KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Referral and Authorization Process			POLICY #: 3.22-P		
DEPARTMENT: Utilization Management					
Effective Date: 01/01/1999	Review/Revised Date: 04/21/2023	DMHC	X	PAC	X
		DHCS	X	QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_________________________ Date _________________________
Emily Duran
Chief Executive Officer

_________________________ Date _________________________
Chief Medical Officer

_________________________ Date _________________________
Chief Operating Officer

_________________________ Date _________________________
Chief Health Services Officer

_________________________ Date _________________________
Senior Director of Provider Network

_________________________ Date _________________________
Director of Pharmacy

_________________________ Date _________________________
Director of Claims

_________________________ Date _________________________
Director of Member Services

_________________________ Date _________________________
Director of Quality Improvement

_________________________ Date _________________________
Director of Utilization Management

POLICY:

Kern Health Systems (KHS) will develop, implement, and continuously improve a utilization management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered behavioral and medical services.[1] For those services which require prior authorization, only KHS UM personnel, the KHS Chief Medical Officer or their designee(s), and the KHS CEO may give authorization for payment by KHS. Services may not be authorized by any other KHS personnel.

Contracted providers are required to obtain prior authorization, unless special circumstances require use of a non-contracted provider, pre-arranged by KHS or determined by KHS to be emergent or urgent in nature. In order to provide continuity of care, KHS will under certain conditions authorize care by a non-contracted provider. See *KHS Policy and Procedures #3.39 –Continuity of Care by Terminated Providers* and *#3.40 – Continuity of Care for New Members* for details.

The referral and authorization process will conform to the requirements outlined in the following statutory, regulatory, and contractual sources:

- ❖ Code of Federal Regulations Title 42 §§431.211; 431.213; and 431.214
- ❖ California Health and Safety Code §§1363.5; 1367.01; 1368.1; 1371.4; 1374.16
- ❖ California Code of Regulations Title 28 §1300.70(b) and (c)
- ❖ California Code of Regulations Title 22 §§51014.1; 51014.2; and 53894
- ❖ California Code of Regulations Title 22§ 51303 Investigational Services
- ❖ 2004 DHCS Contract Exhibit A-Attachment 5; Exhibit A-Attachment 9; Exhibit A-Attachment 13(8)
- ❖ DHCS MMCD Letters 04006 (November 1, 2004) and 05005 (April 11, 2005)

DEFINITIONS:

Request for Acute Continuing Services[2]	Request for extension of approval for acute care services in hospitals when both of the following conditions apply: A. The treating physician has determined that the member cannot safely be discharged because acute care services continue to be medically necessary for one of the following reasons: 1. Further acute care is needed for the purpose of treating the condition or conditions for which the acute care was originally approved for an acute admission requiring prior authorization 2. Complications directly related to the diagnosis for which acute care was originally approved have arisen and necessitate further acute care 3. Further care is needed for an illness contracted during the course of an approved acute admission if the illness most likely occurred because the patient was hospitalized 4. Further care is needed for the purpose of treating a diagnosed condition(s) for which a length of stay was previously approved after an emergency or urgent admission 5. Further diagnostic procedures and/or treatments are needed after a previously approved emergency or urgent admission,

	for which no length of stay was approved, and the acute care stay has been at least 5 days in duration at the time of the request B. The medical record contains documentation consistent with (A) above.
Request for Non-Acute Continuing Services[3]	Request for services received by KHS prior to or no later than 10 working days after expiration of the immediately preceding approved authorization for services in the following categories: A. Long-Term Care, specifically Skilled Nursing Facility, and Subacute levels of care B. Chronic Hemodialysis, including all related services C. Hospice Care D. All other non-acute services under the Medi-Cal program when the treating physician substantiates on or with the request that the same level or frequency of services should be continued because the treatment goal approved on the original authorization has not been achieved.

PROCEDURES:

1.0 TYPES OF SERVICES FOR WHICH AUTHORIZATION IS NOT REQUIRED

Unless specifically excluded, all services must be authorized by KHS in accordance with KHS referral policies and procedures. The following services do not require prior authorization:[4]

A. Primary care from a KHS contracted Primary Care Practitioner (PCP).

B. Emergency care[5]. (See *KHS Policy and Procedure #3.31 – Emergency Services* for details and limitations.)

C. Maternity care. Authorization is required for specialty procedures in the OB/GYN area (i.e., amniocentesis, hysterectomy, and LEEP). (See *KHS Policy and Procedure #3.24 – Maternity Care* for details and limitations.)

D. Family planning services and abortion. (See *KHS Policy and Procedure #3.21 – Family Planning Services and Abortion* for details and limitations.)

E. STD services. (See *KHS Policy and Procedure #3.17 – STD Treatment* for details and limitations.)

F. HIV testing. (See *KHS Policy and Procedure #3.18 – Confidential HIV Testing* for details and limitations.)

G. Sensitive Services[6]. (See *KHS Policy and Procedure #3.20 – Sensitive Services* for details and limitations.)

H. Initial Mental Health Assessment (See *KHS Policy and Procedure #3.14 – Mental Health Services* for details and limitations.)

I. Outpatient Hospice Services (See *KHS Policy and Procedure #3.43 Hospice Services* for details and limitations)

J. Urgent Care

Although the above services do not require authorization, submission of a *Referral/Prior*

Authorization Form and supporting documentation may be required for tracking purposes. See *KHS Policy and Procedure 3.25-P: Prior Authorization Procedures and Services* and the specific scope of service policy for additional information. Absence of an authorization requirement does not relieve the provider of the requirements to use contracting providers (as applicable) and verify eligibility.

1.1 Non-Contracted Providers

With the exception of Family Planning, HIV testing, Initial Mental Health Assessment, and Sexually Transmitted Disease (STD) diagnosis and treatment, prior authorization is required for all non-emergent services performed by non-contracted providers. All requests for such services are reviewed by the KHS Chief Medical Officer, or their designee(s) or UM staff.

See *KHS Policies and Procedures #3.17 – STD Treatment, #3.18-Confidential HIV Testing, and #3.21 – Family Planning Services and Abortion* for additional information on receiving the related services from non-contracted providers.

See *KHS Policy 6.01-P Claims Submission and Reimbursement* for additional information on non-contracted providers.

2.0 VERBAL AUTHORIZATION

Providers and/or members can request verbal authorization for the services indicated in the following table.

Type of Service	Contact Information	Decision and Notification Timeline
Hospice	**Regular business hours:** UM Department (661) 664-5083 or toll free (800) 391-2000 **After business hours:** 24 –hour Telephone Triage Line (800) 391-2000. Must request to speak to KHS administrator on call.	Response within 24 hours.[7]
Non-urgent care following an exam in the emergency room	**Regular business hours:** UM Department (661) 664-5083 or toll free (800) 391-2000 **After business hours:** 24 –hour Telephone Triage Line (800) 391-2000.	Response within 30 minutes or the service is deemed approved.[8]
Post-stabilization	**Regular business hours:** UM Department (800) 391-2000 **After business hours:** 24 –hour Telephone Triage Line (800)	Response within 30 minutes or the service is deemed approved.[9]

Type of Service	Contact Information	Decision and Notification Timeline
	391-2000. Must request to speak to KHS administrator on call.	
Urgent Care	24 –hour Telephone Triage Line (800) 391-2000.	Prior authorization not required.
Urgent Referrals	**Regular business hours:** UM Department (661) 664-5083 or toll free (800) 391-2000	Response within 72 hours from receipt

Telephone/verbal authorization must be followed by submission of a *Referral/Prior Authorization Form* and supporting documentation.

UM staff follow-up verbal authorization decisions with written notification as outlined in *Section 4.3 –Provider and Member Notification*.

3.0 HOSPITAL AUTHORIZATION

For non-elective hospital admissions, notification of admission must be submitted to KHS as outlined in *KHS Policy and Procedure #3.33 – Hospital/Facility Authorization, Admission, and Discharge*. The admission face sheet may be used in lieu of a *Referral/Prior Authorization Form.* Authorization requests will be processed in the same manner and as outlined in the Routine Authorization section or Retrospective Review Decisions of this procedure as appropriate.

Prior authorization must be obtained for all elective hospital admissions.

