KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Provider Disputes Regarding Claims Payment	**Policy #**	6.04-P
Policy Owner	Claims	**Original Effective Date**	1998-07
Revision Effective Date	12/2/2025	**Approval Date**	3/2/2026
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to define a standardized process for Kern Health Systems (KHS) to receive, review, and resolve provider disputes related to claims payment in a timely, consistent, and compliant manner, while ensuring proper documentation to support oversight, audits, and record retention requirements.

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 (disputes). Contracting and non-contracting providers shall have the opportunity to dispute claims for the payment of health care services that have been denied or modified.

Only those disputes regarding 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 as defined by the Department of Health Care Services (DHCS) or the Department of Managed Health Care (DMHC).

Disputes submitted on behalf of an enrollee, or a group of enrollees will be processed according to KHS Policy and Procedure 5.01-P KHS Member Grievance and Appeal System . Disputes regarding authorizations will be processed according to KHS Policy and Procedure 30.49-I – Provider Disputes Regarding Authorization. Disputes regarding all other issues will be processed according to KHS Policy and Procedure 4.03-P – 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. California Health and Safety Code §§ 1367(h), 1371, and 1371.1
B. California Code Regulation (CCR) Title 28 §§1300.71, and 1300.71.38
C. DHCS Contract §6.5.4.5

III. DEFINITIONS

TERMS	DEFINITIONS
Dispute	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 A, 4 of this procedure.

IV. PROCEDURES

A. Submission of Dispute

1. Disputes should be mailed to the following addresses:

Claims Department
Kern Family Health Care
PO Box 85000
Bakersfield, CA 93308-

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

   b. Substantially similar multiple claim disputes may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

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

2. Deadlines

   a. Disputes must be submitted to KHS within three hundred sixty-five (365) calendar days of the date of KHS' action, or in the case of inaction, three hundred sixty-five (365) calendar days after the time for contesting/denying claims has expired.

   b. Disputes that are returned for additional information must be resubmitted to KHS within

thirty (30) working days of the date of receipt.

3. Format

    a. Disputes must be submitted using a Provider Claims Dispute Resolution Request form, which can be obtained from kernhealthsystems.com. (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 unless a cover letter is attached that clearly identifies the dispute as defined in this policy.

4. Content

    a. Disputes must contain the following information:

        i. Provider name
        ii. Provider tax identification number
        iii. Provider contact information
        iv. Clear identification of the disputed item
        v. Date of service
        vi. 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
        vii. Provider dispute number. This number is the same number assigned to the original claim.

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

5. Supporting Documentation

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

B. Acknowledgement

1. To acknowledge receipt of a provider dispute correctly submitted on the Provider Claims Dispute Resolution Request form or clearly disputed by provider cover letter, an acknowledgement letter is prepared by KHS Claims staff and is submitted to the provider within fifteen (15) working days of the date of receipt. Disputes will be acknowledged by fax number provided. If no fax number is provided, then disputes will be acknowledged by mail.

C. Processing

1. First Level Dispute

    a. Providers should use the original claim number to identify the dispute.

2. Administrative Dispute

    a. Upon receipt of an administrative dispute, the KHS Claims Department reviews the facts surrounding the claim and, within thirty (30) calendar days 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. See Policy 60.05-I for Interest and penalties.

    b. Non-contracting Medi-Cal providers have the right to a second-level dispute with the Department of Health Care Services or Department of Managed Health Care. All other providers have the right to a second-level dispute with the Chief Operating Officer (COO) within thirty (30) calendar days of the date of the decision from the first level dispute.

3. Clinical Necessity Dispute

    a. Upon receipt of a clinical necessity dispute, the Medical Director independently reviews the facts surrounding the claim and forwards his/her decision to the Claims Department. The clinical necessity review is performed as if the provider submitted a request for authorization in accordance with the guidelines outlined in KHS Policy and Procedure 3.22-P Referral and Authorization Process. Within thirty (30) calendar days of the date of receipt, the Claims Department issues any necessary claim adjustment (including appropriate interest due) and a written decision either granting the dispute in whole or in part or denying the dispute. See Policy 60.05-I for Interest and penalties.

    b. In addition to notification by the Claims Department, notification is provided by the Utilization Management Department as outlined in KHS Policy and Procedure 3.22-P Referral and Authorization Process, Section 1.5.3 – Notification of Denial.

    c. Non-contracting Medi-Cal providers have the right to a second-level appeal with the Department of Health Care Services or Department of Managed Health Care. All other providers have the right to a second-level dispute with the COO within thirty (30) calendar days of the date of the decision from the first level dispute.

