Provider Manual

Kern Family Health Care

Last updated: March 30, 2023

This manual is revised periodically. For the most recent version, please visit the KFHC website at: www.kernfamilyhealthcare.com or call the **Provider Network Management Department at (661) 632-1590 or (800) 391-2000. Providers can dial 5**, a silent prompt created for Providers to bypass other queues.

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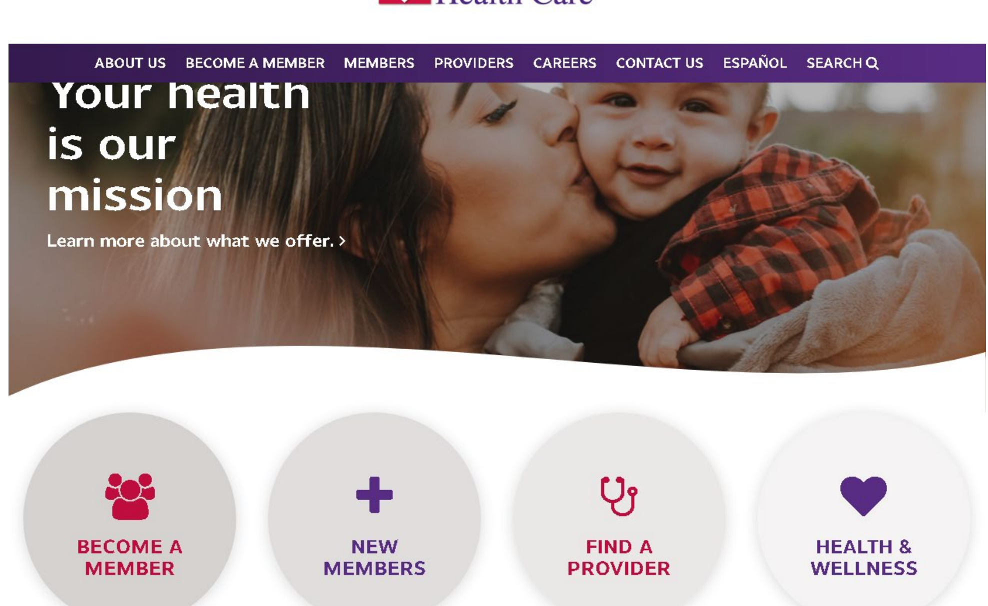
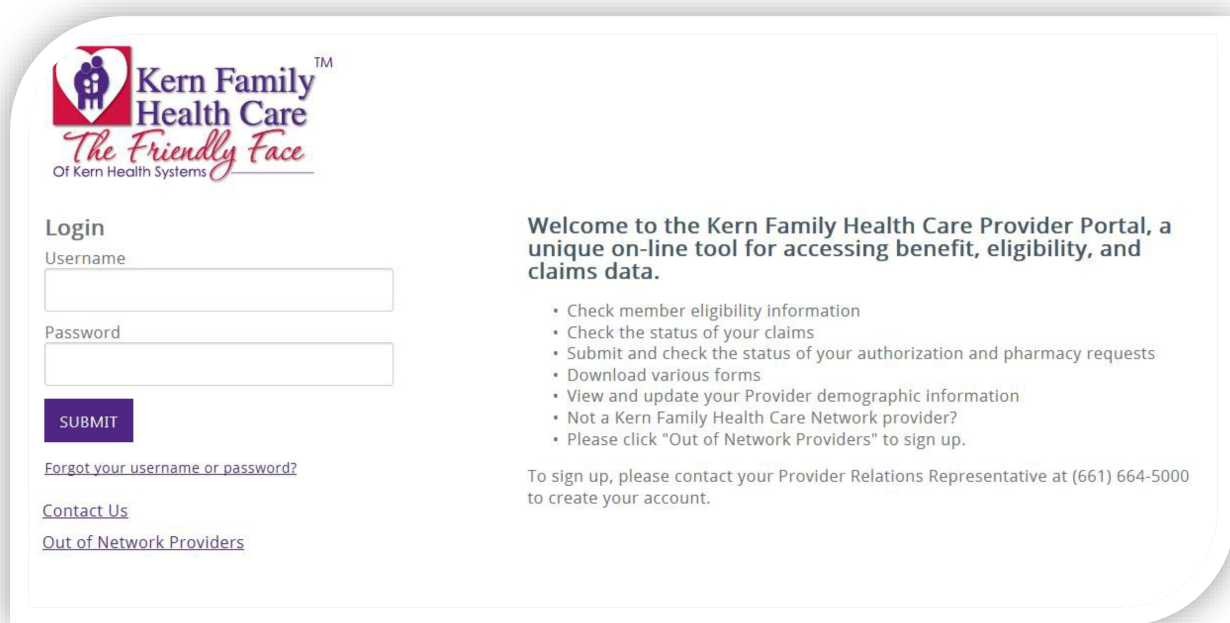
QUICK REFERENCE

Visit our website to access the KFHC Provider Portal, search for a network provider, view and download KFHC Policies and Procedures, and many other helpful resources are available at www.kernfamilyhealthcare.com.





KEY CONTACTS

Department	Contact Information
KFHC	2900 Buck Owens Blvd Bakersfield, CA 93308 Monday – Friday, 8:00 am - 5:00 pm 661-632-1590 (Bakersfield), 1-800-391-2000 (outside of Bakersfield). **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.
KFHC Provider Relations Representative	
KFHC Advice Nurse Line	800-391-2000 Available 24 hours a day, 7 days a week
Claims	**Submit electronic claims to any of the following:** • Change Health • Office Ally • SSI Group Use KHS Payer ID: 77039 • Cognizant Use KHS Payer ID: KERNH (Professional) UERNH (Institutional) **Paper Claims:** Kern Family Health Care – Claims Department P.O. Box 85000 Bakersfield, CA 93380-9998
KFHC Transportation Department	661-632-1590 (Bakersfield), 800-391-2000 (outside of Bakersfield), choose option 3. Available 24 hours a day, 7 days a week for urgent or after-hours assistance. Transportation should be requested at least 5 days in advance.
Interpreting Services Language Line In-Person interpreting	661-632-1590 (Bakersfield), 800-391-2000 (outside of Bakersfield)

KEY CONTACTS

Department	Contact Information
Verify Eligibility	• KFHC Provider Portal • KFHC DIVA (661) 664-5185 • AEVS 800-456-2387 If above options unavailable: • KFHC Member Services Dept. 661-632-1590 (Bakersfield), 800-391-2000 (outside of Bakersfield), **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.
California Relay Services	Call 800-735-2922, if you **do not** have a TTY device in your office or call 800-735-2929 if you **do** have a TTY device in your office.
Denti-Cal	800-322-6284 smilecalifornia.org
California Children's Services (CCS)	Kern County Public Health Services Dept. 2nd Floor, Bakersfield, CA 93306 661-868-0504, fax 661-868-0280 kernpublichealth.com
Behavioral Health & Recovery Services (BHRS)	Mental Health Administration 661-868-6600 Non-crisis Adult Care 661-868-8080 Crisis Line Toll Free 800-991-5272 Crisis Line 661-868-8000 kernbhrs.org
Vision Services Plan (VSP)	800-877-7195 or www.vsp.com
Submit Authorizations	• https://provider.kernfamilyhealthcare.com/v3app/publicservice/loginv1/login.aspx?bc=1215a844-d81f-4be0-ac1c-92dd137dd90c&serviceid=05411915-5bc6-4527-97a6-45b09eecbde3
Pharmacy Prior Authorization	• https://medi-calrx.dhcs.ca.gov/home/

SECTION 1: INTRODUCTION

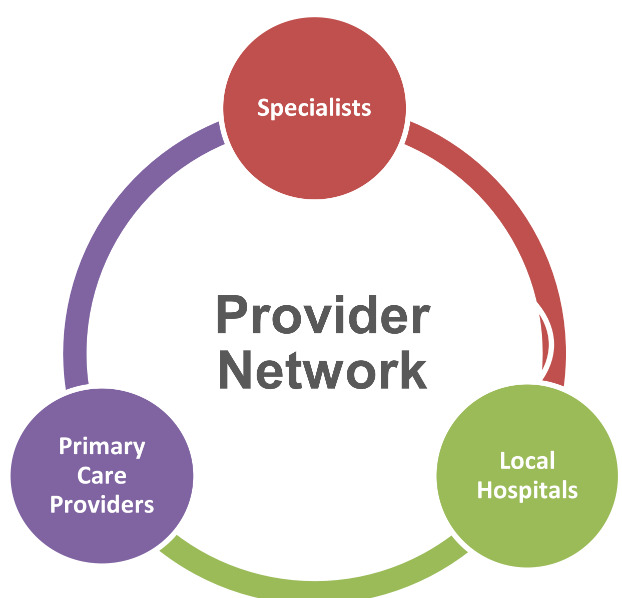
About Kern Health Systems

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 (KHS) is the local initiative managed care plan in Kern County. Currently, Health Net is the commercial plan.

KHS is a Knox-Keene licensed Health Plan and is regulated by the California Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the federal government's Centers for Medicare and Medicaid Services (CMS).

KFHC Provider Network

KFHC Members have access to a compressive network of providers that includes primary care providers, specialists, hospitals, and urgent care facilities.



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.

KFHC Employee Code of Conduct

The Code of Conduct articulates the standards of behavior that each employee is expected to observe while performing their jobs.

Governing Board & Committees

The KHS Board of Directors are appointed by the Kern County Board of Supervisors; it includes physicians, safety-net providers, hospitals, and community representatives. For more information regarding the Board & Committees or to view past agendas, visit www.kernfamilyhealthcare.com. The following is a list and description of the KHS Advisory Committees:

Finance Committee

The Finance Committee reviews, approves, and makes recommendations to KHS' Board of Directors on all financial and contractual matters that are presented by KHS' staff in support of administrative and management operations. It ensures KHS' financial stability by providing oversight on its budget.

Physician Advisory Committee (PAC)

The PAC serves as an advisor to the Board of Directors on health care issues, peer review, provider discipline and credentialing/re-credentialing decisions. The committee is responsible for reviewing provider grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee.

Quality Improvement / Utilization Management Committee (QI/UM)

The QI/UM Committee oversees all covered health care services delivered to members by systematic methods that develop, implement, assess, and improve the integrated health delivery systems of KHS.

Drug Utilization Review (DUR)

The DUR Committee oversees retrospective medication prescribing practices by providers and assesses usage patterns by members. The committee is composed of Physician and Pharmacist providers as well as internal staff. If you would like to serve on the committee, please contact the Director of Pharmacy or Medical Director.

Public Policy / Community Advisory Committee (PP/CAC)

Provides a mechanism for structured input from KFHC members regarding how our operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages.

*If you are interested in becoming a member of any of the above listed committees, please contact KHS Quality Improvement Department at 661-664-5000.

Intent of the Provider Manual

Our provider network is a critical component in serving our mission. We want this manual to be a useful guide which will offer a general overview of information, tools, and guidance needed for you and your staff to facilitate care and services for KFHC Members. If you have any questions, need assistance, or have suggestions for improving the manual, please contact the Provider Network Management Department at (800) 391-2000. **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.

If the terms of your Agreement differ from the information in this Provider Manual, the Agreement will supersede. In addition, if there are conflicts between the Manual and current State or federal laws and regulations governing the provision of health care services, those laws and regulations will supersede this Manual.

How to Use the Provider Manual

Providers can search particular topics by reviewing the table of contents or by using the Adobe/PDF search function. For more detailed information, please refer to Kern Health System policies, procedures located at www.kernfamilyhealthcare.com, if you do not have internet access a hard copy will be provided.

Search tip: To search for a specific topic, hit Ctrl + F on your keyboard to activate the "Find" function, if you are using a PC. If you are using a Mac, hit Command + F.

SECTION 2: ELIGIBILITY

Eligibility

- Eligibility needs to be checked every visit and can be checked in multiple ways:
  - **Provider Portal**
  - **DIVA** (661-664-5185)
  - **AEVS** (800-456-2387)
  - **Medi-Cal website** https://www.medi-cal.ca.gov/MCWebPub/Login.aspx
    - Providers should ensure members do not have Other Health Coverage (OHC), including Medicare, by checking the member's eligibility on the Medi-Cal website. If the member has OHC, then the provider must instruct the member to coordinate their care through their OHC.

If above options unavailable:

- **KFHC Member Service Department** (800-391-2000) **Option 5**

- Kern Family Health Care (KFHC) members can switch PCP's anytime they choose
- KFHC members can switch health plans (KFHC to Health Net & vice versa) month to month

Termination of PCP/Member Relationship

- PCPs can discharge a member by providing a letter requesting member reassignment to their Provider Relations Representative
- PCP is required to provide care to the member for 30 days after notification sent to KFHC

Medi-Cal Enrollment

Individuals who wish to enroll in KFHC must have been determined eligible for the Medi-Cal program through the Kern County Department of Human Services, or the Social Security Administration.

Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a member's eligibility must be verified *before delivery of services* and that the KFHC Member Identification (ID card) *alone* is not a guarantee of eligibility.

The state of California issues a plastic Medi-Cal ID card known as the Benefits Identification Card, or BIC. The BIC shows the member's name, date of birth, 14-digit identification number and the card issue date.

The Kern County Department of Human Services may issue a temporary, emergency "paper card" when the Member cannot wait for the state to issue the BIC.

The new "Poppy" BIC design will be provided to newly eligible recipients and recipients requesting replacement cards. Providers are responsible for verifying the recipient is eligible for services and is the recipient to whom the card was issued. Both BIC designs should be accepted by providers.

"Poppy" design

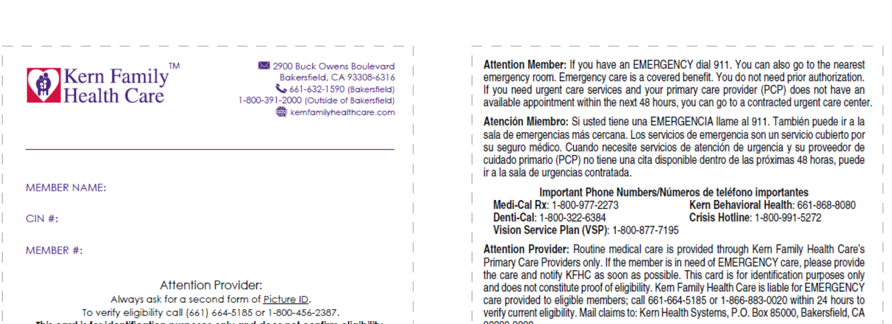
"Blue and White" design

KFHC Member Identification Card

KFHC issues all new Members an Identification Card to be presented to Providers at the time Covered Services are requested. Please note that the KFHC ID card alone should not be considered verification of Member eligibility. The KFHC ID card is issued for identification purposes only and does not guarantee eligibility.

Front KFHC Member Card

Back KFHC Member Card



Verifying Member Eligibility

All providers should verify eligibility on the date that the service is rendered. A Referral or Authorization is not sufficient to guarantee that the patient is eligible on the date of service.

Eligibility can be checked in various ways:

KFHC Provider Portal

To check eligibility via the KFHC Provider Portal, select *Members* on the banner or use the *Member Quick Search* option on the portal home page.

Automated Eligibility Verification System (AEVS)

AEVS, the State Medi-Cal automated eligibility verification system, is a tool that is available 24/7 to verify a Member's eligibility. To use AEVS please call (800) 456-2387 and have your Provider Identification Number (PIN) ready. A confirmation number will be provided which should be maintained to document the verification of eligibility.

KFHC DIVA Automated Eligibility Line

DIVA is another automated tool that is available 24/7 to verify a Member's eligibility. To use DIVA, please call (661) 664-5185 and provide the Member's KFHC identification number or Medi-Cal identification number.

KFHC Member Services Department

Eligibility can also be verified by calling the KFHC Member Services Department. Representatives are available to assist with eligibility verification inquiries Monday through Friday from 8:00 a.m. to 5:00 p.m. To contact the Member Services Department, call (800) 391-2000. **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.

Primary Care Provider (PCP) Assignment

PCPs are the primary provider of covered services for Members and play a crucial role in coordinating care. For this reason, the selection or assignment of each Member to a PCP is of critical importance.

PCP Selection & Change

Members can find available PCP's using the KFHC Provider Directory or the online "Find a Provider" search tool located on the https://www.kernfamilyhealthcare.com/ home page. Members can change their PCP by logging onto the Member Portal located at https://www.kernfamilyhealthcare.com/ or by downloading the free KFHC mobile application,

LINK. Members can also make a PCP change by calling Member Services at 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield). Providers should encourage their assigned KFHC members to create and register a KFHC Member Portal account. Each member who registers a KFHC Member Portal account will receive a $10.00 gift card as an incentive.

Clinic Assignment

Every Medi-Cal enrollee has a right by law to access medical services through a Federally Qualified Health Center (FQHC). If a member chooses a FQHC, it must be contracted with KFHC. The enrollee may either choose a FQHC provider or a FQHC clinic.

PCP Auto Assignment

KFHC members are assigned a Primary Care Provider (PCP) upon enrollment. If KFHC does not receive a PCP selection for a new Medi-Cal member one will be assigned by KFHC through a default, automatic method of assignment. Every effort will be made to provide new members the opportunity to change a PCP assignment provided through the automatic assignment process to the PCP of their choice. This action is part of the New Member Entry (NME) process where the Member Services Department will make two attempts by phone to contact every new member within the first thirty days of enrollment.

All members receive an enrollment packet with their PCP identified in the welcome letter. This packet is mailed within seven days of enrollment.

For more information, see KHS Policy & Procedures: Policy 5.06

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

To allow better access to care, Members can change their PCP at any time via Member Portal, KFHC Mobile Link App or by calling the Member Services Department.

Termination of PCP/Member Relationship – Policy 5.18-P

Primary Care Providers can discharge a member from their practice for the following reasons:

- Documented Communication Problems
- Inappropriate Behavior
- Multiple Missed Appointments
- Non-Compliance, Etc.

PCPs may initiate this process if they have demonstrated efforts to establish a good patient/provider relationship and ultimately feel the member would be better served by another PCP.

Process:

- PCP will send their Provider Relations Representative a letter requesting a member be reassigned and will include a detailed description of the reason for discharge.
- The Provider Relations Representative will send the PCP a letter acknowledging receipt of the request to discharge the member.
- The KHS Member Services Department will contact the member and assist in selection of a new PCP.

Member Disenrollment

Disenrollment of Medi-Cal members is processed by Health Care Options, an enrollment contractor approved by the California Department of Health Care Services (DHCS). KFHC does not enroll or disenroll members. Members requesting disenrollment or information about the disenrollment process are referred to the enrollment contractor, Health Care Options.

For cases requiring mandatory disenrollment, KFHC may request the disenrollment of a Member under specific guidelines set by DHCS such as: Out of Area, Incarceration, etc. Please note that final disenrollment decisions are handled entirely by DHCS.

SECTION 3: POPULATION HEALTH MANAGEMENT

Population Health Management

Under the direction of the DHCS, Kern Health Systems (KHS) is moving toward a population health approach that prioritizes prevention, early intervention and whole-person care. The vision is to strengthen and reinforce primary care as the foundation of health care for all KHS members, address the social determinants of health (SDOH), and break down the siloes to accessing equitable, accessible, and quality health care across the continuum.

In January 2023, DHCS will launch the **Population Health Management (PHM) Program,** which is a cornerstone of CalAIM. The PHM Program seeks to establish a cohesive, statewide approach to all populations that brings together and expands upon many existing population health strategies. Under PHM, Medi-Cal Managed Care (MCMC) plans, and their networks and partners will be responsive to individual member needs within the communities they serve while also working within a common framework and set of expectations.

PHM is a comprehensive, accountable plan of action for addressing member needs and preferences and building on their strengths and resiliencies across the continuum of care which

- Builds trust and meaningfully engages with members;
- Gathers, shares, and assesses timely and accurate data on member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
- Addresses upstream factors that link to public health and social services;
- Supports all members staying healthy;
- Provides care management for members at higher risk of poor outcomes;
- Provides transitional care services for members transferring from one setting or level of care to another; and
- Identifies and mitigates SDOH to reduce disparities.

Population Health Management will provide care coordination under three general categories-Basic Population Health Management, Care Management Services, and Transitional Care Services.

With the many upcoming requirements, PHM is a journey rather than a destination. Provider updates will be sent introducing any new programs or updates.

Case Management

The Case Management Department Staff, consisting of Registered Nurses, Medical Social Workers, and Case Management Assistants, manage a complex population who are identified by a predictive modeler as well as by a variety of referral of sources, including Physician and Community Resource referrals. These are members who have experienced a

critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Additionally, Basic Population Health Management is being newly introduced as defined below:

- Basic Population Health Management (BPHM), is being newly introduced to describe the basic set of services and supports, including primary care, to which all populations served by Medi-Cal Managed Care plans have access.
- BPHM is an approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time in the right setting. BPHM includes federal requirements for care coordination.
- Goals for BPHM and Care Management ensure that every member:
    - Has a source of care that is appropriate, ongoing, and timely to meet the member's needs.
    - Is assigned and engaged with a primary care provider (PCP) to include preventative services.
    - Has access to an appropriate level of care management through person-centered interventions, care coordination, navigation, and referrals across all health care and social needs.

Referrals to Case Management

Referrals may originate from multiple sources including, but not limited to, self-referral, caregiver, PCPs or Specialists, discharge planners at medical facilities, and internal departments at Kern Health Systems such as Utilization Management, Health Education, and Member Services. Provider referrals for Case Management can be made by calling 1-800-391-2000.

Care Plans

Individualized Care Plans are created for these members following an assessment and communicated to the PCP for collaboration. Once care coordination planning is implemented, there is follow up, assistance with transitions of care, and efficient communication post transition to prevent readmission and maintain progress. The eventual goal of Case Management services is for the member to achieve self-management and discharge from the program. The Case Management Department helps members maintain optimum health and/or improved functional capability, educate members regarding their health, and reinforce the PCP prescribed treatment plan. These efforts are anticipated to decrease costs and improve quality through focusing on the delivery of care at the appropriate time and in the appropriate setting.

