free 1-800-391-2000.

Our Member Services and Providers Relations Departments are also available to help with questions regarding KFHC's members' rights and responsibilities, Monday through Friday, from 8 a.m. to 5:00 p.m.

For more information see KHS Policy and Procedure: 5.05-P Member Rights and Responsibilities

SECTION 13: FRAUD, WASTE, AND ABUSE

At KFHC we are deeply committed to acting ethically and responsibly in a culture of compliance, ethics, and integrity. KFHC cooperates with the California Department of Health Care Services (DHCS) in working to identify Medi-Cal fraud, waste, and abuse (FWA).

Abuse: Activity that is inconsistent with sound fiscal, business, or medical practice standards and results in unnecessary cost or reimbursement. It also includes any act that constitutes abuse under applicable federal law (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Waste: The consumption of resources (products or services) due to mismanagement, inappropriate actions or inadequate oversight. Waste is not typically the result of criminal actions.

Laws and Regulations

False Claims Act (Federal – 31 U.S.C. § 3729-3733; California – C.G.C. § 12650-12656): The California and Federal False Claim Acts (FCAs) make it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim. Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines.

Fraud, Waste, and Abuse Investigations

The KFHC Compliance Department is an internal independent review and investigation department, which is responsible for implementing the Anti-Fraud Plan. The Compliance Department conducts, coordinates, and reports audit and investigation activities for the purpose of preventing and detecting fraud, waste, or abuse in the delivery of health care

services to KFHC Member. The Compliance Department also provides analysis and recommendations regarding the activities reviewed or investigated**.** Additionally, the Compliance Department initiates investigations and develops preliminary investigation reports for cases of alleged fraud, waste, or abuse. Preliminary investigation findings are forwarded to the appropriate federal or state investigating agency per contract, statute or law.

KFHC will report to the DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. KFHC will conduct, complete, and report to the DHCS, the results of a preliminary investigation of suspected fraud and/or abuse within ten (10) working days from the date that KFHC first became aware of or noticed such activity.

Member FWA Examples

- A person using someone else's KFHC Member ID Card
- Deliberately providing misinformation to retrieve services
- Selling and/or forging prescriptions

Provider FWA Examples

- Provider submitting claims for services not rendered
- Sending member a bill after the plan had made payment
- Soliciting or receiving kickbacks

Reporting Suspected FWA

Suspicious activities may be reported by phone, in writing, or in person to the KFHC Compliance Department. It is recommended, but not required, that written reports be submitted on a FWA Referral Form.

