KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Out-of-Area Pharmacy Claims Processing				POLICY #: 13.21-P	
DEPARTMENT: Pharmacy					
Effective Date: 08/1997	Review/Revised Date: 03/08/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward — Date 2/8/17
Chief Executive Officer

Chief Medical Officer — Date

Chief Financial Officer — Date 3/7/17

Chief Operating Officer — Date 3-2-17

Director of Pharmacy — Date February 22, 2017

POLICY[i]:
Kern Health Systems (KHS) will pay claims for prescriptions supplied to members at out-of-area pharmacies in emergency situations if the medication is included in the Kern Health Systems' Formulary.

PROCEDURES:

1.0 PROVIDER REIMBURSEMENT

1.1 Authorization

1.1.1 Emergency or Urgent Care Prescriptions

If a member receives a prescription from an out-of-area emergency room or urgent care physician, Kern Health Systems will authorize reimbursement to the out-of-area pharmacy if the medication is included in the KHS Formulary.

If the prescription is not in the KHS Formulary, the pharmacy needs authorization from the Kern Health Systems Chief Medical Officer, Associate Medical Director or Pharmacy Department before completing the prescription. See *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests* for details.

1.1.2 Non-Emergency/Non-Urgent Care Prescriptions

Refills or non-emergency/urgent care prescriptions from an out-of-area pharmacy that is not in the plan network must be authorized by the Kern Health Systems Chief Medical Officer, Associate Medical Director or Pharmacy Department prior to filling the prescription. The pharmacy should submit a Treatment Authorization Request (TAR) to Kern Health Systems. The TAR is processed according to the guidelines in *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests*.

1.2 Claims Submission

The pharmacy should submit either an electronic or a manual claim, preferably on a Medi-Cal 30-1 or similar form, to the KHS Pharmacy Department. The *Pharmacy Claim Form* (30-1) is used by pharmacies to bill Medi-Cal for prescriptions.

Durable Medical Equipment (DME), disposable and incontinence medical supplies, and blood products for provider types other than straight Medi-Cal beneficiaries and for Medi-Cal beneficiaries that have 91 or 97 prefix Service Authorization Requests (SARs), must be billed using the *CMS-1500* claim. See the *CMS-1500 Completion* section of this manual for information.

Pharmacies that do not have a standard Medi-Cal billing form may submit a Pharmacy receipt. The receipt must contain the member's name, member's identification number, address, pharmacy name, pharmacy address and NPI number, medication name, national drug code number, quantity, doctor's NPI number, and amount billed. Once approved, claims are forwarded to Argus for processing so the medication will appear on the patient's profile. All possible claims for non-network pharmacies will be forwarded to Argus so the medication will be on the patient's profile. Claims should be submitted to:

Pharmacy Department
Kern Family Health Care
9700 Stockdale Highway
Bakersfield, CA 93311-3617

1.3 Reimbursement Rate

Kern Health Systems reimburses approved out-of-area pharmacy claims at KHS' pharmacy contract rates.

2.0 MEMBER REIMBURSEMENT

If a member pays for an out-of-area prescription, the member must complete a *Medical Emergency Claim Form*. (See Attachment A). An original itemized receipt must be submitted with the form.

This receipt must include the following information:

A. Patient's name
B. Date of services
C. Name of medication, prescription number, and quantity
D. Pharmacy's complete name, address, and phone number

The pharmacy claim is reviewed by the KHS Chief Medical Officer, Associate Medical Director or Pharmacy Department. If the drug is included in the KHS formulary, the member is reimbursed for the amount of payment. If the drug is not included in the KHS formulary a decision is rendered according to the guidelines in *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests.*

3.0 CONTRACTED OUT-OF-AREA PHARMACIES

KHS is contracted with several chain pharmacies within California. Members should be directed to the nearest contracted chain pharmacy for prescriptions needed outside of the Kern County Service Area. These pharmacies are recommended to patients requiring out-of-area prescriptions.

ATTACHMENTS:

- Attachment A – *Medical Emergency Claim Form*

REFERENCE:

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[i] **Revision 2017-02:** New language added on durable medical equipment in Section 1.2 provided by Director of Pharmacy. **Revision 2013-10:** Review conducted by Director of Pharmacy. Language added for electronic claims submission, titles updated. **Revision 2008-07:** Revised PBM, updated Section 1.2. Medical Emergency Claim Form revised. **Revision 2005-08:** Routine revision. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2001-03**: changes made as result of DHS/DMHC Medical Review Audit (YE 08/31/00). Also addition of HFAM PO Box. **Formerly:** #6.12. Policy changed to a Pharmacy policy per request of the Director of Pharmacy on Revision 2005-08.

Kern Family Health Care
The Friendly Face
Of Kern Health Systems

Medical Emergency Claim Form

- Complete the information below
- Attach Medical Bills
- Mail To: Address Listed Below
  ATTN.: Member Services

Member Information	Name (as shown on ID card)	Member No.
	Address	**Medi-Cal** ☐
	City Zip Code	Daytime Phone Number
Emergency Information	Complete this section explaining the medical reason you received emergency treatment. Please use the reverse side of this form if you need additional space.	
Accident Information	Was this emergency treatment due to an accident? ☐ No ☐ Yes **If yes**, please complete the following information:	
	Date of the accident:	**Location of the accident:**
	Details of the accident:	
Other Coverage Information	Are any of your expenses covered by another group health plan, auto insurance, Medicare, workers compensation or any other type of plan? ☐ **No** ☐ **Yes** **If Yes**, please list the name and address of the insurance company: **Name:** _____ **Address:** _____ **Policy Number:** _____	
Release	**TO ALL PROVIDERS OF HEALTH CARE:** You are authorized to provide Kern Family Health Care information concerning health care advice, treatment or supplies provided to this member. This information will be used to evaluate claims for benefits. This authorization is valid for the term of my coverage with Kern Family Health Care. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. Member or Authorized Person's signature _____ Date _____	

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1-800-391-2000 · Fax (661) 664-5179
Caring for our community