Palliative Care

Palliative Care is a covered benefit geared towards patients with uncontrolled chronic illnesses and are not eligible, or decline, hospice care. Palliative Care services must receive prior authorization from KFHC. Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The Palliative Care benefit will connect members with a palliative care team trained to focus on symptom management and who understand advance care planning and end of life complexities.

Eligible Members

Members eligible for Palliative Care are expected to have one (1) year or less life expectancy, be in the advanced stage of illness, have received appropriate patient-desired medical therapy, or for whom patient desired medical therapy is no longer effective, and have started to access the hospital or emergency department as a means to manage late stage illness. Members should also have one or more of the following disease-specific eligibility criteria:

- Congestive heart failure (CHF): hospitalized due to CHF as primary diagnosis (no further invasive interventions planned) OR NYHA III or higher AND EF <30% or significant comorbidities
- Chronic obstructive pulmonary disease (COPD): FEV1<35% predicted and 24 hour and O2 requirement less than 3L/min OR 24-hour O2 requirement >3L/min
- Advanced cancer: any stage III or IV solid organ cancer, leukemia or lymphoma AND Karnofsky Performance Scale score < 70 OR treatment failure of 2 lines of chemotherapy
- Liver disease: evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices OR evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

Palliative Care Services

Eligible palliative care services include advanced care planning, palliative assessment and consultation with a palliative care team, care coordination, pain and symptom management, and mental health and medical social services for counseling and support. Providers interested in learning more regarding the criteria for providing palliative care services, please contact the KFHC Providers Relations Department. For additional information regarding this new benefit, please refer to the DHCS All Plan Letter 17-015: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-015.pdf

Transition of Care Services

The Transitional Care Model (TCM) is an evidence-based solution that demonstrates improved quality and cost outcomes for high-risk members when compared to standard care in: reductions in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs.

- *Avoidance of hospital readmissions for primary and complicating conditions***.** TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are readmitted, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.

- *Improvements in health outcomes after hospital discharge.* Patients who received TCM demonstrate improvements in physical health, functional status and quality of life.

- *Enhancement in patient and family caregiver experience with care.* Overall patient satisfaction is increased among patients receiving TCM. TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

Major Organ Transplant

Effective January 2022, KHS will be responsible for coordination and payment associated with Major Organ Transplants (MOT). To ensure Members who are referred for MOT are able to seamlessly access care and services needed, KHS will offer a Transplant Case Management program.

Specialty-trained transplant case managers will serve as a resource for Members enrolled in the MOT Case Management Program. They will establish dialogue and support that last throughout the duration of the member's treatment plan. The transplant case manager will remain in frequent contact with the member and throughout the enrollment. During the months or years prior to the transplant, the transplant case manager coordinates all needs that the member has. At the time of the actual transplant, the transplant case manager also coordinates with the member's caregivers reviewing travel and lodging benefits.

The transplant case manager follows the member's admission and continued stay review during the initial transplant period and calls to speak with either the member or the caregiver frequently. The Case Manager typically follows Members throughout the phases of transplant until one year after transplant.

Provider referrals for Case Management can be made by calling 1-800-391-2000.

Long Term Care

Effective January 1, 2023, the LTC benefit for Skilled Nursing Facilities (SNF) will be carved-in to Medi-Cal managed care statewide. The Kern Health System, (KHS), Long Term Care Program provides a comprehensive integrated process that evaluates and manages the utilization of health care services and resource delivery to members requiring long term care (LTC) services. KHS has established mechanisms for identification, authorization, and coordination of services through a designated KHS LTC team to support the LTC Program. The Long-Term Care Program assures that:

- Services delivered is consistent with the medical care needs of the member.
- Service is delivered at the appropriate time.
- Members receive appropriate quantity and quality of services.
- Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care.

DHCS Policy: ***APL 22-018*** *(REVISED) Skilled Nursing Facilities—Long Term Care Benefit Standardization and Transition of Members to Managed Care (October 25, 2022).*

Services

1. **Nursing Facility Services**
   Kern Health Systems (KHS) authorizes utilization of nursing facility services for members when medically necessary. KHS ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities include:

   a. Skilled Nursing Facilities (SNF),
   b. Sub-acute Facilities (pediatric and adult)
   c. Intermediate Care Facility for the Developmentally Disabled

   KHS members receive services that are medically necessary and consistent with their diagnoses and Level of Care (LOC) requirements. Authorization of these services considers the individual needs of the member such as comorbid conditions, behavioral health, and ADL management needs that might exist and the ability of the local health care delivery system to meet these members' needs.

2. **Facility Therapy Services**
   Facility therapy services are performed as part of the nursing facility inclusive services which is covered under the facility's per diem rate.

3. **Specialized Rehabilitative Services**
   Providers submits a Treatment Authorization Request (TAR) for specialized rehabilitative services exceeding the nursing facility inclusive services when it is determined that additional services must be rendered to attain or maintain the highest practicable plan of care.

4. **Other Health Coverage**
   KHS provides medically necessary Medi-Cal services that are not covered by Medicare and for reimbursement to Medicare providers when total Medicare costs, including deductibles and coinsurance, do not exceed the Medi-Cal allowable FFS reimbursement rates.

   - KHS coordinates benefits for members residing in LTC facility with OHC programs or entitlements.
   - For SNF services provided to Members who are dually eligible for Medi-Cal and Medicare, KHS will pay the full deductible and coinsurance in accordance with APL 13-003, Coordination of Benefits.

5. **Case Management**
   KHS ensures Members, receiving LTC SNF services, will have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), complex case management, care management programs, and Community Supports. KHS assigns each LTC member to the LTC team.

Provider referrals for Case Management can be made by calling 1-800-391-2000.

Doula Benefits

Effective January 1, 2023, KHS covers doula services, pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Doulas serving Medi-Cal beneficiaries provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of beneficiaries while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

Services could be at the beneficiary’s home, as part of an office visit, in a hospital, or in an alternative birth center. Services include health education, advocacy, and physical, emotional, and nonmedical support.

Covered Services:

Although prior authorization is not required, a recommendation for doula services must be requested in writing and will include the following services:

1. One initial visit.

2. Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits.
3. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
4. Up to two extended three-hour postpartum visits after the end of a pregnancy.

Doulas offer various types of support, including perinatal support and guidance; health navigation; evidence-based education and practices for prenatal, postpartum, childbirth, and newborn/infant care; lactation support; development of a birth plan; and linkages to community-based resources.

Coverage also includes comfort measures and physical, emotional, and other nonmedical support provided during labor and delivery.

Non-Covered Services

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

The following services are not covered under Medi-Cal or as doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

For additional information about doula benefits, and doula provider requirements and qualifications, the full APL can be found by visiting:

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-031-Doula-Services.pdf

SECTION 4: UTILIZATION MANAGEMENT PROGRAM

Initial Health Appointment (IHA):

- **The IHA must be completed within 120 day of enrollment with KFHC.**
- **If an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.)**
- **Access the KFHC Provider Portal for a list of patients who need an IHA**
- **Elements required include:**
  - **Complete history and physical**
  - **Individual Health Education**
  - **Behavioral Assessment**
  - **Core set of preventative services**
  - **Test results must be documented in the members file even if the test was performed by an outside agency (pap smear, mammograms, etc.)**

KFHC Utilization Management Department (UM), policies and procedures support the provision of quality health care services. The goal of UM is to provide Members with the right care, in the right venue, within the most appropriate timeframe. The key objective of the Program is to improve access to care, maintain the highest quality, and create healthy outcomes while providing the most cost effective care possible.

Preventative Care Services

PCPs are required to ensure that all age and risk appropriate preventive services are provided to assigned members. Members may schedule an appointment for preventive care (including an Initial Health Assessment) by calling their PCP.

When a request is made for CHDP services (Child Health and Disability Prevention), an appointment should be offered for the member to be examined within 2 weeks of the request. If the member cannot be seen within the two-week timeframe because the member refused offered appointments, refusal should be documented. If the member encounters difficulty in scheduling an appointment, he/she may call KFHC Member Services at 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield) for assistance.

Initial Health Appointment (IHA) Policy 3.05-P

The Department of Health Care Services (DHCS) requires that each PCP complete an Initial Health Assessment (IHA) for all Medi-Cal members. The IHA is a comprehensive assessment that is completed during the member's initial visit(s) with his or her primary care provider, or mid-level providers that are qualified to perform patient history and physicals. The purpose of the IHA is to assess and set the baseline for managing the acute, chronic, and preventive health needs of the member.

All new KFHC Members must receive an Individual Health Assessment with their primary care provider. For Medi-Cal members, the IHA must be completed within **120 days** of enrollment. PCP's compliance with this standard will be assessed during audits.

An IHA:

- Must be performed by a Provider within the primary care medical setting.
- Is not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member's medical record.

The assessment allows members to obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status. An IHA must include all of the following:

- A history of the Member's physical and mental health;
- An identification of risks;
- An assessment of need for preventive screens or services;
- Health education; and
- The diagnosis and plan for treatment of any diseases

Exemption of the IHA Requirement

If any member, including emancipated minors, or a member's parent or guardian, refuses an IHA, this should be documented in the member's medical record with a statement signed by the member. IHAs do not need to be performed if both of the following conditions are satisfied:

A. The member's medical record contains complete information, updated within the previous 12 months, consistent with the KFHC assessment requirements for the member's age group and gender

B. Based upon review of the prior medical record, the provider reviews and signs off in the medical record that the patient is current.

Scheduling IHAs

As PCPs receive their assigned patient panels, the Providers' offices should contact members to schedule an IHA to be performed within the time limit. If the provider/staff is unable to contact the member, he/she should contact the KFHC Member Services Department for assistance.

In these cases, KFHC Member Services staff initiates attempts to contact the member via telephone and/or letter and coordinates with the PCP's office in an effort to secure a timely appointment. Contact attempts and results are documented by both the PCP and KFHC Member Services staff.

If an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.).

Immunizations

Providers are responsible for assuring that all members are fully immunized. Children should be immunized in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Adults should be immunized in accordance with the most current California Adult Immunization recommendations.

PCPs are responsible for the tracking and documentation of immunizations for KHS plan members. The member's medical record should have a clearly designated area that identifies the member's immunization history and record. This should include documentation of the following:

- All attempts to provide immunizations
- Provision of instructions as to how to obtain necessary immunizations
- The receipt of vaccines or proof of prior immunizations.

- Proof of any voluntary refusal of vaccines in the form of a signed statement by the member or responsible party. If the member or responsible party refuses to sign this statement, the refusal must be noted in the medical record.
- Immunization record (PM298).
- Date the Vaccine Information Statement (VIS) is provided to the member and its publication date.

Following Member's IHA and all other health care visits which results in an immunization, member-specific immunization information shall be reported to appropriate immunization registry.

For more information see KHS Policy and Procedure: 3.05

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Referral Process – Policy 3.22

Referral Process

- **Requests for referral are submitted via the KFHC portal. Requesting provider must include pertinent medical records, diagnosis, and treatment codes, and member data which support the referral request and will assist the specialty provider in the assessment and delivery of services.**
- **Urgent referrals may be submitted via the KFHC portal.**
- **After hours urgent authorization may be obtained by telephone from a RN on call from Friday 5:00pm – Monday 8:00am.**
- **All requests for scheduled hospital/facility admissions must be approved by KFHC**
- **Admissions will be to contracted facilities unless an exception occurs and special authorization has been granted by KFHC.**
- **A retro authorization for urgent or emergent services may be requested within 60 days of services being rendered**

***If on-line submission is unavailable, please submit referral via fax to our Utilization Management Department at 661-664-5190. (Effective 7/1/2021, only on-line submission will be allowed)**

- It is the responsibility of the PCP to follow-up with the specialist for the results of care and fulfill the responsibilities of a primary care physician.

Time Requirement

- **The PCP initiates referrals to qualified contracted providers for specialty care within 1 working day of the decision to refer the member.**

Paper Referrals

- Submitted via fax must include:
  - The signature of the referring PCP must appear on the Referral/Prior Authorization Form.
  - A signature stamp is acceptable if KFHC is in receipt of certification that the use of such a signature stamp is authorized by the PCP.

Notification

- When a referral is authorized the referral is forwarded to the rendering/requested provider along with any pertinent medical records and data within 24 hours of KFHC decision.

- The PCP and member are notified of the referral authorization within 24 hours of the decision.
- The referral disposition form and criteria used to deny any referral are returned to the referring provider within 24 hours of the denial.
- A denial letter stating the reason for the denial is sent to the member within 48 hours.

A routine request by the PCP for referral authorization is initiated by submitting a Referral/ Prior Authorization Form via the KFHC Provider Portal. The request must include pertinent medical records, diagnoses and treatment codes, and member data which support the referral and will assist the specialty provider in the assessment and delivery of services.

Prescribing physicians may request authorization by completing the Prior Authorization Request form, attaching clinical documentation to support the request, and submitting it by one of the following ways:

- KFHC Provider Portal, www.kernfamilyhealthcare.com
- Utilization Management Department Fax: (661) 664-5190
- Mail:
  Utilization Management Department
  Kern Health Systems
  2900 Buck Owens Blvd.
  Bakersfield, CA 93308
  (mailing will delay process due to postal delivery time)

Provider and Member Notification

Results of the utilization review for non-urgent referrals are communicated by Utilization Management Staff (UM), to the Provider and Member as outlined in the following table. Notification to provider is provided via KHS Provider Portal or fax.

Result of Review	Provider Notice	Member Notice
Approved	**Referring**: Approved *Referral/Prior Authorization Form* (within 24 hours of the decision). **Specialist:** Approved *Referral/Prior Authorization Form* and any pertinent medical records and diagnostics (within 24 hours of the decision). **OR**	Notice of Referral Approval (within 48 hours of the decision).

	Hospital: *Hospital Notification Letter* (within 24 hours of the decision).	
Deferred	**Referring:** Copy of Notice of Action Letter and the *Referral/Prior Authorization Form* (within 24 hours of the decision) **OR** **Hospital:** Requests for hospital services are not deferred.	Notice of Action Documents (within 2 business days of the decision). Documents include all of the following: • *Notice of Action - Delay* letter • *Your rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.
Result of Review	**Provider Notice**	**Member Notice**
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). **Specialist:** *Modified Referral/Prior Authorization Form* and any pertinent medical records and diagnostics (within 24 hours of the agreement).	Notice of Adverse Determination Documents, (within 2 business days of the decision). Documents include all of the following: • *Notice of Adverse Determination – Modify* • *Your Rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.

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).	Notice of Adverse Determination Documents, (within 2 business days of the decision and at least 10 days before the date of action unless falls under exceptions listed in KFHC Policy 3.22-P. Documents include all of the following: • *Notice of Adverse Determination – Terminate* • *Your rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.
Result of Review	**Provider Notice**	**Member Notice**
Denied (Included those carve out services that are denied as not covered by KFHC)	**Referring:** Copy of Notice of Adverse Determination Letter (within 24 hours of the decision). **OR** **Hospital:** *Hospital Notification Letter* (within 24 hours of the decision).	Notice of Adverse Determination Documents, (within 2 business days of the decision). Documents include all of the following: • *Notice of Adverse Determination – Denial* • *Your rights Under Medi-Cal Managed Care*. Medi-cal members only. • *Form to File a State Hearing*. Medi-Cal members only.

Denials and Appeals

- **Administrative denials can be completed by an RN**
- **Denials based on medical necessity require MD review**

- KHS appeal form (located on the KHS website) must be completed 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 if filing on behalf of the beneficiary, 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.

Only the Chief Medical Officer, or their designee may deny an authorization request based on medical necessity within the DHCS timelines of 1-5 days for routine requests. Kern Health System (KHS) ensures that fiscal and administrative management considerations do not influence medical decisions, including those made by subcontractors, Network Providers, and Providers.

Reasons for possible denial include:

A. Not a covered benefit
B. Not medically necessary
C. Continue conservative management
D. Services should be provided by a PCP
E. Experimental or investigational treatment
F. Member made unauthorized self-referral to provider
G. Inappropriate setting
H. Covered by hospice

Sample Provider Appeal Form:

Kern Family Health Care™

PROVIDER AUTHORIZATION APPEAL RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF APPEAL and EXPECTED OUTCOME.
- Provide additional information to support the description of the appeal.
- Fax the form along with any attachments to: (661) 664-4303
- Or mail the completed form to: Kern Family Health Care – Grievance and Appeals
  2900 Buck Owens Boulevard
  Bakersfield, CA 93308

*PROVIDER NAME:	*PROVIDER ID NUMBER:
*PROVIDER ADDRESS:	
*PROVIDER PHONE NUMBER:	

* MEMBER NAME:		*DATE OF BIRTH:
* KFHC ID Number:	MEMBER ADDRESS/PHONE NUMBER	*ORIGINAL AUTH NUMBER: (Please complete a separate form for each appeal)

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

EXPE TED OUTCOME

SAMPLE

*Provider Contact Name (please print) ______ Title ______ ( ) *Phone Number ______

*Signature ______ *Date ______ ( ) *Fax Number ______

*All provider appeals submitted on a member's behalf must include the member's, their parent's (if a minor) or other authorized representative's signature and date indicating provider has their consent to file this appeal.

Member, Parent or Authorized Representative's Signature:______________________ Date:__________

Kern Family Health Care received this appeal on ____________________. If you have a question regarding this appeal, please call the KFHC Member Services Department at 1-800-391-2000 and ask to speak with a Grievance Coordinator.

____
Acknowledgement of Receipt (signature)

Visit www.kernfamilyhealthcare.com to download the Provider Appeal Form.

STAT Referrals

Outpatient STAT 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.

KFHS does require a retrospective referral from the requested provider for STAT services within 60 days of the date of service.

Hospital/Facility Authorization
All Providers must request authorization for scheduled hospital/facility admission from KFHC Utilization Management Department. Admissions will be to contracted facilities unless an exception occurs and the KFHC UM Department has granted special authorization.

Lab, X-Ray and Assistant Services
Routine lab and x-ray services do not require pre-authorization but must be directed to KFHC 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 Prior Authorization list located under the Provider Resources section of the Kern Family Health Care website at: www.kernfamilyhealthcare.com

Covered Services That Do NOT Need Prior Authorization / Referral

Please reference prior authorization (PA) list on the "Quick Links" section of the KHS Provider Connection (Portal) www.kernfamilyhealthcare.com

Please note, 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.

Unless specifically excluded, all services must be authorized by KFHC in accordance with KFHC referral policies and procedures. The following services do not require prior authorization:

- Primary Care from a KFHC contracted Primary Care Provider
- Dental – Providers are expected to refer to Denti-Cal.
- Hospice – Outpatient services.
- Basic prenatal care - Members may self-refer to a KFHC contracted OB/GYN or family practice physician.
- Vision - PCP or member may initiate a referral to VSP contracting optometrists.
- Mental Health - Referrals for mental health services may be generated by self-referral, provider of care, KFHC Case Managers, school systems, or employers.
- Family Planning - Members may access Family Planning Services by self-referral to an appropriate qualified practitioner/provider such as: FQHC, Federally Funded Family Planning Clinic and Public Health Clinic.
- Abortion - Prior authorization is not required unless inpatient hospitalization for the performance of the abortion is requested.
- Gynecology (OB/GYN) - Members may self-refer to any contracted OB/GYN specialist.
- Emergency Care/ Urgent Care
- HIV Testing and STD Services
- Cancer Screening

The Prior Authorization Form and supporting documentation may be required for KFHC tracking purposes.

Obtaining a Second Opinion

***All requests for second opinions are reviewed by the medical director**

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 KFHC Chief Medical Officer or their designee. Authorization or denial of the second opinion is accomplished within 72 hours of KFHC's receipt of the request.

For more information see KHS Policy and Procedure: 3.05, 3.09, and 3.22

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

California Children Services (CCS)

Once member is accepted by the CCS program, KFHC Case Management continues to work with CCS to coordinate care.

Referral submission completed by provider to notify KFHC of potential CCS condition

CCS is a statewide program managed by the Department of Health Care Services (DHCS) and is administered in Kern County by the Kern County Public Health Services Department. The CCS program requires authorization for health care services related to children under the age of 21 with a CCS-eligible medical condition. These services are not covered by KFHC therefore KFHC does not give prior authorization for payment of services related to CCS eligible conditions. Authorization for such services must be received from the CCS program.

CCS eligible conditions are those physically handicapped conditions defined in Title 22, California Code of Regulations (CCR) §41515.1. The following are examples of CCS-eligible conditions include, but are not limited to:

- Cystic fibrosis
- Hemophilia
- Cerebral palsy
- Heart disease
- Cancer
- Traumatic injuries
- Infectious diseases producing major sequelae

For an overview of the CCS program, please visit the California Department of Health Care Services (DHCS) website by clicking here: California Children's Services, or the local office visit the Kern County Public Health Services Department website by clicking here: Kern County CCS

Providers are responsible for identifying members with CCS eligible conditions and for making prompt referrals of such members to the local CCS program and to KFHC. Providers must notify the KFHC Utilization Management Department of members with a potential CCS condition via an authorization which can be submitted on the KFHC provider portal

https://provider.kernfamilyhealthcare.com/v3app/publicservice/loginv1/login.aspx?bc=1215a844-d81f-4be0-ac1c-92dd137dd90c&serviceid=05411915-5bc6-4527-97a6-45b09eecbde3

Referrals to CCS are also accepted from any source, health professionals, parents, legal guardians, school nurses, KFHC, etc. Members may also self-refer. Once a member is

accepted by the CCS program, KFHC Case Management continues to work with CCS to coordinate care. CCS referrals are tracked by the KFHC UM Department to ensure follow through of services to members.

CCS Referral Process

Referral of CCS eligible conditions by a KFHC contracted Provider involves notification of both CCS and KFHC. Referrals to the local CCS program may be initiated via telephone, same-day mail, or fax to:

California Children's Services
1800 Mt. Vernon Avenue, 2nd Floor
Bakersfield, CA 93306-3302

Phone: 661-321-3000
Fax: 661-868-0268

The initial referral should be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the CCS Program.