4.0 ROUTINE AUTHORIZATION

KHS provides written notification to members of any termination or reduction in behavioral or medical services and any denials, modifications, or delays of referrals. Services denied, delayed, or modified based on medical necessity may be eligible for Independent Medical Review (IMR). See *KHS Policy and Procedure #14.51 – Independent Medical Review* for details on the IMR process.

4.1 Request for Authorization

A routine authorization request is initiated by submission of a *Referral/Prior Authorization Form* (See Attachment A) either via fax, mail or online submission. Participating providers treating member must submit the request for authorization via the online submission process. The request must include pertinent medical records and member data which support the medical necessity of the services requested in the referral and will assist the specialist in the assessment and delivery of services. KHS requests only the information reasonably necessary to make a determination regarding the request.[10]

The PCP or specialty provider treating the member must initiate referrals to qualified contract providers for specialty care or services in a time frame appropriate to the acuity of the member's condition. Provider is defined as any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

Referral forms must be filled out completely, with all pertinent patient information and

supporting documentation. The signature of the contracted referring physician or contracted mid-level must appear on the form unless submitted electronically via the online submission process.

In order to submit a referral request online, the provider is required to have internet access and as well as access to the KHS Provider Portal. The Provider Relations and MIS departments will facilitate online authorization access and provide instructions on its use.

Completed *Referral/Prior Authorization Forms* and necessary medical records unable to be submitted electronically should be submitted to the KHS Utilization Management Department via fax or mail.

Utilization Management
Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, CA 93308
Fax: (661) 664-5190

The date of receipt for routine referral/authorization requests that are received by KHS after 3:00 PM will be the next business day.[11] The 3:00 cut off time does not apply to services which require verbal authorization as described in Section 2.0 of this policy.

4.2 Utilization Review

Utilization review includes the actions outlined in the following table.

Action	Timeline	Comments
Review by UM staff		UM staff reviews the referral against established KHS guidelines. Requests are classified as urgent when the member's condition is such that he/she faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize his/her ability to regain maximum function[12]. If a referral does not qualify as an urgent referral, the provider will be notified with a *Re-classification Letter* stating the referral does not meet the criteria for an urgent review (See Attachment K).
Review by Chief Medical Officer, Medical Director, or Physician Advisor		Required if the referral does not meet established criteria for medical necessity. This excludes administrative denials.

Action	Timeline	Comments
Decision (defer, approve, modify, terminate/reduce, or deny)	**Routine**: Five working days of receipt.[13] **Urgent**: within 72 hours from receipt of request (as appropriate for the nature of the member's condition) of the receipt of all information reasonably necessary and requested.[14] **Concurrent Review for Treatment Regimen Already in Place**: Five working days or consistent with urgency of medical condition.[15] **Standing Referral:** Within three business days the date the request and receipt of all appropriate medical records and other items of information necessary to make the determination. (See Section 6.0)[16]	Requests needing additional medical records may be deferred according to the timeliness standards outlined in Sections 4.2.1 and 4.2.1.1 of this document. Urgent referrals are not deferred, as requests for additional information are handled via telephone within 72 hours of receipt. In the case of concurrent review, care will not be discontinued until the treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the member.[17] The date of action must be determined in compliance with the notice requirements outlined in Section 4.3.2 of this document.

4.2.1 Deferrals

Authorization requests needing additional medical records may be deferred, not denied, until the requested information is obtained. If deferred, the UM Clinical Intake Coordinator UM Clinical Intake Coordinator follows-up with the referring provider within 14 calendar days from the receipt of the request if additional information is not received. Every effort is made at that time to obtain the information. Providers are allowed 14 calendar days to provide additional information[18]. On the 14th calendar day from receipt of the original authorization request, the request is approved or denied as appropriate.

4.2.1.1 Extended Deferral

The time limit may be extended an additional 14 calendar days if the member or the Member's provider requests an extension, or KHS UM Department can provide justification for the need for additional information and how it is in the Member's interest. In cases of extension, the request is approved or denied as appropriate no later than the 28th calendar day from receipt of the original authorization request.

If the KHS requires an extension of the initial 14 calendar day authorization timeframe, KHS must:
1) either deny the authorization request or immediately notify the requesting provider to request all specific information the Plan still needs to make its authorization decision.
2) document its justification in the member's medical record of the need for the extension to obtain additional information and demonstrate how the authorization extension is in the member's interest.

4.2.2 Modifications

There may be occasions when recommendations are made to modify an authorization request in order to provide members with the most appropriate care. Recommendations to modify a request based on medical necessity are first reviewed by the Chief Medical Officer, Medical Director, Physician Advisor(s), or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider.

The referrals that qualify for a modification are:

A. Change in place of service
B. Change of specialty
C. Change of provider or
D. Reduction of service

Under KHS's Knox Keene license and Health and Safety Code §1300.67.2.2 , KHS, as a plan operating in a service area that has a shortage of one or more types of providers is required to ensure timely access to covered health care services, including applicable time-elapsed standards, by referring enrollees to, or, ***in the case of a preferred provider network***, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. KHS will arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

KHS's Knox Keene license permits KHS to arrange for the provision of specialty services, which implies that the clause "if either the member or requesting provider disagrees, KHS does not require approval to authorize the modified services.

In the case of radiology requests, modifications to the appropriateness of contrast in performing the study may be changed based on accepted protocols that have been developed by credentialed radiologist's and approved by the PAC. These types of modifications can be done without discussing the modification with the requesting provider. Modifications to the type of study require a discussion and approval by the requesting provider in accordance with KHS DHCS contract.

4.2.3 Denials

If initial review determines that an authorization request does not meet established

utilization criteria for medical necessity, denial is recommended. Only the Chief Medical Officer, Medical Director, Physician Advisor(s), or a licensed health care professional who is licensed in the state of California and who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider may deny an authorization request based on medical necessity.[19] See *KHS Policy 3.73-I Medical Decision Making* for additional information.

4.2.4 Administrative Denials

Administrative denials are denials for requested services that are determined by a qualified health professional that are not made, whole or in part, on the basis of medical necessity.

Often times, these decisions are to facilitate services that are either a carve out from benefits provided under Kern Health Systems health plan coverage or additional local or out of area resources that will be financially responsible for the requested service based on
diagnosis or other criteria.

KHS UM Clinical Intake Coordinators apply critical thinking skills and sound judgment prior to performing an administrative denial. These administrative denials can only be performed if they will not subject the member to a poor outcome based on the decision for service. Administrative denials are exempt from the appeal process.

If the UM Clinical Intake Coordinator is unable to determine if the denial would adversely affect the member or uncertain of the type of denial, the UM Clinical Intake Coordinator should forward the denial to a Chief Medical Officer, or their designee(s) for review and recommendations.

4.2.5 Denials to Terminally Ill Members

KHS is required to provide members and providers with notification of denial for a prior authorization request for services within 5 business days or less. The notification to the member will provide all of the following information:

a. Statement clearly explaining the specific medical and scientific reasons for denying coverage.
b. Description of any alternative treatments, services, or supplies covered by the plan, if any.
c. Information regarding member's rights, including appeal and grievance options and forms.
d. Copies of KHS grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of KHS grievance system provided under Section 1368(a)(3). See KHS Policy and Procedure #5.01-P: Grievance Process for additional information.

A terminal illness means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months

from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

4.3 Provider and Member Notification

Results of the utilization review for non-urgent referrals are communicated by UM staff to the provider and member as outlined in the following table. Notification to providers is provided via the method of submission, either online portal, mail, or facsimile.[20]

Failure to render a decision for standard authorization requests within the required timeframes is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires. As such the member has the right to request an appeal with the KHS and KHS must send the member written notice of all appeal rights.

The term "Action," has been replaced with "Adverse Benefit Determination." The definition of an "Adverse Benefit Determination" encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability.

An "Adverse Benefit Determination" is defined to mean any of the following actions taken by KHS:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network.
7. The denial of a beneficiary's request to dispute financial liability.

Beneficiaries must receive written notice of an Adverse Benefit Determination. The beneficiary (member) notification must be written at a 6th grade literacy level. *All member material is written at or below a 6th grade reading level. UM staff have been trained to use KHS' health literacy assessment tool and have access to plain language terminology resources. These tools allow for verification of the required reading level and aid the UM staff in identification and replacement of technical or high literacy terms prior to sending written material to members.*

Upon generation of a written member informing material, the UM staff enters the text into the health literacy assessment tool. If the material is scored above the 6th grade reading level, the UM staff uses the tool to identify the technical or high literacy terms and replaces these terms with the suggested lower literacy terms provided by the health literacy assessment tool or the plain language terminology resources. Once the material meets the required reading level, the UM staff stamp the material reviewed with the required reading level and process

the member material for mailing.

