


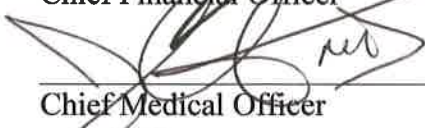

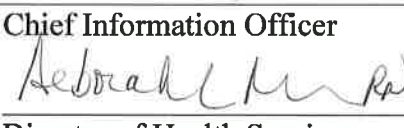
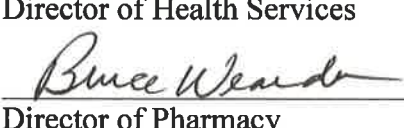
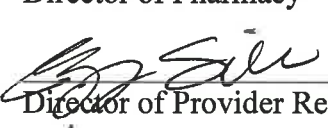
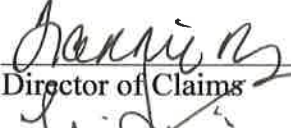
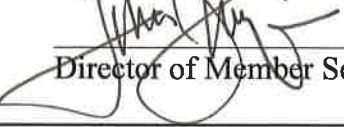


**KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES**

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RESPONSIBLE DEPARTMENT HEAD: Director of Health Services					
Review Date	03/2013				
Effective Date	03/26/13				
Revision No.	2013-03				

Approved		Date	3/26/13
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POLICY¹: Kern Health Systems (KHS) members diagnosed with Hepatitis C and appropriate for medication therapy will be assigned to a designated KHS contracted Clinic Partner who will provide comprehensive management for treatment of the condition. This will be coordinated with the member's Primary Care Physician (PCP), KHS contracted Infectious Disease/Gastroenterology Specialists and the Compliance Program vendor. This policy outlines the administrative and treatment protocols for this

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program.

PURPOSE: To establish a Comprehensive Hepatitis C Management Program for KHS members.

PROCEDURE:

1.0 PROVISION OF SERVICES FOR UTILIZATION MANAGEMENT (UM)

When a member is diagnosed with Hepatitis C, the Primary Care Physician (PCP) shall perform the appropriate diagnostic evaluation and submit relevant documentation (including viral loads and genotypes) to KHS for referral to a Specialist Evaluation for Hepatitis C treatment.

Upon completion of KHS review, clinically appropriate members will become eligible for the Comprehensive Hepatitis C Program and the referral for the Specialist Evaluation will be authorized.

The Specialist will evaluate the member and upon their determination of clinical appropriateness for treatment, will request a specific medication treatment regimen and Compliance Program through KHS UM.

KHS UM will forward the referral to KHS Pharmacy Department for review and approval. Pharmacy will approve the treatment plan and forward back referral to UM. KHS UM will enter an authorization number in MHC which will have one of several treatment levels. These treatment levels will correspond to the KHS Pharmacy approved treatment plan (medications specific to the identified genotype of Hepatitis C). This authorization number is for tracking and payment reconciliation purposes only.

If the member's assigned PCP vendor region is already a Hepatitis C Clinic Partner, then the member's file, including assigned KHS PCP, Specialist, and Compliance Program notes and treatment recommendation will be forwarded to the Hepatitis C Clinic Partner by UM.

If member's PCP is not a participating Hepatitis C Clinic Partner, the KHS UM department will send a change of PCP request to Member Services (MS). MS will contact the member for reassignment options. If the member consents to reassignment, the member shall be reassigned to the participating Hepatitis C Clinic Partner of their choice effective the next business day. KHS Provider Relations will send a notification letter to the member's current PCP informing them of the change.

Should a member not consent to a PCP reassignment, they will be allowed to continue with their currently assigned PCP for routine care. However, the member will be informed that ALL Hepatitis C Treatment will be provided through the Hepatitis C Clinic Provider Partners. The member will then select the Hepatitis C Clinic Partner of their choice. MS will notify UM of the member's selection and UM will create a 6 month open authorization for the Hepatitis C Clinic Partner. It is the responsibility of the contracted Hepatitis C Clinic Partner to request authorization extension with appropriate rationale if needed. The Hepatitis C Clinic Partner will be responsible for exchanging patient care information with the PCP in order to ensure

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coordination of care.

The member's file, including PCP, Specialist, and Compliance Program notes and treatment recommendation will be forwarded to Hepatitis C Clinic Partner by UM prior to the initiation of the treatment.

The Hepatitis C Clinic Partner will evaluate the member and treatment recommendations from the Specialist. Notes from the PCP and Compliance Program provider along with any relevant diagnostic data and provide appropriate medications and related therapies, will be provided.

2.0 CLAIMS SUBMISSION AND PAYMENT

The contracted Hepatitis C Clinic Partner will bill the visit encounter in the usual manner. The medications dispensed will be billed via an invoice process. The invoice must contain the following elements for reimbursement:

- Unique Invoice Number (UIN)
- Client Index Number (CIN) or KHS member ID
- Date of Service
- Prescribing Provider Name, license number, and NPI
- Other health coverage amount (if applicable)
- Medication name and NDC
- Medication quantity
- Number of days supplied
- Hepatitis C Drug manufacturers invoice

KHS Accounting Department will reconcile the invoice with a Business Object Report for authorized members. Accounting will confer with Pharmacy as necessary. Accounting will render the payment to contracted Hepatitis C Clinic Provider at the contractually agreed rates and payment intervals.

3.0 DATA RECONCILIATION AND REPORTING

Required data elements for submission to DHCS will consist of those listed on Attachment A. These elements will consist of information collected from claims and visit encounters, invoiced medication information, and internally derived member specific data.