For more information see KHS Policy and Procedure: 3.16

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Emergency and Urgent Care Services Policy 3.31-P

Emergency services **do not** require prior authorization. Emergency services are covered services required by a member as the result of a medical condition that manifests as the onset of symptoms (including pain) so severe that a prudent layperson would expect the absence of immediate medical attention to:

- Place the health of the member in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.
- Induce an "active labor" in a pregnant woman requiring emergency delivery to avoid threat to the health and safety of either mother or child.

The KHS Chief Medical Officer or a designee is available 24 hours/day, 7 days/week by contacting 1-800-391-2000, to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services and for general communication with emergency room personnel.

Emergency Departments must contact KHS Quality Management Department, Utilization Management Department, or Provider Relations Representative to report any system and/or protocol failures and process for ensuring corrective action is taken.

Post Stabilization Care

When the treating physician believes additional health care services are needed before a member can be safely discharged or transferred after stabilization of an emergency condition, the treating physician should contact our UM Department as soon as possible to request prior authorization. KHS will respond within 30 minutes of receiving the request for a pre-approval for post stabilization/maintenance medical care; if no response is received, the physician may deem the request to be pre-approved/authorized.

KFHC covers all medically necessary, approved health care services to maintain the member's stabilized condition until the member is discharged or transferred.

Recuperative Care Services

The recuperative care benefit is a short-term patient recovery facility where members can temporarily stay after being discharged from the hospital. The following items are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:

- Lodging accommodations and meals
- Transportation for follow-up appointments
- Onsite nursing services
- Social Services referrals

Urgent Care Services

Urgent care services **do not** require prior authorization. Urgently needed services are covered services provided when the member is temporarily absent from a service area or when, as a result of an unforeseen illness or injury, medical services are required without delay and the services could not be obtained reasonably through a normal appointment with a contracted provider. Contracted Urgent Care facilities can be found in the KFHC Provider Directory or by using the Find a Provider search tool on our website, www.kernfamilyhealthcare.com.

Advice Nurse Line

Members can call the KFHC Advice Nurse Line at (661) 632-1590 or 1-800-391-2000 to get medical advice via telephone when their doctor's office is closed or can't be reached.

Community Based Adult Services (CBAS)

The primary objectives of the program are to restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities, age 18 or older; and delay or prevent inappropriate or personally undesirable institutionalization as well as foster a partnership with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence.

Each participant shall receive ALL of the following basic CBAS benefits as bundled services on each day of attendance at the CBAS center:

a) Professional nursing services;
b) Social Services and/or personal care services;
c) Family and/or caregiver training and support
d) Therapeutic activities; and
e) One meal offered daily.

Mental Health Services

KFHC will cover outpatient mental health services that are within the scope of practice of Primary Care Providers or when performed for mild to moderate mental health conditions on an outpatient basis by a licensed mental health provider. Members who need specialty mental health services are referred to and are provided mental health services by an appropriate Medi-Cal Fee-For-Service (FFS) mental health provider or the Kern County Behavioral and Recovery Services (KCBRS) for Serious Emotional Disturbances.

Mental Health Parity

The KFHC Utilization Management Department (UM) collaborates with the KCBRS in the delivery of mental and physical health services to KFHC members. KFHC's UM Program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements.

Mental Health Benefits

PCP's will identify the need for a mental health screening and refer to a specialist within the contracted network. Upon assessment, the mental health specialist can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to the Mental Health Plan (MHP) for a Specialty Mental Health Services (SMHS) assessment. When a member's condition improves under SMHS and the mental health providers in the plan and the County System of care coordinate care, the member may return to

the mental health provider within the KFHC network.

All eligible Medi-Cal HMO Members with a mental health diagnosis and with mild or moderate impairment receive the following mental health benefits administered through KFHC:

1. Individual and group mental health evaluation and treatment (psychotherapy)
2. Family Therapy
3. Psychological testing when clinically indicated to evaluate a mental health condition
4. Psychiatric consultation
5. Outpatient services for the purposes of monitoring drug therapy
6. Outpatient laboratory, supplies, and supplements

For more information see KHS Policy and Procedure: 3.14

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Behavioral Health

BHT/BIS are defined as professional services and treatment programs, including but not limited to Applied Behavioral Analysis (ABA) and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with or without the diagnosis of Autism Spectrum Disorder.

The Centers for Medicare and Medicaid Services (CMS) requires that all children receive EPSDT screenings designed to identify health and developmental issues as early as possible. All children enrolled in Medi-Cal must be screened at regular intervals per recommendations for preventive pediatric health care developed by the American Academy of Pediatrics “Bright Futures” guidelines. When a screening examination indicates the need for further evaluation of a child’s health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay.

To be eligible for BHT/BIS, the member must meet all of the following coverage criteria:

1. Be under 21 years of age.
2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT/BIS is medically necessary.
3. Be medically stable.
4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

KFHC is responsible for coordinating the provision of services with the other entities to ensure that KFHC and the other entities are not providing duplicative services.

Behavioral Treatment Plan

BHT/BIS is provided under a behavioral treatment plan that has measurable goals over a specific timeline for the particular member being treated, and that has been developed by a BHT/BIS Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT/BIS Provider. The behavioral treatment plan may be adjusted if medically necessary. BHT/BIS may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

For more information see KHS Policy and Procedure: 3.72

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 5: ENHANCED CARE MANAGEMENT

The Department of Health Care Services (DHCS), released APL 21-012 on September 15, 2021, for Enhanced Care Management (ECM) Requirements, along with the ECM Program Guide. The ECM program was implemented in January 2022 as part of the CalAIM (California Advancing and Innovating Medi-Cal) Initiative. KFHC Enhanced Care Management, is a physician-led intensive case management program that uses an interdisciplinary team to address the member's physical, behavioral and social needs. This team includes a Provider, Case Manager, Care Coordinator, Pharmacist, and other support staff.

Enhanced Care Management is a whole-person approach to care that addresses both the clinical and non-clinical needs of both high-cost and/or high-need members through the systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM Program Goals are to improve care coordination, integrate services, facilitate community resources, address social determinants of health, improve overall health outcomes, decrease inappropriate utilization and duplication of services, and provide same-day access for our members. Members who enroll in ECM retain their PCP and the ECM Care Team communicates with the PCP regarding the Member throughout their enrollment. ECM is a free and voluntary benefit that is available to eligible KFHC members.

Member Eligibility

Member eligibility is determined by the Department of Health Care Services (DHCS) as follows:

A. Adults experiencing homelessness as defined by: lacking adequate nighttime residence; primary residence that is a public or private place not designed for or ordinarily used for habitation; living in a shelter; exting an institution into homelessness; will imminently lose housing in next 30 days; individuals fleeing domestic violence; or defined as homeless under other federal statues
    a. And have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

B. Adult High Utilizers: Adults with five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;
    a. And/or three or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

C. Adults with SMI/SUD: Adults experiencing a serious mental illness or suffering from a substance use disorder.

- Adults who meet the eligibility criteria for participation in or obtaining services through County Specialty Mental Health and/or Drug Medi-Cal
- And are actively experiencing at least one complex social factor influencing their health
- And meets one (1) or more of the following:
  - Are at high risk for institutionalization, overdose and/or suicide;
  - Use crisis services, the emergency rooms, urgent care, or inpatient hospital as sole source of care
  - Experienced two (2) or more emergency department visits, or two (2) or more hospitalizations due to SMI or SUD in past 12 months
  - Is pregnant or is less than 12 months post-partum

D. Adults who are transitioning from incarceration:

- The individual transitioned from incarceration within the past 12 months and has at least one (1) of the following:
  - Mental illness
  - Substance use disorder
  - Chronic disease
  - Intellectual or developmental disability
  - Traumatic brain injury
  - HIV
  - Pregnancy or Postpartum

E. Individuals living in the community and at Risk for Long-Term-Care Institutionalization:

- Adults who are living in the community who meet the SNF Level of Care (LOC) criteria OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury
- And are actively experiencing at least one complex social or environmental factor influencing their health
- And are able to reside continuously in the community with wraparound supports

F. Adult Nursing Facility Residents Transitioning to the Community

- Adult nursing facility residents who are interested in moving out of the institution
- And are likely candidates to do so successfully
- And are able to reside continuously in the community

G. Adults with an I (Intellectual) /DD (Developmental Disability)

- Adults who have a diagnosed I/DD
- And qualify for eligibility in any other adult ECM Population of Focus

ECM eligibility will expand to include the following Populations of Focus as of July 1, 2023. Children and Youth Populations of Focus generally encompass up to age 21:

H. Children and Youth Transitioning from a Youth Correctional Facility

- Children and youth who are transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months

I. Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness

- Children, Youth, and Families who are experiencing homelessness
- Or are sharing the housing of other persons due to loss of housing, economic hardship, living in hotels, motels, trailer parks, camping grounds, or are living in emergency or transitional shelters.

J. Children and Youth with three (3) or more emergency department visits in a 12-month period or two (2) or more unplanned hospital and/or short-term SNF stays in a 12-month period, all of which could have been avoided with appropriate outpatient care or improved treatment adherence.

K. Children and youth enrolled in California Children's Services (CCS) with additional needs beyond the CCS condition

- Children and youth who are enrolled in CCS or CCS WCM
- And are experiencing at least one complex social factor influencing their health.

L. Children and youth involved in Child Welfare

- Children and youth who meet one or more of the following conditions:
- Are under age 21 and are currently receiving foster care in California
- Or are under age 21 and previously received foster care in California or another state within the last 12 months
- Or have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
- Or are under age 18 and are eligible for and/or in California's Adoption Assistance Program
- Or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

M. Children and youth with serious mental health and/or SUD needs

- Children and youth who meet the eligibility criteria for participation in or obtaining services through County Specialty Mental Health and/or Drug Medi-Cal.

N. Children and youth who have a diagnosed I/DD and qualify for eligibility in any other children and youth ECM population of focus.

ECM eligibility will expand to include the following Populations of Focus as of January 1, 2024:

O. Pregnancy, Postpartum and Birth Equity Population of Focus (Adults and Youth)

- Adults and youth who are pregnant or postpartum (through 12 months period)
- And qualify for eligibility in any other adult or youth ECM Population of Focus OR are subject to racial and ethic disparities as defined by the California Public Health data on maternal morbidity and mortality.

Providers can refer potentially eligible Members by submitting an ECM referral through the Provider Portal or by calling Kern Family Health Care. Members and their families can also self-refer by calling Kern Family Health Care. Members referred for ECM will be evaluated to determine if eligibility criteria are met.

Eligible Members are identified through a weekly stratification process of the entire Kern Health Systems population by utilizing various data points, such as available data feeds, diagnosis codes, claim submissions, etc. Members found to be eligible for ECM by falling into a DHCS-defined population of focus are authorized to receive the ECM benefit for 12 months. Prior to the end of the authorization Members are evaluated to assess if the Member should be reauthorized or transition to another case management program or other service.

ECM Core Services

There are seven core services provided in Enhanced Care Management which include:

- Outreach and Engagement – Contacting eligible members to enroll in ECM
- Comprehensive Assessment and Care Management Plan – Developing and updating an individualized Care Management Plan to guide each member with needed services and care.
- Enhanced Coordination of Care – Implementation of the members' Care Management Plan with coordinating care and connection for health and community services.
- Comprehensive Transitional Care – Facilitating care transitions between the hospital, nursing homes, other treatment facilities and home.
- Coordination and Referral to Community and Social Support Services– Determining needs and coordinating referrals to address Social Determinants of Health.

- Health Promotion – Educating patients about and supporting them in health behaviors.
- Member and Family Support - Supporting the self-management and decision-making efforts of patients and their family or support team.

If you would like more information regarding Enhanced Care Management, you can call KFHC at 1-800-391-2000, option 4, or go to DHCS Enhanced Care Management and In Lieu of Services (www.dhcs.ca.gov/Pages/ECMandILOS.aspx).

SECTION 6: EPSDT

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

For members under age 21, KHS will provide a more robust range of medically necessary services than they do for adults that include standards set forth in federal and state law. This includes the contractual obligation to provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule.

Early and periodic screening, diagnostic and treatment (EPSDT) services.

- Children under 21 years old are covered for well-child visits. Well-child visits are a comprehensive set of preventive, screening, diagnostic, and treatment services.
- KHS will make appointments and provide transportation to help children get the care they need.
- Preventive care can be regular health check-ups and screenings to help find problems early. Regular check-ups identify any issues with medical, dental, vision, hearing, mental health, and any substance use disorders. KHS covers screening services any time there is a need for them, even if it is not during a regular check-up. KHS must make sure that all children enrolled get needed shots at the time of any health care visit.
- When a problem is found during a check-up or screening, KHS covers the care that is medically necessary to correct or help any physical or mental health issues. All of these services are at no cost to members and include:
  - Doctor, nurse practitioner, and hospital care
  - Immunizations
  - Lead screening
  - Physical, speech/language, and occupational therapies
  - Home health services, which could be medical equipment, supplies, and appliances

- Treatment and rehabilitative services for mental health and substance use disorders
- Treatment for vision, hearing, and dental issues and disorders, which could be eyeglasses, hearing aids, and orthodontics
- Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
- Case management, targeted case management, and health education

A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child.

Topical Fluoride Varnish

Fluoride varnish is a form of topical fluoride that is more effective in preventing tooth decay than other forms of topical fluoride, and more practical and safer to use with young children. As part of a CHDP Health Assessment, a CHDP provider is required to conduct an oral exam, which may include a fluoride varnish application.

Fluoride varnish training information is available to network providers and their staff through the KHS website: https://www.kernfamilyhealthcare.com/providers/provider-resources/

Instructions include:

1. How to obtain Fluoride Varnish supplies
2. Fluoride varnish application and periodic dental assessments
3. Parental anticipatory guidance
4. Referring children to a dentist for a dental examination and care at one year of age per CHDP guidelines
5. Coordination of member care with dental professionals

Once the 45-minute training is completed, CHDP will provide some initial start-up materials to the provider and issue a certificate of completion.

Blood Lead Screening

Federal law requires children to be screened for elevated blood levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

The California Department of Public Health's California Childhood Lead Poisoning Prevention Branch (CLPPB) issues guidance for all California providers pursuant to these regulations and required blood lead standards of care.

Guidelines are as follows:

1) Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that at a minimum, includes information that children can be harmed by exposure to lead. This anticipatory guidance must be performed at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age.
2) Perform BLL testing on all children in accordance with the following:
    a) At 12 months and at 24 months of age.
    b) When the health care provider performing a periodic health assessment becomes aware that a child 12 to 24 months of age has no documented evidence of BLL test results taken at 12 months of age or thereafter.
    c) When the health care provider performing a periodic health assessment becomes aware that a child 24 to 72 months of age has no documented evidence of BLL test results taken when the child was 24 months of age or thereafter.
    d) Whenever the health care provider performing a periodic health assessment of a child 12 to 72 months of age becomes aware that a change in circumstances has placed the child at increased risk of lead poisoning, in the professional judgement of the provider.
    e) When requested by the parent or guardian.
    f) The health care provider is not required to perform BLL testing if:
        i) A parent or guardian of the child, or other person with legal authority to withhold consent, refuses to consent to the screening.
        ii) If in the professional judgement of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.
        iii) Providers must document the reasons for not screening in the child's medical record.

Documentation must be included in the member's medical record indicating the reason for not performing the blood lead screening.

Screenings may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. All blood lead screenings should be billed using appropriate and current CPT coding.

Additional resources:

https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

For further information on EPSDT services, please see Policy 3.13-P located on the KFHC website:

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 7: CLAIMS SUBMISSION

Electronic Claims Submission required
KHS acceptable Clearing House:

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 4 exceptions that will be accepted via paper submission:

1. Any claim requiring the PM330 (Sterilization Consent Form) to be attached. (PM330 must be attached)
2. Any claim where contract requires invoice pricing. (Invoice must be attached)
3. Prior KHS claim submission resulted in an EOB where KHS requested documentation to be provided. (Request from KHS or EOB requesting documentation must be attached)
4. 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 4 exceptions identified above, claims must be mailed to:

Kern Family Health Care
PO Box 85000
Bakersfield, CA 93380

Any paper claim submissions that do not meet one of the four exceptions above will be rejected and returned to you with instructions to submit electronically.

Claims must be submitted within 180 days from date of service.

COB (Coordination of Benefit) claims must be submitted within 90 days of primary insurance EOB (Explanation of Benefit) issue date (with the exception of Medicare – Medicare will forward any secondary claims directly to KFHC. These are called Crossover claims.)

Corrected claims submission: 45 days from original paid claim date or denial date.

Disputes: 365 days (must be submitted via Provider Claims Dispute Resolution Request Form which can be located on the KHS website)

Claim Requirements

The KFHC claims editing software program ensures all claims received comply with Medi-Cal billing guidelines. Claims submitted incorrectly will be denied. Providers must ensure their billing processes are following KHS guidelines. The Medi-Cal Provider Manual is available online at www.medi-cal.ca.gov.

Claims Submissions

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.
- Use Member Client Identification Number (CIN) or the Member ID Number.
- Hospitals, long term care facilities, licensed primary care clinics and emergency medical transportation are excluded from the SSN billing restriction. However, these excluded entities are required to make a good faith effort to obtain the member's CIN information for billing purposes.
- 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 certain medical supplies.
- All diagnosis codes are to be submitted to the highest level of specificity, regardless of level used on the authorization.

Our vendors for electronic claims submission are Change Healthcare, Cognizant, Office Ally, and SSI Group. Information on where to file claims is indicated below:

Electronic Claims	Paper Claims for Exceptions Identified Above KFHC	Claims Disputes
Clearinghouses include: • Change Healthcare • Office Ally • SSI Group *Payer ID: 77039* • Cognizant *Professional Payer ID: KERNH* *Institutional Payer ID: UERNH*	Attn: Claims Department Kern Family Health Care PO Box 85000 Bakersfield, CA 93380 *Do not hand-deliver or mail claims to the KFHC physical address.	Attn: Claims Department Kern Family Health Care 2900 Buck Owens Boulevard Bakersfield, Ca 93308 * Must be submitted using a Provider Claims Dispute Request Form: https://res.cloudinary.com/dpmykpsih/image/upload/kern-site-353/media/34647b39956c47ccac2662c59ce6dbc6/claims-dispute-form.pdf

Coordination of Benefits (COB)

State and federal laws require Providers to bill other health insurers prior to billing KFHC. Providers should attempt to be reimbursed for services from any other health insurance program for which the patient is eligible (including Medicare) before submitting a claim to KFHC. Upon receipt of a denial or partial payment from the Members other health insurance, the Provider should submit the claim along with documentation of denial or payment from the primary carrier.

For COB claims, enter the COB information into the electronic claim submission. If you are unsure how to enter, the clearinghouse will be able to direct you as to where to place the COB information. Electronic submission of EOBS and other attachments are not necessary and not being accepted at this time.

Corrected Claims

- Do use Resubmission code 7 in box 22 (CMS1500) or code 0XX7 (XX being the correct type of bill for your facility) in box 4 (UB04) to identify a corrected claim
- Do send corrected claims electronically unless one of the exceptions listed above on page 42.

- Do include the claim number of the claim you are correcting in box 19 (CMS1500) or (Original claim or if submitted more than once, the last claim with payments on it.) **Note, each claim number can only be used once to correct**. Example: If you are splitting a billing from the original due to date differences or contract requirements, one claim should be sent as a correction and the other should be sent as a new claim.)
- Do include all services that were performed (whether billed or paid previously), as the corrected submission will negate previous claim in its entirety.
- **Do not submit corrected claims as disputes.** They will be returned to you. Disputes follow the current process and are required to be mailed to the address indicated above.

If you are unsure how to provide the resubmission/frequency code or original claim number electronically, please contact your clearinghouse and they will direct you. Please find additional information below which identifies where KHS needs to receive the information electronically:

Resubmission frequency code:

Loop 2300, Segment CLM, Data Element 05, Composite 01 (CLM0501)

Reference for original claim number:

Loop 2300, Segment REF, Data Element 01 = F8, Data Element 02 = <Original KHS claim Id or if more than 1 - most recent KHS claim Id where paid>

Reporting Provider-Preventable Conditions (PPC)

Provider Preventable Conditions (PPCs) are either Health Care-Acquired Conditions (HCACs) or Other Provider-Preventable Conditions (OPPCs) as defined under Title 42 of the Code of Federal Regulations (CFR) sections 438.3(g), 434.6(a)(12)(i), and 447.26447.26. Providers must report PPCs to the Department of Health Care Services (DHCS) via the PPC secure online portal. Providers are also required to send KFHC a copy of PPCs submitted to DHCS. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of beneficiary information. KFHC will not reimburse providers for PPC-related health care services.

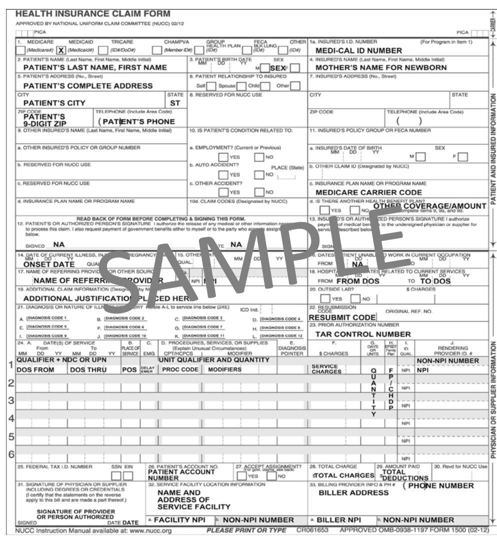
For more information visit http://www.dhcs.ca.gov/individauls/Pages/AI_PPC.aspx

Providers can send copies of their PPC submissions by mail, fax or by secure email to:

Kern Health Systems
PO Box 85000
Bakersfield, Ca 93380
Attn: Compliance Director
Fax: (661) 664-5420
PPCreports@khs-net.com

Sample CMS 1500 Format

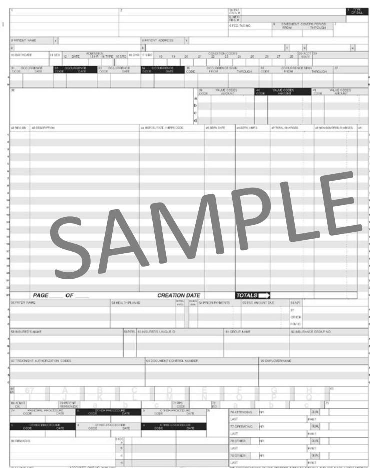
The CMS 1500 format should be used by physicians, laboratories, and allied health professionals to submit claims for medical services. Durable medical equipment and blood products should also be billed using this format. Pharmacies may also use this form to bill for supplies not billable through the on-line pharmacy claims processing service. Providers should follow the Medi-Cal instructions for completing the CMS 1500 Form, located on the www.cms.gov website.



