KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Adverse Organization Determinations: Fully Denied-Partially Denied	**Policy #**	30.66-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	01/29/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To Define Kern Health Systems (KHS) procedural management for fully or partially denied organization determinations and notifications to Medicare enrollees are consistent with the requirements established by the Centers for Medicare and Medicaid Services (CMS) and the delegation agreement with the KHS Delegation client.

II. POLICY

A. KHS, when making organization determinations, will utilize processes and standards consistent with CMS requirements.

B. KHS have established processes that include, but are not limited to the following Part C Organization Determination activities:
   1. Expedited
   2. Extensions
   3. Adverse Standard Pre-Service
   4. Favorable and Partially Favorable Standard Pre-Service
   5. Reconsideration (1st level appeal, if contractually delegated).

C. The determination of medical necessity is the standard for the authorization of all covered services for KHS members. Denial of medical services resulting from the Utilization Management (UM) review processes are established on medical necessity criteria, benefits coverage, or based on requests for experimental/investigational treatment/device. Only California licensed physicians may fully or partially deny medical service or treatment.

D. KHS organizational determinations decisions, in whole or in part, are communicated to members via CMS compliant notices and in accordance with detailed member notification requirements.

E. KHS follow CMS timeliness of decision making for UM requests including Medicare Part B drugs, reviewed for Part C members.

F. Failure to provide the members with timely notice of an Organization Determination, regardless of outcome or if decision has not yet been rendered, constitutes an adverse organization determination and is subject to appeal.

A. KHS as a Medicare Fully Integrated Dual Eligible (FIDE) plan will issue the Integrated Denial Notice (IDN) developed by CMS to inform enrollees of their appeal rights, as applicable, upon denial of coverage of items and services, and for discontinuation or reduction of a previously authorized course of treatment.

G. In accordance with Title 42 § 422.631, Integrated Organization Determinations (c)(3), the applicable integrated plan (KHS) must complete an expedited integrated organization determination KHS determines (based on a request from the member or on its own) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

H. Pursuant to Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, written notice of determination is to be provided to the enrollee, or the enrollee's appointed or authorized representative, if a Medicare health plan decides to deny services or payments, in whole or in part, or discontinues/reduces a previously authorized ongoing course of treatment.

III. DEFINITIONS

TERMS	DEFINITIONS
Adverse Organization Determination	Adverse Organization Determination means that KHS denies authorization or payment for services based on established, evidence based clinical review criteria. Denials may be based on fully or partially denied prospective (pre-service, i.e., requests from a practitioner or member before services are delivered) concurrent (i.e., review of services currently being provided in a clinical setting), or retrospective (post service, i.e., submission of a request for authorization or payment after services are delivered).
Integrated Denial Notice (IDN)	Integrated Denial Notice (IDN) is a CMS mandated notice that KHS is required to issue when discontinuing previously authorized services.

Notice of Medicare Non-Coverage	Notice of Medicare Non-Coverage (NOMNC) is used for termination of ongoing Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), and Home Health Agency (HHA) services.
Utilization Management Review	Utilization management review is a function performed by qualified clinical professionals to review and determine whether medical services planned or provided are medically necessary.
Physician Reviewer	Physician Reviewer (PR): a physician who holds a current California license, with appropriate credentials in his/her own specialty, and is employed by or contracted with KHS to carry out utilization review.
PR Referral	PR Referral: referral of a case to a Physician Reviewer for review that the Registered Nurse (RN) was not able to approve based on the available clinical information.
Utilization Screening Criteria	Utilization Screening Criteria: a set of medical necessity indicators based on clinical profiles, local and national clinical consensus panels, and outcomes research.

IV. PROCEDURAL REQUIREMENTS

A. KHS procedurally require prior authorization for certain procedures, drugs, items, and supplies.

B. The determination of medical necessity is the standard for the authorization of all covered services for members.

C. Denial of medical services is based on medical necessity criteria, benefits coverage, or based on requests for experimental/investigational treatment/device.

