Kern Family Health Care®

Medicare (D-SNP)

Provider Manual

Last Updated: January 1, 2026

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Kern Family Health Care

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 is the local initiative managed care plan in Kern County.

Effective January 1, 2026, KFHC is offering a Dual Special Needs Plan (D-SNP), aimed at expanding access to coordinated care for individuals eligible for Medicare and Medicaid called Kern Family Health Care Medicare (HMO D-SNP) (KFHCM). A D-SNP is a type of Medicare Advantage Plan for individuals eligible for both Medicare and Medi-Cal, to provide coordinate care that improves health outcomes.

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.

Model of Care

- KFHCM has developed a Model of Care (MOC) program that outlines how personalized, coordinated and comprehensive care is provided to our members. This approach aims to improve health outcomes, reduce costs and enhance members' quality of life. The MOC is the framework used to deliver high- quality, individualized services to our enrolled members.

- All providers are required to complete KFHCM MOC training prior to providing services to plan members and on an annual basis thereafter.

- MOC Provider training is available on the Provider Training section of the KHS website:
  - https://www.kernfamilyhealthcare.com/providers/provider-training/

Provider Portal

- **The Kern Family Health Care Medicare (HMO D-SNP) Provider Portal (KFHCM Provider Portal) is separate from the Kern Family Health Care Medi-Cal Portal**.
- The KFHCM Provider Portal is hosted by Universal Health Care through their EZ-NET Portal. It can be found here: **https://eznetportal.universalhealthcareipa.com/**
- The KFHCM Provider Portal allows providers too:
  - Search for network providers
  - Submit authorization requests
  - Check the status of authorization requests
  - Verify member health plan eligibility
  - View member authorization history
  - Check the status of claims and encounters
  - Access member panel lists (for PCPs)
  - Look up procedure codes, diagnosis codes, and other general reference information
- More information on the KFHCM Provider Portal:
  - Visit the the Provider Resources section of the KHS website.
  - Contact your Provider Relations Representative
  - Contact KFHCM at (866-661-3767)

Eligibility Verification

Eligibility needs to be checked every visit and can be checked in multiple ways:

- **KFHCM Provider Portal**
- **KFHC Medicare (HMO D-SNP) (KFHCM):**
  - 866-661-3767

24 Hour Telephone Triage

- KFHCM offers a 24 hour Nurse Triage Center, please contact: 866-661-3767
- The provider or the member may call the Triage Center for any urgent/immediate needs.
- If the member's condition does not meet the protocols for urgent/emergent care, the member will be directed to their PCP.

Referral Process

- A routine request by the ordering provider for referral is initiated by submitting a request via the **KFHCM Provider Portal**. The requesting provider must include pertinent medical records, diagnosis and treatment codes, and member data which support the referral and will assist the specialty provider in the assessment and delivery of services.

- If on-line submission is unavailable, please submit referral via fax to our Utilization Management Department at **1-661-605-0315**
  - a copy of the referral form can be found on the Provider Resources section of the KHS website.
  - https://www.kernfamilyhealthcare.com/providers/provider-resources

Referral Process

Result of Review	Provider Notice	Member Notice
Approved	**Referring:** Approved Referral/Prior Authorization Form (within 24 hours of the decision). Initial notification may be oral, written and/or electronic fax or portal. **Specialist:** Approved Referral/Prior Authorization Form and any pertinent medical records and diagnostics (within 24 hours of the decision). Initial notification may be oral, written and/or electronic fax or portal. **OR** **Hospital: Hospital** Notification Letter (within 24 hours of the decision).	Next business day after decision date
Deferred	**Referring:** Copy of Notice of Action Letter and the Referral/Prior Authorization Form (within 24 hours of the decision). Initial notification may be oral, written and/or electronic fax or portal. **OR** **Hospital: Requests** for hospital services are not deferred.	Next business day after decision date
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). Initial notification may be oral, written, and/or electronic fax or portal. **Specialist:** Modified Referral/Prior Authorization Form and any pertinent medical records and diagnostics (within 24 hours of the agreement). Initial notification may be oral, written and/or electronic fax or portal.	Next business day after decision date

Referral Process

Result of Review	Provider Notice	Member Notice
Terminated or Reduced (Subsequent request for a continuing service or treatment that was previously approved)	**Treating:** Copy of Notice of Adverse Determination Letter sent to the member (within 24 hours of the decision). Initial notification may be oral, written and/or electronic fax or portal.	Next business day after decision date
Denied (Included those carve out services that are denied as not covered by KFHCM)	**Referring:** Copy of Notice of Adverse Determination Letter (within 24 hours of the decision). Initial notification may be oral, written and/or electronic fax or portal. **OR** **Hospital:** Hospital Notification Letter (within 24 hours of the decision).	Next business day after decision date

Utilization Management will provide copies of criteria used to make medical necessity determinations as requested by calling 661-716-5342 or toll free at 1-866-661-3767 during business hours Monday - Friday.

Referral Process

Outpatient Urgent Referrals

- Prior authorization for emergent medical conditions is not required when:
  - There is an imminent and serious threat to health including but not limited to the potential loss of life, limb, or other major bodily function.
  - A delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.

- KFHCM does require a retrospective referral from the requested provider for stat services within 60 days of date of service.

Referral Process

Hospital/Facility Admission

- All providers must request authorization for scheduled hospital/facility admissions from the Utilization Management Department.
- Admissions will be to contracted facilities unless an exception occurs and special authorization has been granted by the Utilization Management Department.

Referral Process

Lab, X-ray, and Assistant Services

- Routine lab and x-ray services do not require pre-authorization but must be directed to KFHCM 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 D-SNP prior authorization list on the Provider Resources section of the KHS website.