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12
PICA PICA
1. MEDICARE (Medicare#) MEDICAID X (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDI-CAL ID NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PATIENT'S LAST NAME, FIRST NAME
3. PATIENT'S BIRTH DATE MM DD YY SEX M F: SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial): MOTHER'S NAME FOR NEWBORN
5. PATIENT'S ADDRESS (No., Street): PATIENT'S COMPLETE ADDRESS
6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY: PATIENT'S CITY STATE: ST
8. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE: PATIENT'S 9-DIGIT ZIP TELEPHONE (Include Area Code): (PATIENT'S PHONE
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE CARRIER CODE
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO: OTHER COVERAGE/AMOUNT
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED NA DATE NA
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: ONSET DATE QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM NA TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NAME OF REFERRING PROVIDER 17b. NPI: NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: FROM DOS TO: TO DOS
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ADDITIONAL JUSTIFICATION PLACED HERE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. DIAGNOSIS CODE 1 B. DIAGNOSIS CODE 2 C. DIAGNOSIS CODE 3 D. DIAGNOSIS CODE 4
E. DIAGNOSIS CODE 5 F. DIAGNOSIS CODE 6 G. DIAGNOSIS CODE 7 H. DIAGNOSIS CODE 8
I. DIAGNOSIS CODE 9 J. DIAGNOSIS CODE 10 K. DIAGNOSIS CODE 11 L. DIAGNOSIS CODE 12
22. RESUBMISSION CODE: RESUBMIT CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: TAR CONTROL NUMBER
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #
1 QUALIFIER + NDC OR UPN | UNIT QUALIFIER AND QUANTITY | NON-NPI NUMBER
DOS FROM | DOS THRU | POS | DELAY EMER | PROC CODE | MODIFIERS | SERVICE CHARGES | QUANTITY | FP/CHDP | NPI | NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: PATIENT ACCOUNT NUMBER
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE: $ TOTAL CHARGES
29. AMOUNT PAID: $ TOTAL DEDUCTIONS
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE OF PROVIDER OR PERSON AUTHORIZED
SIGNED DATE DATE
32. SERVICE FACILITY LOCATION INFORMATION: NAME AND ADDRESS OF SERVICE FACILITY
a. FACILITY NPI b. NON-NPI NUMBER
33. BILLING PROVIDER INFO & PH #: (PHONE NUMBER BILLER ADDRESS
a. BILLER NPI b. NON-NPI NUMBER
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)
SAMPLE

Sample UB-04 (CMS-1450) Format

The UB-04 (CMS 1450) format should be used to submit claims for inpatient Hospital accommodations and ancillary charges and for hospital outpatient services, Ambulatory Surgery Centers, Skilled Nursing Facilities, and Home Health Care agencies. Providers should follow the Medi-Cal instructions for completing the UB-04 (CMS 1450) Form, located on the www.cms.gov website.



SAMPLE
PAGE OF CREATION DATE TOTALS

Claims for Contracted Providers

In order to receive full compensation, contracted providers should submit to a complete, electronic bill for all covered services rendered within **one hundred and eighty (180) calendar days** following the provision of the covered services.

Claims received after **180 calendar days** following the provision of the covered services are denied with the following exceptions:

A. Other Primary Insurance: Claims submitted within 90 calendar days of the date of the primary carrier's Explanation of Benefits (EOB).

B. California Children's Services: Claims must be submitted within 90 calendar days of the CCS denial letter.

Claims Payment or Denial Timeframes

KFHC will reimburse 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities, within 30 calendar days of the date of receipt. KFHC will reimburse each completed claim, or portion thereof, as soon as possible, but no later than 45 working days after the date of receipt of the complete claim. In accordance with State regulations, interest will be paid on clean claims not paid within 45 working days of receipt.

Claims Reimbursement

Claims for Providers will be reimbursed according to the terms specified in the Provider's Agreement. Claims for non-contracted providers will be adjudicated primarily in accordance with Medi-Cal guidelines and fee schedules. When no fee schedule exists, KFHC reasonable and customary rates will apply.

Claims Overpayment

When recovery for an overpayment is pursued, KFHC sends a refund request letter to the provider. Within thirty (30) working days of receipt of the letter, the Provider must submit to KFHC either a complete refund of the overpayment, permission to deduct from future claims or, a provider dispute indicating why the provider disagrees with the overpayment identification.

KFHC shall require providers to report to KFHC when it has discovered it has received an overpayment, to return the overpayment to KFHC within sixty (60) calendar days after the

date on which the overpayment was identified, and to notify KFHC in writing of the reason for the overpayment.

Providers shall submit the overpayment and written reason to the KFHC Claims Department at the following address:

Claims Department
Kern Health Systems
PO Box 85000
Bakersfield, CA 93380

Claims Payment Disputes

A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing, or requesting reconsideration of a claim that has been denied, adjusted, or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim. Disputes are required by law to be **very specific** as to what the provider feels was processed incorrectly and specifically how the claim should have been resolved.

Disputes must be submitted within 365 calendar days of the date of KFHC' action, or in the case of inaction, 365 calendar days after the time for contesting/denying claims has expired. Disputes that are returned for additional information must be resubmitted to KFHC within 30 working days of the date of receipt.

Disputes should be mailed to the following address:

Claims Department
Kern Family Health Care
2900 Buck Owens Boulevard
Bakersfield, Ca 93308

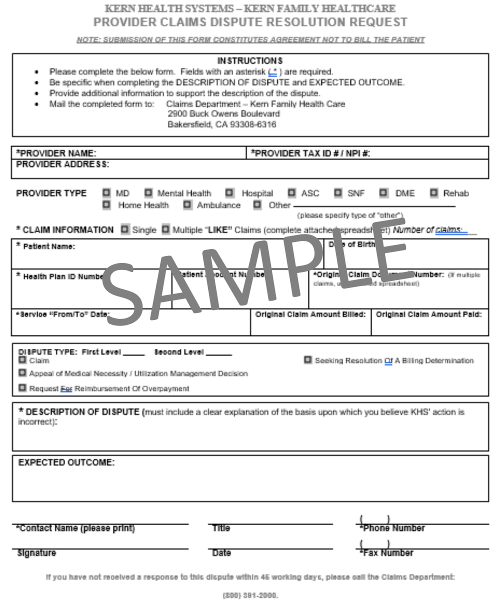
An acknowledgement letter is submitted to the Provider within **15 working days** of the receipt date and resolved within **45 working days** of the receipt date of the dispute. Providers can make inquiries regarding disputes by calling the KFHC Claims Department.

Prior to submitting a claims dispute, KFHC encourages Providers to call the KFHC Claims Department to discuss the claim at 661-632-1590 (Bakersfield), 1-800-391-2000 (outside of Bakersfield), dial 5 to bypass other queues. Many times we can resolve the issue without the need of a claims dispute, saving both the Provider and KFHC time and effort.

For further instructions on how to submit a Provider Claims Dispute Resolution Request, please see Policy 13.05-P located on the KFHC website, www.kernfamilyhealthcare.com.

Sample Provider Claims Dispute Resolution Request Form

Claims Disputes must contain the information highlighted below. Disputes that do not contain all the necessary information are returned to the Provider. Supporting documentation must also accompany all disputes. Visit www.kernfamilyhealthcare.com to download the Provider Claims Dispute Form.



KERN HEALTH SYSTEMS – KERN FAMILY HEALTHCARE
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 Boulevard
  Bakersfield, CA 93308-6316

*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 attache[illegible] spreadsh[illegible]) *Number of claims:* ___

SAMPLE

* Patient Name:		D[illegible] of Birth
* Health Plan ID Numbe[illegible]	[illegible]atient [illegible] Nu[illegible]be[illegible]	*Origin[illegible] Claim Do[illegible] Number: (If multiple claims, u[illegible] 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: (800) 391-2000.

For more information see KHS Policy and Procedure:

6.01 Claims Submission and Reimbursement

6.08 Coordination of Benefits

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 8: PAYSPAN

KFHC utilizes a third-party vendor, PaySpan, to process all payments and remittance advice. You have the option through PaySpan to receive a paper check or an electronic funds transfer. All EOP's are electronic and are only available through PaySpan.

The first payment that you receive from KHS will include instructions on how to register with PaySpan. If you have any questions, please contact PaySpan at **1-877-331-7154**.

Providers can access the PaySpan website through the KHS Provider Portal. After logging in to the KHS Provider Portal, click on the Claims tab and scroll to the bottom to locate the PaySpan link.

SECTION 9: ACCESSIBILITY STANDARDS – TIMELY ACCESS

Appointment Waiting Time and Scheduling

KFHC adheres to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). These standards are to ensure Medi-Cal beneficiaries are offered appointments for care within a time period appropriate for their condition. Members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization	Within 48 hours of a request
Urgent appointment for services that do require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointment with a mental healthcare provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

Telephone Accessibility

Providers and administrative personnel must maintain a reasonable level of telephone accessibility to KFHC members. At minimum, the following response times are required:

Nature of Telephone Call	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 9-1-1 or (661) 868-8000
Urgent medical	30 Minutes
Non-urgent medical	By close of following business day
Non-urgent mental health	By close of following business day
Administrative	By close of following business day

Provider offices must provide procedures to enable patient access to emergency services 24 hours per day, seven days per week. Patients must be able to call the office number for information regarding physician availability, on call provisions or emergency services. An answering machine or service must be made available after normal business hours with direction in non-emergency and emergency situations.

Office Waiting Time – Maximum

Service	Urgent	Routine
Primary Care Services (including OB/GYN)	1 hour	1 hour
Specialty Care Services	1 hour	1 hour
Diagnostic Testing	1 hour	1 hour
Mental Health Services	1 hour	1 hour
Ancillary Providers	1 hour	1 hour

Physicians are not held to the office waiting time standards for unscheduled non-emergent walk-in patients.

Appointment Rescheduling

When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of KHS policy 4.30-P Accessibility Standards-Timely Access.

Monitoring Access Standards

KFHC will monitor all network Providers using the following sources to study and assure compliance with access standards:

A. Quarterly Appointment Availability Survey
B. Quarterly After-hours Call Survey
C. Access Grievance Review
D. Annual Appointment Availability Survey
E. Provider and Member Satisfaction Survey

For more information see KHS Policy and Procedure: 4.30

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 10: TELEHEALTH SERVICES

Telehealth is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Each telehealth provider must meet KHS credentialing standards including maintaining an active California medical license and enrollment in Medi-Cal program. Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason.
Telehealth services require:

- documentation of either verbal or written consent from the patient
- compliance with all state and federal laws regarding the confidentiality of health care information
- patient's rights to information
- the right to an in-person visit

For additional information please refer to the DHCS All Plan Letter 19-009: *Telehealth Services Policy*
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-009.pdf

SECTION 11: TRANSPORTATION

Transportation Services

American Logistics (AL), a national passenger transportation management company, manages the scheduling component of Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. Transportation provided via ambulance and air requires prior authorization through the current KFHC prior authorization process.

NMT (Non-Medical Transportation)

NMT services are a covered benefit for all KFHC eligible members to obtain medically necessary KFHC or Medi-Cal covered services. NMT does not include transport of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who require to be transported by ambulance. NMT services will be provided at the least costly method that meets the member's needs. Methods of NMT include:

- Mileage Reimbursement will be no less than the current Internal Revenue Service (IRS) rate for medical purposes (A family member, neighbor, etc. can provide transportation and be reimbursed by downloading the mileage reimbursement form located on the KHS website)
- Private Conveyance via Rideshare or Taxi (if available)
- Greyhound Transportation for long distance appointments where Rideshare is unavailable
- Public Transit Systems via bus pass

NEMT (Non-Emergency Medical Transportation)

NEMT includes transportation by ambulance, wheelchair vans, and gurney vans to or from KFHC covered services and can be used when:

- Medically needed
- Is requested by a treating physician
- A member cannot use a bus, taxi, car, or van to get to their appointment because they require assistance to travel

NEMT via gurney or wheelchair vans, prior authorization will not be required. Providers will be required to complete a Physician Certification Statement (PCS) form prior to the member receiving NEMT services.

Scheduling Transportation

Members and Providers can call our Transportation Department, Monday through Friday, from 7:00 am to 6:00 pm, at 661-632-1590 or 1-800-391-2000 and choose option #3. The

Transportation Department is available 24 hours a day, 7 days a week for urgent or after-hours assistance.

For more information, see KHS Policy & Procedures: 3.25

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

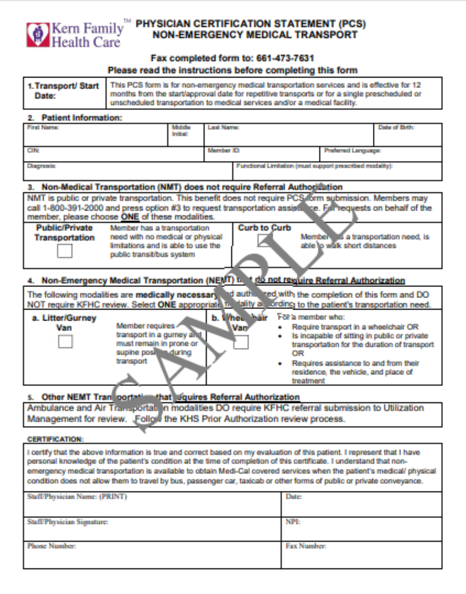
Receiving Trips

ALC will email or fax a schedule to the contracted transportation provider with a list of trips five days in advance. The provider must verify if they can accept all scheduled trips or communicate back to AL regarding any trips which are unable to be accommodated. Please ensure eligibility is checked for every trip. ALC does verify eligibility prior to sending out weekly trip sheets; however, the eligibility does not provide information on other healthcare coverage (OHC) the member might have. Please check the Medi-Cal website to ensure the member does not have OHC.

Sample Physician Certification Statement (PCS) Form

The PCS form is available on the KFHC Provider Portal and on our website at

https://www.kernfamilyhealthcare.com/providers/provider-resources/manuals-and-forms/



Kern Family Health Care™

PHYSICIAN CERTIFICATION STATEMENT (PCS)
NON-EMERGENCY MEDICAL TRANSPORT

Fax completed form to: 661-473-7631
Please read the instructions before completing this form

1. Transport/ Start Date:	This PCS form is for non-emergency medical transportation services and is effective for 12 months from the start/approval date for repetitive transports or for a single prescheduled or unscheduled transportation to medical services and/or a medical facility.

2. Patient Information:

First Name:	Middle Initial:	Last Name:	Date of Birth:
CIN:	Member ID:	Preferred Language:	
Diagnosis:	Functional Limitation (must support prescribed modality):		

3. Non-Medical Transportation (NMT) does not require Referral Autho[illegible]ation

NMT is public or private transportation. This benefit does not require PCS [illegible]orm submission. Members may call 1-800-391-2000 and press option #3 to request transportation assis[illegible]ce. F[illegible] requests on behalf of the member, please choose **ONE** of these modalities.

Public/Private Transportation ☐	Member has a transportation need with no medical or physical limitations and is able to use the public transit/bus system	**Curb to Curb** ☐	Member [illegible] a transportation need, is able [illegible] walk short distances

4. Non-Emergency Medical Transportation (NE[illegible]T) [illegible] do not require Referral Authorization

The following modalities are **medically necessary** [illegible]d auth[illegible]ed with the completion of this form and DO NOT require KFHC review. Select **ONE** appropriat[illegible] [illegible]dality a[illegible]ording to the patient's transportation need.

a. Litter/Gurney Van ☐	Member requires transport in a gurney a[illegible]d must remain in prone or supine pos[illegible] during transport	**b. Whee[illegible]hair Van** ☐	For a member who: • Require transport in a wheelchair OR • Is incapable of sitting in public or private transportation for the duration of transport OR • Requires assistance to and from their residence, the vehicle, and place of treatment

5. Other NEMT Tran[illegible]portat[illegible] that [illegible]equires Referral Authorization

Ambulance and Air Transportat[illegible]n modalities DO require KFHC referral submission to Utilization Management for review. Follo[illegible] the KHS Prior Authorization review process.

CERTIFICATION:

I certify that the above information is true and correct based on my evaluation of this patient. I represent that I have personal knowledge of the patient's condition at the time of completion of this certificate. I understand that non-emergency medical transportation is available to obtain Medi-Cal covered services when the patient's medical/ physical condition does not allow them to travel by bus, passenger car, taxicab or other forms of public or private conveyance.

Staff/Physician Name: (PRINT)	Date:
Staff/Physician Signature:	NPI:
Phone Number:	Fax Number:

SAMPLE

SECTION 12: CULTURAL & LINGUISTIC SERVICES

Kern Family Health Care (KFHC) will provide equal access to health services for members who are Limited English Proficient (LEP), deaf or hard of hearing, or blind or have low vision by providing appropriate interpreter interpreters and auxiliary aids and services.

The following Language assistance services are available at no cost to Members and Providers:

- 24/7 Over-the-phone interpreter support during medical appointments via Language Line
- Video Remote Interpreting (VRI) support for spoken languages and sign language via Language Line
- American Sign language interpreters via LifeSigns
- In-person interpreter support via KFHC or CommGap
- Services for the hearing or speech impaired via California Relay Services
- Member informing materials in alternative formats (i.e., large print, audio, and Braille)

Interpreter Access to Members

Interpreters must be made available upon request by face to face or via telephone with physicians, physician extenders, registered nurses, or other personnel who provide medical or health care advice to members. Interpreter services must also be available at all pharmacy sites.

Discourage the Use of Family Members as Interpreters

Family members, friends, and especially minors are discouraged from performing interpretive services for KFHC Plan members. The use of family or friends may jeopardize the quality and/or accuracy of information that is relayed to the member and may also present a hardship if the family member or friend must deliver confidential information.

Telephone Interpreting Services

During KFHC Office Hours: Providers and Members may contact the KFHC Member Services Department for an interpreter that is on staff or a Member Services Representative will connect the Provider or Member with Language Line Solutions- an interpreting service available with over 240 language options.

After KFHC Office Hours: Providers and Members are connected to Language Line Solutions via the KFHC Advice Nurse Line which is available by calling (800) 391-2000. KFHC's telephone interpreter service is available 24-hours a day, 7 days a week.

In-person Interpreter Services

Members or providers may also request in-person interpreter services for a medical appointment. Providers can contact the KFHC Member Services Department to schedule an in-person interpreter. KFHC will send either a qualified KFHC interpreter or a qualified contracted interpreter to the provider's office. Future appointments, if necessary, should be scheduled to include a KFHC staff member/interpreter or contracted interpreter. It is advisable that providers contact KFHC's Member Services Department at least 7 business days in advance of an appointment to request an in-person interpreter.

After regular business hours, in-person interpreter services are provided by KFHC contracted Hospitals/Urgent Care Facilities from a pool of their employees that are identified as qualified interpreters.

Alternative Format Selection (AFS) Services

Providers are required to document any new AFS that you receive from Kern Family Health Care members at the time of the request. To enter the member's selection into the AFS online screen, please visit: https://afs.dhcs.ca.gov/; or to utilize the AFS Helpline: 1-833-284-0040. For instructions regarding how to submit AFS data online, please visit

Alternative-Format-Selection-Application-User-Guide

Examples of Alternative Format Selections (AFS) include:

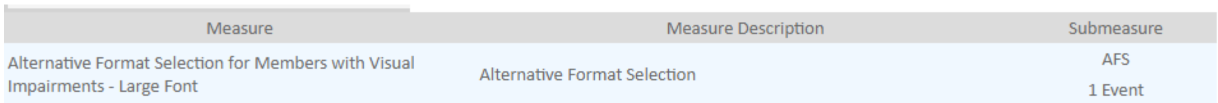
- Large Print (no less than 20-point Arial font)
- Audio Format
- Accessible Electronic Format
- Braille

To verify if a member requested alternative format, please login to the KFHS Provider Portal: https://provider.kernfamilyhealthcare.com/v3app/publicservice/loginv1/login.aspx?bc=1215a844-d81f-4be0-ac1c-92dd137dd90c&serviceid=05411915-5bc6-4527-97a6-45b09eecbde3

Select:

- Provider Practice
- Click Here to Proceed
- Enter Member's CIN or MEM # and Date of Birth
- View Report
- Gaps in Care

If the member has chosen an alternative format, you will see an alternative format indicated under measure:



Measure	Measure Description	Submeasure
Alternative Format Selection for Members with Visual Impairments - Large Font	Alternative Format Selection	AFS 1 Event

:

Please review this section of the portal for every member and if an alternative format has been selected, all member communications must be provided in the format selected.

If you need assistance or would like to have KHS enter the AFS on your behalf, please contact Member Services at 1-800-391-2000.

KHS offers training on the effective communication requirements of Title II of ADA:

https://res.cloudinary.com/dpmykpsih/image/upload/kern-site-353/media/1534/better_communication_better_care_-_provider_tools_to_care_for_diverse_populations.pdf

Medical Record Documentation

All providers are required to document the member's language in the medical record. Requests or refusals for interpreter services by members must also be indicated in the member's medical record.

Provider Requirements

Providers are required to report their language capabilities as well as languages spoken by their staff. The information provided is included in the Provider Directory and the KFHC website to assist Members in selecting the best Provider for their needs.

Cultural & Linguistic Resources & Training

To assist KFHC Providers in better communicating with patients that are limited in their English proficiency (LEP), the following resources available on www.kernfamilyhealthcare.com .

