KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	D-SNP Specialty Referral and Use of Board-Certified Practitioners	**Policy #**	30.67-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	1/6/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To describe the process by which board-certified physician consultants are utilized to perform consultations related to medical necessity. The consultants must have education, training, or professional experience in medical or clinical practice and a current license to practice without restriction.

To establish procedures for requesting board-certified medical or behavioral health consultations or second opinions from board-certified specialists or subject matter experts individually or via Independent Review Organizations (IRO) to assist in making Utilization Management medical necessity determination.

II. POLICY

A. Kern Health Systems (KHS) utilize external board-certified consultants as a vendor for medical necessity reviews as additional guidance and recommendations based on scholarly references to ensure appropriate medical decision making.

B. The KHS Utilization Management (UM) physician reviewers or medical director shall consult with the board-certified physicians of the specific specialty for the referral under review.
   1. The external board-certified consultants may also assist in the review of denials/modifications for determining covered medical benefits as defined in the Member's evidence of coverage and KHS criteria and guidelines. The KHS Medical Director and Physician Reviewer is responsible in making the final UM determination.

C. The KHS UM physician reviewers shall consult with a psychiatrist, doctoral-level psychologist, or certified addiction medicine specialist to review any denial of behavioral health care that is based on medical necessity.

III. DEFINITIONS

TERMS	DEFINITIONS
Specialist	A physician who has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification.
Consultation	Written opinion or advice rendered by a consultant/specialist whose opinion or advice is requested by the health plan Medical Director, a Behavioral Health Medical Director, and/or the Medical Advisory Committee (MAC) for the further evaluation or management of the Member by the attending physician.
Independent Review Organization (IRO):	An entity that conducts independent external Medical or Behavioral Health reviews of medical necessity determinations and adverse health care treatment decisions and performs independent peer reviews
Medically Necessary Services:	Medically Necessary Services: Procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are: A. In accordance with generally accepted standards of medical practice; and B. Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the covered individual's illness, injury, or disease; C. Not primarily for the convenience of the covered individual, physician, or other health care provider; 1. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered an individual's illness, injury, or disease

IV. PROCEDURES

A. KHS use board-certified consultants to assist in making medical necessity decisions for specialty requests requiring additional specialty expertise review. The final determination will rest with the designated KHS physician reviewer.

B. Requests for board-certified consultations or second opinions may occur for, but are not limited to:
   1. Situations involving unusually complex cases when the facts are not clearly defined and there are alternative decisions that may be made based upon assessment of the clinical condition of the situation.

2. Cases requiring special expertise in order to determine medical necessity and expertise is not readily available within the network of credentialed providers to provide a nonbiased and evidence-based review.
3. Situations where conflicts of interest are identified with the current potential reviewers.
4. Situations involving discordance between the treating provider and the health plan Medical Director or a Behavioral Health Reviewer about a treatment plan or a medical necessity appeal decision, such that an external objective opinion is warranted to attest credibility of the process.
5. Second and third opinions.

C. External board-certified consultants may also assist in the review of denials/modifications for determining covered medical benefits as defined in the Member's evidence of coverage and national recognized criteria and guidelines and or as necessary peer review published guidelines in congruence with industry standards.

D. The UM Medical Director/Physician Reviewer shall share all pertinent information and records with the specialist for his/her review and assist in making the necessary determination.

E. For external board-certified consultations KHS will use Expert Vendors medical necessity reviews when:
   1. If there is no board-certified physician available in the network with the specialty for the referral under review.
   2. When a second opinion or third opinion is required and there is no board-certified physician available in the network with the specialty for the referral under review
   3. As additional guidance based on scholarly references is needed to ensure appropriate medical decision making.

F. The referring Medical Director, Behavioral Health Medical Director, or designee reviews the report of the consultant or the contracted IRO and makes a medical necessity determination, which is documented in the Member's clinical record.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other Centers for Medicare and Medicaid Services (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
Other	NCQA Standards and Guidelines (Use of Board -Certified Consultants) UM 11 Factor 1

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.		

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