KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Provider Disputes Regarding Pharmacy Claims Payment				POLICY #: 13.05-P	
DEPARTMENT: Pharmacy					
Effective Date: 04/2009	Review/Revised Date: 02/22/2024	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Senior Director of Claims

_____ Date _____
Director of Pharmacy

POLICY:
Kern Health Systems (KHS) shall establish and maintain a fast, fair, and cost-effective dispute resolution mechanism to process and resolve provider disputes (disputes). Contracting and non-contracting[1] providers shall have the opportunity to dispute pharmacy claims that have been denied or modified.

Only those disputes regarding pharmacy National Council of Prescription Drug Programs (NCPDP) claims payment are subject to this policy and procedure. This includes non-contracted provider disputes regarding the appropriateness of KHS' computation of the reasonable and customary value[2]. Pharmacy NCPDP claims with a date of service after January 1, 2022 are not subject to the plan and will be directed to Medi-Cal Rx for handling.

Disputes submitted on behalf of an enrollee, or a group of enrollees will be processed according to KHS Policy and Procedure #5.01 – Grievance Process.[3] Disputes regarding authorizations will be processed according to KHS Policy and Procedure #3.23 – Provider Disputes Regarding Authorization. Disputes regarding non-pharmacy claims payment will be processed according to KHS Policy and Procedure #6.04 – Practitioner/Provider Disputes Regarding Claims Payment. Disputes regarding all other issues will be processed according to KHS Policy and Procedure #4.03 – Practitioner/Provider Disputes Regarding Issues Other than Authorization and Claims Payment.

Disputes will be processed in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

A. Health and Safety Code §§ 1367(h), 1371, and 1371.1
B. CCR Title 28 §§1300.71, and 1300.71.38
C. Contract §6.5.4.5

DEFINITIONS:

Dispute[4]	A contracted or non-contracted provider's written notice to KHS challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, or contested or seeking resolution of a billing determination or disputing a request for reimbursement of an overpayment of a claim that contains the information required by Section 2.3 of this procedure.

PROCEDURES:

A. DISPUTES SUBMITTED TO THE PHARMACY BENEFITS MANAGER

The KHS contract Pharmacy Benefits Manager (PBM) has a dispute process through which providers may resolve pharmacy claims disputes. Providers are encouraged, but not required, to first utilize the PBM dispute process before submitting a dispute to KHS.

All remaining sections of this procedure relate to the KHS dispute process.

B. SUBMISSION OF DISPUTE[5]

Disputes should be mailed/faxed to the following addresses:

Pharmacy Department[6]
Kern Family Health Care
2900 Buck Owens Boulevard
Bakersfield, CA 93308
661-664-5191

Disputes may be physically delivered to 2900 Buck Owens Boulevard, Bakersfield, California.

Substantially similar multiple claims disputes may be filed in batches as a single dispute, provided that disputes are submitted in the following format[7]:

a. Batched by similar issue.
b. One Provider Pharmacy Claims Dispute Resolution Request form completed for each batch.

1. Deadlines

Disputes must be submitted to KHS within 365 calendar days of the date of KHS' action, or in case of inaction, 365 calendar days after the time for contesting/denying claims has expired.[8]

Disputes that are returned for additional information must be resubmitted to KHS within 30 days of the date of receipt.

2. Format

Disputes must be submitted using a Provider Pharmacy Claims Dispute Resolution Request form. (See Attachment A). Simple resubmission of the claim is not sufficient to qualify as a dispute. Claims resubmitted without the appropriate form will be denied as a duplicate claim.

3. Content

Disputes must contain the following information[9]:

a. Provider name
b. Provider tax identification number /provider contact information
c. Clear identification of the disputed item
d. Date of service
e. Clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.
f. Provider dispute number. This number is the same number assigned to the original claim.[10]

Disputes that do not contain all the necessary information are returned to the provider.

4. Supporting Documentation

Supporting documentation must accompany all disputes. It is not necessary to resubmit supporting documentation that was submitted with the original claim.[11]

C. ACKNOWLEDGEMENT[12]

To acknowledge receipt of a provider dispute, the Provider Pharmacy Claims Dispute Resolution Request form is signed upon receipt by KHS Pharmacy staff and a copy is submitted to the provider within 15 working days of the date of receipt.