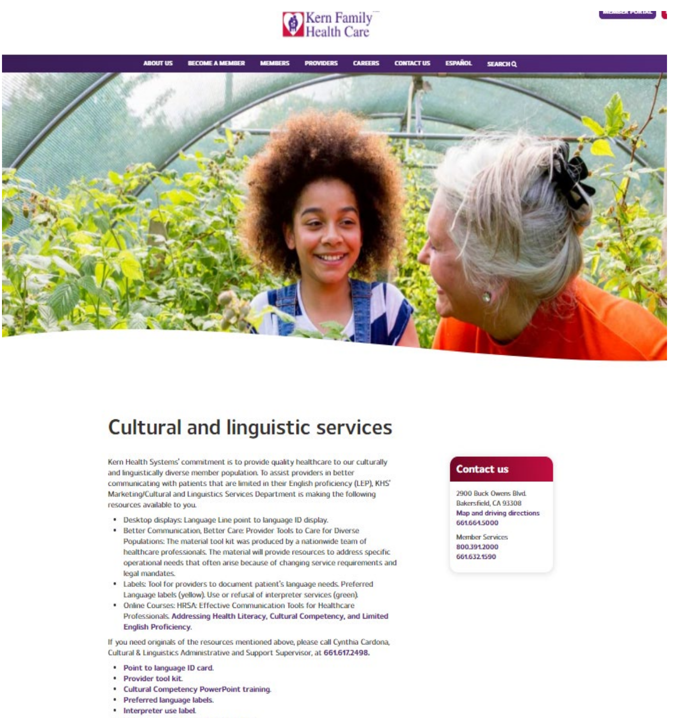
- Training: “Effective Use of Interpreters” is available to all KFHC contracted providers
- Desktop displays: Language Line point to language ID display
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations: The material tool kit was produced by a nation-wide team of health care professionals. The material will provide resources to address specific operational needs that often arise because of changing service requirements and legal mandates.
- Online Courses:
  HRSA: Effective Communication Tools for Healthcare Professionals
  Addressing Health Literacy, Cultural Competency, and Limited English Proficiency

For more information or to schedule a training session, please contact Cynthia Cardona, Cultural & Linguistic Services Manager at (661) 617-2498, cynthia.cardona@khs.net.com.

For more information see KHS Policy and Procedure: 11.22

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Cultural & Linguistic Provider Materials Visit www.kernfamilyhealthcare.com to download Cultural & Linguistics Resources for your office.



SECTION 13: PHARMACY SERVICES

Pharmacy services are covered under Medi-Cal RX.

Most pharmacy services are covered by Medi-Cal Rx beginning January 1, 2022. Examples of these services include: covered drug lists, networks, authorizations, appeals, and some pharmacy dispensed medical supplies and devices.

Medi-Cal RX contact information:

Fax: 1-800-869-4325

Call: 1-800-977-2273

https://medi-calrx.dhcs.ca.gov/home/

Services that are MCRx's responsibility and may be billed through their pharmacy processor (Magellan) are:

Outpatient Medications | **Vaccines** | **Enterals**

Condoms | **Diaphragms** | **Cervical Caps**

Peak Flow Meters | **Aerochambers** | **All Syringes**

Pen Needles | **Diabetic Test Strips** | **Lancets**

Continuous Glucose Monitor/Supplies **Disposable Insulin Delivery Devices (Omnipod/VGo {pumps})**

Over the Counter EUA (Emergency Use Authorization) COVID-19 Antigen Tests

Blood Pressure Machines

Pharmacy services covered by KFHC:

Some pharmacy services are retained by the health plan. These include some pharmacy dispensed medical devices and supplies and the ability for eligible pharmacists to perform some functions as a provider.

Medical supplies and devices that are the health plan's responsibility and may be billed through the PBM (SS&C) are: [SS&C BIN: 600428, PCN: 04970000, Group: not required/blank]

Incontinence Supplies | **Ostomy Supplies** | **Crutches/canes**

Thermometers | **Hand Sanitizer** | **T.E.D. Hose**

Nebulizers & Supplies | **Tablet Cutter** | **Braces (wrist/ankle/back/neck)**

Advanced Practice Pharmacists who are eligible to provide the services as outlined by AB1114 are able to bill for those services after completing an enrollment process with the plan. These services are billed as a medical claim to the plan. [Bill via electronic claims submission (ASC X12n 837Pv.5010)].

SECTON 14: GRIEVANCE AND APPEAL PROCESS

KFHC responds promptly to complaints from either a Provider or a Member. The two types of formal complaints that may be submitted by or on behalf of a Member are: a Grievance and an Appeal.

A **Grievance** means a member's written or oral expression of dissatisfaction, regarding KFHC and/or a network Provider, including quality of care concerns and shall include a complaint, dispute, and request for reconsideration or appeal made by a Member or the member's representative. There is **no time frame or deadline** for a Member to file a grievance.

An **Appeal** pertains to an Adverse Benefit Determination, a formal request for KFHC to reconsider a determination (e.g., denial, deferral or modification of a decision about health care coverage). An appeal may be filed to request reconsideration of a proposed resolution of a reported grievance. The Member has 60 calendar days from the date on the Notice of Adverse Benefit Determination (NOA) to file an appeal.

Filing a Member Grievance or Appeal

A grievance from a Member or a member's representative may be submitted either in person, verbally or in writing in following ways:

- Online via KFHC website: kernfamilyhealthcare.com or Member Portal
- Contact Member Services at 661-632-1590 (Bakersfield), 1-800-391-2000 (outside of Bakersfield). Monday-Friday: 8:00 am-5:00 pm.
- By mail or in-person:

KFHC Member Services Department
2900 Buck Owen Blvd
Bakersfield, Ca 93308

Routine Grievances

If possible, the grievance is resolved over the phone before the close of the next business day. An acknowledgement is mailed to the member within five (5) calendar days of receipt of the grievance. The grievance is reviewed by the *Grievance Review Committee*, and a resolution is provided to the member within thirty (30) calendar days of receipt.

Urgent/Expedited Grievances

If a grievance qualifies as an "urgent grievance", the Member is notified immediately of the classification and of their right to notify the Department of Managed Health Care (DMHC) of the grievance. Urgent Grievances are resolved within seventy-two (72) hours of receipt. In such cases KFHC will attempt to inform the Member as soon as possible. An acknowledgement is mailed to the Member within seventy-two (72) hours of receipt.

Grievances Filed in a Provider's Office

If a Member requests to file a grievance in the provider's office, the Provider must supply the member with a *Member Report of Complaint/Grievance* form and provide the following options:

A. Member can call the KFHC Member Services Department at 661-632-1590 or 1-800-391-2000 from the Provider's office to file a grievance verbally or for assistance regarding the complaint/grievance form.

B. The Member may submit the grievance in writing using the *Member Report of Complaint/Grievance* form. Providers are required to make forms and assistance readily available in accordance with California Code of Regulations, Title 28 §1300.68 (b)(7). Providers are also required to email or fax the form to KFHC on the day of receipt to grievance@khs-net.com or send via fax to 661-664-4303. The forms are available in English and Spanish.

A member who files a grievance may not be discriminated against and cannot be dis-enrolled from the provider's office or facility in retaliation of filing a grievance. As part of the KFHC investigation process, the provider is required to respond in writing to the complaint and provide medical records if applicable.

Provider Cooperation

Providers are contractually obligated to submit medical records and, if requested, a written response to the KFHC Grievance Coordinator within ten (10) business days of the date of their receipt of the request or if otherwise specified in the request. Providers who do not comply with contract requirements may be subject to disciplinary action.

Routine Member Appeal

All routine appeals are reviewed by the KFHC Grievance Review Committee and are resolved within 30 calendar days of receipt by the plan. An acknowledgement is mailed within five (5)

calendar days of receipt of the appeal. A Provider may submit an appeal in-writing on behalf of a Member with member's written consent. All pertinent supporting documentation must be provided to KFHC within the appeal. The Member or Provider, as appropriate, are notified in writing of the appeal resolution.

If the appeal is overturned and approved, KFHC must notify the member within seventy-two (72) hours from the date and time of the decision. A written notice will be mailed to the member, member's representative and/or provider. Unfavorable determinations are submitted to the member, member's representative and/or provider in writing with further rights, including the right to request a State Fair Hearing. Medi-Cal members are also advised of their right to seek assistance from the Ombudsman Program. Members have the right to request and receive continuation of benefits while the State Fair Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made must be included.

A member can request a State Fair Hearing by phone or mail:

By Phone: 1-800-952-5253 (TTD 1-800-952-8349)

By Mail: Complete form included with appeal resolution notice and mail to:
California Department of Social Services
State Hearings Division
PO Box 944243, Mail Station 09-17-37
Sacramento, CA 94244-2430

Expedited Appeals

If an expedited appeal is requested and the expedited criteria is met, the Member will receive verbal notification of the resolution within seventy-two (72) hours, and a written notice will be mailed within **seventy-two (72) hours.**

When requesting an appeal on behalf of a Member, Provider must complete the provider appeal form and include the Member's written consent before filing the appeal.

For more information see KHS Policy and Procedure: 5.01

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Member Report of Complaint/Grievance

Members are encouraged but not required to submit their grievance in writing using the Member Report of Complaint/Grievance form. The Complaint/Grievance form is available on the KFHC's website at kernfamilyhealthcare.com. An Online Grievance Form is also available on the KFHC website. Member Services staff can assist with filling out the form. This form is also available in Spanish.

MEMBER REPORT OF COMPLAINT/GRIEVANCE

In order to file a complaint (also known as a grievance), you may call Kern Family Health Care or complete the following form and return it to the Kern Family Health Care Member Services Department. Following receipt of your complaint (also known as a grievance), Kern Family Health Care will send you additional information within (5) calendar days. **The Member Services Department can be reached at 661-632-1590 (Bakersfield) or al 1-800-391-2000 (outside of Bakersfield if you need assistance.**

Member's Name: ______________________ **Date:** __________

Member's I.D.#: ______________________ Effective Date of Coverage: _____

Address: ______________________
(Street)

______ ______ ______
(City) (State) (Zip)

Phone: ______ ______
(Home) (Work)

Name of Person Making/ Filing Complaint: ______________________
Relationship to Patient: ______________________
Phone Number (if different): ______________________
Complaint Summary: ______________________

SAMPLE

Desired Outcome/Resolution:

____

Please see the back of this form for additional important information.

Member's Signature: ______________________ **Date:** __________

Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros 1-800-391-2000.

Grievance Dispositions

KFHC will classify the Grievance using the following dispositions based on the information provided in the members compliant.

Continuity of Care	Grievance related to continuity of care review standard. Member's perception that their request for continuity of care is being rejected or not considered.
Geographic Access	Grievance related to geographic access to a state plan approved provider, or hospital within the geographic requirements based on type of appointment and condition of member's health.
Language Access	Grievance related to the inability to access or concerns with linguistic and interpreter services at the providers office.
Out-of-Network	Grievance related to inability to obtain services from a non-contracted provider.
Physical Access	Grievance related to the inability to physically access a provider or health plan due to office closure, not having wheelchair access, inadequate ramp, elevators, inadequate parking, or other requirements under the American with Disabilities Act.
Provider Availability	Grievance related to the inability to see providers during normal hours of operation or concerns with the providers' hours of operation.
Timely Access	Grievance related to timely access to a state plan approved provider within the timeframe requirements based on type of appointment and condition of member's health.
Driver Punctuality	Grievance related to driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Driver showed up either early, late, or not at all.
Vehicle	Grievance related to the transportation vehicle's cleanliness, not having wheelchair access or other requirements under the American with Disability Act, or issues related to the state of the vehicle that jeopardizes the member's safety.

Injury	Grievance related to a member incurring a physical injury.
Scheduling	Grievance related to member experiencing difficulties in arranging, scheduling, or accessing transportation services
Discrimination	Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, or sexual orientation. May also include complaints where the member is treated differently after filing a grievance.
Disability Discrimination	Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on disability. Include allegations of failure to provide auxiliary aids, or to make reasonable accommodations in policies and procedures, when necessary to ensure equal access for persons with disabilities.
Fraud / Waste / Abuse	Grievance related to intentional or unintentional misuse of resources, fraudulent, non-compliant, dishonest or unethical conduct committed by a health network, plan, provider, vendor, consultant, and current or potential member.
PHI / Confidentiality / HIPAA	Grievance related to the breach of Personal Health Information (PHI) or confidentiality. Privacy rules were not followed. For example, complaints regarding the provider inappropriately accessing, using or disclosing a member's PHI
Authorization	Grievance related to the timeliness of an authorization or communication regarding the result (approval, denial or modification) of the authorization
Eligibility	Grievance related to Medi-Cal plan member's eligibility or share of cost requirements.
Enrollment	Grievance related to Medi-Cal plan enrollment information received, enrollment process, Medi-Cal plan

	member being disenrolled from plan, providers, or any of its health network, etc.
Referral	Grievance related to the MCP's processing of referrals to covered services.
Assault / Harassment	Grievance related to the physical, emotional, or sexual misconduct by a medical professional.
Case Management / Care Coordination	Grievance related to case management or care coordination.
Inappropriate Care	Grievance related to the overuse, underuse, or misuse of health care services. Medi-Cal covered services.
Member Informing Materials	Grievance regarding written materials provided in alternative formats or translation in threshold languages.
Provider / Staff Attitude	Grievance related to interactions with the provider's staff/representatives (e.g., nonclinical staff such as provider offices or facilities), including but not limited to, inappropriate behavior, poor attitude, rudeness, mistreatment, or long wait times.
Technology / Telephone	Grievance related to on-line scheduling systems, health plan system's connectivity, user friendliness, excessive waits, accessibility, via plan's website; or a member's inability to reach a provider or health plan's staff via phone or waiting on the phone too long.
Quality of Care	Grievances related to complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.
Abuse / Neglect / Exploitation	Grievances related to cases involving potential or actual patient harm.
Timely Response to Auth / Appeal Request	Grievances related to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).
Expedited Appeal Request Denied	Grievances related to a plan denying a request for an expedited appeal.

Plan's Reduction / Suspension / Termination of Previously Authorized Service *Effective May 1, 2022	Grievances related to a plan reducing or suspending or termination a service that was previously authorized.
Plan's Failure to Meet Timeframes for Resolution *Effective May 1, 2022	Grievances related to a plan not meeting the timeframes for resolution of grievances and appeals provided at 42 CFR §438.408(b)(1) and (2)
Rural Member Denied Out of Network Request *Effective May 1, 2022	Grievances related to a plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO)
Barriers / Impeded Access to Prenatal Doula Services *Effective May 1, 2022	Grievances related to barriers and/or impeded access to prenatal doula service
Barriers / Impeded Access to Labor and Delivery Doula Services *Effective May 1, 2022	Grievances related to barriers and/or impeded access to labor and delivery doula services
Barriers / Impeded Access to Postpartum Doula Services *Effective May 1, 2022	Grievances related to barriers and/or impeded access to postpartum doula services
Plan Customer Service	Grievance related to interactions with the plan's staff/representatives (e.g., member services, plan marketing agents), including but not limited to, inappropriate behavior, poor attitude, rudeness, mistreatment, or long wait times.
Denial of Payment Request	Grievance related to the denial, in whole or in part, of a member's request of payment for a service.
Denial of Request to Dispute Financial Liability	Grievance related to the denial of a member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

SECTION 15: PROVIDER SERVICES

New Provider In-Service

Provider orientations (In-Service) will be conducted for all contracted providers and their staff within **ten days** of becoming active with KFHC's provider network. If an unexpected emergency occurs and the provider is unable to complete the training within the ten-day timeframe, the contract effective date will be postponed. Therefore, the contracted provider is made aware that they may not provide services to Plan members, until the provider completes training.

Provider Directory Updates

KFHC is required to provide accurate information regarding their Provider Network. Contracted providers are responsible to ensure KFHC has accurate directory information for their office. In addition, KFHC asks all contracted providers to attest to the accuracy of their reported provider directory information in accordance with the frequency and time frames defined in Health and Safety Code section 1367.27 (SB-137). Kern Health Systems utilizes Gaine, an outside vendor, to conduct outreach for directory accuracy.

To update your provider directory information, you may:

- Make updates via KFHC Provider Portal

  https://provider.kernfamilyhealthcare.com/v3app/publicservice/loginv1/login.aspx?bc=1215a844-d81f-4be0-ac1c-92dd137dd90c&serviceid=05411915-5bc6-4527-97a6-45b09eecbde3

- Contact your Provider Relations Representative
- Contact the KFHC Member Services Department, 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield)
- Email: ProviderDirectoryFeedback@khs-net.com

Providers can direct members or prospective members' questions or comments regarding directory inaccuracies to the Member Services Department at 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield).

In addition to contacting KFHC, Providers may also direct the member or a prospective member to the California Department of Managed Health Care at **1-888-466-2219** to report any inaccuracy with the KFHC Provider Directory.

Provider Bulletin

Provider Bulletins are valuable updates, information, and action requests. Bulletins are distributed on an as-needed basis primarily to provide timely notification of new plan information, including changes in regulations relating to Medi-Cal Managed Care. Bulletins are faxed and posted online at www.kernfamilyhealthcare.com

Provider Portal

The KFHC Provider Portal (Provider Connection) is one of the most beneficial resources to help with:

- **Verify member eligibility**: Providers can verify eligibility by KFHC ID number, CIN, member's name, and date of birth.
- **Check claim status**: Providers can review submitted claims and determine payment status.
- **Online Authorizations**: Providers can submit authorization requests electronically as well as check status of submitted referrals.
- **TAR:** Providers can submit electronic TAR's and check status of submitted requests.
- **Other resources available:** monthly membership lists, download various forms, P4P scoreboard, etc.
- **View and update** your Provider demographic information.

To obtain access to the KFHC Provider Portal, please contact your office designated admin user. If you are unsure who your admin user is, please contact your Provider Relations Representative or the Provider Network Management Department at (661) 632-1590.

Resources available on KFHC Website

The policies, procedures, forms, and documents referenced in this manual can also be found at **www.kernfamilyhealthcare.com** under the For Providers tab. The For Provider section is the hub of information for providers, including the latest bulletins, regulatory updates, and training opportunities.

For more information see KHS Policy and Procedure: 4.23

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 16: HEALTH EDUCATION

Members will receive health education services at no charge as part of preventive and primary health care visits. To facilitate this process, Providers are required to utilize the "Staying Healthy" assessment form, (see Section 3 in this manual and KFHC Policy and Procedure 3.05 Preventative Medical Care

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Health Education promotes healthy living, improving health outcomes, reducing risks of disease and empowering members to be active participants in their health care.

The goal is to help Members be engaged and informed so they can be active participants in their care and the care of their children. The services below are provided in English and Spanish.

- Weight Management
- Diabetes Prevention
- Smoking and Tobacco Cessation
- Nutrition Counseling
- Asthma Education and Management
- Prenatal Care and more

KFHC Health Education Classes

Health Education Classes are hosted by KFHC and are at no cost to anyone interested. Class dates and times are posted on the KFHC Calendar of Events

https://www.kernfamilyhealthcare.com/calendar/

or facebook.com/KernFamilyHealthCare

Classes include:

- Healthy Eating and Active Lifestyle Classes
  - Members can earn $20 gift card for attending all classes in a class series.
  - There is a limit of 1 gift card every 6 month.
- Asthma Classes
  - Members with asthma can receive a $15 gift card per class attended with a limit of 2 gift cards every 6 months.
- Fresh Start Tobacco and Smoking Cessation Program

    - Members can earn up to $100 in gift cards each month for attending Fresh Start Classes, up to $300 in a six-month period. Members can attend unlimited classes as long as the member is attempting to quit smoking.
- Diabetes Prevention Program
    - Members can receive gift cards based on attendance and weight management goals, more information is provided upon registration.

To learn more about class dates, times and locations or how to refer patients, call 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) and ask for our Health Education Department. Classes are now offered virtually through Zoom.

Health Education Referrals

Health education services are available by referral from KFHC staff, members (self-referral), providers, or community service providers. Members can request health education services by phone, the KFHC Member Portal, or the LINK App. Providers can send referrals via the KFHC Provider Portal. Upon receipt of a health education referral, health education staff will contact the member to assess their interest in participating in health education services. Transportation and interpreter services are provided accordingly. The best available health education service is then identified for the member.

Asthma Remediation and Education

KFHC offers in-home asthma remediation and education to members with high-risk or uncontrolled asthma. This service is covered under CalAIM Community Support Services. It includes an in-home asthma trigger assessment, minor and permanent home modifications (such as mold removal, ventilation improvements and pest control), and supplies (such as allergen impermeable mattress and pillow dust covers, HEPA filtered vacuums, de-humidifiers, air filters, and asthma-friendly cleaning products) that can control or remove asthma triggers in the home. A trained asthma educator works with members to develop and implement a plan to control triggers in the home and provides asthma education.

Member eligibility for asthma remediation requires signs of uncontrolled or poorly controlled asthma and a doctor’s referral or approval. To determine member eligibility or refer a member for asthma remediation, you can complete a referral in the KHHC Provider Portal. See asthma remediation in the Community Support Services section on pages 97-98 for more information.

KFHC Baby Step Program

The Baby Steps Program was developed to encourage KFHC members to get early and consistent pregnancy care. The program provides health and pregnancy education through various channels including the KFHC website and member portal, social media channels and via printed health guides. Members may also receive an outreach call to provide education and resources. Members are eligible to receive a Member Reward for completing specific pregnancy care visits. See Member Rewards below.

Health Education Materials

KFHC has developed health education brochures addressing important health issues facing our local community. These materials are provided at no cost to providers and members. Contact your Provider Relations Representative for more information on how you can receive health education brochures for your office. They are also available on the KFHC website. Click on the link below to view brochures on each of the topics:

Control Asthma	Control COPD	Control High Blood Pressure
Diabetes Control	Growing Up Healthy Series	Taking Care of Yourself & Your Baby
Eat Healthy	Urgent Care	Exercise

https://www.kernfamilyhealthcare.com/members/health-and-wellness-services/education-programs/

Brochures are also available in Spanish.

KFHC takes into account the specific needs of Seniors and Persons with Disabilities (SPD). Upon request by the SPD member, family caregiver or provider, KFHC provides educational materials in alternative formats such as Braille, large print, audio, or other appropriate methods. The Health Education Department will handle requests for health educational material in alternative formats.

