KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Pharmacy Claims Submission and Reimbursement				POLICY #: 13.02-P	
DEPARTMENT: Pharmacy					
Effective Date: 04/2009	Review/Revised Date: 09/02/2016	DMHC		PAC COMMITTEE	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Doug A. Hayward
Chief Executive Officer — Date 9/2/16

Chief Medical Officer — Date 9/1/16

Chief Financial Officer — Date 8/31/16

Director of Claims — Date 8/26/16

Director of Pharmacy — Date August 25, 2016

POLICY:
Kern Health System (KHS) guidelines for Point of Service (POS) and manual claims submission shall be communicated to KHS contracted pharmacy providers for timely and accurate claims submission and reimbursement.

KHS contracts with a Pharmacy Benefit Manager (PBM) to adjudicate POS claims and process approved manual claims for contracted providers. Approved manual claims from non-contracted pharmacy providers are also processed by the PBM

The KHS staff will make every effort to identify members that are covered under any other State or Federal Medical Care Program or under other contracted or legal entitlement including, but not limited to, a private group or indemnification program. KHS staff will make every effort to recover any

monies paid for services provided to members prior to identifying such other coverage.

KHS staff will identify cases which involve Casualty Insurance, Tort Liability, or Workers' Compensation. KHS will notify the Department of Health Care Services (DHCS) or its designated contractor of all such cases involving Medi-Cal Product members.

Claims will be processed in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code §§ 1371, 1371.35, 1371.36, 1371.37, and 1371.39
- CCR Title 28 §§1300.71, 1300.71.38; 1300.77.4

DEFINITIONS:

Information necessary to determine payer liability[1]	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
Reasonably relevant information[2]	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
Working Days[3]	Monday through Friday, excluding recognized federal holidays. Recognized federal holidays are as follows[4]: A. New Year's Day: closest week day to January 1st B. ML King's Birthday: 3rd Monday in January C. Washington's Birthday: 3rd Monday in February (aka Presidents' Day) Memorial Day: last Monday in May D. Independence Day: closest week day to July 4th E. Labor Day: 1st Monday in September F. Columbus Day: 2nd Monday in October G. Veteran's Day: Closest week day to November 11th (aka Armistice Day) H. Thanksgiving Day: 4th Thursday in November I. Day After Thanksgiving J. Christmas Day: Closest week day to December 25th

PROCEDURES:

1.0 CLAIMS SUBMISSION

Electronic billing is the preferred method of billing KHS for medications and related materials. Claims are adjudicated electronically through KHS' PBM. Claims that do not adjudicate may

be submitted by the provider for approval as outlined in *KHS Policy and Procedure #13.01 – Non-Formulary Treatment Requests*. If approved, the provider then may adjudicate the claim electronically. Electronic claims should be submitted as follows:

Product	Address
Medi-Cal	Argus Health Systems Inc. BIN 600248 PCN 04970000

Manual claims should be mailed to the following addresses:

Product	Address
Medi-Cal	Claims Department Kern Family Health Care 9700 Stockdale Highway Bakersfield, CA 93311

Manual claims may be physically delivered to 9700 Stockdale Highway, Bakersfield, California.

1.1 Deadlines

POS claims may be submitted by approved pharmacy providers up to 45 calendar days from the date of service. Claims older than 45 days must be submitted manually for approval and processing by the PBM.

Practitioners/providers may submit a practitioner/provider dispute regarding a claim that was denied as a late submission. If good cause for the delay is demonstrated, the 180 day deadline will be waived and the claim adjudicated as if it was submitted after 120 calendar days but within 180 days following the provision of covered services.[5]

Claims submission deadlines for contracted and non-contracted practitioners/providers differ as described below.

1.1.1 Contracted Practitioners/Providers

In order to receive full compensation, including incentives, contracted practitioners/providers should submit a complete, written bill for all covered services rendered within one hundred and twenty (120) calendar days following the provision of the covered services.