Attachments:

- ❖ Attachment A – Hepatitis C Encounter Data Element Matrix
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Attachment A – Hepatitis C Encounter Data Element Matrix

DE #	DHCS Encounters Data Element (DE)	KHS Requirements	KHS Populated	Invoice Requirements	Notes
1	Unique Invoice Number (UIN)	<-----	<-----	Required	
2	Plan Code	Required	00303 (Fixed)	Not Required	
3	Format Code	Required	P (Fixed)	Not Required	
4	Program Code	Not Required	Not Required	Not Required	
5	Adjustment Code	Not Required	Not Required	Not Required	
6	Adjustment Claim Reference Number (CRN)	Not Required	Not Required	Not Required	
7	Medi-Cal Beneficiary Identification (BID)	Required	From MS	Not Required	
8	SSN (not used) or Client Index Number (CIN) -see notes	<-----	<-----	Required	DE8 : Only CIN or KHS Member Id
9	Name of Medi-Cal Recipient	Required	Derived from DE 7 or 8	Not Required	
10	Birth Date of Medi-Cal Recipient	Required	Derived from DE 7 or 8	Not Required	
11	Sex of Medi-Cal Recipient	Required	Derived from DE 7 or 8	Not Required	
12	Ethnic/Race Code of Medi-Cal Recipient	Required	Derived from DE 7 or 8	Not Required	
13	Provider Number (Reporting/Billing)- see notes	Required	From Finance	Not Required	DE13: Medi-Cal or state license number. Must always contain a provider number for each record in order to identify the provider billing the health plan. If the provider does not have an individual or group Medi-Cal provider number, the provider's State license number must be used. When the service is reported by a Clinic the Medi-Cal provider number is to be reported. If the clinic does not have a Medi-Cal provider number, the State clinic license number must be used. If the service is reported/billed by a health facility, the Department of Health Services assigned facility number must be entered. When making entries in this field, enter the entire provider or license number, plan provider identifier number, tax identifier number, or national provider identification number, including all leading and trailing
14	Provider Name (Reporting/Billing)	Required	Derived from DE 13	Not Required	
15	Zip of Provider (Rendering)	Required	Derived from DE 13	Not Required	
16	County of Provider (Rendering)	Required	Derived from DE 13	Not Required	
17	Provider Type Code	Required	Derived from DE 13	Not Required	
18	Physician and Dental Specialty Codes	Not Required	Not Required	Not Required	
19	Beginning Date of Service	<-----	<-----	Required	
20	Ending Date of Service	Required	Derived from DE 19	Not Required	
21	Referring/Prescribing/Admitting Provider- see notes	<-----	<-----	Required	
22	Prior Authorization or Primary Care Physician	Not Required	Not Required	Not Required	
23	Primary Diagnosis (ICD 9 CM)	Not Required	Not Required	Not Required	
24	Secondary Diagnosis (ICD 9 CM)	Not Required	Not Required	Not Required	
25	Tertiary Diagnosis (ICD 9 CM)	Not Required	Not Required	Not Required	
26	Family Planning Indicator	Not Required	Not Required	Not Required	
27	Adjudication Status Code	Required	P (Fixed)	Not Required	
28	Adjudication Date	Required	From Claims	Not Required	
29	Date of Payment by Plan (Check Date)	Required	From Finance	Not Required	
30	Billed Amount	Required	From Finance	Not Required	
31	Reimbursement Amount	Required	From Finance	Not Required	
32	Patient Liability Amount (Share of Cost)	Required	From MS	Not Required	
33	Medicare Deductible Amount	Required	From MS	Not Required	
34	Medicare Co-Insurance Amount	Required	From MS	Not Required	
35	Other Health Coverage Amount	<-----	<-----	Required	
36	Empty	Not Required	Not Required	Not Required	DE21: For all pharmacy records, enter the provider number, license number, or Drug Enforcement Authority number of the physician who prescribed the medication or authorized the medical supply
37	Tooth Surface Locations	Not Required	Not Required	Not Required	
38	Place of Service (POS)	Required	From PR (Fixed)	Not Required	
39	Procedure Code (CPT-4 or Dental Codes)	Not Required	Not Required	Not Required	
40	Procedure Modifier Code or Tooth	Not Required	Not Required	Not Required	
41	Medical Outpatient and Dental Procedure Quantity	Not Required	Not Required	Not Required	
42	Rendering Provider Number	Not Required	Not Required	Not Required	
43	Drugs/Medical Supplies (NDC)	<-----	<-----	Required	
44	Drug/Medical Supply Indicator Code	Required	From PR (Fixed)	Not Required	
45	Drug/Medical Supply Quantity	<-----	<-----	Required	
46	Days Supply	<-----	<-----	Required	
47	Long Term Care (LTC) Accommodation Codes	Not Required	Not Required	Not Required	
48	Days Stay	Not Required	Not Required	Not Required	
49	Admission Date	Not Required	Not Required	Not Required	
50	Discharge Date	Not Required	Not Required	Not Required	
51	Patient Status Code	Not Required	Not Required	Not Required	
52	Admission Necessity Code	Not Required	Not Required	Not Required	
53	Primary Surgical Procedure Code	Not Required	Not Required	Not Required	
54	Secondary Surgical Procedure Code	Not Required	Not Required	Not Required	
55	Empty	Not Required	Not Required	Not Required	
56	Number of Claim Lines	Not Required	Not Required	Not Required	
57	Accommodation and Ancillary Codes	Not Required	Not Required	Not Required	