KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Cancelling or Withdrawing or Dismissing a UM Referral Request	**Policy #**	30.73-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	3/2/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To establish a standardized, compliant framework for KHS Health System (KHS) clinical staff to defining a process for which a referral request can be cancelled, withdrawn, and when applicable by the plan, the request to cancel or withdraw is dismissed.

II. POLICY

A. KHS allows a referral request withdrawal or cancellation under the following circumstances:

1. A referral request may be cancelled or withdrawn if one or more of the following findings are present.

    a. An approved authorization of the same request exists in the system.
    b. The referral request is unused, and the time limit has expired.
    c. The request is a duplicate note received on the same day.
    d. There is an addition or change in diagnosis and/or procedure codes by referring provider
    e. The requesting member or referring provider request to cancel or withdraw the referral.
    f. The party that submits a request for an initial determination may withdraw the request in writing any time before the decision is made.

B. Requesting providers will be notified of any cancelled or withdrawn request either verbally, by written or electronic notification.

C. If an enrollee or the enrollee's representative files a request, but the enrollee dies while the request is pending, and both of the following apply:

1. The enrollee's surviving spouse or estate has no remaining financial interest in the case.

2. No other individual or entity with a financial interest in the case wishes to pursue the request.

III. DEFINITIONS

Withdrawn Organization Determination or Reconsideration.	A decision indicating that, upon request, the referral request was removed from the plan's review process. This category excludes appeals that are dismissed.
Dismissal	An action taken by a Medicare health plan or delegate organization when an organization determination request or reconsideration request lacks required information or otherwise does not meet CMS requirements to be considered a valid request. For example, an individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf per the guidance set forth in section 10.4.1 of Chapter 13. The plan must follow Chapter guidance in addition to guidance provided in the September 10, 2013 HPMS memo regarding Part C Reconsideration Dismissal Procedures prior to issuing the dismissal.

IV. PROCEDURES

A. Withdrawal requirements, 42CFR: 422.568(k), 422.592(h), 422.631(i), 422.633(g), 423.568(m), and 423.600(f) offer withdrawal requirements, specifying that a party can make a request to withdraw at any time before the decision is issued. Centers for Centers for Medicare and Medicaid Services (CMS) modified the proposed provisions to permit both verbal and written withdrawal of requests for organization determinations, coverage determinations, reconsiderations, and redeterminations

B. KHS receives a referral request, and the Utilization Management (UM) staff determine it meets one of the policy criteria to cancel or withdraw the request the UM staff will proceed as follows for referral requests that are:

1. An approved authorization of the same request exists in the system.

2. The request is a duplicate note received

3. When the time limit of the referral request has expired.

4. Providers who request an addition or change in diagnosis and/or procedure codes which change the service or treatment in its entirety, the UM staff will inform the referring provider that a new review will be required therefore they must re-submit the referral with the correct information. The notification to the provider will be documented in the referral notes section and a verbal or written notification that the referral request was cancelled or withdrawn will be given to the requesting provider.

5. A request to cancel or withdraw a referral made by a member or referring provider will be cancelled or withdrawn as requested.

    a. The UM staff will document the requests made and cancel the request.

6. If the withdrawal request was done verbally, KHS will document in the system the date and the reason why the party chose not to proceed with the initial determination procedure.

C. Dismissal Notice Requirements – All Dismissals

1. KHS must mail or otherwise transmit a written notice of the dismissal of the request to the parties, including applicable appealable rights. The notice must state all of the following:

    a. The reason for the dismissal.

    b. The right to request that the plan vacate the dismissal action.

    c. The right to request reconsideration of the dismissal.

2. KHS may dismiss a request for an initial determination under any of the following circumstances:

    a. The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.

    b. KHS determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a).

        i. A valid request, as contemplated in §§ 422.568(a) and 423.568(a), includes sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number or at least one means of contact (e.g., address, telephone number, email).

        ii. In addition, under Part D, an enrollee may not request a tiering exception for an approved non-formulary prescription drug. See 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.

    c. The enrollee dies while the request is pending, and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.

    d. The individual or entity who requested the review submits a timely verbal or written

request for withdrawal of their request for an initial determination with the plan. When the plan's dismissal is due to a timely withdrawal request, the plan is required to dismiss the initial determination request and issue a dismissal notice in accordance with the notice requirements at section 40.15.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal.

3. Requests Review by Independent Review Entity (IRE) – (KHS or Only Appeal Delegates)

    a. If the Medicare Advantage (MA) organization dismisses a request for a reconsideration, the enrollee or other proper party under 42CFR422.578 has the right to request review of the dismissal by the independent entity. A request for review of a dismissal must be filed in writing with the independent entity within sixty (60) calendar days from the date of the MA organization's dismissal notice. Note: For Part C, there's no existing process for enrollees to request IRE review of adverse decisions, as there's an auto-forward process in place; this auto-forward process does/will not include dismissals.

    b. A dismissal by the IRE is binding and not subject to further review unless a party meets the amount in controversy (AIC) threshold requirements necessary for the right to a review by an administrative law judge or attorney adjudicator and the party files a proper request for review with the Office of Medicare Hearings and Appeals.

4. Vacating a dismissal - A dismissal may be vacated by the entity that issued the dismissal (that is, MA organizations, applicable integrated plans, Part D plan sponsors, and the IRE) if good cause for doing so is established within six (6) months of the date of the dismissal notice.

5. Effect of dismissal - The dismissal of a request is binding unless it is modified or reversed by the MA organization, applicable integrated plan, or Part D plan sponsor, as applicable, upon reconsideration or vacated.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other CMS, Department of Health Care Services (DHCS), and or Department of Managed Health Care (DMHC) guidance, including applicable All Plan Letters (APLs), Health Plan Management System (HPMS) memos, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

N/A	

VI. REFERENCES

Reference Type:	Specific Reference
Regulatory	Medicare Managed Care Manual Chapter 13, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance 40.13, 40.14, 40.15, 40.15.1 https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf
Other KHS Policies	National Committee on Quality Assurance (NCQA) Utilization Management Standards and Guidelines
Regulatory	42CFR: 422.568(a)(k), 422.592(h), 422.631(i), 422.633(g), 423.568(a)(m), 423.600(f) 422.578, and 423.578(c)(4)(iii).

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with D-SNP	UM

VIII. APPROVALS

Committees | Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		