KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Organization Determination Mail Policy	**Policy #**	30.89-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	1/20/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To Define Kern Health System (KHS) policy in accordance with the Department of Managed Health Care (DMHC), California Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), and National Committee for Quality Assurance (NCQA) Standards and Guidelines regarding member notifications and returned mail.

II. POLICY

A. KHS will ensure timely and confidential delivery of Member notifications/letters according to health plan/regulatory standards in a Health Insurance Portability and Accountability Act (HIPAA) compliant manner.

B. For timeliness purposes, CMS considers completion of written notification to be the date the letter leaves the KHS establishment via US Postal Service (USPS), fax, or electronic communication.

III. PROCEDURE REQUIREMENTS

Notification Workflow Process

A. Identification of Recipients

1. Upon finalizing any Utilization Management (UM) decision, KHS will have an established authorization workflow to determine handling mail notification to all parties requiring notice (e.g., member, ordering practitioner, institutional facility).

2. Workflow will include Roles authorized to identify recipients should include:

   a. UM Coordinator
   b. Clinical Review Nurse

c. UM Manager (for complex cases/exigent conditions)

Notification Methods

A. There are three (3) notification Methods

1. Verbal: Direct conversation with practitioner or their staff (voicemail does not constitute valid verbal notice).
2. Written: USPS mail, fax, or secure electronic message.
3. Electronic: Secure portal message or encrypted email.

Template Selection

A. KHS is responsible for dispersing the Integrated Care Denial Notice (ICDN) Template

Template Content Requirement

A. Medicare Marketing ID

1. Every letter template used for Medicare enrollees must include the exact Plan Medicare Marketing Identification code for KHS (e.g., "Plan-12345") in the header or footer, as provided in the "Letter Templates" library.

B. Required Disclaimers

1. The text "Important Plan Information." must appear prominently on the envelope and as a bolded header on the first page of the letter body for all Medicare member communications.

Consideration of Exigency

A. If member condition meets "exigent" criteria (e.g., life-threatening or seriously disabling), escalate to "urgent concurrent" process and notify within twenty-four (24) hours.

Review Type & Timeframes

A. All reviews follow the system timeframes listed:

1. Expedited (urgent concurrent): twenty-four (24) hrs.
2. Expedited (pre-service): seventy-two (72) hrs.
3. Standard (pre-service): seven (7) calendar days
4. Retrospective (post-service): fourteen (14) calendar days

B. Extensions or delays may only be initiated per applicable CMS/ National Committee for Quality Assurance (NCQA) regulations and must be documented in the UM system with rationale.

Documentation of Notification

A. All notices (verbal, written, electronic) must be logged in the clinical UM system.

B. System fields include: Date/Time, Method, Recipient, Template ID, Staff Initials.

NCQA Valid Verbal Notice

A. Verbal notice to the practitioner is only valid if communication occurs live with the practitioner or their staff; voicemails are not permitted per NCQA UM 5 Factors 1–3.

CMS Part B Drug Determinations for Part B drug overdose (ODs) and reconsiderations:

1. Expedited: twenty-four (24) hrs. from receipt—no extensions permitted.
2. Standard: seventy-two (72) hrs. from receipt—no extensions permitted.

A. KHS adheres to the following timeframes for notification of non-behavioral and behavioral healthcare UM decisions:

1. For urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within twenty-four (24) hours of the request.
2. For urgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request.
3. For nonurgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within seven (7) calendar days of the request.
4. For post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within fourteen (14) calendar days of the request.

B. Member letters are to generated daily on business days.

1. All member letters shall include the statement on the envelope: “Important Plan Information.” The name of the contracted health plan will also be included as directed by the plan.

C. Daily, an internal KHS designated staff delivers mail at a designated time each business day to the designated mail drop location for pick up by U.S. Postal Mail courier. Post office drop-off at the local USPS should occur before pick-up.

1. When applicable, mailings may also occur on Saturdays to ensure and maintain compliance with KHS Expedited Determination and regulatory timeliness standards. Written notification will be mailed out the same day.

D. Member demographic information is updated according to KHS schedule at least monthly to ensure complete and accurate mailing address information. Should that information be missing from an eligibility file or incorrect, or returned as undeliverable, steps will be taken to update and document database by:

1. If the USPS returned mail with a new forwarding address, member notification will be forwarded to the member along with advisement to update new address with KHS.
2. Contacting members by phone.
3. Contacting member's Primary Care Physician and / or requesting specialist if he/she has already seen the member and is requesting continued care services, Contacting Health Plan.

a. Any outreach efforts as described in three (3). (a to d) pertaining to returned mail that will be documented in the UM module accordingly and linked to the specific authorization resulting in the returned mail notice.

E. Member notifications that are returned as undeliverable will be processed per KHS policy.

F. The provider will be notified verbally or electronically via web portal, fax, mail and/or telephone within twenty-four (24) hours of the decision to approve, deny, defer, or modify the request.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other CMS, DHCS, and or 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.

IV. ATTACHMENTS

Attachment A:	N/A

V. REFERENCES

Reference Type	Specific Reference
Regulatory	42 CFR §422.616 (MA)
Regulatory	Medicare Managed Care Manual Chapter 13, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance
Regulatory	42 CFR § 422.568 Standard timeframes and notice requirements for organization determination
Regulatory	42 CFR § 422.572 Timeframes and notice requirements for expedited organization determinations
Regulatory	42 CFR § 422.2267 Required materials and content.
Regulatory	APL 21-011
Regulatory	CCR Title 22 §53880

VI. REVISION HISTORY

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

VII. 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.		
Choose an item.		
Choose an item.		