



KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Provider Disputes Regarding Pharmacy Claims Payment	Policy #	13.05-P
Policy Owner	Pharmacy	Original Effective Date	4/2009
Revision Effective Date	9/2024	Approval Date	12/11/2024
Line of Business	<input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Corporate		

I. PURPOSE

The policy will govern how provider disputes of pharmacy claims will be managed. This pertains to National Council of Prescription Drug Programs claims.

II. POLICY

Kern Health Systems (KHS) shall establish and maintain a fast, fair, and cost-effective dispute resolution mechanism to process and resolve provider disputes. Contracting and non-contracting¹ 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 Appeals regarding authorizations will be processed according to KHS Policy and Procedure #3.23-P – Provider Appeals Regarding Authorization. Disputes regarding non-pharmacy claims payment will be processed according to KHS Policy and Procedure #6.04 – Provider Disputes Regarding Claims Payment. Disputes regarding all other issues will be processed according to KHS Policy and Procedure #4.03 – Provider Disputes on 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

III. DEFINITIONS

TERMS	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 B.3 of this procedure.

IV. 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 format⁷:

- i. Batched by similar issue.
- ii. One Provider Pharmacy Claims Dispute Resolution Request form completed for each batch.

1. Deadlines

Disputes must be submitted to KHS within three hundred and sixty-five (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 thirty (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 fifteen (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 forty-five (45) working days¹⁴ 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 ten (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

V. ATTACHMENTS

Attachment A: Provider Claims Dispute Resolution Request
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VI. REFERENCES

Reference Type	Specific Reference
Regulatory	¹ HSC §1367(h)(2)
Regulatory	² CCR Title 28 §1300.71(g)(3)
Regulatory	³ CCR Title 28 §1300.71.38(c)(4)
Regulatory	⁴ CCR Title 28§1300.71.38(a)(1)
Other	⁵ Required disclosures: Directions (including the mailing address) for the electronic submission (if available), physical delivery, and mailing of provider disputes. (60.04 §5.0)
Other	⁶ Required disclosures: Identity of the office responsible for receiving and resolving provider disputes (60.04 §5.0)
Other	⁷ Required disclosures: Directions for filing substantially similar multiple claims disputes in batches (60.04 §5.0)
Regulatory	⁸ CCR Title 38 §1300.71.38(d)(1)
Regulatory	⁹ CCR Title 28§1300.71.38(a)(1)
Regulatory	¹⁰ CCR Title 28 §1300.71.38(c)(1)
Regulatory	¹¹ CCR Title 28 §1300.71.38(d)(2)
Regulatory	¹² CCR Title 28 §1300.71.38(e); CCR Title 28 §1300.71(l)(3). Required disclosure: timeframe for acknowledgement (60.04 §5.0)
Regulatory	¹³ CCR Title 28 §1300.71.38(c)(1)
Regulatory	¹⁴ 45 day time limit; CCR Title 28 §1300.71.38(f). Technically allowed 5 days beyond issuance of determination to make payment. We will issue both simultaneously.
Regulatory	¹⁵ CCR Title 28 §1300.71(f)
Regulatory	¹⁶ CCR Title 28 §1300.71(f)
Regulatory	¹⁷ CCR Title 28 §1300.71(l)(3). Required disclosure: Phone number for inquiries and filing information (60.04 §5.0)

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2024-9	Per annual routine review, made name changes to reflect current policies.	CK Pharmacy
Revised	2023-07	Updated to reflect actual date of effectuation of MCRx. APL 22-012. 10/19/2023 DHCS File and Use.	Pharmacy
Revised	2020-10	Revision provided by Director of Pharmacy to direct claims to Medi-Cal Rx January 1, 2021, for handling.	Pharmacy
Revised	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.	Pharmacy
Revised	2017-02	Policy reviewed and updated by Director of Pharmacy.	Pharmacy
Revised	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.	Pharmacy
Revised	2003	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".	Pharmacy
Revised	2001-08	Clarify denial codes for appeals, add HFAM PO Box, lengthen submission/response deadlines.	Pharmacy

VIII. APPROVALS

Committees Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		

Regulatory Agencies (if applicable)	Date Reviewed	Date Approved
Department of Health Care Services (DHCS)	For APL 22-012.	10/19/2023 DHCS File and Use.
Choose an item.		
Choose an item.		

Chief Executive Leadership Approval *		
Title	Signature	Date Approved
Chief Executive Officer Emily Duran		
Chief Medical Officer Dr. Martha Tasinga		
Chief Operating Officer		
Choose an item.		
*Signatures are kept on file for reference but will not be on the published copy		



Policy and Procedure Review

KHS Policy & Procedure: 13.05-P Provider Disputes Regarding Pharmacy Claims Payment

Last approved version: 2023-7

Reason for revision: Per annual routine review, revisions include name changes to reflect current policies.

Director Approval		
Title	Signature	Date Approved
Director of Pharmacy Bruce Wearda		
Robin Dow-Morales Senior Director of Claims		

Date posted to public drive: _____

Date posted to website (“P” policies only) : _____

PROVIDER PHARMACY 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: Pharmacy Department –Kern Family Health Care
2900 Buck Owens Boulevard
Bakersfield, CA 93308

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

*** 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 _____	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	
<input type="checkbox"/> Request For Reimbursement Of Overpayment	

* DESCRIPTION OF DISPUTE (must include a clear explanation of the basis upon which you believe KHS' action is incorrect):
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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 (661) 391-2000.

(signature)

Acknowledgement of Receipt

13.05-P Attachment A

PROVIDER PHARMACY CLAIMS DISPUTE RESOLUTION REQUEST

(For use with multiple “LIKE” claims)

N u m b e r	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim Document Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								