Referral Process

Denials and Appeals

- Reasons for possible denial include:
  - Not a covered benefit
  - Not medically necessary
  - Continue conservative management
  - Services should be provided by a PCP
  - Experimental/investigational treatment
  - Inappropriate setting
  - Covered by Hospice

Referral Process

Denials and Appeals

- For **appeals**, the KFHCM Prior Authorization Appeal form must be used.
  - The KFHCM Prior Authorization is available on the Provider Resources section of the KHS website.
- The form must be filled out in its entirety with documentation supporting the appeal.
- Appeals may be filed by the beneficiary or provider prior to the service being rendered and before 60 days. After 60 days a new request is required.
- If the provider is filing on the beneficiary behalf, the appeal must be accompanied with the beneficiary's written consent.
- Appeals returned for additional information must be received within 30 working days of receipt
  - Treating providers can be modified without the provider's permission based on access, prior relationships/COC, or plan preference.

Referral Process

Covered Services That Do Not Require Authorization/Referral

- Please refer to the Medicare Prior Authorization (PA) list on the Providers Section of the KHS website.
- The PA list is updated the first of each month and it is the provider/facilities responsibility to check for any updates prior to rendering services

Referral Process

Second Medical Opinions

- 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 Medical Director.
- Authorization/denial and evaluation of the second opinion is accomplished within 72 hours for urgent requests or within 5 business days for routine requests.

Claims Submission

- KFHCM acceptable clearinghouses:

Office Ally Payer ID: 77039	Change Healthcare (Emdeon, Relay Health) Payer ID: 77039
SSI Payer ID: 77039	Cognizant Professional Payer ID: KERNH Institutional Payer ID: UERNH

There are 3 exceptions that will be accepted via paper submission:

- Any claim where contract requires invoice pricing. (Invoice must be attached)
- Prior KFHCM claim submission resulted in an EOB where KFHCM requested documentation to be provided. (Request from KFHCM or EOB requesting documentation must be attached). Do not include the claim form in this case. Only send the EOB or letter requesting the documentation and the requested documentation NO CLAIM FORM NEEDED
- Claims with a California Children's Services (CCS) Notice of Action (NOA) which show CCS has denied the case for coverage by CCS

Note: For these claims, a standard CMS/UB04 Red and White claim form must be used.

For the 3 exceptions identified above, claims must be mailed to:

Kern Family Health Care Medicare
PO Box 9187
Bakersfield, CA 93389-0187

Claims Submission

- Claims must be submitted within 1 year from the date of service. COB (Coordination of Benefit) claims must be submitted within 90 days of primary insurance EOB (Explanation of Benefit) issue date.
- Claims received after 1 year will be denied for timely filing.

Important Billing Tips

- Before filing a claim, be sure to verify the Member's eligibility.
- Be sure covered services requiring prior authorization have received prior authorization. A list of Prior Authorization Status for CPT Codes is available at www.kernfamilyhealthcare.com
- File claims within the required timely filing requirements.
- Avoid using members Social Security Numbers (SSN) on claims.
- 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 all drugs and certain medical supplies.
- All diagnosis codes are to be submitted to the highest level of specificity, regardless of level used on the authorization.

ePayment Center (EPC)

- KFHCM utilizes a third-party vendor, ePayment Center, to process all payments and remittance advice. You have the option through ePayment to receive payment via Virtual Credit Care, Kern ACH, and paper check. All EOP's are electronic and are only available through ePayment Center.
- The first payment that you receive from KFHCM will include instructions on how to register with ePayment. If you have any questions, please contact ePayment Center 855-774-4392 or help@epayment.center.

Cultural and Linguistic Services

- During office hours, providers and members may contact the KFHCM Member Services Department for an interpreter and be connected with the language line.
- After hours, providers and members may contact the 24-hour Triage Line to be connected to the language line.

Phone: 866-661-3767

Pharmacy

- KFHCM contracts with MedImpact (MI) to administer the outpatient pharmacy benefits through its retail, home infusion, and long-term pharmacies. The PBM is primarily responsible for processing pharmacy claims and assists with day-to-day pharmacy billing problems and issues. The customer service and help desk telephone number is 1-833-546-0101. You may contact them at any time (24 hours a day, seven days a week). Questions regarding prior authorizations may also be directed to this number.
- Billing information for processing a pharmacy claim is:
  - Rx Group: KFHC01
  - Rx BIN: 015574
  - Rx PCN: ASPROD1

Pharmacy

- The KFHCM formulary is available on the Plan's website:
  - https://www.kernfamilyhealthcare.com/medicare
- Participating providers are encouraged to prescribe drugs that are on the KFHC Medicare (HMO D-SNP) formulary. If there is a need to prescribe a drug not on the formulary, a pharmacist may contact the prescriber recommending switching to a formulary alternative when appropriate. If an alternative is not available or inappropriate for a member's condition, the provider should submit a prior authorization or call 1-833-546-0101.

Transportation Services

KFHC provides and coordinates non-emergency medical transportation (NEMT) and non-medical transportation (NMT) services for our members. KFHC uses American Logistics (AL) to manage scheduling of all NEMT and NMT transportation.

- **Non-Emergency Medical Transportation (NEMT)**

  For members requiring NEMT via litter van or wheelchair transport, KFHC providers are required to complete a Physician Certification Statement (PCS) form. Prior authorization is not required.

- **Non-Emergency Transportation (NMT)**

  NMT Services are coordinated through ALC. Members can reach our transportation department to schedule a ride by calling: 1-800-391-2000, Option # 3

The PCS form can be found the Provider Resources section of the KHS website. They should be submitted through the KFHC portal – not the KFHCM portal.