Health Education Resources

Health Education services are also provided to Members through:

- KFHC 24-Hour Advice Nurse Line – In addition to Advice Nurse services, the Health Information Library has an audio library with hundreds of health topics recorded in English and Spanish. The Advice Nurse Line can be reached at (661) 632-1590 or (800) 391-2000.

- *Family Health, a* newsletter that is mailed twice a year to KFHC Members which includes health education and local resources. View current and past newsletters at www.kernfamilyhealthcare.com
- Community Events & Health Fairs – KFHC participates in health fairs and community events to promote personal health awareness and preventive health care to Members and the community. View a list of community events at www.kernfamilyhealthcare.com or facebook.com/KernFamilyHealthCare

For more information see KHS Policy and Procedure: 3.05

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Member Rewards

KFHC offers wellness-based rewards for members.

Blood Lead Screening – members who complete a blood lead test before 2 years of age are mailed a $25 gift card.

Breast Cancer Screening – Women 50-74 years of age who complete a mammogram are mailed a $25 gift card. Limit 1 reward per year.

Cervical Cancer Screening – Women 21-64 years of age who complete a Pap Smear test are mailed a $25 gift card. Limit 1 reward per year.

Chlamydia Screening – Women 18-24 years of age who complete a chlamydia test are mailed a $25 gift card. Limit 1 reward per year.

Initial Health Appointment (IHA) – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a $25 gift card.

Pregnancy – pregnant members who complete a prenatal care visit during the 1st trimester are mailed $50 gift card. They can also receive an additional $30 gift card for completing the postpartum care visit 1-12 weeks after delivery. Limit two gift cards per pregnancy.

Well Baby – members 0-15 months old are mailed a $10 gift card for the first four well baby visits they complete, and $25 for 2 more visits before they turn 15 months of age for up to 6 visits. Members 15-30 months are mailed a $25 gift card for each well baby visit they complete for up to 2 visits. Total rewards not to exceed $160 per member.

Well Care – members 3 -21 years old who complete an annual well child visit are eligible to receive a $25 gift card. Limit one gift card per year.

Smoking and Tobacco Cessation

KHS requires providers to provide tobacco cessation services to members, including:

- **Identify tobacco use**
- **Conduct initial and annual assessment of tobacco use**
- **Utilize FDA approved tobacco cessation medications**
- **Referral to a tobacco cessation program for individual, group, and telephone counseling for members of any age who use tobacco products, such as KHS' Fresh Start Tobacco and Smoking Cessation Program**
- **Prevention of tobacco use in children and adolescents**

Services for pregnant tobacco users

- **Ask all pregnant members if they use tobacco or are exposed to tobacco smoke**
- **Offer all pregnant members at least one face-to-face tobacco cessation counseling session per quit attempt.**
- **Referral to a tobacco cessation quit line, such Kick it California (previously the California Smokers Helpline) 1-800-300-8086**
- **Refer to tobacco cessation guidelines by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy**

One of the behavioral change models Kern Family Health Care recommends is the "**5 A's**"(**A**sk, **A**dvise, **A**ssess, **A**ssist, and **A**rrange)

- For more information regarding the 5 A's:
  https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.html

The Other validated behavior change model KFHC recommends is the "**5 R's**" (**R**elevance, **R**isks, **R**ewards, **R**oadblocks, **R**epetition)

- For more information regarding the 5 R's: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.html

KFHC encourages providers to implement the USPSTF comprehensive tobacco use treatment recommendations and the DHCS recommended education resources available in All-Plan Letter 16-014

SECTION 17: ALCOHOL AND DRUG: SCREENING, ASSESSMENT, BRIEF INTERVENTIONS AND REFERRAL TO TREATMENT (SABIRT)

PCP's must screen members 11 years and older, including pregnant members as recommended by the American Academy of Pediatrics Bright Futures Initiative and the United States Preventive Services Task Force (USPSTF) Grade A or B recommendations.

Screening

Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
  - The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

Assessment

When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

For KHS Members with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder

(SUD). Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a Member regarding additional treatment options, referrals, or services.

Brief interventions must include the following:

- Providing feedback to the patient regarding screening and assessment results.
- Discussing negative consequences that have occurred and the overall severity of the problem.
- Supporting the patient in making behavioral changes; and
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Documentation Requirements

KHS Member medical records must include the following:

- The service provided (e.g., screen and brief intervention);
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and
- If and where a referral to an AUD or SUD program was made.

KHS PCPs must maintain documentation of SABIRT services provided to KHS Members. When a KHS Member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services.

For criteria and additional resources please refer to: All Plan Letter 21-014

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf

For more information see KHS Policy and Procedure: 3.10-P

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 18: MEMBER RIGHTS & RESPONSIBILITIES

KFHC Members have specific rights and responsibilities outlined under Title 22, California Code of Regulations. KFHC provides this information to members in the Member Handbook (Evidence of Coverage, EOC), member newsletter, on KFHC's website, and upon request.

Members have the right to all of the following:

A. To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the member's medical information

B. To be provided with information about the organization and its services

C. To be able to choose a PCP within the KFHC provider network

D. To participate in decision making regarding their own health care, including the right to refuse treatment

E. To voice grievances, either verbally or in writing, about the organization or the care received

F. To receive oral interpretation services for their language

G. To formulate advance directives

H. To have access to Family Planning Services, Federally Qualified Health Centers (FQHCs), American Indian Health Programs, Sexually Transmitted Disease (STD) services, and Emergency Services outside the KFHC network pursuant to the federal law

I. To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible

J. To have access to, and where legally appropriate, receive copies of, amend or correct their medical record

K. To change Medi-Cal Managed Care Health Plans upon request, if applicable

L. To access minor consent services

M. To receive written member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with W & I Code Section 14182 (b)(12)

N. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

O. To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

P. To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526

Q. Freedom to exercise these rights without adversely affecting how they are treated by KFHC, Providers, or the State.

R. To file a request for an Appeal of an action within 60 days of the date on a NOA

S. To receive upon request a statement describing KFHC policies and procedures for preserving the confidentiality of medical information.

Members also have the following responsibilities:

A. To cooperate with their health care practitioners/providers.

B. To provide, to the extent possible, accurate information needed by professional staff who are caring for them.

C. To follow instructions and guidelines given by those providing health care services.

D. To keep appointments which they or their practitioner have made.

Member Handbook / Evidence of Coverage (EOC)

A Member Handbook also known as EOC, is sent to members upon enrollment and annually thereafter. The EOC provides members with a description of the scope of covered services and information about how to access such services under KFHC's Medi-Cal plan. The EOC is available electronically online at www.kernfamilyhealthcare.com under the "For Members" tab or in hard-copy by calling our Provider Services Department at 661-632-1590 (Bakersfield) or toll free 1-800-391-2000.

Our Member Services and Providers Relations Departments are also available to help with questions regarding KFHC's members' rights and responsibilities, Monday through Friday, from 8 a.m. to 5:00 p.m.

For more information see KHS Policy and Procedure: 5.05

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 19: FRAUD, WASTE, AND ABUSE

At KFHC we are deeply committed to acting ethically and responsibly in a culture of compliance, ethics, and integrity. KFHC cooperates with the California Department of Health Care Services (DHCS) in working to identify Medi-Cal fraud, waste, and abuse (FWA).

Abuse: Activity that is inconsistent with sound fiscal, business, or medical practice standards and results in unnecessary cost or reimbursement. It also includes any act that constitutes abuse under applicable federal law (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Waste: The consumption of resources (products or services) due to mismanagement, inappropriate actions or inadequate oversight. Waste is not typically the result of criminal actions.

Laws and Regulations

False Claims Act (Federal – 31 U.S.C. § 3729-3733; California – C.G.C. § 12650-12656): The California and Federal False Claim Acts (FCAs) make it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim. Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines.

Fraud, Waste, and Abuse Investigations

The KFHC Compliance Department is an internal independent review and investigation department, which is responsible for implementing the Anti-Fraud Plan. The Compliance Department conducts, coordinates, and reports audit and investigation activities for the purpose of preventing and detecting fraud, waste, or abuse in the delivery of health care services to KFHC Member. The Compliance Department also provides analysis and recommendations regarding the activities reviewed or investigated. Additionally, the

Compliance Department initiates investigations and develops preliminary investigation reports for cases of alleged fraud, waste, or abuse. Preliminary investigation findings are forwarded to the appropriate federal or state investigating agency per contract, statute or law.

KFHC will report to the DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. KFHC will conduct, complete, and report to the DHCS, the results of a preliminary investigation of suspected fraud and/or abuse within ten (10) working days from the date that KFHC first became aware of or noticed such activity.

Member FWA Examples

- A person using someone else's KFHC Member ID Card
- Deliberately providing misinformation to retrieve services
- Selling and/or forging prescriptions

Provider FWA Examples

- Provider submitting claims for services not rendered
- Sending member a bill after the plan had made payment
- Soliciting or receiving kickbacks

Reporting Suspected FWA

Suspicious activities may be reported by phone, in writing, or in person to the KFHC Compliance Department. It is recommended, but not required, that written reports be submitted on a FWA Referral Form

www.kernfamilyhealthcare.com/members/report-fraud/

Kern Family Health Care
Director of Compliance & Regulatory Affairs
2900 Buck Owens Blvd
Bakersfield, CA 93308
1-800-391-2000

If you have questions about Compliance efforts, please contact your Provider Relations Representative.

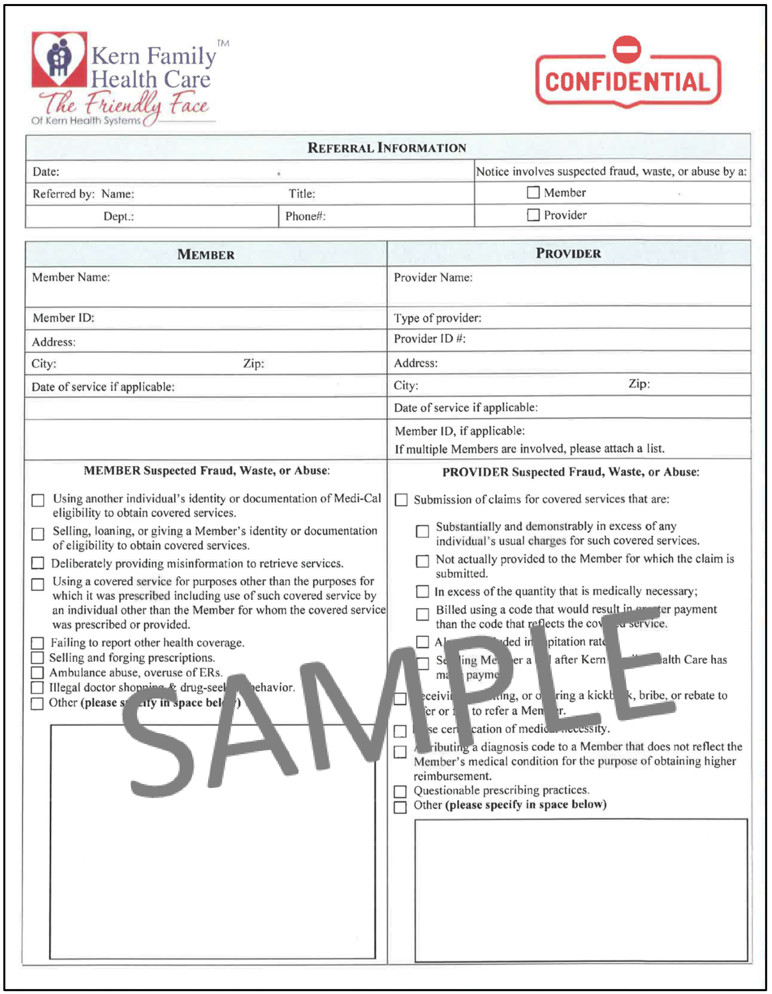
For more information see KHS Policy and Procedure: 14.04

www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Sample FWA Referral Form

The FWA Referral form is located on the kernfamilyhealthcare.com website under the For Providers tab:

www.kernfamilyhealthcare.com/members/report-fraud/



Kern Family Health Care™
The Friendly Face
Of Kern Health Systems

CONFIDENTIAL

SAMPLE

REFERRAL INFORMATION		
Date:		Notice involves suspected fraud, waste, or abuse by a:
Referred by: Name:	Title:	☐ Member
Dept.:	Phone#:	☐ Provider

MEMBER	PROVIDER
Member Name:	Provider Name:
Member ID:	Type of provider:
Address:	Provider ID #:
City: Zip:	Address:
Date of service if applicable:	City: Zip:
	Date of service if applicable:
	Member ID, if applicable: If multiple Members are involved, please attach a list.

MEMBER Suspected Fraud, Waste, or Abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.
- ☐ Selling, loaning, or giving a Member's identity or documentation of eligibility to obtain covered services.
- ☐ Deliberately providing misinformation to retrieve services.
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the Member for whom the covered service was prescribed or provided.
- ☐ Failing to report other health coverage.
- ☐ Selling and forging prescriptions.
- ☐ Ambulance abuse, overuse of ERs.
- ☐ Illegal doctor shop[illegible] & drug-seek[illegible] behavior.
- ☐ Other **(please s[illegible] in space bel[illegible])**

PROVIDER Suspected Fraud, Waste, or Abuse:

- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services.
  - ☐ Not actually provided to the Member for which the claim is submitted.
  - ☐ In excess of the quantity that is medically necessary;
  - ☐ Billed using a code that would result in [illegible]er payment than the code that reflects the co[illegible] service.
  - ☐ A[illegible] [illegible]ded in [illegible]pitation rat[illegible]
  - ☐ Se[illegible]ing Me[illegible]er a [illegible] after Kern [illegible]alth Care has ma[illegible] payme[illegible]
- ☐ [illegible]ceivi[illegible] [illegible]ing, or o[illegible]ring a kickb[illegible]k, bribe, or rebate to [illegible]er or [illegible] to refer a Mem[illegible]r.
- ☐ [illegible]se cer[illegible]cation of medi[illegible] necessity.
- ☐ [illegible]ributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement.
- ☐ Questionable prescribing practices.
- ☐ Other **(please specify in space below)**

SECTION 20: MARKETING

Compliance with Laws and Regulations

The Department of Health Care Services (DHCS) has established guidelines for appropriate marketing activities for the Medi-Cal Managed Care Program. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

KFHC Marketing Materials

If you are interested in receiving marketing material including the KFHC Member Newsletter, Member Handbook, Provider Directory or brochures, please contact the Kern Family Health Care Provider Network Management Department at (800) 391-2000.

Acceptable Marketing Methods

As a Medi-Cal health care provider, you may:

- Tell your patients the name of the health plan or plans with which you are affiliated.
- Actively encourage your patients to seek out and receive information and enrollment material that will help them select a Medi-Cal health care plan for themselves and their family.
- Provide patients with the phone number of the outreach and enrollment or member services departments of the plan(s) with which you are affiliated.
- Provide patients with the toll-free phone number of Health Care Options (HCO), the DHCS enrollment contractor (1-800-430-4263) and inform patients of locations and times when they may receive information from HCO about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information and activities, presentations, and problem resolution functions.

Prohibited Marketing Methods

As a Medi-Cal health care provider, you may NOT:

- Tell patients they could lose their Medi-Cal health benefits if they do not choose a particular health plan.

- Make any reference to competing plans, e.g., comparing plans in a positive or negative manner.
- Engage in marketing practices which discriminate against prospective members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Sign an enrollment application for the member.

Use of Name and Logo

The Kern Health Systems (KHS) and Kern Family Health Care (KFHC) names carry considerable value, particularly for external entities seeking to associate themselves with our organization. Moreover, the role of KHS as a public agency requires that our names and reputation be preserved and protected, and that activities and organizations associated with the KHS name(s) must be consistent with our mission and purpose. Thus, requests for an Endorsement, including Letter of Support (LOS) and use of a KHS name or logo, shall be approved by KHS.

An external entity may submit a request for an Endorsement if the entity is a community-based, non-profit organization, or health care partner. Such requests shall require the written approval of the KHS Chief Executive Officer (CEO) or designee. Written requests from external entities shall include the following information, as appropriate:

1. The name, background, description of the organization seeking a LOS or use of a KHS name or logo and the organization's contact information. Also include any other entity whose name will appear on the document, project, or event;
2. Name of the program or project, and name of the program or project director, or primary contact;
3. Description of the project, event, publication, or other purpose for which a KHS name or logo will be used and why;
4. Intended audience for the project, event, or publication for which a name or logo will be used;
5. Time frame during which a name or logo is requested to be used; and
6. A proof of the name/logo as it will appear.

All requests shall be submitted at least thirty (30) days in advance of the date for which the LOS or use of a name or logo is requested, or if in a shorter amount of time, at the discretion of the KHS CEO or designee, so long as such request is submitted to the CEO or designee in a reasonable and sufficient amount of time so that KHS can complete a meaningful review and evaluation of the request.

The KHS Marketing Department will notify the organization that requests a LOS or use of a name or logo in writing after the determination is made. Organizations shall enter into a written agreement with KHS restricting the use of a KHS name or logo before being permitted to use the name or logo. Use or reproduction of the KHS name or logo by external entities shall be restricted by KHS, in accordance with federal and state trademark rules and regulations. Any external entity that is no longer in good standing with KHS shall update its marketing materials and cease the use of a KHS name or logo.

Definitions:

Endorsement means either (1) a Letter of Support or (2) KHS's approval for another entity to use a KHS name or logo in connection with that entity's project, event, document, program, or initiative. Endorsement does not include any sponsorship, educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.

Letter of Support (LOS) is a letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between KHS and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.

Marketing Activity is any activity conducted by or on behalf of KHS where information regarding the services offered by KHS is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of KHS.

The Kern Health Systems Name and Logo Use Protocol follows guidelines outlined in Kern Health Systems Policy & Procedure # 9.05-I.

SECTION 21: QUALITY IMPROVEMENT

Overview

In a commitment to the community of Kern County and the members of Kern Health Systems (KHS), the Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of our members served. KHS' Quality Improvement Department manages the Program and oversees activities undertaken by KHS to achieve improved health of the covered population. All contracting providers of KHS are required to participate in the Quality Improvement (QI) program.

To review KHS' complete QI Program Description and workplan, please visit Kern Family Health Care's website at www.kernfamilyhealthcare.com. Click the Providers tab and then Quality Improvement.

Facility Site Reviews

KHS conducts a full scope facility site review for all PCPs as well as providers as part of the Provider credentialing process. Facility site reviews are conducted at the time of the initial Provider credentialing process, and every three years thereafter. An interim review is completed midway between the three-year period. A Certified Site Review nurse uses the California Department of Health Care Services (DHCS) approved review tools to conduct the review. To view the DHCS mandated tools, visit Kern Family Health Care's website at www.kernfamilyhealthcare.com. Click the Providers tab and then Quality Improvement.

Facility and medical record reviews are intended to ensure that all KHS network providers meet the quality and safety requirements established by the State for treating Medi-Cal members. All KHS network providers are advised that the CA Department of Health Care Services may audit Medi-Cal providers at any time with or without advance notice.

There are three components to the Site Review process:

1. The Facility Site Review (FSR)- The site review is part of the credentialing and re-credentialing process and evaluates the physical aspects of the site for basic requirements in areas such as safety, regulatory compliance, and infection control as well as interviews with office personnel.

2. The Medical Record Review (MRR)- The medical record review survey is conducted three to six months after initial member linkage. It is conducted every three years thereafter and may include an interim review at eighteen-month intervals. It is part of the credentialing and re-credentialing process and focuses on required elements of the medical record.

3. The Physical Accessibility Review (PAR)- The physical accessibility review survey is not a scored review and focuses entirely on physical accessibility of the healthcare site for seniors and persons with disabilities (SPDs).

Site Review Preparation

As part of the of the facility review, KHS QI Nurses review the following potential safety issues that are considered critical elements:

1. Exit doors and aisles are unobstructed and egress (escape) accessible
2. Airway management supplies in place
3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia
4. Qualified/trained personnel retrieve, prepare, or administer medications
5. Physician review and follow-up of referral/consultation reports and diagnostic test results
6. Lawfully authorized persons dispense drugs to patients
7. Drugs and vaccines are prepared and drawn only prior to administration.
8. Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use
9. Blood, other potentially infectious materials, and Regulated Wastes are appropriately disposed
10. Needlestick safety precautions are practiced on site
11. Proper cold chemical sterilization/high level disinfection process
12. Appropriate PPE is available for Cold chemical sterilization/high level
13. Monthly spore testing of autoclave/steam sterilizer with documented results
14. Autoclave/steam sterilization management of positive mechanical, chemical, and biological indicators of the sterilization process.

Corrective Action Plan (CAP)

If deficiencies are identified during the Facility Site and Medical Record Reviews, a Corrective Action Plan will be issued to the Provider which will include specific corrective actions along with time frames for addressing deficiencies. Providers who do not correct deficiencies will not be assigned new members until corrections are completed and verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and plan members will be reassigned to other network providers.

For more information see KHS Policy and Procedure: 2.22

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Medi-Cal Managed Care Accountability Set (MCAS)

The Managed Care Accountability Set (MCAS) is a set of performances measures that the CA Department of Health Care Services (DHCS) selects for annual reporting by Medi-Cal managed care health plans (MCPs). Results of compliance with the measures are used by DHCS to evaluate a MCP's performance. Many are HEDIS measures from the National Committee for Quality Assurance (NCQA). Some are from other sources such as the Centers for Medicare & Medicaid (CMS). All of them center around preventive health and chronic condition management.

The measures are listed by Measurement Year (MY) and Report Year (RY). The report year are the compliance rates for the measures in the previous year. An example would be MCAS measures for MY 2023 are reported to DHCS in RY 2024. DHCS posts the most current list of measures on their website at:

https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx

Note that the Reporting Year (RY) reflects the measures for the previous measurement year.

Data Collection

KHS collects and reports MCAS data through a series of coordinated activities, including encounter and claims analysis, and medical records data. Some examples of information needed from medical records include specific lab results, diabetes care, immunization status, prenatal and postpartum care, and progress notes. Providers are contractually obligated to provide KHS access to member's medical records for evaluation of compliance with these measures.

Why is it Important?

Data obtained from MCAS helps KHS focus quality improvement activities, evaluate performance, and identify further opportunities for improvement based on these compliance results. The benchmarks for these measures help providers and KHS identify gaps in care and implement actions to improve care for members.

