KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Emergency Provider Education and Protocols				POLICY #: 4.11-P	
DEPARTMENT: Provider Relations					
Effective Date: 08/1997	Review/Revised Date: 11/14/2014	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer
Date 11/04/04

Chief Operating Officer
Date 11/11/14

Director of Provider Relations
Date 10/1/14

POLICY:

Kern Health Systems (KHS) will endeavor to keep local Kern County emergency facilities, as well as those facilities outside of the county that regularly serve residents of Kern County, informed and knowledgeable about KHS membership benefits, administrative procedures, and methods of administrative contact. KHS shall develop and maintain protocols for communicating and interacting with emergency departments. Protocols shall be distributed to all emergency departments in the contracted Service Area.[1]

PROCEDURES:

Each contracted provider receives an initial in-service within 10 days of their active status with KHS. During the in-service, the provider receives a packet that contains educational materials and emergency department protocols (See Attachment A). Information included in the packet includes, but is not limited to the following[2]:

A. Description of telephone access to triage and advice systems used by KHS including notification that members needing assistance with a language other than English will be assisted by the triage center's staff or the AT&T language line[3]

B. Plan contact person responsible for coordinating services and who can be contacted 24 hours a day

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Medi-Cal Members who present at the emergency department for non-emergency services
D. Procedures for emergency departments to report system and/or protocol failures and process for ensuring corrective action
E. General information regarding member benefits and administrative procedures for notification, checking eligibility, and claims submission

Periodic follow-up contacts are made either by correspondence, telephone, or in person visits in order to maintain communication and to provide a means by which questions can be answered and problems solved. Specific problems concerning individual providers are addressed as they arise. It is the responsibility of Provider Relations to coordinate administrative responses to these problems.

All non-contracted providers within Kern County and our service area will be notified via fax on an annual basis (See Attachment B) that KHS will not provide payment for services other than for a medical screening exam unless the clinical situation causing the patient to present to the facility is a life threatening emergency. Otherwise the facilities are instructed to refer patients to their primary care practitioners or to the nearest contracted facility. Practitioners/facilities may call the number on the Members ID Card (1-800-391-2000) for a list of contracted urgent care or emergency rooms.

ATTACHMENTS:

Attachment A – *Emergency Services Provider In-Service* packet
Attachment B – *Emergency/Urgent Care Reminder Letter*

REFERENCE:

Revision 2014-11 Routine review requested by Compliance Department. Attachment A updated by Claims and UM Departments. **Revision 2009-06:** Routine review. **Revision 2005-11:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). Revised per DHS Workplan Comments 6h (9/1/05).

[1] DHS Contract A-7 (7)
[2] DHS Contract A-7(7)
[3] Information regarding language assistance added per C. Sorrell. Language previously in deleted policy #3.15.

Kern Family Health Care

The Friendly Face

Of Kern Health Systems

Emergency Services Provider In-Service

24-Hour Telephone Triage Service
Policy 3.15

Urgent conditions that are not life threatening do not need pre-authorization from KHS. Members or PCP may call the 24-Hour Telephone Triage Service at (800) 391-2000 for advice on seeking care.

Members will be directed back to the PCP for routine care not found to meet protocols for urgent/emergent care.

KHS contact person for coordinating services

Policy 3.31

The KHS Chief Medical Director or a designee is available 24 hours/day, 7 days/week 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.

Cell: 661-331-7656

Documentation

Policy3.31

Although emergency services do not require prior authorization, practitioners/providers must submit a Referral/Prior Authorization Form to KHS as soon as reasonably possible after care has been provided. This requirement does not apply to ER Physicians but only to other types of Providers who perform emergency services.

Referral Process

Policy 3.22

A routine request by the PCP for referral authorization is initiated by submitting an online referral form through the portal or a written referral form. The PCP must include pertinent medical records and member data which support the referral and will assist the specialty provider in the assessment and delivery of services.

Referral Process
Policy 3.22

- The signature of the referring PCP must appear on the Referral/Prior Authorization Form or within the submitted documentation as handwritten or electronic.