D. PROCESSING

1. First Level Dispute

Providers should use the original claim number to identify the dispute.[13]

Upon receipt of an administrative dispute, the KHS Pharmacy Department

reviews the facts surrounding the claim and, within 45 working days[14] of the date of receipt, issues any necessary claim adjustment (including appropriate interest due) and a written determination either granting the dispute in whole or in part or denying the dispute.

The written determination states the pertinent facts and explains the reasons for the determination.[15]

Non-contracting Medi-Cal providers have the right to a second-level dispute with the Department of Health Care Services. All other providers have the right to a second-level dispute with the Chief Executive Officer within 10 calendar days of the date of the decision.

2. Second-Level Dispute

With the exception of the deadline, second level disputes must be submitted and are acknowledged in the same manner as first level disputes. Providers should use the original claim number to identify the dispute.

Non-contracted Medi-Cal providers do not have the right to a second dispute with KHS. For informational purposes only, all second-level disputes from such providers are forwarded to the CEO.

Upon receipt of a second-level dispute from a qualifying provider, the CEO independently reviews the facts surrounding the claim and, within 45 working days of receipt, issues both any necessary claim adjustment (including appropriate interest due) and a written determination either granting the dispute in whole or in part or denying the dispute. The written determination states the pertinent facts and explains the reasons for the determination. [16]

The decision by the Chief Executive Officer is final.

E. INQUIRIES REGARDING DISPUTES

Providers can make inquiries regarding disputes by calling 1-800-391-2000.[17]

ATTACHMENTS:

Attachment A – Provider Claims Dispute Resolution Request

REFERENCE:

Revision 2023-07: Updated to reflect actual date of effectuation of MCRx . APL 22-012. 10/19/2023 DHCS File and Use. **Revision 2020-10:** Revision provided by Director of Pharmacy to direct claims to Medi-Cal Rx January 1, 2021, for handling. **Revision 2019-09:** Policy reviewed and update by Director of Pharmacy. Section 4.1.2 Clinical Necessity Dispute removed, policy deals with pharmacy claims not medical necessity. Address update to new KHS location. **Revision 2017-02:** Policy reviewed and updated by Director of Pharmacy. **Revision 2013-07:** Policy reviewed by Director of Pharmacy. No revisions required at time of review. Revision 2009-04: Policy reviewed by Director of Pharmacy; no revision needed. Not reviewed by the AIS Department. **Revision 2003-XX:** Updated KHS address and phone numbers 9/14/05. Revised to comply with new AB1455 DMHC Regs (effective 01/01/04). Changed title from "Appeal of Denied or Modified Claims". **Revision 2001-08**: Clarify denial codes for appeals, add HFAM PO

Box, lengthen submission/response deadlines.

[1] HSC §1367(h)(2)

[2] CCR Title 28 §1300.71(g)(3)

[3] CCR Title 28 §1300.71.38(c)(4)

[4] CCR Title 28§1300.71.38(a)(1)

[5] Required disclosure: Directions (including the mailing address) for the electronic submission (if available), physical delivery, and mailing of provider disputes. (60.04 §5.0)

[6] Required disclosure: Identity of the office responsible for receiving and resolving provider disputes(60.04 §5.0)

[7] Required disclosure: Directions for filing substantially similar multiple claims disputes in batches (60.04 §5.0)

[8] CCR Title 38 §1300.71.38(d)(1)

[9] CCR Title 28§1300.71.38(a)(1)

[10] CCR Title 28 §1300.71.38(c)(1)

[11] CCR Title 28 §1300.71.38(d)(2)

[12] CCR Title 28 §1300.71.38(e); CCR Title 28 §1300.71(l)(3). Required disclosure: timeframe for acknowledgement (60.04 §5.0)

[13] CCR Title 28 §1300.71.38(c)(1)

[14] 45 day timelimit; CCR Title 28 §1300.71.38(f). Technically allowed 5 days beyond issuance of determination to make payment. We will issue both simultaneously.

[15] CCR Title 28 §1300.71(f)

[16] CCR Title 28 §1300.71(f)

[17] CCR Title 28 §1300.71(l)(3). Required disclosure: Phone number for inquiries and filing information (60.04 §5.0)