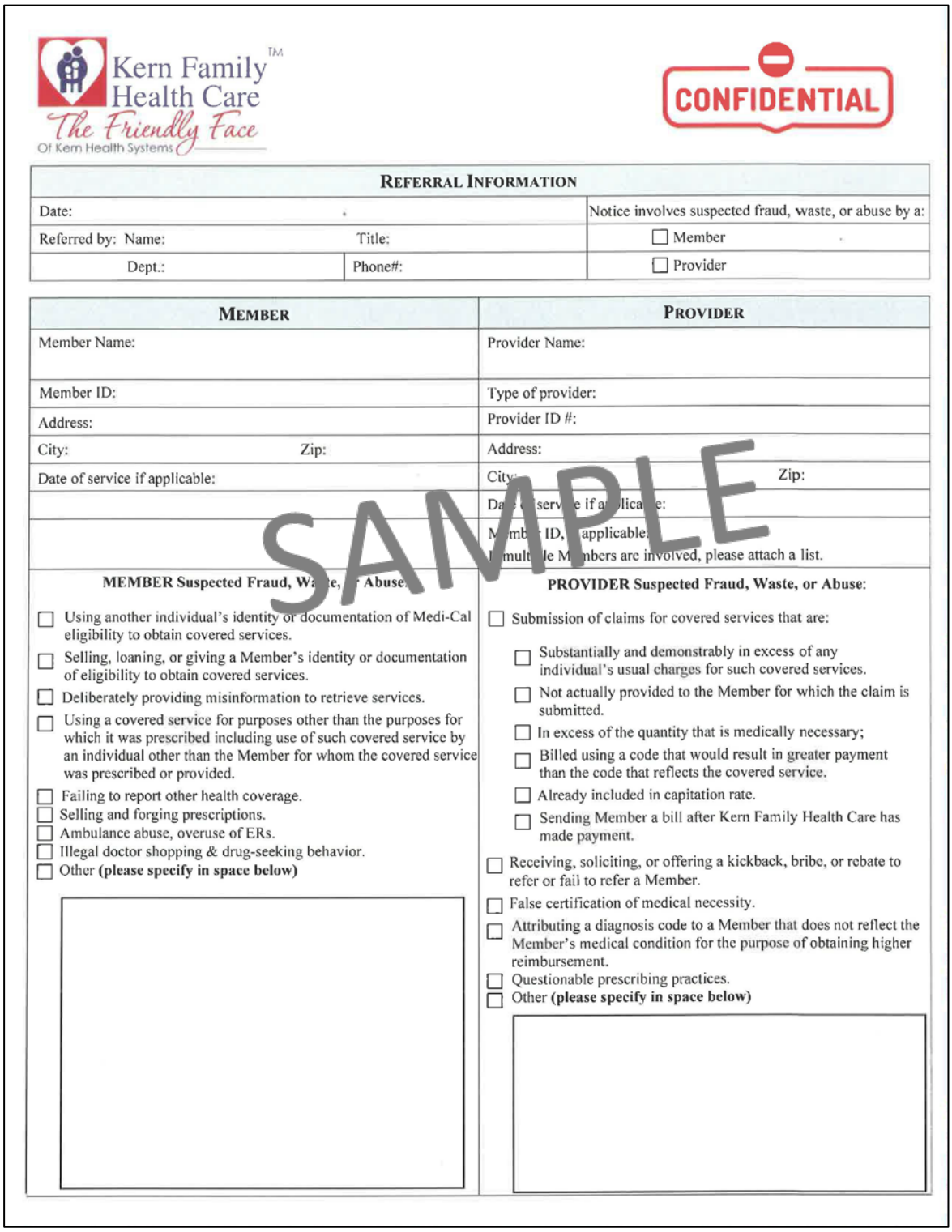
Kern Family Health Care
Director of Compliance & Regulatory Affairs
9700 Stockdale Highway
Bakersfield, CA 93311
1-800-391-2000

If you have questions about Compliance efforts, please contact your Provider Relations Representative.

For more information see KHS Policy and Procedure 14.04-P – Prevention, Detection, and Reporting of Fraud, Waste, or Abuse.

Sample FWA Referral Form

The FWA Referral form is located on the kernfamilyhealthcare.com website under the For Providers tab.



Kern Family Health Care™
The Friendly Face
Of Kern Health Systems

CONFIDENTIAL

REFERRAL INFORMATION		
Date:		Notice involves suspected fraud, waste, or abuse by a:
Referred by: Name:	Title:	☐ Member
Dept.:	Phone#:	☐ Provider

MEMBER	PROVIDER
Member Name:	Provider Name:
Member ID:	Type of provider:
Address:	Provider ID #:
City: Zip:	Address:
Date of service if applicable:	City: Zip:
	Date of service if applicable:
	Member ID, if applicable: If multiple Members are involved, please attach a list.