The correspondence notification must be provided in alternative formats (large font, braille or audio file) if requested by the beneficiary.

KHS will utilize DHCS-developed, standardized NOA templates for common scenarios (denial, delay, modification, termination) and corresponding "Your Rights" attachments to comply with new federal regulations. The following five distinct NOA templates accommodate actions that MCPs may commonly take:

1. Denial of a treatment or service
2. Delay of a treatment or service
3. Modification of a treatment or service
4. Termination, suspension, or reduction of the level of treatment or service currently underway
5. Carve-out of a treatment or service

KHS shall utilize the revised NOA templates and corresponding "Your Rights" attachments. KHS shall not make any changes to the NOA templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required. All Plan Letter 21-011 supersedes All Plan Letter 17-006. KHS has updated NOA templates based on the 2021 revision.

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services (HHS), Office for Civil Rights (OCR) issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require KHS to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries. "Nondiscrimination Notice" and "Language Assistance" taglines templates provided by DHCS will be used by KHS to make modifications or create new templates. DHCS review and approval must be obtained prior to use. These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: Adverse Benefit Determination, Grievance acknowledgment letter, Appeal acknowledgment letter, Grievance resolution letter, and NAR.

<table>
<tr><th>Result of Review</th><th>Provider Notice</th><th>Member Notice</th></tr>
<tr><td>Approved</td><td>Referring: Approved Referral/Prior Authorization Form (within 24 hours of the decision).[21]

Specialist: Approved Referral/Prior Authorization Form and any pertinent medical records and diagnostics (within 24 hours of the decision).

OR

Hospital: Hospital Notification Letter (within 24 hours of the decision). See Attachment to KHS Policy and Procedure #3.33 – Admission/Discharge Notification and Authorization Process for Contracted Facilities.</td><td>Notice of Referral Approval (within 48 hours of the decision). See Attachment B.</td></tr>
<tr><td>Deferred</td><td>Referring: Copy of Notice of Adverse Determination Letter and the Referral/Prior Authorization Form (within 24 hours of the decision)[22].

OR

Hospital: Requests for hospital services are not deferred.</td><td>Notice of Adverse Determination Documents (within 2 business days of the decision).[23] Documents include all of the following:
❖ Notice of Adverse Determination - Delay letter. (Attachment C)
❖ Your Rights Under Medi-Cal Managed Care (Attachment G) Medi-Cal members only
❖ Form to File a State Hearing (Attachment H). Medi-Cal members only</td></tr>
</table>

Result of Review	Provider Notice	Member Notice
Modified (Initial request for a service or treatment)	**Referring**: Copy of Notice of Adverse Determination Letter and modified *Referral/Prior Authorization Form* (within 24 hours of the agreement).[24] **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).[25] Documents include all of the following: ❖ *Notice of Adverse Determination – Modify* (Attachment D) ❖ *Your Rights Under Medi-Cal Managed Care* (Attachment G) Medi-Cal members only ❖ *Form to File a State Hearing* (Attachment H). 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 section 4.3.2 of this document).[26] Documents include all of the following[27]: ❖ *Notice of Adverse Determination – Terminate* (Attachment F) ❖ *Your Rights Under Medi-Cal Managed Care* (Attachment G) Medi-Cal members only ❖ *Form to File a State Hearing* (Attachment H). Medi-Cal members only

Result of Review	Provider Notice	Member Notice
Denied (Includes those carve out services that are denied as not covered by KHS).[28]	**Referring**: Copy of Notice of Adverse Determination Letter (within 24 hours of the decision).[29]. **OR** **Hospital**: *Hospital Notification Letter* (within 24 hours of the decision). See Attachment to *KHS Policy and Procedure #3.33 – Admission/Discharge Notification and Authorization Process for Contracted Facilities.*	Notice of Adverse Determination Documents (within 2 business days of the decision).[30]Documents include all of the following: ❖ *Notice of Adverse Determination – Denial* (Attachment E) ❖ *Your Rights Under Medi-Cal Managed Care* (Attachment G) Medi-Cal members only ❖ *Form to File a State Hearing* (Attachment H). Medi-Cal members only

The Notice of Adverse Determination letters together with the indicated enclosures contain all of the required elements for both provider and member notice of delay, denial, or modification including the following[31]:

A. The action taken
B. A clear and concise explanation of the reason for the decision (including clinical reasons for decisions regarding medical necessity)[32]
C. A description of the criteria/guidelines used
D. A citation of the specific regulations or plan authorization procedures supporting the action[33]
E. Information on how to file a grievance with KHS including the Plan's name address and phone number
F. Information regarding a Medi-Cal member's right to a State Fair Hearing including:
   1. The method by which a hearing may be obtained
   2. That the member may either be self-represented or represented by an authorized third party such as legal counsel, relative, friend, or any other person
   3. The time limit for requesting a fair hearing.
   4. The toll free number for obtaining information on legal service organizations for representation.
G. Information regarding the member's right to an Independent Medical Review with DMHC
H. DMHC required language regarding grievances[34]
I. The following information in cases of delay:
   1. Disclosure of the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required in order to make a decision
   2. The anticipated date on which a decision may be rendered
J. Name and telephone number of the Chief Medical Officer, or their designee(s)[35]

K. The NOA must be written at 6th grade literacy for beneficiary understanding.

L. KHS currently translates all grievance resolution and appeal NARs, including the clinical rationale for the decision, into the member's threshold language before mailing. Members with visual impairment may also receive their grievance and appeal correspondence in the alternative format of their choice, including Braille, audio cd or data cd.

4.3.0 Request for Additional Information

KHS written notice requesting for additional medical information must:
1) specify the information the KHS requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied;
2) include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay;
3) be sent within the required timeframe, or as soon as KHS becomes aware that it will not meet the initial authorization timeframe, whichever is earlier.

When additional and specific information is requested, KHS must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but no longer than five (5) business days from KHS receipt of information reasonability necessary and requested by KHS to make a determination, not to exceed the additional fourteen (14) calendar days.

4.3.1 Expedited Referrals

In the case of expedited referrals, the UM Clinical Intake Coordinator provides written notification to the provider on the same day as the decision via facsimile or the online portal.

In the event an expedited request requires an extension of the initial 72-hour authorization, KHS must send written notice to the member and the provider using the appropriate NOA template within the required timeframe and meeting requirements outlined in APL 21-011

KHS' failure to render a decision for expedited authorization requests within the required timeframes is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires. In this situation, the member has the right to request an appeal with the KHS and KHS must send the member written notice of all appeal rights.

4.3.2 Termination or Reduction of a Continuing Service That Was Previously Approved[36]

Use of the *Notice of Adverse Determination – Terminate* letter and the timeliness guidelines outlined in this section apply in any of the following conditions:

A. KHS intends to reduce or terminate authorization for a medical service prior to expiration of the period covered by the authorization.[37]

B. KHS intends to take either of the following actions on a request for non-acute

continuing services as defined in the Definitions section of this document:[38]

1. Termination: Denial
2. Reduction: Approval at less than the amount or frequency requested and less than the amount or frequency approved on the immediately preceding authorization. There is no reduction if a shorter time period of services than requested is approved, as long as the amount or frequency of services during that period has not been reduced from the previously approved level.

C. KHS intends to terminate (deny) a request for acute continuing services as defined in the Definitions section of this document[39]. There is no termination if less than the full number of days requested is approved. Such notices must be personally delivered to the member in his/her hospital room unless the member's treating physician has certified in writing that such personal delivery may result in serious harm to the member. In such cases, the notice shall be mailed to the member or his/her beneficiary.

Unless specifically covered by one of the exceptions below, KHS will mail the Notice of Adverse Determination Documents to the member at least 10 days before the date of action.[40]

KHS will mail the Notice of Adverse Determination Documents to the member at least 5 days before the date of action if[41]:

A. KHS has facts indicating that action should be taken because of probable fraud by the member; and
B. The facts have been verified, if possible, through secondary sources.