- A signature stamp is acceptable if KHS is in receipt of certification that the use of such a signature stamp is authorized by the PCP.

Referral Process

Policy 3.22

The preferred method of referral requests are through the online portal. Otherwise fax the completed referral form and necessary medical records to the KHS Utilization Management Department at: 661-664-5190

or mail to:

Utilization Management
Kern Health Systems
9700 Stockdale Hwy
Bakersfield, Ca 93311

Referral Process

Policy 3.22

Time Requirement

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

Referral Process

Policy 3.22

Notification

When a referral is authorized the referral is forwarded to the contracting provider along with any pertinent medical records and data within 24 hours of the decision.

The PCP and member are notified of the referral authorization within 24 hours of the decision.

Referral Process
Policy 3.22
Denied Referrals

- Reasons for possible denial include:
- Not a covered benefit
- Not medically necessary
- Member not eligible
- Continue conservative management
- Services should be provided by a PCP
- Experimental or investigational treatment
- Member made unauthorized self-referral to provider
- Services covered by CCS
- Inappropriate setting
- Vision care services
- Covered by Hospice
- Administrative denials
    - Kern Regional Center
    - Duplicate request
    - Signature verification

Referral Process

Policy 3.22

Denied referrals

All recommended denials are reviewed by the Chief Medical Director, Medical Director or Associate Medical Director within one working day.

Only the Chief Medical Director, Medical Director or Associate Medical Director may deny an authorization request that is not administrative in nature.

Referral Process

Policy 3.22

Notification of Denial

- The Referral Disposition form and the criteria used to deny the referral are returned to the referring provider within 24 hours of the decision.

- A denial letter stating the reason for the denial is sent to the member within 24 hours of the decision.

Referral Process

Policy 3.22

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.

KHS does however require a follow-up referral form from the referring provider for tracking purposes.

Referral Process

Policy 3.22

URGENT Referrals

- A provider may obtain urgent referral authorization by contacting the KHS UM department for verbal authorization during office hours.

- After hours urgent authorization may be obtained by telephone from the administrator on call at KHS.

- Depending on the nature of the request, the authorization can be immediate or within 3 working days.

Referral Process

Policy 3.22

HOSPITAL/FACILITY ADMISSION

All providers must request authorization for scheduled hospital/facility admissions from the KHS Utilization Management Department.

Admissions will be to contracted facilities unless an exception occurs and special authorization has been granted by the KHS UM Department.

Referral Process

Policy 3.22

Lab, X-Ray and Assistant Services

Routine lab and X-ray services do not require pre-authorization, but must be directed to providers under contract with KHS.

Non-emergent specialty x-ray procedures require pre-authorization. Contracting providers must be utilized for all non-emergent lab and imaging procedures.

Referral Process

Policy 3.22

Automatic Referral Services; Medi-Cal

Members can self-refer for the following services:

Family Planning -Members may self-refer to any FQHC, Federally Funded Family Planning clinic and Public Health Clinic or other contracted OB/Gyn provider.
Dental -Providers are expected to refer to Denti -Cal
Mental Health -Members may self- refer to Kern County Mental Health Department or any contracted Mental Health provider.
Vision -PCP or member may initiate a referral to VSP contracting optometrists.

Referral Process

Policy 3.22

Automatic Referral Services; Medi-Cal

Pregnancy -Members may self-refer to a KHS contracted *OB/GYN* or family practice physician.

Abortion -Prior authorization is not required unless inpatient hospitalization for the performance of the abortion is requested.

Sonogram -One sonogram is automatically authorized with routine OB care. Authorization is required for high level sonograms.

Referral Process

Policy 3.22

Automatic Referral Services; Medi-Cal

Gynecology -Members may self-refer to contracted providers for an annual Pap Smear. Specialists must request authorization for routine diagnostic, ancillary, or surgical services as required in the referral process.

Cancer Screening -Covered tests include; chest x-ray , PAP smear, lab tests (PSA, stool guiac etc.) mammogram and flexible sigmoidoscopy/colonoscopy.

