KERN HEALTH SYSTEMS | PROVIDER bulletin

October 13, 2021

PHARMACIST SERVICES AS A MEDI-CAL BENEFIT
ASSEMBLY BILL 1114

Pursuant to Welfare and Institutions (WIC) Code Section 14132.968, Kern Health Systems (KHS) provides reimbursement for specified pharmacist services when rendered to a Kern Family Health Care member.

Senate Bill (SB) 493 (Hernandez, Chapter 469, Statutes of 2013) expanded a pharmacist's scope of practice to allow independent administration of routine immunization, to furnish self-administered hormonal contraceptives, nicotine replacement products, and prescription medications which do not require a diagnosis and are recommended for traveling internationally. SB 493 also established the requirement for Advanced Practice Pharmacists to furnish the opioid overdose drug naloxone hydrochloride in accordance with standardized protocols and procedures.

A maximum of six (6) services, per member, may be billed within a ninety (90) day period. If a member requires more than six services, a prior authorization request will need to be submitted through the KHS provider portal. Applicable CPT codes must be billed in order to receive payment for services rendered:

Evaluation and Management (E&M) billing codes:
- 99202 - New patient
  - Office or other outpatient visit for the E&M of a new patient with a problem focused history and examination, and straightforward medical decision-making.
- 99212 - Established patient
  - Office or other outpatient visit for the E&M of an established patient with a problem focused history and examination, and straightforward medical decision-making.

Administration code:
- 90471 – Vaccine administration

In order to qualify for these reimbursable benefits, interested pharmacies must be able to demonstrate and attest to the following:
- The pharmacy must be enrolled with Medi-Cal, and the pharmacist rendering services must be registered as an ORP.

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- The pharmacist must meet and attest to the applicable education and training as specified in the Business & Professions code and Title 16 CCR as noted above.
- The pharmacy must be able to bill ASC X12N837P v. 5010 electronic claims submission.
- The pharmacy must demonstrate the ability to bill with appropriate CPT and ICD-10 codes.
- The pharmacy and pharmacist must meet all documentation requirements for billed pharmacy services, beyond what is required by the Board of Pharmacy and/or other applicable regulations and must meet those documentation requirements as outlined in SB 1114 including KHS Policy and Procedures.
- The pharmacy and pharmacist agree to be subject to auditing and must be available during the pharmacy or facility's business hours.
- The pharmacy agrees to notify KHS of any changes, within 10-days, in pharmacist's licensure status, location changes or additions, termination of employment or additional education and training obtained by the pharmacist rendering services to KHS members.

To request consideration, please have each individual pharmacist complete the attached Pharmacist Services (AB 1114) KHS - Request Form and return to credentialing@khs-net.com or via fax to 661-664-5442. Requests will be processed in the order received. Once the attestation/licensure are verified and the contract has been amended and fully executed, you will receive a notification which will include approved pharmacist indicating which services may be rendered along with their effective date.

If you have questions, please contact your KHS Provider Relations Representative at (661) 664-5000.