KHS will mail the Notice of Adverse Determination Documents not later than the date of action if any of the following conditions apply[42]:

A. KHS has factual information confirming the death of the member
B. KHS receives a clear written statement signed by the member that:
   1. The member no longer wishes services; or
   2. The member gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
C. The member has been admitted to an institution where he is ineligible under the plan for further services
D. The member's whereabouts are unknown, and the post office returns KHS mail directed to the member indicating no forwarding address (See 42 CFR Sec. 431.231 (d) for procedure if the recipient's whereabouts become known);
E. KHS establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth
F. A change in the level of medical care is prescribed by the member's physician;

4.3.2.1 State Fair Hearings Regarding Terminations or Reductions

In cases where a State Fair Hearing is pending for a terminated or reduced service, authorization for services shall be maintained or begin as outlined in California Code of Regulations Title 22 §51014.2.

5.0 Retrospective Authorization Request:

Retrospective authorization request may be submitted within sixty (60) calendar days of the date of service for outpatient/office visits/procedures that are identified as an additional procedure performed during an authorized visit or an unauthorized visit or procedure that is deemed urgent or emergent. All supporting documentation must be included with the request. Any outpatient/office referral request that requires prior authorization received by KHS with a date of service greater than sixty (60) calendar days will be denied by the UM Clinical Intake Coordinator. UM Clinical Intake Coordinators will review the retrospective request and approve if the information received meets medical necessity for the services rendered, and the services were in conjunction with an approved visit or are identified as urgent or emergent in nature**.**

All retrospective reviews will be completed within 30 calendar days. KHS must communicate its decision to the member who received services, or to the member's designee, within 30 days of the receipt of determination, and must communicate the decision to the provider in a manner that is consistent with current law

Failure to obtain prior authorization by the provider due to eligibility verification for previously scheduled appointments are not considered urgent or emergent requests. A Notice of Adverse Determination Denial Letter will be generated if the referral is denied. Providers are encouraged to contact KHS UM department directly via phone at 1-800-391-2000 if an authorization is needed for the same day. Most requests can be accommodated if documentation is received for review to determine medical necessity.

If KHS is not notified of a hospital admission, the decision for authorization request may also be submitted within sixty (60) calendar days from date of admission. All supporting documentation must be included with the request for retrospective authorization. The UM Nurse RN will review the retrospective request and approve if the information received meets medical necessity for the services rendered.

Authorization for payment may not be given if facility fails to notify KHS of admission and the admission is other than emergent in nature. A Notice of Adverse Determination Denial Letter will be generated if the referral is denied.

5.1 Claim Denials for Services Performed without Obtaining Prior Authorization:

Claims submitted by KHS contract and non-contract providers are matched against authorizations entered into the claims payment system. Providers are required to determine a member's eligibility and obtain prior authorization before initiating non emergent services. If the provider fails to obtain prior authorization or retrospective authorization as defined in 5.0 for non-emergent services, the claim(s) for those services will be denied. Procedures and services for which no authorization paperwork is required are described in KHS Policy and Procedure 3.25-P: Prior Authorization Procedures and Services.

Requests for retrospective payment for unauthorized services may be reviewed at the discretion of the health plan, and the decision to review will be based on the documentation submitted detailing the extenuating circumstances that explains why the prior authorization request was not submitted. All such requests must include complete medical records. Requests for retrospective authorization submitted only with records, will not be reviewed for

medical necessity; but, instead denied as prior authorization was not obtained.

Providers may submit a Claims Dispute in accordance with KHS Policy 6.04-P.

6.0 STANDING REFERRALS[43]

Occasionally a member will have a disease that requires prolonged treatment by or numerous visits to a specialty care provider. Once it is apparent that a member will require prolonged specialty services, UM may issue a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the members health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the Chief Medical Officer or their designee(s) determines that this specialized medical care is medically necessary for the enrollee. A standing referral is an authorization that covers more visits than an initial consultation and customary follow-up visits and typically includes proposed diagnostic testing or treatment without the primary care physician having to provide a specific referral for each visit. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by KHS.

Conditions that may be best treated using a standing referral may be life-threatening, degenerative, or disabling and include, but are not limited to, HIV and AIDS.

A standing referral and treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the member. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the member's primary care physician, subject to the terms of the treatment plan. It is only valid during periods when the member is eligible with KHS.

A standing referral may be issued to contracted or non-contracted providers as deemed appropriate by the Chief Medical Officer, or their designee(s). The Chief Network Administration Officer, or their designee(s), will negotiate letters of agreement for services not available within the network. Members with a need for a standing referral are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity. Members with a need for a standing referral to a physician with a specialized knowledge of HIV medicine are referred to an HIV/AIDS specialist as outlined in *KHS Policy and Procedure #4.01-P: Credentialing*.

Determinations regarding standing referrals are made within three business days of the date of request and receipt of all appropriate medical records and other items of information necessary to make the determination. Once a determination is made, the referral is made within four business days of the date the proposed treatment plan, if any, is submitted to the plan Chief Medical Officer, or their designee(s).[44]

6.1 Treatment Plan

The Chief Medical Officer or their designee(s) may require the treating provider to submit a treatment plan setting forth the expected course of diagnosis and treatment including projected number of visits, proposed therapies, requirements for communication between the treating provider and PCP, and a means for assessing the patient. A treatment plan may be deemed

not necessary provided that the appropriate referral to a specialist or specialty care center is approved by KHS or its contracting provider. The Chief Medical Officer, or their designee(s) reviews the treatment plan for appropriateness and may use specialists to assist in the review as needed.

7.0 CRITERIA AND GUIDELINES[45]

Review criteria are consistently applied. Medi-Cal is KHS' primary criteria source. The list below is not exhaustive but written in order of criteria use:

A. Medi-Cal guidelines-DHCS/DMHC
B. MCG (Milliman Care Guidelines)
C. Up to Date
D. Professional Society Organizations Examples:
    a. American Academy of Pediatrics
    b. American Academy of Orthopaedic Surgeons
    c. American College of Cardiology

KHS discloses or provides for disclosure to the commissioner, contract providers, or enrollees, the process and criteria KHS uses to authorize, modify, or deny health care services under the benefits provided by the Plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities.[46]

7.1 Disclosure of Criteria to the Public

KHS makes available to the public upon request, criteria or guidelines for specific procedures or conditions requested. [47] Beneficiaries may request, free of charge, copies of all documents and records relevant to the NOA, including criteria or guidelines used.

All requests for criteria/guidelines from the public are directed to the Chief Health Services Officer or their designee. He/she speaks with the requestor and makes the necessary arrangements to provide a copy of the criteria/guideline and cover letter. (See Attachment I). The request is logged in the *Public Request for Criteria Log*. (See Attachment J).

8.0 APPEALS PROCESS

Both providers and members may appeal a denied/modified referral.

Provider appeals must be submitted and are processed in accordance with *KHS Policy and Procedure #3.23-P: Practitioner/Provider Appeals Regarding Authorization*. Member appeals must be submitted and are processed in accordance with *KHS Policy and Procedure #5.01-P: Grievance Process*.

DHCS has deemed it necessary to create two distinct "Your Rights" attachments to accommodate the following scenarios:

1) Beneficiaries who receive a NOA and
2) Beneficiaries who receive a Notice of Appeal Resolution (NAR). A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

While the "Your Rights" attachment sent out to beneficiaries who receive a NOA will contain general

information on State Hearing and IMR rights, the notice will primarily inform the beneficiary on how to request an Appeal with KHS. A State Hearing form will not be attached, as the beneficiary would need to exhaust the MCP's Appeal process first. Similarly, an IMR form will not be attached, as the beneficiary would also need to exhaust the MCP's Appeal process prior to requesting an IMR unless the Department of Managed Health Care (DMHC) determines that an expedited review is warranted due to extraordinary and compelling circumstances. Requirements pertaining to IMRs remain unchanged.

Conversely, the "Your Rights" attachment sent out to beneficiaries who receive a NAR that upholds the original Adverse Benefit Determination will not contain information on how to file a request for an Appeal as the beneficiary will have already exhausted the MCP's Appeal process. The notice will primarily inform the beneficiary on how to request a State Hearing and/or IMR. State Hearing and IMR application forms will be attached as appropriate.

9.0 SPECIALIST SERVICES

Upon receipt of authorization from KHS, the specialist provides the authorized medical services within the normal scope of the designated specialty. In compliance with access standards, specialists should contact members to schedule appointments for care following the receipt of authorizations.