SAMPLE

MEMBER Suspected Fraud, Waste, or Abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.
- ☐ Selling, loaning, or giving a Member's identity or documentation of eligibility to obtain covered services.
- ☐ Deliberately providing misinformation to retrieve services.
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the Member for whom the covered service was prescribed or provided.
- ☐ Failing to report other health coverage.
- ☐ Selling and forging prescriptions.
- ☐ Ambulance abuse, overuse of ERs.
- ☐ Illegal doctor shopping & drug-seeking behavior.
- ☐ Other **(please specify in space below)**

PROVIDER Suspected Fraud, Waste, or Abuse:

- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services.
  - ☐ Not actually provided to the Member for which the claim is submitted.
  - ☐ In excess of the quantity that is medically necessary;
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service.
  - ☐ Already included in capitation rate.
  - ☐ Sending Member a bill after Kern Family Health Care has made payment.
- ☐ Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a Member.
- ☐ False certification of medical necessity.
- ☐ Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement.
- ☐ Questionable prescribing practices.
- ☐ Other **(please specify in space below)**

SECTION 14: MARKETING

Compliance with Laws and Regulations

The Department of Health Care Services (DHCS) has established guidelines for appropriate marketing activities for the Medi-Cal Managed Care Program. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

KFHC Marketing Materials

If you are interested in receiving marketing material including the KFHC Member Newsletter, Member Handbook, Provider Directory or brochures, please contact the Kern Family Health Care Provider Relations Department at (800) 391-2000.

Acceptable Marketing Methods

As a Medi-Cal health care provider, you may:

- Tell your patients the name of the health plan or plans with which you are affiliated.
- Actively encourage your patients to seek out and receive information and enrollment material that will help them select a Medi-Cal health care plan for themselves and their family.
- Provide patients with the phone number of the outreach and enrollment or member services departments of the plan(s) with which you are affiliated.
- Provide patients with the toll-free phone number of Health Care Options (HCO), the DHCS enrollment contractor (1-800-430-4263) and inform patients of locations and times when they may receive information from HCO about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information and activities, presentations, and problem resolution functions.

Prohibited Marketing Methods

As a Medi-Cal health care provider, you may NOT:

- Tell patients they could lose their Medi-Cal health benefits if they do not choose a particular health plan.
- Make any reference to competing plans, e.g., comparing plans in a positive or negative manner.
- Engage in marketing practices which discriminate against prospective members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Sign an enrollment application for the member.

Use of KFHC Logo

KFHC reserves the right to review and ensure correct usage of the KFHC and KHS logos, including the contents of the material that contains the logo. KFHC must review and approve the use of the logo(s) prior to publishing.

SECTION 15: FACITLITY SITE REVIEW

Facility Site Review

KFHC conducts a full scope facility site review for all PCPs (including OB/GYNs, and pediatricians) as well as providers who serve high volume of SPD beneficiaries as part of the Provider credentialing process. Facility site reviews are conducted at the time of initial Provider credentialing process, and every three years thereafter. A follow-up review is completed at least once within that three year period. To view the DHCS mandated tools, click here or visit the For Providers tab at www.kernfamilyhealthcare.com.

There are three components to the Facility Site Review process:

1. The Facility Site Review- The site review reviews the physical aspects of the site for basic requirements in areas such as: safety, regulatory compliance, and infection control as well as interviews with office personal.

2. The Medical Record Review- The medical record review survey is conducted three to six months after initial member linkage and as part of re-credentialing along with the site review survey, and focuses entirely on medical record review.

3. The Physical Accessibility Review- The physical accessibility review survey is not a scored review, and focuses entirely on physical accessibility of the healthcare site for seniors and persons with disabilities (SPDs). The physical accessibility review does not need to be conducted by a registered nurse or physician.

Site Review Preparation

As part of the of the facility review, KFHC QI Nurses reviews the following potential safety issues:

- Medication storage practices to ensure that oral and injectable medications, and “like labeled” medications, are stored separately to avoid confusion.
- The physical environment is safe for all patients, personnel and visitors.
- Medical equipment is properly maintained.
- Professional personnel have current licenses and certifications.
- Infection control procedures are properly followed.
- Medical record review includes an assessment for patient safety issues and sentinel events.

- Bloodborne pathogens and regulated wastes are handled according to established laws.