4. Second-Level Dispute

    a. 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.

    b. 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 COO.

    c. Upon receipt of a second-level dispute from a qualifying provider, the COO

independently reviews the facts surrounding the claim and, within thirty (30) calendar 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 upholding the original decision. The written determination states the pertinent facts and explains the reasons for the determination. See Policy 60.05 for Interest and penalties.

d. The decision by the Chief Operating Officer is final.

D. Inquiries Regarding Disputes

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

E. Dispute Resolution Process Between Mental Health Plans and KHS (DHCS APL 21-013)

1. See Health Services – Utilization Management Policy and Procedure 3.14 – P, Mental Health Services.

V. ATTACHMENTS

Attachment A:	Provider Dispute Resolution Request

VI. REFERENCES

Reference Type	Specific Reference
Other KHS Policies	5.01-P Member Grievance Process
Other KHS Policies	30.49-I Practitioner/Provider Disputes Regarding Authorization
Other KHS Policies	4.03-P Provider Disputes on Issues Other Than Authorization and Claims Payment
Other KHS Policies	3.22-P Referral and Authorization Process
Other KHS Policies	3.14-P Mental Health Services
Other KHS Policies	60.05-I Payment of Interest on Late Claims
Regulatory	California Health and Safety Code §§ 1367(h), 1371, and 1371.1
Regulatory	CCR Title 28 §§1300.71, and 1300.71.38
All Plan Letter(s) (APL)	DHCS APL 21-013
Regulatory	HSC §1367(h)(2)

Regulatory	CCR Title 28 §1300.71(g)(3)
Regulatory	CCR Title 28 §1300.71.38(c)(4)
Regulatory	CCR Title 28§1300.71.38(a)(1)
Regulatory	Required disclosure: All claim dispute requirements. (60.04 §5.0)
Regulatory	Required disclosure: Directions (including the mailing address) for the electronic submission (if available), physical delivery, and mailing of provider disputes. (60.04 §5.0)
Regulatory	Required disclosure: Identity of the office responsible for receiving and resolving provider disputes(60.04 §5.0)
Regulatory	CCR Title 28 §1300.71(l)(3)
Regulatory	Required disclosure: Directions for filing substantially similar multiple claims disputes in batches (60.04 §5.0)
Regulatory	CCR Title 28 §1300.71.38(d)(1)
Regulatory	CCR Title 28 §1300.71.38(a)(1)
Regulatory	CCR Title 28 §1300.71.38(c)(1)
Regulatory	CCR Title 28 §1300.71.38(d)(2)
Regulatory	CCR Title 28 §1300.71.38(e); CCR Title 28 §1300.71(l)(3). Required disclosure: timeframe for acknowledgement (60.04 §5.0)
Regulatory	CCR Title 28 §1300.71.38(c)(1)
Regulatory	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	CCR Title 28 §1300.71(f)
Regulatory	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	2025-12	Policy revised per DMHC Comment Table-APL 25-007 (OFR) AB 3275, eFile 20253455. DMHC closure letter received on 12/29/2025.	Claims
Revised	2022-04	Per DHCS Contract Manager, minor updates made per APL 21-013 do not require CM review	-

Revised	2021-12	Director of Claims added policy reference for DHCS dispute process between MCPS and MHPs from APL 21-013	Claims
Revised	2021-04	Minor revisions to correct endnotes and dates. Policy revised to correct address for claims submission	-
Revised	2017-01	Minor revision provided by Deputy Director of Claims.	Claims
Revised	2012-06	Added clarifying language, minor revisions.	-
Revised	2009-02	Revision requested by Chief Operating Officer	-
Revised	2003-12	Revised to comply with new AB1455 DMHC Regs (effective 01/01/04). Changed title from "Appeal of Denied or Modified Claims."	-
Revised	2001-08	Clarify denial codes for appeals, add HFAM PO Box, lengthen submission/response deadlines.	-

VIII. APPROVALS

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

Kern Family Health Care
The Friendly Face of Health Care
A DIVISION OF KERN HEALTH SYSTEMS

PROVIDER 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: Claims Department – Kern Family Health Care
  2900 Buck Owens Blvd.
  Bakersfield, CA 93308

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

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

*** 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 _____

☐ Claim
☐ Seeking Resolution Of A Billing Determination
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment

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

EXPECTED OUTCOME:

***Contact Name (please print)**	**Title**	**( ) *Phone Number**
Signature	**Date**	**( ) *Fax Number**

If you have not received a response to this dispute within 45 working days, please call the Claims Department at (800) 391-2000.

PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST

(For use with multiple "LIKE" claims batched by similar issue with one Provider Claims Dispute Resolution Request form completed for each batch)

Number	* 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								