9.1 PCP Notification

The specialist is required to communicate the assessment, findings, and recommended treatment plan to the member's PCP in writing in a timely manner as the patient's condition warrants.

It is the responsibility of the PCP to contact the specialist should the PCP disagree with the diagnostic or treatment plan of the specialist and/or additional services authorized by the plan. In the case of continued disagreement between the PCP and the specialist, the specialist and/or PCP should contact the KHS Chief Medical Officer, or their designee(s), who will take appropriate action.

9.2 Requests for Authorization of Additional Services

Specialists must initiate a referral for all services not authorized on the initial referral form that require prior authorization as outlined in *KHS Policy and Procedure 3.25-P: Prior Authorization Procedures and Services.* Referrals from specialists are handled in the same manner as referrals from PCPs.

9.3 Specialty Consultations via Telemedicine

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve the member's clinical health status through the use of two way video, email, smart phones, wireless tools and other forms of telecommunications technology. No prior authorization is required for all consultations performed utilizing telemedicine and limited to those KHS contracted providers who have demonstrated adequate office space, availability of a patient navigator, and suitable telemedicine equipment to connect with a remote medical group.

10.0 REFERRAL GUIDELINES FOR SPECIFIC TYPES OF CARE

Prior authorization requirements for specific services can be found in the scope of services policy. Procedures and services for which no authorization paperwork is required are described in *KHS Policy*

and Procedure 3.25-P: Prior Authorization Procedures and Services.

10.1 Coordination of Covered Services[48]

KHS shall arrange for the timely referral and coordination of covered services if a member's provider has a religious or ethical objection to perform various types of services.

The UM Department will arrange and coordinate the services by referring the member to another provider who does not have religious or ethical objections in providing the covered services. The process for the coordination of care shall not generate additional expenses to DHCS.

11.0 DOCUMENTATION, TRACKING, AND MONITORING [49]

Letters regarding authorization requests, including those sent by KHS to both members and providers, are retained as outlined in *KHS Policy and Procedure #10.51-I: Records Retention.*[50]

KHS tracks all referral requests through the KHS computerized MIS system. Requests are entered into the system at the time of authorization. The UM Department maintains adequate staffing to manage referrals in a timely manner.

For referrals that contain requests for medications, the KHS UM Clinical Intake Coordinators will review guidelines for appropriateness. Referrals may be routed to the Pharmacy department, as appropriate, for determination of medical necessity. The Pharmacy department will notify the UM department within 24-hours of the decision.

On occasion, referrals will be routed to the Health Education department for further review. Health Education will notify the UM department within 24-hours of the results of the review.

If a potential quality of care is identified during review of medical records for prior authorization or concurrent review requests, the UM staff will notify the QI department via currently defined processes for review. After the initial screening is completed, the QI RN drafts a summary of findings. The nurse will assign the review to the QI Medical Director or their physician designee to determine whether a Quality of Care Issue exists and to take action. The QI Medical Director or their physician designee reviews the records for internal or external quality of care issues and opportunities for improvement. The QI nurse works with the QI Medical Director or their physician designee for any follow up actions requested. Follow up action may include both internal and external opportunities for improvement. Internal issues will be discussed with the relevant department(s) and a mitigation plan developed as appropriate. The QI nurse and QI Medical Director or their physician designee will coordinate for external quality of care issues to identify who will communicate with the external provider and the necessary follow up actions. See *KHS Policy and Procedure #2.70 – Potential Inappropriate Care (PIC)* for details on the QI PIC review process.

Where indicated a referral to KHS's other medical management programs such as Case Management will be made to manage complex or challenging member issues.

It is the PCPs responsibility to track referrals and follow-up care. To assist in this effort KHS provides the PCP with access to view submitted referrals through an online provider portal. Providers/vendors are able to monitor the referrals received, closed and decision dates. The PCP should investigate all open authorizations and follow up with the member as necessary. PCP follow-

up and documentation is monitored by the Quality Improvement Department through facility site review.[51]

KHS will conduct random audits quarterly to document department compliance with documentation of provider notification within 24 hours of decision by method of submission.

KHS will conduct random audits quarterly for purposes of compliance with the referral process and identifying any correspondence issues. Issues will be brought to the attention of the Director of Utilization Management for corrective action.

An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Bi-annually, both physicians and staff involved with making UM decisions participate in the IRR process. Results are reported to Compliance Department, Chief Medical Officer, and Chief Health Services Officer.

Semiannual random audits are conducted by the Director of Compliance to ensure staff compliance requirements related to member and provider notification of deferred, modified, and denied referrals. A sample of thirty deferred, thirty modified, and thirty denied referrals are reviewed semi-annually. Any unjustified non-compliant trend is discussed with the responsible UM Clinical Intake Coordinator. Results of the audit are reported as outlined in *Section 14.0 – Reporting.*

KHS monitors under- and over-utilization of services through various aspects of the UM process. Through the referral authorization process, the UM Clinical Intake Coordinator/UM Nurse monitors under and over-utilization of services and intervenes accordingly. The UM department monitors underutilization of health service activities through collaboration with the QI department.

Concerns for possible overutilization or fraud, waste, or abuse by a provider are evaluated using various reports and analytics. Appropriate follow up is completed to ameliorate any identified adverse trends and may include any of the following:

a. Provider education on criteria and/or documentation requirements.
b. Discussion with provider or provider's staff on concerns or trends noted.
c. Referral to Physician Advisory Committee and/or Fraud, Waste, Abuse Committee.
d. Provider corrective action plan (CAP) as outlined in *KHS Policy and Procedure #4.40-P Corrective Action Plans.*

12.0 PCP FOLLOW-UP AND DOCUMENTATION

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

PCP office staff should coordinate and confirm the specialist appointment and notify the patient either in person or by phone. The PCP should call the specialist if necessary and must complete a referral slip for office staff to schedule an appointment for the patient. The patient should be provided with the specialist's name, address, and phone number. If prior authorization is required for the appointment, office staff should date a copy of the referral slip and place in a tickler file system for future follow up. Upon receipt of authorization, the appointment should be scheduled, and patient notified.

PCP office staff should call specialists to follow-up on appointments. Any missed appointments

should be documented in the member's medical record. PCP office staff should contact the member to encourage him/her to reschedule the appointment. Contacts with the member should be documented in the member's chart.

A log of all external referrals should be maintained to ascertain receipt of consult reports. The specialist should be contacted if the report is not received in a timely manner.

Documenting emergency and follow-up care in the patient medical record and monitoring and follow-up of on-going conditions, medications, and abnormal diagnostic reports are responsibilities of the PCP. PCPs should review all diagnostic tests (lab, x-ray, etc.) and consult reports within 10 days of receipt. The PCP should initial and date all diagnostic test results and consult reports prior to filing in the medical record. PCP staff should follow-up on all diagnostic test results not received in a timely manner.

The PCP shall work in a cooperative manner with KHS and Utilization Management personnel to monitor and manage hospital admissions (either by the PCP, designated hospitalist or treating specialist), continued stay, and hospital discharge planning and documentation of same.

13.0 REPORTING

Reports are submitted as outlined in the following table.

Reported To	Report	Due Date	Responsibility
QI/UM Committee	Results of UM referral audits	Semi-annually	Director of Utilization Management
QI/UM Committee	Results of QI audit of referral follow up by PCP as described in *Section 11.0 – Documentation, Tracking, and Monitoring*	Quarterly	Director of Quality Improvement,

14.0 DELEGATED OVERSIGHT

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including applicable APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

ATTACHMENTS:

Attachment A: *Referral/Prior Authorization Form*
Attachment B: *Notice of Referral Approval*[52]
Attachment C: *Notice of Action - Delay*[53]
Attachment D: *Notice of Action - Modify*[54]
Attachment E: *Notice of Action - Denial*[55]
Attachment F: *Notice of Action - Terminate*[56]
Attachment G: *Your Rights Under Medi-Cal Managed Care*[57]
Attachment H: *Form to File a State Hearing*[58]
Attachment I: *Public Letter – Criteria Request*
Attachment J: *Public Request for Criteria Log*

Attachment K: *Re-classification Letter*
Attachment L: *Notice of Action – CCS Denial*
Attachment M: *Notice of Action – IP CCS Denial*
Attachment N: *Carve Out NOA*

REFERENCE:

Revised 2023-11: Compliance Department updated Attachment "H", State Fair Hearing Form, associated with DHCS APL 21-011 dated 11/9/2023**. 2022-10:** Revisions made by HS Manager per internal review. DHCS File and Use, 1/17/2023, DMHC approval, 2/15/2023. **2022-06:** Updated per APL 21-011. DHCS approval received on 7.19.2022 and DMHC approval received on 2/15/2023. **2022-02:** APL 22-002 Alternative Format Selection for Members with Visual Impairments**. 2021-11:** APL 21-015 Major Organ Transplant; MOT 1: Exhibit A, Attachment 5, Provision 1-5; **APL 20-011;** California Advancing and Innovating MEDI-CAL (CALAIM) APL Attachment 1 Major Organ Transplants Requirements **2021-04:** Minor revision to language in section 4.2.3 by Director of Utilization Management. **2021-04:** Revisions by Director of Utilization Management per DMHC policy checklist review. **2020-10:** Revisions by Director of Utilization Management to specify behavioral and medical services. **2020-08:** Revisions by Director of Utilization Management for retrospective authorization timeframes and per DMHC Routine Survey (Audit) findings regarding denials to terminally ill members, Notice of Action (NOA) attachment updated to reflect current KHS address. **2018-11:** Updated per APL-18-013 Hepatitis C Virus Treatment Policy by Administrative Director of Health Services. **2018-05**: Revisions by Administrative Director of Health Services per Mega Regulations and DHCS contract updates. Types of Services updated, titles updated, attachments updated. Additional language added in November 2017 on modified services. [1] **2016-09:** Recommendation by Dr. Bennetts to remove reference to Policy 3.44 in §4.2.3. during the DMHC 1115 Waiver SPD/DMHC Routine Survey (Audit). **2015-03:** Administrative Director of Health Services removed NO prior authorization references. **2014-08:** Formatting changes to policy, no material changes. Notice of Action letters **(**NOAs) revised as a result of the DHCS 2013 Medical Audit ending in 2014- CAF-9. "Your Right's Forms" updated to ensure continued compliance. Translation changes made to comply with MMCD APL 05005. **2013-07:** Revision provided by Chief Operating Officer concerning retrospective authorization request. Policy approved by KHS Board of Directors July 2013. 2004 DHS Contract Exhibit A-Attachment 5(1)

[2] 22 CCR §51003(c)(2)

[3] 22 CCR §51003(c)(1). List only includes applicable services.

[4] 2004 DHS Contract Exhibit A – Attachment 5 (2)(F)

[5] HSC §1371.4; 2004 DHS Contract Exhibit A-Attachment 5(2)(F)

[6] New DHS Contract 03-76165 does not contain any definition for sensitive services nor does it include sensitive services in the list of no prior auth services (A-5(2)(F)). The DHS/DMHC Medical Audit (YE Oct03) Finding 1.2.2 is based on the old contract provision 6.5.9.4. Decision was made to go ahead and make policy comply with old contract.

[7] 2004 DHS Contract Exhibit A-Attachment 5(3)(I)

[8] CCR Title 22§53855(a); 2004 DHS Contract Exhibit A-Attachment 5(3)(C)

[9] CCR Title 22§53855(a); 2004 DHS Contract Exhibit A-Attachment 5(3)(B)

[10] HSC §1367.01(g)

[12] Definition of urgent request from HSC 1367.01(h)(2)

[13] HSC §1367.01(h); 2004 DHS Contract Exhibit A-Attachment 5(3)(G)

[14] HSC §1367.01(h)(2). Requirement is 72 hours, but per A. Watkins, urgent referrals are processed within 48 hours.

[15] HSC 1367.01 (h)(1); 2004 DHS Contract Exhibit A-Attachment 5(3)(D)

[16] HSC 1374.16(c)

[17] HSC 1367.01 (h)(3)

[18] 14 day requirement found in DHS Contract 03-76165 Exhibit A-Attachment 5 (3)(G). CCR Title 22 Section 53894(b) superceded by the more strict 14 day requirement.

[19] HSC §1367.01(e); 2004 DHS Contract Exhibit A-Attachment 5(2)(A)

[20] HSC §1367.01(h)(4)

[21] HSC §1367.01(h)(3)

[22] Written notice required. HSC §1367.01(h)(3)

[23] Written notification required. HSC §1367.01(h)(3) and (4)

[24] Written notification required. HSC §1367.01(h)(3) and (4)

[25] Written notification required. HSC §1367.01(h)(3) and (4)

[26] Written notification required. HSC §1367.01(h)(3) and (4); 42 CFR §431.211 – 10 day prior to action requirement.

[27] Although the NOA Letter does not indicate any enclosures, it is not clear why the requirements to provide notice would not apply cases of termination or reduction. As such, KHS will include the same enclosures as included with the other types of NOA

letters.
[28] (8/31/05). KHS previously sent carve out letters instead of denial notices. DHS has stated that they do not see an exemption for carve out services in SB59 and will not approve ICE's request to substitute a carve out letter for the NOA. ICE has recommended that Plans use the NOA for carved out services.
[29] Written notification required. HSC §1367.01(h)(3) and (4)
[30] Written notification required. HSC §1367.01(h)(3) and (4)
[31] HSC §1367.01(h)(4) and (5) and 1367.24(b); CCR Title 22 §53894
[32] DHS Contract 03-76165 Exhibit A – Attachment 5 (2)(C)
[33] Required for member notice only. CCR Title 22 §53894(d)(3)
[34] Required for member notice only. HSC §1367.24(b)
[35] Only required for provider notice. Although it is not required for member notice, since provider notice is a copy of the member notice, the information is included in the member notice. HSC §1367.01(h)(4)
[36] MMCD Letter 04006 page 3 #5.
[37] 22 CCR §51014.1(c)
[38] 22 CCR §51014.1(e)
[39] 22 CCR §51014.1(f)
[40] 42 CFR §431.211
[41] 42 CFR §431.214
[42] 42 CFR §431.213. Two exceptions in the regs regarding skilled nursing facilities are not included in this policy.
[43] AB1181(Escutia 1998); HSC §1374.16; DHS Contract 03-76165 Exhibit A-Attachment 9(5)
[44] HSC 1374.16(c)
[45] DHS Contract 03-76165 Exhibit A – Attachment 5 (2)(B)
[46] Health and Safety Code §1363.5
[47] Health and Safety Code §1363.5
[48] DHCS Contract Exhibit A – Attachment 9 (4)
[49] HSC §1367.01(j)
[50] DHS Contract 03-76165 Exhibit A – Attachment 5 (2)(G)
[51] CAP response for DHS/DMHC Medical Audit (YE Oct03).
[52] Must include specific service approved (HSC §1367.01(h)(4)
[53] Exact letter required by MMCD 04006 and 05005.
[54] Exact letter required by MMCD 04006 and 05005.
[55] Exact letter required by MMCD 04006 and 05005.
[56] Exact letter required by MMCD 04006 and 05005.
[57] Exact letter required by MMCD 04006 and 05005.
[58] Exact letter required by MMCD 04006 and 05005.

Kern Family Health Care
The Friendly Face
Of Kern Health Systems

Referral/Prior-Authorization Form
Phone: 661/664-5083
Fax: 661/664-5190

Please Check Type: ❑ Routine ❑ Urgent/Expedited
Please Check Product: ❑ KFHC Medi-Cal

PLEASE PRINT	**Member Information: (Complete in full)**			
Patient Name:	Alternate Contact Information:			
Address	City	State	Zip	Daytime Phone
KFHC Member ID#	DOB:	Age:		CCS Eligible Condition: YES NO
Alternate ID#				CCS Open Case #:

PLEASE PRINT	**Facility / Provider Information: (Complete in full)**	
Requesting Provider:	Phone:	Fax:
Address:		
Provider Signature:	Date:	

Requested Service(s):

ICD10 Code(s) ____________________________________

CPT Code(s) ____________________________________

❑Patient Request

Facility ____________________________________

❑Allergy	❑Endocrine	❑Hem/Onc	❑Neurology	❑ Orthopedics	❑Podiatry	❑Urology
❑Cardiology	❑ENT	❑Home Health	❑Neurosurgery	❑Pain Mgmt	❑Radiology	
❑Dermatology	❑GE/GI	❑Mental Health	❑OB/GYN	❑Pharmacy	❑Rheumatology	
❑DME	❑General Surgery	❑Nephrology	❑Ophthalmology	❑ Physical Therapy	❑Pulmonology	

Requested Provider: Phone: Fax:

Address:

INFORMATION BELOW **MUST** BE COMPLETED TO PROCESS SERVICE REQUEST

Diagnosis / Clinical Problem:

KFHC Date Rec'd Stamp

Clinical History / Date of Onset:

To facilitate processing of request, please attach clinical documentation including progress notes, reports, labs, imaging, etc. (Total additional pages _____)

For Kern Family Health Care Use ONLY:

❑Approved ❑Denied ❑Modified ❑Withdrawn ❑Delayed ❑Duplicate Request ❑Disenrolled

Auth # ________________________

❑ Commentary/UM Criteria Not Met:____

____

Reviewer Signature ____________________________________ Date ________________

PCP________________

AUTHORIZATION CONTINGENT UPON ELIGIBILITY ON DATE OF SERVICE Eligibility Date ______________

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document (s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender.