Corrective Action Plan

If deficiencies are identified during the PCP Facility Site and Medical Record Reviews, a Corrective Action Plan will be given to the Provider, which will include specific corrective actions along with time frames for addressing deficiencies. Providers who do not correct deficiencies, shall not be assigned new members until corrections are verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and plan members shall be appropriate reassigned to other network providers. The Physical Accessibility Review does not require correction action.

For more information see KHS Policy and Procedure 2.22 P – Facility Site Review

SECTION 16: HEDIS MEASURES AND REPORTING

Healthcare Effectiveness Data and Information Set (HEDIS) is set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA) to evaluate consumer health care across the country. HEDIS allows for assessment based in quality and performance, altogether it, consist of 91 measures across six domains of care:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health Plan Descriptive Information
6. Measures Collected Using Electronic Clinical Data Systems

Data Collection

KFHC collects and reports HEDIS data through a series of coordinated activities, including encounter and claims analysis, and medical records. Some examples of information needed from medical records include diabetes care, immunization status, prenatal and postpartum care. Providers are contractually obligated to provide KFHC access to member's medical records.

Why is it Important?

Data obtained from HEDIS helps KFHC to direct its quality improvement activities, evaluate performance and identify further opportunities for improvement. HEDIS was designed to allow consumers to compare health plans performance to other plans and to national or regional benchmarks, these benchmarks help KFHC identify gaps in care which lead to plans for improvement.

Tips for Providers

KFHC may contact selected medical office to review patient medical records as part of the HEDIS medical records review process. Here are helpful tips to prepare:

- Keep accurate, legible and complete medical records for their patients. Each document in medical record must contain the member name and date of birth to acceptable for HEDIS.
- Encourage patients to receive appropriate preventative services to ensure their health and well-being. If a service is declined by the member, providers may document it on the chart.

- HEDIS reporting is mandated by the DHCS, CMS, and the NNCQA, providers and their staff should become familiar with HEDIS measures to understand what KFHC and other health plans are required to report.

SECTION 17: CREDENTIALING & RE-CREDENTIALING

Credentialing

All healthcare providers who contract with KFHC must have credentials verified through the credentialing process in order to treat Members. To maintain health care quality standards, Members will not be assigned or referred to providers who have not completed the credentialing process.

Initial Credential Application Process

Applicants must submit a signed application and supporting documentation to the KFHC Provider Relations Department. Applications are available on the KFHC website, www.kernfamilyhealthcare.com, under the *For Providers* tab, or through the Provider Relations Department. Applications will be reviewed by the Provider Relations Department for accuracy and completeness. KFHC will render a decision within 180 days from the signature date, and if approved, the provider will receive an official letter of credentialing approval with an effective date.

Confidentiality

The information obtained during the credentialing process, whether directly from the provider, or from another source, will be treated as confidential information.

DHCS Medi-Cal Enrollment

Managed Care Plans (MCPs) are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers as well as prospective network providers.

MCP providers may apply for enrollment through the electronic Provider Application for Validation and Enrollment (PAVE) portal. For instructions and training on how to apply using the PAVE Portal go to http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx . Enrollment

forms are available on the Medi-Cal website at http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp#Forms.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes.

Application Review and Verification

The Physician Advisory Committee (PAC) shall serve as the Credentials Committee. The PAC is responsible for peer review and credentialing/re-credentialing decisions.

KFHC monitors the initial credentialing process and will ensure that providers considered for network participation and continued participation are in good standing and meet the required criteria identified in Policy and Procedure 4.01-P Credentialing before being accepted in the network. The criteria includes but is not limited to:

- Valid, unrestricted, and current State license
- Current and valid federal Drug Enforcement Agency (DEA) registration for the State
- Current NPI number
- Graduation from an approved medical school and completion of an accredited residency or specialty program
- Board Certification, if applicable
- Clinical privileges in good standing at a KFHC contracted hospital (if applicable)
- Work history
- Professional liability claims history from National Practitioner Data Bank (NPDB)
- History of any sanctions imposed by Medi-Cal, Medicaid, Medicare
- A lack of present illegal drug use
- Current adequate professional and general liability insurance
- Sanctions or limitations on licensure from State agencies or licensing boards
- Validation of approved Medi-Cal enrollment status with the Department of Health Care Services.
- For certain provider types, a facility site review is required to be completed by the Quality Improvement Department.