Claims received after 120 calendar days but within 180 days following the provision of the covered services are reimbursed at the applicable normal contracted rates and withholds; however, such claims are not considered in the risk pool calculations.[6]

Claims received after 180 calendar days[7] following the provision of the covered services are denied with the following exceptions:

A. Other Primary Insurance: Claims must be submitted within 90 days[8] of the date of the primary carrier's Explanation of Benefits (EOB). Any

such claims received after the deadline are denied.

B. California Children's Services: Claims must be submitted within 90 days8 of the CCS denial letter. Any such claims received after the deadline are denied.

1.1.2 Non-Contracted Practitioners/Providers

Claims received after 365 calendar days[9] following the provision of the covered services are denied with the following exceptions:

A. Other Primary Insurance: Claims must be submitted within 90 days[10] of the date of the primary carrier's Explanation of Benefits (EOB). Any such claims received after the deadline are denied.

B. California Children's Services: Claims must be submitted within 90 days8 of the CCS denial letter. Any such claims received after the deadline are denied.

1.2 Format

Appropriate claim forms or electronic data formats should be used. Electronic submissions to the PBM must be in NCPDP D.0 format. The *Pharmacy/Medical Supplies Claim Form* (State of California Department of Health Services 30-1C) must be used for manual claims unless the provider is billing Medicare. Medicare co-insurance claims may be submitted on a *CMS1500* form.

1.3 Content

The billed amount should be based on the same fee schedule used to bill other third party payers. Any copayment or coordination of benefits (COB) payments collected should be indicated in the appropriate data field of the claim.

Practitioners/providers should follow the Medi-Cal instructions for completing the *CMS 1500* and *30-1C* Forms. Submitted claims must include a full itemization of charges and the following information:

A. Pharmacy name
B. Pharmacy address
C. Pharmacy phone number
D. Pharmacy National Provider Identifier (NPI) Number
E. Member name
F. Member KHS identification number
G. Sex
H. Date of Birth
I. Drug name
J. Drug strength
K. Prescription number
L. Date of Service
M. Quantity
N. Days supply
O. NDC Number
P. Charge or co-payment amount
Q. Prescriber NPI number
R. Code 1 restriction met

S. Authorization number (TAR)
T. Provider or representative signature
U. Date of billing
V. Other coverage payment(s)

1.4 Supporting Documentation

If the medication is compounded, providers must submit a compound sheet with the claim.

2.0 REIMBURSEMENT

KHS reimburses providers based on the compensation agreement specified in their contract. The complete fee schedule is included in the provider contract.

2.1 Coordination of Benefits and Third Party Liability

If the member has other medical coverage, the practitioner/provider must first file the claim with the other primary insurance carrier. Upon receipt of partial payment or denial from the other carrier, the practitioner/provider should submit the claim to KHS/the PBM along with documentation of payment or denial from the primary carrier. A copy of the other Plan's payment determination is required prior to releasing payment for those members covered by another Plan.

KHS secondary payment for eligible services is limited to the maximum that KHS would compensate practitioners/providers as specified in the practitioner's/provider's contract. The primary and secondary payments may not add up to more than 100% of eligible charges.

KHS does not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates either third party coverage, designated by the Other Health Coverage (OHC) code, or Medicare coverage without proof that the practitioner/provider has first exhausted all other sources of payment. An exception to this guideline exists for services and OHC codes which request post-payment recovery. Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y or Z.

KHS does not attempt recovery in circumstances involving Casualty Insurance, Tort Liability, or Workers' Compensation awards to plan members. Circumstances which may result in Casualty Insurance payments, Tort Liability payments, or Worker's Compensation awards are reported, in writing, to DHCS as appropriate within 10 (ten) calendar days after discovery by KHS.

2.2 Payment of Interest on Late Claims[11]

KHS pays interest on clean claims not paid within 45 working days of receipt[12]. KHS calculates and pays interest automatically without requiring the provider to make a request.[13]

Interest on each claim is accrued at the rate of 15% per annum beginning with the first calendar day following the 45th working day and ending with the anticipated date when

the payment checks will be issued and sent to applicable providers. Claims for emergency services are paid a minimum interest of $15 for each 12-month period or portion thereof on a non-prorated basis.[14].