Notice of Referral Approval/Aviso de Aprobacion de la Referencia

Month DD, YYYY

MEMBER NAME
STREET ADDRESS
CITY, STATE ZIPCODE

Member ID Number: MEMBER #

Dear Member,

The following service have been recommended by your doctor and approved by Kern Family Health Care.

*Procedure: CODE, DESCRIPTION

*Name of Provider: PROVIDER NAME
STREET ADDRESS
CITY, STATE ZIPCODE
PROVIDER PHONE NUMBER (XXXXXXXXXX

* Approval/Authorization #: AUTH NUMBER

* Expiration Date of Referral: MM/DD/YYYY

If you have not already been contacted, please call the above provider to schedule your appointment or procedure. Authorization is valid if you are still an eligible member with Kern Family Health Care on the date of service.

We hope you will call Kern Family Health Care at 800-391-2000; if you have any questions about your referral authorization.

Thank you,
Kern Family Health Care

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Kern Family Health Care's Member Service Department at 800-391-2000 right away.

SPANISH: IMPORTANTE: ¿Puede leer esta carta? Si no, nosotros le podemos ayudar a leerla. Ademas, usted puede recibir esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al Departamento de Servicios para Miembros al 800-391-2000.

"Delay"

NOTICE OF ACTION
About Your Treatment Request

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

[Name of requesting provider] has asked Kern Family Health Care to approve *[Service requested].* We need more time to make a decision. This is because *[Insert a clear and concise explanation of the reasons for the delay, indicating the specific information or whatever additional information the plan needs what further information is needed and/or additional steps need be taken. If further information is being requested, input the deadline for receipt of information.]* We will send you another letter on *[date]*, to tell you the decision.

You can appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at 1-888-452-8609. You can also get help from your doctor, or call us at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

"Modify"

NOTICE OF ACTION
About Your Treatment Request

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

[Name of requesting provider] has asked Kern Family Health Care to approve *[Service requested].* We cannot approve this treatment the way it is. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

We have instead approved: *[Clear and concise explanation of modification of request and service approved].*

You can get free copies of all information used to make this decision. To ask for this, please call Kern Family Health Care at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

You can appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director’s Name]

Enclosed: “Your Rights under Medi-Cal Managed Care”

(Enclose notice with each letter)

"Deny"

NOTICE OF ACTION
About Your Treatment Request

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

[Name of requesting provider] has asked Kern Family Health Care to approve *[Service requested].* This request is denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

You can get free copies of all the information used to make this decision. To ask for this, please call Kern Family Health Care at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

You can appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

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This letter does not change your other Medi-Cal care.

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

"Terminate"

NOTICE OF ACTION
About Your Treatment Request

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service to be terminated]*

You are currently getting *[service to be terminated].* This care is no longer approved. *[Service to be terminated]* will end on *[date]*. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

Kern Family Health Care will stop paying for this care on *[date].*

You can get free copies of all information used to make this decision. To get this, please call Kern Family Health Care at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

You may appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You can also get help from your doctor, or call us at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

For Knox-Keene Plans (NOA)

"YOUR RIGHTS"

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

IF YOU DO NOT AGREE WITH THE DECISION YOUR HEALTH PLAN MADE FOR YOUR HEALTH CARE, YOU CAN ASK YOUR HEALTH PLAN FOR AN APPEAL.

HOW DO I ASK FOR AN APPEAL?

You have 60 days from the date of this Notice of Action letter to ask for an appeal. If your health plan decided to reduce, suspend or terminate a service(s) you are getting now, you may be able to keep getting the service(s) until your appeal is decided. This is called Aid Paid Pending. To qualify for Aid Paid Pending, you must ask your health plan for an appeal within 10 days from the date of this Notice of Action letter, or before the date your health plan says the change to your service(s) will happen. Even though your health plan must give you Aid Paid Pending when you ask for an appeal within these timelines above, you should let your health plan know when you ask for an appeal that you want to get Aid Paid Pending until your appeal is decided.

If you miss the 10-day period to request an appeal OR do not ask for an appeal before the date the change to your service(s) will happen, you still have 60 days from the date of this Notice of Action letter to ask for an appeal. However, you will not get Aid Paid Pending while your appeal is being decided.

You can ask for an appeal yourself. Or, you can have someone like a relative, friend, advocate, doctor, or attorney to ask for one for you. This person is called an Authorized Representative. Your health plan can provide a form for you to identify your Authorized Representative. You, or your Authorized Representative, can send in anything you want your health plan to look at to make a decision on your appeal. A doctor who is different from the doctor who made the first decision will look at your appeal.

You can file an appeal by phone, in writing, or electronically:

- By phone: Contact Kern Family Health Care between 8:00 a.m. to 5:00 p.m. by calling **(661) 632-1590** inside Bakersfield, or **1-800-391-2000** outside Bakersfield. If you cannot hear or speak well, please call **711**.

- In writing: Fill out an appeal form or write a letter and send it to:

  Kern Family Health Care
  2900 Buck Owens Boulevard
  Bakersfield, CA. 93308

  Your doctor's office will have appeal forms available. Your health plan can also send a form to you.

- Electronically: Visit your health plan's website. Go to **https://www.kernfamilyhealthcare.com**

WHEN WILL MY APPEAL BE DECIDED?

For Standard Appeals, your health plan must respond to your appeal in writing within 30 days. If you think waiting 30 days will hurt your health, you may be able to get a decision in 72 hours. When you ask for an appeal with your health plan, say why waiting will hurt your health. Make sure you ask for an Expedited Appeal.

For Expedited Appeals, your health plan must try to give you an oral notice of its decision on your appeal. For both Standard and Expedited appeals, your health plan will mail you a Notice of Appeal Resolution letter. This letter will tell you what your health plan decided on your appeal.

CAN I ASK FOR AN INDEPENDENT MEDICAL REVIEW AND A STATE HEARING?

An Independent Medical Review is where a doctor(s) that is not related to the health plan will review your case. A State Hearing is where a judge will review your case.

If you disagree with your health plan's decision regarding your service(s), you can ask your health plan for an appeal. If you still disagree with your health plan's decision on your appeal, or it has been at least 30 days since you filed your appeal with your health plan, you can request an Independent Medical Review with the Department of Managed Health Care (DMHC). DMHC staff will determine whether your issue qualifies for an Independent Medical Review.

In most instances, you are not eligible to request a State Hearing until you have first completed your health plan's internal appeal process. However, there are times when you can directly request a State Hearing. This can happen if your health plan did not notify you correctly or timely about your service(s). This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- The health plan did not make this Notice of Action letter available to you in your preferred language.
- The health plan made a mistake that affects any of your rights.
- The health plan did not give you a written Notice of Action letter informing you of its intended action regarding your service(s).
- The health plan made a mistake in its written Notice of Appeal Resolution letter.
- The health plan did not decide your appeal within 30 days and send you a Notice of Appeal Resolution letter.
- The health plan decided your case was urgent, but did not respond to your appeal within 72 hours and send you a Notice of Appeal Resolution letter.

Sometimes, you can ask for both an Independent Medical Review and a State Hearing at the same time. You can also ask for one before the other to see if one will resolve your problem first. For example, if you ask for an Independent Medical Review first, and you do not agree with what was decided, you can ask for a State Hearing. But, if you

ask for a State Hearing first, and your hearing has already taken place, you cannot ask for an Independent Medical Review. In this case, the State Hearing has the final say.

You will not have to pay for an Independent Medical Review or a State Hearing.

HOW DO I REQUEST AN INDEPENDENT MEDICAL REVIEW?