Recommendations

The PAC recommends acceptance or denial of an applicant to the Board of Directors as follows:

If the recommendation is for **DENIAL**, the applicant receives written notification of the decision and supporting reasons. If the denial is due to medical quality of care, the appeal process is included. If the recommendation is for **APPROVAL**, the supporting information is transmitted to the Board of Directors. The applicant receives written notification of the decision.

Recredentialing

KFHC also requires its Providers to be recredentialed every three (3) years. The recredentialing criteria includes but it not limited to:

- Valid, unrestricted, and current State license
- Professional liability claims history since initial credentialing or last recredentialing cycle
- National Practitioner Data Bank (NPDB)
- Recent sanctions imposed by Medi-Cal, Medicaid, Medicare,
- Current adequate professional and general liability insurance
- Sanctions or limitations on licensure from State agencies or licensing boards
- Revalidation of Medi-Cal enrollment status
- Performance reviews which includes Quality Improvement, Utilization Management, Member Services, and Compliance;
- Facility site review results, if applicable

On an ongoing basis, KFHC monitors its contracted providers for any potential sanctions, exclusions or debarments from federal and state programs. On a monthly basis, the Credentialing Department reviews the required federal and state databases.

A provider may be reviewed any time at the request of the QI/UM Committee, the PAC, the Chief Executive Officer, the Chief Medical Officer, or the Board of Directors. For questions regarding the credentialing or recredentialing process, contact Provider Relations Department at 800-391-2000, dial 5 to bypass other queues.

For more information see KHS Policy and Procedure 2.22 P – Facility Site Review, 4.01-P Credentialing, and 4.43-P Medi-Cal Enrollment Policy

GLOSSARY OF TERMS

Acronym	Definition
AAP	American Academy of Pediatrics
AIM	Access for Infants and Mothers Program
ALC	American Logistics Company
APL	All Plan Letter
ACOG	American College of Obstetrics and Gynecology
AMSC	Alcohol Misuse Screening and Counseling
BICs	Benefits Identification Card
CAP	Correction Action Plan
CBAS	Community Based Adult Services
CCS	California Children's Services
CHDP	Child Health & Disability Prevention
CIN	Client Identification Number
CMS	Centers for Medicare and Medicare
CCR	Code of Regulation
CPT	Current Procedural Terminology
DDS	Developmental Disability Services
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
EOB	Explanation of Benefits
EOC	Evidence of Coverage
FFS	Fee for Service
FQHC	Federally Qualified Health Centers
HCO	Health Care Options
HEDIS	Healthcare Effectiveness Data and Information Set
ICD	International Classifications of Diseases

Acronym	Definition
ICE	Industry Collaborative Effort
IEHBA	Individual Health Education Behavioral Assessment
IHA	Initial Health Assessment
KFHC	Kern Family Health Care
KHS	Kern Health Systems
LEP	Limited English Proficient
LTC	Long Term Care
NEMT	Non-emergency Medical Transportation
NMT	Non-medical transportation
NCQA	National Committee for Quality Assurance
OHC	Other Health Coverage
OTC	Over-the-counter
PAVE	Provider Application for Validation and Enrollment
P4P	Pay for Performance
PCP	Primary Care Provider
PBM	Pharmacy Benefit Manager
PDL	Preferred Drug List
PCS	Physician Certification Statement
QI	Quality Improvement
SHA	Staying Healthy Assessment
SNF	Skilled Nursing Facility
TAR	Treatment Authorization Request
USPTF	United States Preventative Services Task Force
WIC	Women, Infant & Children's Nutritional Supplemental Program

KERN HEALTH SYSTEMS

Kern Family Health Care™

800-391-2000

kernfamilyhealthcare.com