KERN HEALTH SYSTEMS

PROVIDER bulletin

April 14, 2021

Coordination of Benefits

Dear Provider,

In most cases, KHS does not require prior authorization submission to KHS for covered services when a member has Medicare or other health insurance as their primary insurer. KHS will coordinate benefits to either the Medi-Cal allowable or the primary allowable, whichever is less. KHS coordinates benefits at the claim level not the line level. Since Medi-Cal is always the payor of last resort, when other Health Coverage exists, including Medicare, the other insurance details must be entered in the correct loop and segments of the electronic claim submission.

There is an exception to the authorization waiver as well as an exception for non-covered services listed below.

In the event KHS determines the services were not a medically necessary covered Medi-Cal benefit, KHS may deny payment for such services.

In the event the primary insurance denies a service as a non-covered service, KHS requires a retro authorization for consideration of payment when the service is on the KHS PA list. Please keep in mind, KHS allows 60 days from the primary insurance denial date to submit a retro authorization request.

If you have any questions, please feel free to contact your Provider Relations Representative.

Thank you,

Melissa Lopez
Provider Relations Manager