KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Lack of Clinical Information	**Policy #**	30.88-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	12/1/2025
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To describe Kern Health System's (KHS) process for handling medical necessity determinations for requested health care services when requested clinical information is not received.

II. POLICY

A. KHS Medicare Utilization Management applies Centers for Medicare & Medicaid Services (CMS) criteria and guidelines, National and Local Coverage Determinations (NCD/LCD), Medicare Benefit Manual Guidelines, MCG (Milliman Criteria Guidelines) Criteria and Peer Reviewed Guidelines in the medical necessity and benefit interpretation process.

1. This suite of guidelines covers the spectrum of inpatient, outpatient, and rehabilitation, and care for medical, surgical, and behavioral health issues. In addition, KHS partners with vendors External Expert Review who provide clinical expertise for specific services.

B. When processing Organization Determinations, KHS will attempt to obtain any additional clinical information necessary for the disposition of the coverage request

III. DEFINITIONS

TERMS	DEFINITIONS
Lack of Information	Not having the clinical data needed to make a medical necessity determination based on nationally recognized criteria sets.

Organization Determination	Any determination made by KHS with respect to any of the following: a. Payment for temporary out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services. b. Payment for any other health services furnished by a provider other than the Health Plan organization that the enrollee believes i. Are covered under Medicare. ii. If not covered under Medicare, it should have been furnished, arranged for, or reimbursed by KHS. iii. KHS's refusal to provide or pay for services, in whole or in part, including the type or level of services that the enrollee believes should be furnished or arranged for by the health plan. iv. Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment. v. Failure of KHS benefits to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

IV. PROCEDURES

Lack of Clinical Information or Insufficient Information

A. Requests for prior authorization that do not include any clinical information are placed in pend or hold status/activity pending the necessary clinical information to make a determination.

B. Requests that include some clinical information are evaluated by a UM Licensed Reviewer (RN),

C. If the information received is adequate to render a medical necessity determination and meets medical necessity criteria, the request is approved by the Licensed Registered Nurse (RN) and appropriate notification issued within two (2) business days of the decision.

D. If the information received is not sufficient to satisfy the medical necessity criteria, additional information is requested by UM from the referring provider with at least one (1) attempt.

E. Requests with insufficient information are placed in a pended or hold status/activity and notice is sent to the provider informing them of the specific additional information that must be received to complete the request.

F. If additional information is submitted, the request is processed, and a determination issued within the applicable timeframe.

G. If additional information is not submitted, at least one outreach attempt will be made by telephone and/or fax to contact the provider to obtain the necessary information required to complete the case.

H. Expedited Organization Determinations (EOD) KHS decides the request meets the EOD criteria, but the service is denied due to lack of medical necessity, or other reason, KHS must notify the Member. If KHS first notifies the Member of denial verbally, written confirmation to the Member within three (3) calendar days of the verbal notification. When completing the standardized notice KHS indicates the specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and special language requirements.

I. Routine/Standard requests

1. Outreach attempts will be thoroughly documented in the record and continue unless one of the following occurs:

    a. the provider responds to the request
    b. outreach attempts are exhausted.

J. Concurrent Review Requests

1. The requestor will be notified of the information needed upon receipt of the notification.
2. UM staff will process within regulatory guidelines

K. Post Service Reviews Requests

1. Within fourteen (14) calendar days after receipt of request
2. May extend up to fourteen (14) calendar days required within a maximum of twenty eight (28) calendar days after receipt of request.
3. Note: Extensions are allowed only if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from noncontracted providers may change a decision to deny)

L. KHS Members and providers will be notified as expeditiously as the enrollee's health condition requires but no later than seven (7) calendar days after the date the request was received for a standard organization determination, or if a formal extension was initiated, no later than fourteen (14) calendar days from the date of the extension.

M. If the decision is to administratively deny the services due to lack of information, written notification shall be sent to the facility, patient, and the physician within one day of the determination to administratively deny, specifying it is an administrative denial for Lack of Information.

1. The written notification includes information regarding the basis for denial, necessary information, and appeal rights and processes.
2. KHS must make coverage decisions as expeditiously as the enrollee's health condition requires, and in accordance with the timelines as specified in 42 CFR Part 422 Subpart M.

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

Attachment A:	N/A

VI. REFERENCES

Reference Type:	Specific Reference:
Regulatory	Medicare Managed Care Manual Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
Regulatory	42 CFR Part 422 Subpart M
All Plan Letter(s) (APL)	APL 21-011
Other	NCQA: UM9(a) and (c)
Regulatory	California Code, Health and Safety Code - HSC § 1367.01

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.		
Choose an item.		
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	Date Reviewed	Date Approved
Choose an item.		
Choose an item.		