The paragraph below provides you with information on how to request an Independent Medical Review with DMHC.[1] Note that the term grievance is talking about both complaints and appeals:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-391-2000** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

HOW DO I REQUEST A STATE HEARING?

As stated above, you may be eligible to request a State Hearing.

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov
- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.
- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

  Mail: California Department of Social Services

[1] Health and Safety Code (HSC) Section 1368.02(b). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/home.xhtml.

State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Fax: (916) 309-3487 or toll-free at 1-833-281-0903

A State Hearing Form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think that waiting 90 days will hurt your health, you can request an Expedited Hearing. If the State Hearings Division approves your request for an Expedited Hearing, you may be able to get a hearing decision within 3 days from the date it receives your case file from your health plan.

You can ask for an Expedited Hearing by calling the State Hearings Division at the number above. Or, you can send the State Hearing form or a letter to the State Hearings Division. You must explain how waiting for up to 90 days for a decision will harm your life, health or ability to get or keep maximum function. You can also get a letter from your doctor to help show why you need an Expedited Hearing.

You can speak for yourself at the State Hearing. Or, you can have someone like a relative, friend, advocate, doctor, or attorney speak for you. If you want someone else to speak for you, then you must sign a form telling the State Hearings Division that the person can speak for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the Greater Bakersfield Legal Assistance at (661) 325-5943. You may also call the local Legal Aid Office in your county at 1-888-804-3536.

State of California – Health and Human Services Agency Department of Health Care Services

FORM TO FILE A STATE HEARING FROM A MANAGED CARE DENIAL

You can ask for a State Hearing by calling: **1-800-743-8525**. **TDD users, call 1-800-952-8349**. You can also request a hearing in the following ways:

- You can request a hearing **ONLINE** at **WWW.CDSS.CA.GOV**
- You can fill out this form and **FAX** it to State Hearings at **916-309-3487** or toll-free at **1-833-281-0903**
- You can fill out this form and **EMAIL** it to **SCOPEOFBENEFITS@DSS.CA.GOV**
- **(Note:** If you send it by email, *please understand there is a risk that someone other than the State Hearings Division could intercept your email. Please consider using a more secure method of sending your request.)*
- You can also **MAIL** this State Hearing Request **to:**
  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, MS 9-17-433
  Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on the attached 'Your Rights' Notice

I do not agree with the decision about my health care. State the treatment, drug, equipment, or service that the doctor requested. I disagree because:

____
____
____
____
____

(If you need more space, use another piece of paper and attach it to this one.)

PLEASE PROVIDE THIS INFORMATION ABOUT THE BENEFICIARY
(This is the person who was denied medical benefits)

NAME: ____

DATE OF BIRTH: ____

ADDRESS (Where you can get mail): _____________________________________

TELEPHONE NUMBER: ____

Do we have your permission to communicate with you by email? [ ] YES [ ] NO

If Yes, what is your **EMAIL ADDRESS:** ____

Please provide your **Medi-Cal BIC Card Number and /or Social Security Number** if you have one: ____

Do you have Straight Medi-Cal (**Fee for Service**) or **Managed Care**?
____

If **Managed Care**, what is the **name of your HEALTH PLAN**:
____

PLEASE ANSWER EVERY QUESTION THAT APPLIES TO THE BENEFICIARY

My Doctor requested this health benefit on this date: _____________________________

The Health Plan denied this health benefit on this date: ___________________________

I have appealed the case to the Health Plan:
YES [ ] **On what date**? __________ NO [ ]

The Health Plan gave an answer to the appeal:
YES [ ] **On what Date?** ________ NO [ ]

Did you ask the Health Plan for an expedited (72 Hour) appeal? [ ] YES [ ] NO

Did the Health Plan decide the appeal in 72 Hours? [ ] YES [ ] NO

I NEED THESE FOR MY HEARING (Check these Boxes if they apply to you):

☐ **I need an Expedited Hearing because my situation is urgent.** My case must be decided very quickly and I cannot wait for up to 90 days. This is what will happen without a quick decision:
____
____
____

EXPLAIN WHY YOU CANNOT WAIT UP TO 90 DAYS. **If you do not explain, your case will not be expedited and will be scheduled** on the normal calendar. You can submit a letter from your doctor or plan to show why you cannot wait.

☐ **Continued Services / Aid Paid Pending: Please continue my treatment** until the Judge decides my case. (Describe the treatment that you want to continue and say **what date the plan stopped it** or **is planning to stop it**):
____
____

☐ **I want a Free Interpreter**. My language or dialect is: _______________________

☐ **I have a disability and want a reasonable accommodation to help me participate in my hearing**. The accommodation(s) I want is:
____
____

☐ **I want someone else to speak for me (represent me) at the hearing.** She/he can see my medical records that relate to this hearing and come to the hearing. The person I have chosen to speak for me is:

Name: _______________________ Phone Number: ___________________

Address: ____

My signature: _________________________ Today's Date: ____________

SEND THIS FORM WITH A COPY OF THE LETTER (NOTICE OF APPEAL RESOLUTION) YOU RECEIVED FROM YOUR PLAN IF YOU HAVE IT. (IF YOU WANT A COPY OF THIS FORM FOR YOURSELF, COPY IT BEFORE YOU SEND IT.)

Date:

Re: Public Letter – Criteria Request

Dear [insert name],

Attached is a copy of the criteria that you requested on [insert date mm/dd/yyyy]. The materials provided to you are guidelines used by Kern Family Health Care to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

The criteria are guidelines only, Kern Family Health Care strongly recommends that you discuss your health care needs with your provider.

Sincerely,

Kern Family Health Care

Utilization Management Department

KERN HEALTH SYSTEMS
UTILIZATION MANAGEMENT
PUBLIC REQUEST FOR UM CRITERIA LOG

DATE	NAME	ADDRESS	CRITERIA REQUESTED	REASON FOR REQUEST	DATE MAILED	COMMENT

Date:

Dear Provider,

The attached referral does not meet the criteria for an urgent expedited review process within our utilization department. It has been re-classified as routine and will be processed within five business days.

This is in accordance with Kern Health Systems policy 3.22 regarding referrals and authorizations and as defined in the Health and Safety Code 1367.01(h)(2), which states, "requests are classified as urgent when the member's condition is such that he/she faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize his/her ability to regain maximum function."

Nurse Case Manager
(661) 664-5083

NOTICE OF ACTION
About Your Treatment Request - Deny

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number: *[MEM#]*

RE: *[Service requested]*

[Name of requesting provider] has asked Kern Family Health Care to approve *[Service requested].* This request is denied. This is because this service may be covered by California Children's Services (CCS). We do not pay for services that are paid by CCS. The request will be sent to the CCS Program to see if it will be paid. You can call your local CCS office at (661) 868-0531 for details. This letter is for your information only.

You can get free copies of all the information used to make this decision. To ask for this, please call Kern Family Health Care at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

You can appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at 1-888-452-8609. You can also get help from your doctor, or call us at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

NOTICE OF ACTION
About Your Treatment Request - Deny

[Date]

[Member's Name]	*[Treating Provider's Name]*
[Address]	*[Address]*
[City, State Zip]	*[City, State Zip]*

Identification Number: *[MEM#]*

RE: *[Service requested]*

[Name of requesting provider] has asked Kern Family Health Care to approve *[Service requested].* This request is denied. This is because this service may be covered by California Children's Services (CCS). We do not pay for services that are paid by CCS. The request will be sent to the CCS Program to see if it will be paid. You can call your local CCS office at (661) 868-0531 for details. This letter is for your information only.

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The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at 1-888-452-8609. You can also get help from your doctor, or call us at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

NOTICE OF ACTION
About Your Treatment Request – Carve Out

[Date]

[Member's Name]	*[Treating Provider's Name]*
[Address]	*[Address]*
[City, State Zip]	*[City, State Zip]*

Identification Number

RE: *[Service requested]*

This is NOT a denial of services.

This letter tells you that Kern Family Health Care, cannot provide the care you asked for (shown above).

You can get the care from *[Entity responsible for carved-out service]*. You can call them at *[telephone number]*. You can also contact Kern Family Health Care and we will help you get the care you need and contact *[entity responsible for carved-out service]*. *[Insert additional action taken by the Health Plan to coordinate care and/or additional follow-up needed by the Member].*

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at 1-888-452-8609. You can also get help from your doctor or call us at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]