Tips for Providers

KHS may contact selected medical offices to obtain or access patient medical records as part of the MCAS medical records review process. Allowing KHS' QI Department access to the

provider EMR is the most efficient way to accomplish retrieval of the needed medical record information. Here are helpful tips to prepare:

- Keep complete and accurate medical records for patients. Each document in the medical record must contain the member's name and date of birth to be acceptable for MCAS compliance measurements.
- Identify gaps in care at every visit and address them during the visit. If a service cannot be addressed during a visit, schedule a follow up appointment to address the gaps in care.
- To view your group's compliance level with MCAS measures, please login to the KHS Provider Portal.
- Information about members with gaps in care is available for your practice on the KHS Provider Portal. Outreach to patients in need of preventative health or chronic condition management services to ensure their health and well-being.
- MCAS reporting is required by the DHCS, the Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA). Providers and their staff should become familiar with MCAS measures to understand what KFHC and other health plans are required to report.
- Allowing KHS' access to the EMR or establishing a data exchange for KHS members is the most efficient way to accomplish retrieval of the needed medical record information versus copying or faxing records. Contact your KHS provider representative to initiate providing either or both of these options.
- MCAS Provider Resources Guide and Common Codes for MCAS Measures documents are available on Kern Family Health Care's website at www.kernfamilyhealthcare.com. Click the Providers tab and then Quality Improvement.

Performance Improvement Projects (PIP)

KHS is required by DHCS to participate in two (2) Performance Improvement Projects (PIP). PIPs span over an approximate eighteen-month time frame and are broken into four (4) modules using the Plan, Do, Study, Act (PDSA) model. The PDSA method is a way to test a change that is implemented. Going through the prescribed four steps guides the thinking process into breaking down the task into segments and then evaluating the outcome, improving on it, and testing again. Most of us go through some or all of these steps when we implement change in our lives, and we don't even think about it. Having them written down often helps people focus and learn more. Each module for the PIPs are submitted to DHCS for review, input, and approval incrementally throughout the project. As a requirement for participation in and support of KHS' Quality Improvement Program, select providers may be asked to participate in a particular PIP.

Potential Quality of Care Issues (PQI)

Potential Quality of Care Issues (PQI) are possible adverse deviations from expected clinician performance, clinical care, or outcome of care. PQIs are investigated to determine if an actual quality issue or opportunity for improvement exists. Providers are required to cooperate with investigations KHS' Quality Improvement Department conducts for identified PQIs. If a Quality of Care (QOC) issue is validated after investigation, a corrective action plan or other remediation may be required. All QOC determinations are made by a KHS Medical Director.

SECTION 22: CREDENTIALING & RE-CREDENTIALING

Credentialing

All healthcare providers are required to be contracted and credentialed in accordance with KFHC credentialing criteria and standards of the Department of Health Care Services (DHCS), National Committee on Quality Assurance (NCQA), and Centers for Medicare & Medicaid Services (CMS) in order to treat KFHC Members and to be reimbursed for non-emergent services. To maintain health care quality standards, Members will not be assigned or referred to providers who have not completed the credentialing process. Thereafter, providers are required to be recredentialed within 36 months of initial credentialing or last recredentialing approval date in order to continue with network participation.

DHCS Medi-Cal Enrollment

All healthcare providers, where there is a state pathway for enrollment, must be actively enrolled and approved to participate in the State DHCS Medi-Cal FFS Program and CMS Program in order to participate in all KFHC lines of business. Failure to meet DHCS Medi-Cal FFS requirements, NCQA and CMS requirements may be cause for denial or removal from KFHC's network.

As of January 1, 2018, Managed Care Plans (MCPs) are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. Title 42 CFR, Part 438 and Part 455 (Subparts B and E), including Section 438.214 now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans. These requirements apply to both existing contracting network providers as well as prospective network providers that have a state-level state pathway must enroll in the Medi-Cal FFS Program. This includes, but not limited to, current and prospective NMT/NEMT providers who must also be screened, enrolled and approved through DHCS Medical Fee-for-Service in accordance with APL 22-013 Screen and Enrollment and KHS policies and procedures, 4.43-P Medical Enrollment and Policy and 5.15-P Member Transportation Assistance to be considered for KHS network.

MCP providers may apply for enrollment through the electronic Provider Application for Validation and Enrollment (PAVE) portal. For instructions and training on how to apply using the PAVE Portal go to http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx . Provider Enrollment instructions and requirements are available on the Medi-Cal website at https://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. If you are not enrolled and have questions, please contact your Provider Relations Representative who will be able to assist and guide you to the DHCS PAVE Portal.

Initial Credential Application Process

Applicants must submit a signed application and supporting documentation to the KFHC Provider Network Management Department. Applications are available on the KFHC website, www.kernfamilyhealthcare.com, under the *For Providers* tab, or through the Provider Network Management Department. Applications will be reviewed by the Provider Network Management Department for accuracy and completeness, verification of enrollment with the State Department of Health Care Services Medi-Cal FFS Program (if applicable), and have a signed provider agreement. KFHC will render a decision within 180 days from the signature date, and if approved, the provider will receive an official letter of credentialing approval with an effective date.

Confidentiality

The information obtained during the credentialing process, whether directly from the provider, or from another source, will be treated as confidential information.

Application Review and Verification

The Physician Advisory Committee (PAC) shall serve as the Credentials Committee. The PAC is responsible for peer review and credentialing/re-credentialing decisions.

KFHC monitors the initial credentialing process and will ensure that providers considered for network participation and continued participation are in good standing and meet the required criteria identified in Policy and Procedure 4.01-P Credentialing before being accepted in the network. The criteria includes but is not limited to:

- Application is signed and dated with attestation by the applicant of the correctness and completeness of the application including statements by the applicant:
  - Reasons for any inabilities to perform the essential functions of the position with or without accommodations;
  - History of loss of license and/or felony conviction(s); including but not limited to plea of nolo contendere to felony, misdemeanor to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to practice medicine or deliver health care services or involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services.
  - History of loss or limitation of privileges including any disciplinary activity;
  - Lack of present illegal drug and alcohol use.

- Valid, unrestricted, and current State license to practice in California
- Current and valid federal Drug Enforcement Agency (DEA) registration for the State
- Current NPI number
- Graduation from an approved medical/professional school and completion of an accredited residency or specialty program
- Board Certification, if applicable
- Clinical privileges in good standing at a KFHC contracted hospital (if applicable)
- Work history
- Claims history and/or disciplinary actions from National Practitioner Data Bank (NPDB)
- History of any sanctions, exclusions or debarments imposed by Medi-Cal, Medicaid, Medicare and System for Award Management
- Current adequate professional and general liability insurance
- Sanctions or limitations on licensure from State agencies or licensing boards
- Validation of approved Medi-Cal enrollment status with the Department of Health Care Services.
- For certain provider types, a facility site review is required to be completed by the Quality Improvement Department.

Recredentialing

KFHC also requires its Providers to be recredentialed every 36 months. The only exceptions include active military assignments, maternity/medical leave of absence or sabbatical. The recredentialing criteria includes but is not limited to:

- Attestation by the applicant of the correctness and completeness of the application including statements by the applicant:
    - Reasons for any inabilities to perform the essential functions of the position with or without accommodations;
    - History of loss of license and/or felony conviction(s); including but not limited to plea of nolo contendere to felony, misdemeanor, to any crime involving moral turpitude or otherwise relating to the provider’s fitness or ability to practice medicine or deliver health care services or involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties or the provider of services:
    - History of loss or limitation of privileges including any disciplinary activity;
- Lack of present illegal drug and alcohol use
- Valid, unrestricted, and current State license to practice in California
- Professional liability claims history since initial credentialing or last recredentialing cycle
- National Practitioner Data Bank (NPDB)

- Current and valid Drug Enforcement Agency (DEA) registration
- Current NPI number
- Recent sanctions, exclusions or debarments imposed by Medi-Cal, Medicaid, Medicare, and System for Award Management
- Current adequate professional and general liability insurance
- Sanctions or limitations on licensure from State agencies or licensing boards
- Revalidation of Medi-Cal enrollment status
- Performance reviews which includes Quality Improvement, Utilization Management, Member Services, and Compliance;
- Facility site review results, if applicable

Recommendations

The PAC recommends acceptance or denial of an applicant to the Board of Directors as follows:

If the recommendation is for **DENIAL**, the applicant receives written notification of the decision and supporting reasons. If the denial is due to medical quality of care, the appeal process is included. If the recommendation is for **APPROVAL**, the supporting information is transmitted to the Board of Directors. The applicant receives written notification of the decision.

Practitioner Rights

In the event there is information obtained by the credentialing staff that substantially differs from that supplied by the applicants, the credentialing staff will contact the applicant to have them either correct or provide an explanation of the differences. Practitioners have the right to correct erroneous information submitted during the application process; corrections must be submitted in writing (or email) to the PNM Department Attention: Credentialing within 10-calendar days of the notification.

Practitioners have the right, upon request, to review the information submitted in support of their credentialing application; additionally, practitioners have the right to:

- Review information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. This includes information obtained from outside sources such as malpractice carriers or state licensing boards but does not extend to review of information from references, or recommendations protected by law from disclosure. Practitioners may submit their request for review to their Provider Relations Representative via email, letter or fax.
- Correct erroneous information;
- Be informed of the status of his/her application during the credentialing process, upon request.

- To be notified, in writing, the initial credentialing decisions within 60-days from the date the decision was made.

Provider Directory, Attestation of Practice Information, Changes or Terminations

In December 2016, The Department of Managed Health Care (DMHC) released Senate Bill (SB) 137 indicating uniform standards and timely updates for all Managed Care Plan Provider Directories. Provider Directory Standards allow members to receive and search accurate , up-to-date information regarding physicians, hospitals, clinics and other contracted providers with the KFHC network.

In an effort to provide Member and Providers with the most current information, KFHC's Provider Director is updated on a routine basis. In addition, KFHC has an agreement with Symphony IHA, powered by Availity, allowing providers to verify and attest to the accuracy of their information. Provider can submit their updates via Availity Attesation or submit changes, additions and deletions to their KFHC Provider Relations Representative.

By notifying KFHC with any practice changes, you are not only complying with your Provider Agreement, you are also ensuring KFHC is in compliance with the DHCS and DMHC provider data regulations. The following are changes that require immediate notification:

- Change to Mailing and/or Pay to addresses
- Adding additional rendering physician or other provider types
- Adding or changing business owners, officers, and managers
- Changes in member age limitations and new member acceptance
- Changes in office hours
- Changes in language capabilities provided at your office

Moving, Retiring or Terminating Network Participation
If you have decided to leave KFHC, please submit a notification in writing via email to KFHC Provider Contracting Department at prcontracting@khs-net.com, 60-days in advance for notification of business closure, retirement or resignation from KFHC.

Changes to your Tax ID Number, DBA or legal business name, including purchases by another owner may require a new Provider Agreement requiring 60-days notification to process these types of changes.

Exclusion, Debarment, Sanction, Suspension, or Ineligibility

On an ongoing basis, KFHC monitors its contracted providers for any potential sanctions, exclusions or debarments from federal and state programs. On a monthly basis, the Credentialing Department reviews the required federal and state databases. In the event a contracted facility, ancillary organization or licensed/certified practitioner is found to be listed on the federal or state database as excluded, sanctioned or debarred, immediate action, up to and including termination from the provider network, will be taken in accordance with 45 CFR (Code of Federal Regulations) Part 76, KHS Policy and Procedure and contractual agreement. Should you or any provider affiliated under your provider service agreement become excluded, debarred, or suspended or ineligible to receive state or federal funds, you are required to notify KHS immediately.

A provider may be reviewed any time at the request of the QI/UM Committee, the PAC, the Chief Executive Officer, the Chief Medical Officer, or the Board of Directors. For questions regarding the credentialing or recredentialing process, contact Provider Network Management Department at 800-391-2000, dial 5 to bypass other queues.

For more information see KHS Policy and Procedure:

2.22 Facility Site Review
4.01 Credentialing
4.43 Medi-Cal Enrollment Policy

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 23: COMMUNITY SUPPORTS SERVICES (CSS)

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations, and Kern Family Health Care has elected to offer some Community Support services.

Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members. Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers if they have appropriate experience.

Community Supports are an optional service for Kern Family Health Care to offer and are optional for members to receive. As of July 1, 2022, Kern Family Health Care offers the following Community Supports:

Housing Transition Navigation Services	The program assists members in their search for available housing options. Options including assisting with completing housing applications, securing required documentation, and providing rental payment assistance.	The service is provided by Kern County Housing Authority This service is also provided by the Central California Asthma Collaborative for opened clients in their program
Housing Deposits	The program coordinates and secures one time housing funds to support independent living. Funds may be utilized to pay security deposits, initial utility fees, medical equipment, and basic household expenses.	The service is provided by Kern County Housing Authority
Housing Tenancy and Sustaining Services	The program provides support and resources to prevent the loss of housing. Support and resources include the education of tenant and landlord rights and responsibilities as well as	The service is provided by Kern County Housing Authority

	identifying lease violations such as hoarding.	
Recuperative Care (Medical Respite)	This short-term residential care program helps members continue their recovery following hospitalization and receive post discharge treatment. Other services include transporting members to appointments, as well as providing food and housing assistance.	The service is provided by Good Samaritan Healing Center
Asthma Remediation	The program helps members make necessary modifications to their home or living environment, to ensure they can maintain a healthy and supportive lifestyle while living with asthma. This may include the purchasing of air purifiers and other medical supplies.	The service is provided by Central California Asthma Collaborative
Short Term Post Hospitalization	The program assists members with temporary shelter while recovering from a procedure. During the aftercare, members obtain assistance in gaining housing, which allows them to have a higher level of independency.	The service is provided by Papo Hernandez, Respite, Rest and Recovery Home

Starting January 1, 2023, the following services will be offered

- Medically Tailored Meals
- Sobering Centers
- Respite for Caregivers

Members Eligible to Receive Community Supports

Kern Family Health Care must determine eligibility for all pre-approved Community Supports using the DHCS Community Supports policy guide, which contain specific eligibility criteria for each Community Supports. Kern Family Health Care is also expected to determine that a

Community Supports is a medically appropriate and cost-effective alternative to a Medi-Cal Covered Service. When making such determinations, Kern Family Health Care must apply a consistent methodology to all members within a particular county and cannot limit the Community Supports only to individuals who previously were enrolled in the WPC Pilot.

Making a Referral for Community Supports

Referrals for Community Supports may be made by a physician, internal staff, members or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Supports providers. Referrals are accepted through the provider portal, internal nurses portal or by calling Kern Family Health Care 1-800-391-2000 and choosing option #6.

Community Supports Authorizations

An authorization through Kern Family Health Care is required for members to obtain Community Supports. Kern Family Health Care staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, and decision-making by Kern Family Health Care staff. If approved after the Kern Family Health Care screening/assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime and asthma remediation has a rate limitation associated with the services.

Utilization management will monitor and approve the services after a detailed review. Kern Family Health Care will not categorically deny or discontinue a Community Supports irrespective of member outcomes or circumstance. Some Community Supports will require periodic reauthorization by submitting an Authorization Request to the Utilization Management Department, along with any necessary documentation for review.

You can reach the CSS Department by calling Kern Health Systems at 661-632-1590 option 6

Or 1-800-391-2000 option 6

SECTION 24: PROVIDER DISPUTES ON ISSUES OTHER THAN AUTHORIZATION AND CLAIMS PAYMENT

A contracted or non-contracted provider can express dissatisfaction by completing a Provider Dispute Resolution Request Form:

The Provider Dispute Resolution Request Form must contain the following information:

A. Provider Name
B. Provider tax identification number
C. Provider contact information
D. Clear explanation of the issue and provider's position thereon
E. Any applicable supporting documentation

A dispute that does not contain all necessary information will be returned to the provider.

The dispute must be mailed to the following address:

Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, Ca 93308

The Provider Dispute Resolution Request Form can be located on the KHS website:

https://res.cloudinary.com/dpmykpsih/image/upload/kern-site-353/media/38879d95e1c54e7595cfaea1aa2c3f38/provider-authorization-appeal-resolution-request-form.pdf

For additional information, please refer to KHS policy: 4.03

https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

SECTION 25: PROPOSITION 56 Directed Payments

California voters approved Proposition 56 on November 8, 2016, which increased the excise tax rate on cigarettes and tobacco products. A portion of the tobacco tax revenue goes to the Department of Health Care Services (DHCS) to help fund specific DHCS health care programs including but not limited to:

Proposition 56 Directed Payments for Physician Services:

APL19-015 – Eligible network providers who render qualified services will receive directed payments as outlined in APL 19-015 Services include but are not limited to:

- New Outpatient Visits
- Established Outpatient Visits
- Psychiatric Diagnostic Evaluation

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-015.pdf

Proposition 56 Directed Payments for Family Planning Services:

APL20-013 – Intended to enhance the quality of patient care by offering an enhanced payment to eligible providers in California who offer family planning services as outlined in APL20-013.

Services include but are not limited to:

- Long-acting contraceptives
- Contraceptives (other than oral) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-013.pdf

Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services:

APL19-018 – Eligible providers who evaluate children and adults for trauma that occurred within the first 18 years of life receive a minimum reimbursement for conducting a qualified ACEs screening. Eligible providers must complete a one-time state-sponsored trauma-informed care training and self-attest to the completion of the training program.

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-018.pdf

Proposition 56 Directed Payments for Developmental Screening Services:

APL19-016 – Eligible providers will receive directed payments for qualified developmental screening service performed in accordance with the AAP/Bright Futures periodicity schedule and guidelines.

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-016.pdf

Proposition 56 HYDE Reimbursement Requirements for Specified Services:

APL19-013 – Qualified providers who provide and bill for medical pregnancy termination services.

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-013.pdf

SECTION 26: POLICIES AND PROCEDURES

KHS policies and procedures are updated and reviewed as needed. All current versions of Kern Health Systems' Policies and Procedures can be accessed on the KFHC website at www.kernfamilyhealthcare.com

Contents of this manual are subject to change at any time. To ensure you are reviewing the most recent version, accessed on the KFHC website at www.kernfamilyhealthcare.com

GLOSSARY OF TERMS

TERM	DEFINITION
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Accrual	The amount of money that is set aside to cover expenses. The accrual is the plan's best estimate of what those expenses are and (for medical expenses) is based on a combination of data from the authorization system, the claims system and the lag studies, and the plan's prior history.
Actuarial Assumptions	The assumptions that an actuary uses in calculating the expected costs and revenues of the plan. Examples include utilization rates, age and sex mix of enrollees, and cost for medical services.
ADA	Americans with Disabilities Act.
Administrative Costs	Means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.
Advance Directive	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.
AIDS Beneficiary	Means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.
Ambulatory Care	A type of health services that are provided on an outpatient basis.
Allied Health Personnel	Means specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.
Appropriately Qualified Healthcare Professional	A PCP, specialist, or other licensed health care provider, who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular

	illness, disease, or condition associated with the request for a Second Opinion.
ASC	Ambulatory Surgical Center - A facility other than a hospital that provides outpatient surgery.
Authorized Representative	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process.
Balance Billing	The practice of a provider billing a patient for all charges not paid by the insurance plan. KHS prohibits providers from balance billing members in most cases.
Basic Case Management	Means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.
Beneficiary Assignment	means the act of the California Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, Provision 2 of KHS' contract with DHCS.
BIC	Beneficiary Identification Card - a permanent plastic card issued by the State to Medi-Cal recipients that is used by facilities and providers to verify Medi-Cal eligibility and health plan enrollment.
Business Associate	A person or organization that performs a function or activity on behalf of KHS, but is not a KHS employee. A Business Associate can also be a Covered Entity in its own right.
CalAIM	California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.
CAP	Corrective Action Plan - A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by KHS, the State or Federal oversight agency, or designated representatives. Delegates may be required to complete CAPs to ensure

	they are in compliance with statutory, regulatory, contractual, KHS policy, and other requirements identified by KHS and its regulators.
Capitation	A set amount of money received or paid out; it is based on membership rather than on services delivered and usually is expressed in units of per member per month (PM/PM) and may be varied by such factors as age and health status of the enrolled member.
Capitation Rate	The percent of the gross Capitation Payment that KHS receives from DHCS on behalf of Members for the delivery of Covered Services.
Care Coordination	Means services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.
Carve-out	Means a service that is covered under Medi-Cal and restricted from MCP coverage according to the DHCS contract.
Case Management	A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes. This generally is a dedicated function in the utilization department.
Catastrophic Coverage Limitation	Means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.
CCS	California Children Services means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.
CCS Eligible Condition	Means a physically handicapping condition defined in Title 22 CCR Section 41800.
CCS Program	Means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.
Center of Excellence	Facilities that are approved by the California Department of Health Care Services (DHCS) or the Centers for Medicare and Medicaid (CMS) to provide specific transplant services.