D. Only California licensed physicians may render a determination to fully or partially deny a medical service or treatment.

1. National Committee on Quality Assurance (NCQA) also considers the following practitioner types for review of the specified UM denial decisions.
    a. Physicians, all types: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.

b. Doctoral level clinical psychologists or certified addiction- medicine specialists: Behavioral healthcare denials.
c. Pharmacists: Pharmaceutical denials
d. Doctoral level board certified behavioral analysts.
e. Board certified specialist for expert reviews.

2. KHS will ensure that physicians or health care professionals reviewing partial or fully adverse organizational determinations have both of the following:
    a. Expertise in the field of medicine or health care that is appropriate for the services at issue. (Expertise may be shown by training, certification, or clinical experience).
    b. Knowledge of Medicare coverage criteria.
        i. The reviewer does not need to be of the same specialty or sub-specialty.

3. KHS will maintain information about the physician or health care professional making organizational determinations, including their name, specialty, board certification, relevant training, experience, or similar, will be provided within each case or separately as a list of reviewers and relevant credentials. The professional Physician profiles will be maintained in compliance with CMS credentialing standards and frequency of credentialing reviews.

4. When the review pertains to multiple services requested that are interrelated, it may be appropriate to use the same reviewer.
    a. If the services are not interrelated, decisions to deny each item/service must be made by a reviewer with appropriate expertise. Note: Peer-to-peer conversations are not separate/distinct from an organizational determination and must follow these guidelines.

5. KHS will not deny items or services for lack of medical necessity if they were previously approved through prior authorization or a pre-service determination.

6. KHS will not reopen the case for any reason except for good cause or if there is reliable evidence of fraud or similar theft.

E. Medical Necessity Defined:

1. Medical, dental, behavioral, rehabilitative, or other health care services which:
    a. Are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability; and
    b. Are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; and
    c. Are consistent with the diagnoses of the conditions; and

d. Are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence and.
e. Will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, with consideration to both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
f. Procedures, supplies, equipment, or services that are determined to be:
    i. Appropriate for the symptoms, diagnosis, or treatment of the medical condition, and
    ii. Provided for the diagnosis or direct care and treatment of the medical condition, and
    iii. Within the standards of good medical practice within the organized medical community, and
    iv. Not primarily for the convenience of the patient's physician or another provider.
g. Additionally, the most appropriate procedure, supply, equipment, or service must satisfy the following requirements:
    i. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit for the patient with the particular medical condition being treated than other possible alternatives; and
    ii. For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that it is not possible to provide safe and adequate as an outpatient or in a less intensified medical setting.

F. Requirement for Processing Organization Determination Notices

1. Requests for medical services that do not meet medical necessity as per the utilization screening criteria or are non-covered benefits, or in the Utilization Management/Case Management nurse's judgment requires further medical review, shall be routed to a Physician Reviewer (PR).

2. The Physician Reviewer reviews the request for medical necessity and/or benefit coverage and renders a decision.

G. Classification of Denials:

1. For each non-medical necessity denial, KHS will document within the UM processing system the reason for, the specific benefit provision, the administrative procedure or regulatory limitation used to classify the denial.
    a. The denial information shall reference the sources to make the determination (e.g., Certificate of Coverage or Summary of Benefits). This information is incorporated into the denial notice and sent to the member or the member's authorized representative.

2. For Appeals of Denials, refer to KHS Appeals Policy and Procedure.
    a. KHS follows Industry Collaboration Effort (ICE) Denial Notification Specifications & Time Frames for the Medicare Line of Business (LOB) in congruence with CMS standards.
    b. KHS will make criteria utilized in determining the medical necessity available to the provider, member, and the public on request.

H. Peer-to-Peer Discussion Offer and Timing

1. Upon issuing any pre-service denial, KHS must offer the provider the opportunity for a peer-to-peer discussion before sending the formal notice of denial to the member.

2. The offer may be made by phone, fax, or within the same written/electronic notice.

3. The provider has up to two (2) business days from the time of the offer to request the discussion.

4. If no request is received within two business days, KHS will proceed with issuing the appropriate final formal denial notices to the member and provider.