3.0 RECOVERY OF OVERPAYMENTS[15]

KHS pursues recovery of overpayments that meet cost-benefit guidelines. When recovery is pursued, KHS sends a refund request letter to the practitioner/provider. Within 30 working days of receipt of the letter, the practitioner/provider must submit to KHS either a complete refund of the overpayment or a practitioner/provider dispute. Disputes must be submitted and will be processed in accordance with *KHS Policy and Procedure # 13.05 – Practitioner/Provider Disputes Regarding Pharmacy Claims Payment.*[16] As stipulated in the practitioner/provider contract, if a dispute is not received within 30 working days, the overpayment will be offset against additional amounts due to the practitioner/provider.

4.0 INQUIRIES REGARDING UPAID CLAIMS[17]

Practitioners/providers may confirm the date of receipt of paper claims within 15 working days of receipt by calling 1-800-391-2000. Practitioners/providers receive an electronic acknowledgement of the receipt of electronic claims within 2 working days of the date of receipt.

5.0 UNFAIR BILLING PATTERNS[18]

Providers who engage in an unfair billing pattern may be reported to the Department of Managed Health Care. KHS will make efforts to work with providers to distinguish billing errors from unfair billing patterns and to help providers correct billing errors. Providers will only be reported to DMHC after efforts to resolve such billing issues have failed.

REFERENCE:

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[1] **Revision 2016-08:** Reference to Health Families removed. **Revision 2013-10:** Policy reviewed by Director of Pharmacy. Reference to NPI numbers added, **Revision 2009-04**: Revised by Director of Pharmacy to bring PBM and KHS address current. Not reviewed by the AIS Department. **Revision 2003-12**: Revised to comply with AB1455 Claims Settlement Regulations; effective 01/01/2004. Revised per request of Claims Manager. Policy #6.03 – Unbundled Claims (2001-03) is deleted and incorporated into this policy. Policy #6.08 – Coordination of Benefits (2000-10) is deleted and incorporated into this policy and the associated internal policy. Policy #60.05 – Payment of Interest on Late Claims (2002-02) is deleted and incorporated into this policy and the associated internal policy. Policy #60.06 – Third Party Liability (2001-08) is deleted and incorporated into this policy and the associated internal policy. **Revision 2002-05:** Revised per DHS request. Clarify that 90 submission deadline applies only to contracted providers. Also added Processing Guidelines section. Revised per Amendment to 2002 Service Agreements (11/8/01). **Revision 2001-03**: Changes made per Provider Relations request. Changed submission deadline from 60 to 90 days to match contract; added HFAM PO Box. Issue date changed to correct previous error.

[1] CCR Title 28 §1300.71(a)(11)

[2] CCR Title 28 §1300.71(a)(10)

[3] CCR Title 28 §1300.71(a)(13)

[4] Title 5 USC 6103 specifies the federal holiday schedule. See www.canb.uscourts.gov/canb/genifo.nsf (click on "general information"; click on "search"; enter "federal holidays" in the search box) for a yearly schedule.

[5] CCR Title 28 §1300.71(b)(4)

[6] Amendment to 2002 Service Agreements (November 8, 2001)

[7] KHS may not impose a deadline less than 90 days after the date of service (CCR Title 28 §1300.71(b)(1).

[8] KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).
[9] KHS may not impose a deadline less than 180 days after the date of service (CCR Title 28 §1300.71(b)(1). B. Davenport requested the deadline remain 365 days for non-contracted providers because that is what straight MCAL allows.
[10] KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).
[11] HSC §1371
[12] Health and Safety Code Sections 1371, 1371.35
[13] Health and Safety Code §1371
[14] Health and Safety Code §1371.35(e); CCR Title 28 §1300.71(i)(1)
[15] CCR Title 28 §1300.71(d)(3) through (6)
[16] CCR Title 28 §1300.71(d)(4)
[17] CCR Title 28 §1300.71(c)
[18] HSC §1371.39(b)