Referral Process

Policy 3.22

Second Medical Opinions

- Requests for second opinions may be initiated by the member or provider and should document the initial opinion and the person requesting the second opinion.
- All requests for second opinions are reviewed by the KHS Chief Medical Director, Medical Director or Associate Medical Director.
- Authorization/denial and evaluation of the second opinion is accomplished within 72 hours of KHS receipt of the request, whenever possible.

Referral Process

Policy 3.22

PCP Follow up and Documentation

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

Eligibility
Medi-Cal Members

- It is always best to ask for the member's **Beneficiary Identification Card (BIC)**, that is the most up to date source of eligibility verification.

- **AEVS** (State Medi-Cal automated eligibility verification system) **1-800-456-2387**

Eligibility

Medi-Cal Members

- **DIVA** is also a good way to verify eligibility. This is the automated phone verification system that can be accessed at *661/664-5185*
- **KFHC** Member Lists
- **KFHC** member services department **1-800-391-2000**

Guidelines for Claims Submission

Policy 6.01

Any copayment or COB collected should be indicated in the appropriate data field of the claim form. Appropriate claim forms should be used.

Guidelines for Claims Submission

Policy 6.01

- Contracted providers should submit a complete written bill within 180 calendar days following the applicable event listed:

  -Provision of the covered services.

  -Receipt of EOB from primary insurance.

  -Receipt of CCS denial letter.

Claims Submission

All claims should be mailed to:
PO Box 25003
Bakersfield, Ca 93311-3617

Or

9700 Stockdale Hwy
Bakersfield, Ca 93311

Practitioner/Provider Disputes Regarding Claims Payment

Policy 6.04

Disputes must be submitted to KHS within 365 calendar days of the date of KHS' 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 KHS within 30 working days of the date of receipt.

Practitioner/Provider Disputes Regarding Claims Payment

Policy 6.04

Disputes must be submitted using a *Provider Claims Dispute Resolution Request* form. Simple resubmission of the claim is not sufficient to qualify as a dispute.

Claims resubmitted without the appropriate form will be denied as a duplicate claim unless a cover letter is attached that clearly identifies the dispute as defined in this policy.

Practitioner/Provider Disputes Regarding Claims Payment

Policy 6.04

Disputes ***must*** contain the following information:

- Practitioner/provider name
- Practitioner/provider tax ID number
- Practitioner/provider contact information
- Clear identification of the disputed item
- Date of service
- Clear explanation of the basis which the provider believes payment/action is incorrect.
- Provider dispute number. The number is the same number assigned to the original claim

Disputes that do not contain all necessary information will be returned.

California Children's Services (CCS)

Policy 3.16

Once a member is accepted by the CCS program, KHS case management continues to work with CCS to coordinate care.

- Providers notify KHS via referral when a potential CCS condition is identified.

- CCS referrals are tracked by the UM department to ensure follow through of services to members.

Cultural and Linguistic Services
Policy 11.01

- During KHS office hours, providers and members may contact the Member Services Department for an interpreter and be connected with the AT&T language line.

- After KHS office hours, providers and members may contact the 24 hour Triage Line to be connected to the AT&T language line.

Grievance Process
Policy 5.01

- A grievance from a member may be submitted to KHS' Member Services Department via personal letter, *Member Report of Complaint/Grievance Form,* phone call, or in person.

- Providers are required to provide the "Member report of Complaint/Grievance" form to any member requesting one. They are available in English and Spanish.

- Providers are contractually obligated to submit requested records within 10 days.

Attachment B

Reminder

Kern Health Systems will not reimburse non-contracted emergency facilities or urgent care facilities for services rendered to any Kern Family Health Care member other than for a medical screening exam (MSE) unless the clinical situation causing the patient to present to the facility is a life threatening emergency. Otherwise, the facilities are instructed to refer patients to their primary care provider or to the nearest contracted facility.

Facilities can call Kern Health Systems directly for a list of contracted urgent care or emergency rooms at 1-800-391-2000. Members should also be directed to contact the health plan at the number listed on their Member ID card.

If you have any questions please contact Kern Health Systems at 661-664-5146.