CERTS	Claims and Eligibility Real-Time System - the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.
CHDP	Children's Health and Disease Prevention.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
CIN	Client ID number.
Claims Resubmission	The process by which a Provider requests PHC to re-review an initial claim outcome.
Clean Claim	A claim for Covered Services that has no defect, impropriety, or particular circumstance requiring special treatment that prevents timely payment within thirty (30) calendar days after receipt of such claim.
Clinical Trials	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
Closed Panel	A Primary Care Provider (PCP) who has requested that new members not be assigned to their practice, or whose maximum number of assigned members has been reached.
CMS	Centers for Medicare and Medicaid Services.
COB	Coordination of Benefits. An agreement that uses language developed by the National Association of Insurance Commissioners and prevents

	double payment for services when a subscriber has coverage from two or more sources. The agreement gives the order for what organization has primary responsibility for payment and what organization has secondary responsibility for payment. KHS is the payer of last resort in most cases.
Code of Conduct	The statement setting forth the principles and standards governing KHS' activities to which KHS' Board of Directors, employees, contractors, and agents are required to adhere.
Cold-Call Marketing	Means any unsolicited personal contact by KHS with a potential Member for the purpose of marketing (as identified within the definition of Marketing).
Complex Case Management	Means the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
Comprehensive Medical Case Management Services	Means services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
Contracting Providers	Means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with KHS to provide medical services to Members.
Cost Avoid	Means Contractor: requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Section 160.
Credentialing	Means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
Criteria	Clinical statements that help determine the appropriateness of a proposed medical intervention. Criteria are an objective tool used to

	support a clinical rationale for decision-making and are an integral component of a utilization management program. Criteria also aid in protecting against over-utilization and under-utilization of clinical resources. Criteria are: 1. Clinically-based on best practice, clinical data. and medical literature; 2. Patient-specific, allowing for each patient's presentation to be considered; and 3. Objective, rule-based, and reliable, allowing for consistently replicable reviews.
CSS	Community Support Services is a program under CalAIM, offering "Community Supports," such as housing supports and medically tailored meals, which will play a fundamental role in meeting enrollees' needs for health hand health-related services that address social drivers of health.
Delivery	Means a live birth that generates a Vital Record for the State of California.
DHHS	The Department of Health and Human Services is a Federal agency responsible for the management of the Medicaid Program.
DHCS	The Department of Health Care Services is a single State Department responsible for the administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, CCS, CHDP, and other health related programs.
Diagnosis of AIDS	Means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.
Dietitian/Nutritionist	Means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow- up, increase medication safely and support safe transitions.
Disenrollment	The process of termination of coverage. Termination of coverage usually occurs when the KHS member's Medi-Cal eligibility status has changed to a Share of Cost (SOC) benefit, or the member is no longer eligible for

	Medi-Cal benefits. A member may also choose to change to the other Medi-Cal Managed Care Plan within the county. (See also Mandatory Disenrollment.)
DMH	The Department of Mental Health is a State agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community based public mental health services statewide.
DMHC	The Department of Managed Health Care is a state agency governing managed health care plans, sometimes referred to as Health Maintenance Organizations (HMO) and is responsible for enforcing the Knox-Keene Health Care Service Plan Act of 1975 and other related laws and regulations.
DSH	A Disproportionate Share Hospital is a health facility licensed pursuant to Health and Safety Code, Chapter 2, Division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, Section 14105.98.
EAS	External Accountability Set means a set of HEDIS® and DHCS-developed performance measures selected by DHCS for evaluation of health plan performance.
ECM	Enhanced Care Management is a program under CalAIM that focuses on person-centered care management provided to the highest-need Medi-Cal enrollees, primarily through in-person engagement where enrollees live, seek care, and choose access to services.
Eligible Beneficiary	Any Medi-Cal beneficiary residing within KHS' service area with a mandatory aid code.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Covered Services furnished by a Provider that are needed to evaluate or stabilize an Emergency Medical Condition.

Encounter	Any single medically related service rendered by (a) medical provider(s) to a member enrolled in KHS during the date of service. It includes, but is not limited to, all services for which KHS incurred any financial liability.
Encrypt	The process of encoding messages or information in such a way that only authorized parties can read it.
Enrollment	Means the process by which an Eligible Beneficiary becomes a Member of KHS.
EOB	Explanation of Benefits (statement). A statement mailed to a member or covered insured explaining how and why a claim was or was not paid; the Medicare version is called an EOMB (also see ERISA).
EOC	Evidence of Coverage.
EQRO	External Quality Review Organization is a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in the State's Medicaid managed care plans.
Experimental Services	Drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans.
Facility	Means any premise that is: 1. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract, or 2. Maintained by a provider to provide services on behalf of the Contractor.
Facility Services	The room charge, supplies, equipment, and ancillary services associated with the provision of a medical procedure to a Member in an inpatient or outpatient hospital facility or Ambulatory Surgical Center (ASC).
FFP	Federal Financial Participation - federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.
FFS	Fee-For-Service - a method of payment based upon per unit or per procedure billing for services rendered to a member.
FFS Medi-Cal	Means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under the Medi-Cal Contract.
Finance Committee	The Finance Committee reviews, approves, and makes recommendations to KHS' Board of Directors on all financial and contractual matters that are presented by KHS' staff in support of administrative and management operations. It ensures KHS' financial stability by providing oversight on its budget.

Financial Performance Guarantee	Means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's capitation.
Financial Statements	Means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.
FMLA	Family Medical Leave Act.
Formulary	A listing of drugs that a physician may prescribe. The physician is requested or required to use only formulary drugs unless there is a valid medical reason to use a non-formulary drug in which case a Treatment Authorization Request (TAR) may be submitted with supporting documentation for review and consideration of coverage.
FQHC	Federally Qualified Health Center - an entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
FQHMO	Federally Qualified Health Maintenance Organization - a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC §300e).
FTE	Full-time Equivalent of one full-time employee. For example, two part-time employees are 0.5 FTE each, for a total of 1 FTE.
FY	Fiscal Year - any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30th. The federal Fiscal Year is October 1 through September 30.
Grievance	Means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or appeal made by a Member.
HCO	Health Care Options is the program established to provide assistance to Medi-Cal beneficiaries who are required or elect to enroll in a Medi-Cal Managed Care Plan.
HHIP	Homeless and Housing Incentive Program aims to improve health outcomes and access to whole person care services by addressing housing insecurity and instability as a social determinant of health for Medi-Cal population.
HMO	Health Maintenance Organization. An organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including

	the requirements under Section 903(m)(2)(A)(ivii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment. A health plan that places at least some of the providers at risk for medical expenses, and a health plan that utilized primary care physicians as gatekeepers (although there are some HMOs that do not).
HEDIS®	Health Effectiveness Data Information Set. A set of standardized performance measures designed to provide purchasers and consumers with relevant information on health plan performance and facilitate the comparison of managed care organizations. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA)
HEDIS® Compliance Audit	An audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.
HIPAA	Health Insurance Portability and Accountability Act. Kassebaum-Kennedy Act, also known as the Health Insurance Portability and Accountability Act of 1996 establishes national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.
Home Health Care	Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, Durable Medical Equipment, medical supplies, and other services.
HRA	Health Risk Assessment is a DHCS approved mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs. HRA surveys are administered to newly enrolled SPDs within 45 days of enrollment.
IHSS	In Home Supportive Services. Provides in-home services to Seniors and Persons with Disabilities (SPD).
Indian Health Programs	Are facilities operated with funds from the Indian Health Service (IHS) under the Indian Self- Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by

	contract, to the eligible Indian population within a defined geographic area. (See Title 22, §55000.)
ICD-9 CM	International Classification of Diseases, 9th revision, clinical modification. The classification of disease by diagnosis codified into 6-digit numbers. (ICD-9 CM will be replaced by ICD-10
ICF	An Intermediate Care Facility is a facility that is licensed as an ICF by DHCS or a hospital or skilled Nursing Facility which meets the standards specified in Title 22 CCR §51212 and has been certified by DHCS for participation in the Medi-Cal program.
IHA	Initial Health Appointment - A tool designed to identify potential critical health factors and that is completed by a Member during initial enrollment period. The weighted scoring of the answers stratifies health interventions based on the overall score.
IMR	Independent Medical Review is a program that was created by the California Legislature to provide health plan members the opportunity for an objective review of a request for services or treatment that was denied, modified or delayed by the health plan. If the member's issue qualifies for an IMR, the review performed by doctors outside of the member's health plan at the expense of the health plan.
Informed Consent	The process by which a treating Provider informs a Member or a Member's Authorized Representative about the procedure, indications, contraindications, significant risks, alternate treatment approaches, and answers questions regarding the procedure prior to the procedure being performed.
IPA	Independent Practice Association. An organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA in turn contracts with individual providers to provide the services either on a capitation basis or on a fee-for-service basis.
IPP	Incentive Payment Programs. IPP incentives are intended to support the implementation, expansion of ECM & CSS programs and infrastructure development of these programs.
JCAHO	The Joint Commission on the Accreditation of Health Care Organizations. An organization composed of representatives of the American Hospital Association, the American Medical Association, American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

Knox-Keene Health Care Service Plan Act of 1975	Means the law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health and Safety Code.
LOA	Letter of Agreement means a short term agreement with a non-par provider for services to a member.
Limited Data Set	Protected Health Information that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
LOB	Line of Business means a health plan that is set up as a line of business within another, larger organization usually an insurance company. This legally differentiates it from a freestanding company or a company set up as a subsidiary. It may also refer to a unique product type (e.g., Medicaid) within a health plan.
Long Term Care	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Managed Health Care	A system of health care delivery managing the cost of health care, the quality of that health care, and the access to that care. Common denominators include a panel of contracted providers that is less than the entire universe of available providers, some type of limitations on benefits to subscribers who use non-contracted providers (unless authorized to do so), and some type of authorization system. Managed health care is actually a spectrum of systems, ranging from so-called managed indemnity, through PPOs, POS, open panel HMOs, and closed panel HMOs.
MBC	Medical Board of California: - The state agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.
MCP	Managed Care Plan. A generic term applied to a managed care plan. At times referred to by the term HMO as it encompasses plans that do not conform exactly to the strict definition of an HMO.
Marketing	Means any activity conducted by or on behalf of KHS where information regarding the services offered by KHS is disseminated in order to persuade or influence Medi-Cal beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of KHS.

Marketing Materials	Means materials produced in any medium, by or on behalf of KHS that can reasonably be interpreted as intended to market to potential enrollees.
Marketing Representative	Means a person who is engaged in marketing activities on behalf of KHS.
MEDS	Medi-Cal Eligibility Data System means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.
Medical Home	Means a place where a member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Provider (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a member; whole person orientation where the PCP is responsible for providing all of the member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards set forth in W&I Code 14182(c)(13)(B).
Medical Loss Ratio	The ratio between the cost to deliver medical care and the amount of money that was taken in by a plan. Insurance companies often have a medical loss ratio of 92% or more; tightly managed HMOs may have a medical loss ratio of 75% to 85%, although the overhead (or administrative cost ratio) is concurrently higher. The medical loss ratio is dependent on the amount of money brought in as well as the cost of delivering care; thus, if the rates are too low, the ratio may be high, even though the actual cost delivering care is not really out of line.
Medically Necessary **or Medical Necessity**	Means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury or to improve the functioning of a malformed body member. Social Security Act Title XVIII 1862(a)(1)(A); when determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in Title 22 CCR §§51340 & 51340.1.

Medical Records	Means written documentary evidence of treatments rendered to plan members.
Member	Means any Eligible Beneficiary who is enrolled in KHS' plan.
Member Appeal	Means a request for review of a request for a service or treatment that has been denied, modified or delayed.
Mental Health Provider	A person or entity that is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide Mental Health Services and that meets the standards for participation in the Medicare program. Mental Health Providers include clinics, hospital outpatient departments, certified residential treatment facilities, Skilled Nursing Facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, and registered nurses authorized to provide Mental Health Services.
MET	Member Evaluation Tool means the information collected from a health information form completed by beneficiaries at the time of enrollment by which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. KHS shall receive the MET from the enrollment broker with the enrollment file and shall use the MET for early identification of members' healthcare needs. For newly enrolled SPD beneficiaries KHS must use the MET as part of the health risk assessment (HRA).
Mid-Level Practitioner	A Registered Nurse Practitioner (RNP), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Optometrist, Acupuncturist, Licensed Clinical Social Worker (LCSW), or Chiropractor.
Minimum Performance Level	Refers to a minimum requirement performance of KHS on each of the External Accountability Set measures.
Minimum Necessary	The principle that, to the extent practical, individually identifiable health information should be disclosed or used only to the extent needed to support the purpose of the disclosure or use, including Payment and Health Care Operations.
Minor Consent Services	Means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to: 1. Sexual assault, including rape. 2. Drug or alcohol abuse for children 12 years of age or older. 3. Pregnancy. 4. Family planning.

	5. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older. 6. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.
MLP	Midlevel Practitioner (Non-Physician Medical Practitioners). A physician's assistant, clinical nurse practitioners, nurse midwives.
MMCD Policy Letter or **All Plan Letter**	Means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, and provides clarification of Contractor's obligations pursuant to this Contract, and clarifies mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation, but does not add new obligations to the contract.
NCQA	National Committee on Quality Assurance – A not-for-profit organization responsible for evaluating and publicly reporting on the quality of managed care plans.
NCQA Licensed Audit Organization	Is an entity licensed to provide auditors certified to conduct HEDIS® Compliance Audits.
Newborn Child	Means a child born to a member during her membership or the month prior to her membership.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of PHC or a Physician Group.
Non-Emergency **Medical Transportation**	Means ambulance, litter van and wheelchair van medical transportation services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22 CCR §§51323, 51231.1, and 51231.2, rendered by licensed providers.
Non-Medical Transportation	Means transportation of members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.
Non-Par	A shorthand term for a non-participating provider (i.e. one who has not signed an agreement with a plan to provide services).
Not Reported	Means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even

	though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.
NPP	Notice of Privacy Practices - Notice provided to a Member that describes PHC's practices in the use and disclosure of Protected Health Information, Member rights, and PHC legal duties with respect to Protected Health Information.
Nurse	A person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).
OHC	Other Health Care means the responsibility of an individual or entity, other than KHS or the member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a member. Such OHCs may originate under any other State, Federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Open Panel	A contracted PCP whose member assignment has not reached the maximum allowed or who has not requested for his/her panel to be closed or restricted.
Out-of-Area	Outside of the Service Area.
Out-of-Network	Outside of the selected Physician Group's participating provider network within the Service Area.
Outpatient Care	Means treatment provided to a member who is not confined in a health care facility.
P4P	Pay for Performance program incentivizes Primary Care Providers (PCPs) to improve quality of care in MCAS and other quality measures
P&T Committee	The Pharmacy & Therapeutics Committee Committee monitors the KHS Formulary, oversees medication prescribing practices by contracting providers, assesses usage patterns by members and assists with study design and clinical guidelines development.
PAC	The Physician Advisory Committee (PAC) serves as an advisor to the Board of Directors on health care issues, peer review, provider discipline and credentialing/recredentialing decisions. This committee is responsible for reviewing provider grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee.

Par Provider	A shorthand term for participating provider (i.e. one who has signed an agreement with a plan to provide services).
PBM	Pharmacy Benefits Manager is a contracted entity that processes pharmacy claims for an MCP or other health plan.
PCP	Means Primary Care Provider; a person responsible for supervising, coordinating, and providing initial and primary care to patients including initiating referrals and maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.
Pediatric Sub-acute Care	Means health care services needed by a person who is under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical Necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.
PERS	Public Employee Retirement System.
Person-Centered Planning	Means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Basic and Complex Case Management and Discharge Planning.
Pharmaceutical Services	Covered drugs and related professional services provided to a Member pursuant to applicable state and federal laws, PHC's Pharmacy Services Program Manual, and the standard of practice of the pharmacy profession of the state in which the Pharmacy is located.
Pharmacy	An area, place, or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
PHI	Protected Health Information - All individually identifiable health information that is transmitted electronically, maintained in any electronic medium, or transmitted or maintained in any other form or medium. This information has been created or received by Partnership Advantage and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Physician	Means a person duly licensed as a physician by the Medical Board of California.

Physician Incentive Plan	Means any compensation arrangement between KHS and a physician or a physician group that may not directly or indirectly have the effect of reducing or limiting services provided to members under the DHCS Contract.
PMPM	Per Member, Per Month - Specifically applies to revenue or cost for each enrolled member each month.
Policy Letter	Means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, provides clarification of MCPs' obligations pursuant to the DHCS Contract, and may include instructions to MCPs regarding implementation of mandated changes in state or federal statutes or regulations, or pursuant to judicial interpretation.
PHM	Population Health Management is a program under CalAIM. MCPs will be required to implement a whole-system, person-centered strategy that includes assessments of each enrollee's health risks and health-related social needs, focuses on wellness and prevention, and provides care management and care transitions across delivery systems and settings.
POS	Point of Service – A plan where members do not have to choose how to receive services until they need them.
Post-Payment Recovery	Means KHS pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.
Post-Stabilization Services	Means Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Member's condition.
Potential Enrollee	Means a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan.
PP/CAC	The Public Policy/Community Advisory Committee provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages.
Practitioner	A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA),

	Optometrist (OPT), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist.
Preventive Care	Means health care designed to prevent disease and/or its consequences.
Primary Care	Means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasized caring for member's general health needs as opposed to specialists focusing on specific needs.
Prior Authorization	Means a formal process requiring a health care to obtain advance approval to provide specific services or procedures.
Provider Grievance	Means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or appeal made by a provider. DHCS considers complaints and appeals the same as a grievance.
Public Benefit Program	Programs including the Medi-Cal program, social security disability insurance benefits, and Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP).
QC	Quality of Care means the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
QI	Quality Improvement means the result of an effective Quality Improvement System.
QI/UM Committee	Quality Improvement/Utilization Management Committee oversees all covered health care services delivered to members by systematic methods that develop, implement, assess and improve the integrated health delivery systems of KHS.
QIPs	Quality Improvement Projects means studies selected by MCPs, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a 24-month time frame.
QIS	Quality Improvement System means the systematic activities to monitor and evaluate the medical care delivered to members according to the standards set forth in regulations and contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.
QOS	Quality of Service - Service issue resulting in inconvenience or dissatisfaction to member.

Quality Indicators	Means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.
RA	Remittance Advice.
Reason Codes	The alpha/numeric codes used to identify each issue within a Member's Appeal or Grievance.
Recredentialing	The process by which KHS or a delegated entity verifies the qualifications of Practitioners in order to make determinations relating to their continued eligibility for participation in.
Referral Authorization Request	A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.
RHC	Rural Health Clinic means an entity defined in Title 22 CCR Section 51115.5.
Safety-net Provider	Means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety-net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and Indian Health Programs; disproportionate share hospitals; and public, university, rural and children's hospitals.
Sanction	Action taken by a state regulator including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a failure to comply with statutory, regulatory, contractual, KHS policy, and other requirements related to KHS' contractual and licensure requirements.
Second Opinion	A consult visit to an Appropriately Qualified Health Care Professional in order for a Member or Contracted Provider who is treating the Member, to receive the additional information for the Member to make an informed decision regarding care and treatment.
Self-Referral	Any service or specialty appointment that a Member may schedule and obtain without having to seek a Provider's request for Direct Referral Authorization or Pre-service Review (i.e., women's health services and covered immunizations). Sensitive Services: means those services related to: a) Family Planning b) Sexually Transmitted Disease (STD)

	c) Human Immunodeficiency Virus testing
Serious Chronic Condition	A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that either: 1. Persists without full cure or worsens over an extended period, or 2. Requires ongoing treatment to maintain remission or to prevent deterioration.
Service Appeal	An appeal involving an organizational determination regarding provision of services prior to a member's receipt of such services (i.e. denial of a request for prior authorization of services).
Service Location	Means any location at which a member obtains any health care services provided by KHS under the terms of the DHCS contract.
SNF	Skilled Nursing Facility as defined in Title 22CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unity of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing facility".
SOC	Share of Cost. The amount of money a client pays or is obligated to pay before Medi-Cal pays.
SPD	Seniors and Persons with Disabilities are Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the DHCS.
Specialty Care Center	Means a center that is accredited or designated by the state or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
Specialty Mental Health Provider	Means a person or entity who is licensed, certified or otherwise recognized or authorized under state law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide specialty mental health services.
Specialty Mental Health Services	A. Rehabilitative services, including mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

	B. Psychiatric inpatient hospital services; C. Targeted Case Management; D. Psychiatric services; E. Psychologist services; and F. EPSDT supplemental Specialty Mental Health
SSI	Supplemental Security Income is the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.
Standing Referral	Means a referral by a PCP to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the PCP having to provide a specific referral for each visit.
State	In the context of discussion concerning the regulatory requirements of KHS, means the State of California.
Stop Loss	A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year- by-year basis. This may apply to an entire health plan or to any single component. For example, the health plan may have stop-loss reinsurance for cases that exceed $100,000. After a case hits $100,000, the plan receives 80% of expenses in excess of $100,000 back from the reinsurance company for the rest of the year. Another example would be the plan providing a stop-loss to participating physicians for referral expenses over $2,000. When a case exceeds that amount in a single year, the plan no longer deducts those costs from the physician's referral pool for the remainder of the year.
Subacute Care	Means, as defined in Title 22 CCR Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.
Subcontract	means a written agreement entered into by KHS with any of the following: A. A provider of health care services who agrees to furnish covered services to members. B. Any other organization or person(s) who agree(s) to perform any administrative function or service for KHS specifically related to fulfilling KHS' obligations to the DHCS under the terms of the DHCS contract.
Sub-Subcontractor	Means any party to an agreement with a subcontractor descending from and subordinate to a subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under KHS' contract with the DHCS.
TAR	Treatment Authorization Request means a request for the prior authorized coverage for a non-formulary or formulary restricted drug by

	a provider and is usually submitted by the pharmacy that the member utilizes for prescription fills.
TCM	Targeted Case Management means services which assist Medi-Cal members within specific target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through state or local government entities and their contractors.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Tertiary healthcare	is specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment.
TPL	Third Party Liability.
TPTL	Third Party Tort Liability means that the responsibility of an individual or entity other than KHS or the member for the payment of claims for injuries or trauma sustained by a member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g. auto accidents or other personal injury casualty claims or Workers' Compensation appeals).
Traditional Provider	Means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a MCP. The term includes physician and hospital providers only, either profit or non- profit entities, publicly or non-publicly owned and operated.
Transitional Medi-Cal	Persons discontinued from AFDC due to loss of 30 1/3 or increased earnings that will continue to receive Medi-Cal with no share of cost for at least 8 months and possibly up to 14 months.
Treatment	Activities undertaken on behalf of a member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Un-Bundling	The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressings and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments. Unprocessable Claim: Any claim that: 1. Is incomplete or is missing required information; or

	2. Contains complete and necessary information, however, the information provided is invalid.
Urgent Care	Means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e. sore throats, fever, minor lacerations, and some broken bones).
Utilization Review	Means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.
VFC	Vaccines for Children Program is the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating providers. Providers contracting with KHS are eligible to participate in this program.
VSP	Vision Services Plan is a KHS contracted provider delegated to provide optometry services to KHS members
Working day (s):	Means State calendar (State Appointment Calendar, Standard 101) working day (s).