Thank you,

Melissa Lopez
Provider Relations Manager
Kern Health Systems

Pharmacist Services (AB 1114)
KHS - Request Form

FURNISHING PHARMACIST: **(FIRST, LAST, DEGREE)**	**PHARMACY NAME:**
FURNISHING PHARMACIST INDIVIDUAL NPI #:	**PHYSICAL ADDRESS WHERE SERVICES ARE RENDERED:**
PHARMACIST LICENSE #:	**PHARMACY TAX ID NUMBER:**
PHARMACIST IS ENROLLED WITH DHCS MEDI-CAL ODERING/REFFERING/PRESCRIBING PROVIDER (ORP): ☐ YES ☐ NO *	**PHARMACY IS ENROLLED WITH DHCS MEDI-CAL FFS:** ☐ YES ☐ NO *
***If no, Pharmacist must first become Medi-Cal ORP enrolled and approved before you can participate in these services.**	***If no, Pharmacy must first become Medi-Cal FFS enrolled and approved before you can participate in these services.**
REQUIREMENTS:	**ATTESTATION:**
1. Eligibility – I understand this is a benefit for Medi-Cal Fee-for-Service beneficiaries including Medi-Cal Managed Care Plan beneficiaries such as Kern Family Health Care members?	☐ YES ☐ NO
2. Billing Provider (Pharmacy) – I understand my billing provider must be enrolled by Medi-Cal FFS as a Pharmacy Provider (not the pharmacist)?	☐ YES ☐ NO
3. Furnishing Pharmacist – I attest, as an individual furnishing pharmacist, I am enrolled as a Medi-Cal ordering, referring and prescribing provider (ORP)?	☐ YES ☐ NO
4. Reimbursement & Billing – I attest, that my billing provider (Pharmacy) is able to bill ASC X12N 837 electronic claims submission. I further understand I may not submit claims on a Pharmacy claim Form or on a Compound Drug Pharmacy Claim Form for these services?	☐ YES ☐ NO **KHS Payer ID 77093** **KHS acceptable clearinghouses:** **Office Ally, SSI, Relay Health, Change Healthcare**
5. ELIGIBLE SERVICES Please refer to "What are the Eligible Services" of the AB 1114 FAQ. https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/AB1114FAQ.aspx	**I attest that the eligible services will be provided consistent with the requirements outlined in the Business and Professions Code and California Code of Regulations and I can provide the necessary documentation upon request:**
a. Furnishing travel medications (BPC § 4052(a) (10) (A) (3) and 16 CCR 1746.5)	☐ YES - I possess the necessary requirements ☐ NO - I do not possess the necessary requirements ☐ N/A – I do not provide this service
b. Furnishing naloxone hydrochloride (BPC § 4052.01 and16 CCR §1746.3)	☐ YES - I possess the necessary requirements ☐ NO - I do not possess the necessary requirements ☐ N/A – I do not provide this service
c. Furnishing self-administered hormonal contraception (BPC § 4052.3 and 16 CCR §1746.1).	☐ YES - I possess the necessary requirements ☐ NO - I do not possess the necessary requirements ☐ N/A – I do not provide this service
d. Initiating and administering immunizations (BPC § 4052.8 and 16 CCR §1746.4)	☐ YES - I possess the necessary requirements ☐ NO - I do not possess the necessary requirements ☐ N/A – I do not provide this service
e. Providing tobacco cessation and furnishing nicotine replacement therapy (BPC § 4052.9 and 16 CCR §1746.2).	☐ YES - I possess the necessary requirements ☐ NO - I do not possess the necessary requirements ☐ N/A – I do not provide this service

Pharmacist Services (AB 1114)
KHS - Request Form

6. For audit purposes: • **Pharmacist providing the service will retain proof of successful completion of any required certification, training or continuing education.** • **Pharmacy will retain all required documentation of patient, physician or other provider interactions**	☐ YES ☐ NO
7. Medical Record Documentation Requirements – I understand and attest to the DHCS Medical Record documentation requirements; the record storage and security requirements; and that the record must be complete, legible and concise?	☐ YES ☐ NO

Release of Information:

I, furnishing pharmacist, grant Kern Health Systems permission to contact any individual, institution, facility or agency identified, to evaluate the information provided or requested in support of my request to provide Pharmacist Services pursuant to AB 1114.
I, further understand, that I have the burden of producing adequate information for the proper evaluation upon request from KHS, or DHCS if requested, to validate my qualifications, and resolve any doubts about my qualifications.

I hereby grant permission for Kern Health System Representatives to conduct on-site and medical record reviews as necessary. I agree that I, the furnishing pharmacist and my pharmacy will participate in and support Kern Health System's quality improvement and utilization review programs.

Release from Liability:

I, the undersigned, hereby release from any and all liability Kern Health Systems (KHS or Health Plan name: Kern Family Health Care), its respective agents and employees, for acts performed in good faith in connection with evaluating my qualifications. I also release from any and all liability all individuals and organizations who in good faith, at any time, provide KHS with information concerning this application.

I also herby attest to the correctness and completeness of this request and agree to notify KHS of any changes to information provided herein in accordance with timely notification as outlined in the contractual agreement.

Attestation:

I understand and hereby attest, and certify, that all information submitted on this form is true, accurate, and complete to the best of my belief and knowledge. I fully understand that any falsifications, misstatements in or omissions from the form, whether intentional or not, may constitute cause for termination from participation from the KHS Health Plan Pharmacist Eligible Services.

Signature: ____ Date: _____________________

Print Name: ____

Credentialing Office Use Only:

☐ Pharmacist License Verified In good Standing: ☐ YES ☐ NO / Date Verified: _________ Initials: _____

☐ Pharmacist ORP Verified In good Standing: ☐ YES ☐ NO / Date Verified: _________ Initials: _____

☐ Pharmacy FFS Verified In good Standing: ☐ YES ☐ NO / Date Verified: _________ Initials: _____