5. If, upon request for a peer-to-peer review, the provider or their representative submits new and material evidence not previously considered that would change the decision or its rationale, the case will not be treated as a reopening.

6. KHS will provide the provider with instructions on how to file a formal Reconsideration under the KHS appeals process and.
    a. Document receipt of new evidence, date/time received, and the instructions provided in the case file.

7. KHS Staff must have the following case documentation requirements included:
    a. Telephone Documentation:
        i. UM staff must include the name of the UM staff who notified the provider, and the exact date and time of the call.
    b. Voicemail Documentation:
        i. UM staff must include the name of the UM staff who left the message, and the exact date and time.

I. Determination Notifications for Non-behavioral and Behavioral Health Denials:

1. The requesting provider is notified by KHS of the determination utilizing CMS OMB approved NOMNC Template.

a. The notification will include the name and phone number of the Physician Reviewer who made the determination.
    i. This affords the opportunity of the requesting provider to discuss the UM denial decision with the reviewing physician.

2. The notification will also state how members and providers can obtain UM criteria used to make the determination.

3. The notification shall contain enough information for members and practitioners to assist them in understanding how a decision was made to deny care or coverage and to decide whether to appeal the decision.

4. The NOMNC template (Form CMS-10003-NDMCP) will contain the source of information/criteria used to make the determination:
    a. Evidence of Coverage
    b. Medicare Benefit Manual
    c. National Coverage Determination
    d. Local Coverage Determination
    e. Milliman Care Guidelines (MCG) Guidelines
    f. Other

5. An explanation for the reason for the denial / refusal to furnish an item, service, or Part B drug (if applicable) based on the criteria used to make the determination and,
    a. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal process for thorough, appropriate, and timely resolution of appeals.
    b. Other elements in the denial notice will contain an overall explanation of the appeal process, including:
        i. A description of both the standard and expedited appeal processes (urgent preservice & urgent concurrent denials, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process
        ii. An explanation of the appeal process, including the right to member representation and time frames.
        iii. Members are granted the right to be represented by anyone they choose, including an attorney. Verbal notification or including this in the member handbook does not meet the intent of this element.
        iv. Notification that expedited external review can occur concurrently with the internal process for urgent care and ongoing treatment.
        v. Notice of non-discrimination and notice of translation (Form1557).

J. Denial Notice Content Requirements

1. The written denial notice must also include all the following:
    a. Information needed to reverse the decision.
        i. a clear description of what additional clinical data or documentation would support approval of the requested service or benefit.
    b. Readability and formatting
        i. plain-language text at a 6th–8th grade reading level, set in 12 pt Arial or Times New Roman (or another font as required by state/contract).
    c. Member-specific rationale
        i. a personalized explanation in plain language of why this service was denied.
    d. Alternate treatment options
        i. at least one medically appropriate alternative service or treatment.
    e. External review rights
        i. contact details for Independent Medical Review (IMR), state fair hearing, your state's ombudsman or consumer assistance program, and ERISA external review if applicable.
    f. State-mandated fields.
        i. all required elements per the member's state (e.g., MD name and credentials).
    g. All denial notices shall include: the legal name/DBA, Plan logo (MMP), and any required State Plan logo.
    h. The denial rationale must reference the exact service(s) requested; descriptions in the letter must mirror the initial request verbatim.
    i. KHS must provide translated or alternative-format notices per 42 CFR 422.2267(e): Translate into any non-English language used by ≥ 5% of plan members (and state-specified Medicare-Medicaid Plan/Applicable Integrated Plan (MMP/AIP) languages).
    j. Furnish accessible formats (Braille, large print, audio) upon request within:
        i. One (1) business day for expedited notices
        ii. Two (2) business days for standard notices.

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 Care Services (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	Medicare Managed Care Manual Chapter 13, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance
Other	Title 42 § 422.631
Other	https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ma-denial-notice
Other	42 CFR 422.2267(e)

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.		