KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	UM Referral Processing Turn Around Times (TATs)	**Policy #**	30.65-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	01/23/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To define Kern Health Systems (KHS) referral decision processing timeframes.

II. POLICY

A. Requests for Utilization Management (UM) determinations are accepted from the member, the member's authorized representative, a provider, or the health plan on behalf of the member.

B. Referral processing timelines are from the time the referral requests are received by the plan, up to the time members and providers are formally notified of the UM determination to include the mailing of the written notice.
   1. Written notification is considered delivered on the date (and time, if applicable) the notice has left the possession of the plan entity.
   2. Generally, this occurs when the notice has been deposited into the courier drop box or external outgoing mail receptacle (e.g., U.S. Postal Service or FedEx bin) or for electronic delivery of required materials, the date the plan sends the materials to the enrollee (see Section 100.2.2 of the Medicare Marketing Guidelines for requirements on delivering electronic materials to enrollees).

C. KHS shall process requests for Prior Authorization, Concurrent Review, Retrospective Review and Part B Medication Reviews in accordance with regulatory requirements defined in Medicare Advantage regulations found at 42 CFR 422, Subpart M.

D. KHS will follow standards for determining the urgency of coverage requests, triage incoming requests against established criteria, and prioritize each request according to these standards.
   1. Medical Exigency Standard the medical exigency standard requires KHS to make decisions as "expeditiously as the enrollee's health condition requires." This standard is set forth in

regulations at Part 44 Subpart M and Part 423 Subpart M with respect to coverage requests and effectuation of favorable decisions. This standard requires that the plan or the independent review entity apply, at a minimum, established accepted standards of medical practice in assessing an individual's medical condition. Evidence of the individual's condition can be obtained from the treating provider or from the individual's medical record (e.g., diagnosis, symptoms, or test results).

E. KHS shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

F. Service determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members.

G. Administrative denials must meet the same timeframes as medical necessity denials.

H. .

I. As identified in the CMS Interoperability and Final Rule (CMS-0057-F) effective as of January 1, 2026:
    1. Prior authorization decisions must be processed within Seventy-two (72) hours for expedited (i.e., urgent) requests and
    2. Routine/Standard are seven (7) calendar days (i.e., non-urgent) requests for medical items services regardless of whether all necessary information has been submitted.
    3. .
    4. A provider must issue advance written notice Before termination of services in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF).
        a) The Notice of Medicare Non-coverage (NOMNC) must be delivered no later than two (2) calendar days or two (2) visits prior to the proposed termination date and must include member name and delivery date and the date that coverage of services ends

J. KHS shall send a service denial/approval notice, or Coverage Decision Letter to Members in a timely and culturally and linguistically appropriate manner.

K. The Centers for Medicare and Medicaid Services (CMS) has developed standardized notices and forms for use by plans, providers and enrollees. A CMS Form number and Office of Management and Budget (OMB) approval number specific to KHS must appear on the notice.

L. Processing time is calculated to include the Hour, Minute, and Second of receipt of the request through mailing of the notice.

M. KHS shall maintain a system for tracking and monitoring all Referrals for Provider and Member-requested health care services and supplies requiring Prior Authorization as follows:
    1. Referral turnaround time for issuing a determination,

2. Criteria used in making the determination,
3. If denied, deferred, or modified, a copy of the Notice of Action (NOA), and
4. Specific services and supplies approved, denied, deferred, or modified, including classifying non-medical necessity denials.

III. DEFINITIONS

TERMS	DEFINITIONS
Pre-Service	Any request that has been made in advance of the requested medical care or treatment being provided.
Post-Service-Retrospective	Any review of care or services that have already been received.
Urgent -Expedited Request	Any request for medical care or treatment with respect to which the application of the time-periods for making non-urgent care determinations could result in the following circumstances: A. Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment. B. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
Part B Medications	Generally, Part B covers drugs that usually aren't self-administered. These drugs can be given in a doctor's office as part of their service. In a hospital outpatient department, coverage generally is limited to drugs that are given by infusion or injection.
Non-Urgent - Routine-Request	Any request for medical care or services for which application of the time periods for deciding does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
CR - Concurrent Review	Concurrent review decisions are reviews for the extension of previously approved ongoing care. Examples are the review of inpatient care as it is occurring or ongoing ambulatory care.
Calculation of Days for Assessing Plan Timeliness	For the purpose of assessing the timeliness of completion of an initial determination, the day a plan receives the request is not counted as "day one". "Day one" is the day after receipt of the request. (Day/days are calendar days unless otherwise specified and include weekends and holidays). Timeframes measured in hours must be met within the number of hours indicated.

IV. PROCEDURES

A. KHS will have processes in place to accept referrals/authorization requests twenty-four (24) hours a day, seven (7) days a week (including holidays).

1. Requests are deemed "received" as of the date and time.
2. KHS accept coverage requests via:
    a. US Mail (e.g., U.S. Postal Service, UPS, FedEx, or DHL) delivers the document,
    b. A faxed document is successfully transmitted to the plan, as indicated on the fax transmission report.
    c. A verbal request is made by telephone with a customer service representative
    d. A message is left on the plan's voicemail system Per the directive of KHS determination to utilize a voicemail system to accept requests or supporting statements after normal business hours; or
    e. A request is through the website and/or portal meets all applicable regulatory requirements.

B. KHS will utilize the CMS Interoperability and Final Rule effective January 1, 2026 which is as follows:

1. Prior Authorization Routine /Standard are seven (7) calendar days (i.e., non-urgent) requests for medical items services regardless of whether all necessary information has been submitted.

2. Urgent (Expedited)and Concurrent Requests:
    a. Seventy-two (72) hours from the time of the receipt is when the requests are considered made to the KHS by the member or its authorized representative in accordance with the filing requirements and procedures, regardless of whether all information necessary to make the decision is included at the time of the request.

    b. The time received is the date and time when the request arrives at the KHS UM Department via fax, or mail, regardless of regular business hours. Time is calculated to include the Hour, Minute, and Second of receipt of the request.

3. For reductions or terminations in a previously approved course of treatment, KHS shall issue the determination fourteen (14) days prior to the reduction or termination of services in order to allow the member enough time to request a review.

4. For requests to extend a current course of treatment, KHS issues the determination within:
    a. Twenty-four (24) hours of the request for a UM determination, if the request is considered urgent and the request for extension was received at least twenty -four (24) hours before the expiration of the currently approved period or treatments.

b. Seventy-two (72) hours of the request for a UM determination, if it is a case involving urgent care and the request for extension was received less than twenty-four (24) hours before the expiration of the currently approved period or treatments.
c. Extensions must not be used to pend any organizational determinations while waiting for medical records from contracted providers.

C. Non-Urgent/Routine Requests (Standard Organization Adverse Determination):
1. KHS will maintain fax machines and accept requests outside of normal business hours. For routine requests, the day KHS receives the request is not counted as "day one. "Day one" is the calendar day after receipt of the request which includes weekends and holidays.

D. Voluntary Member Agreement to Extension
1. Members may voluntarily agree to extend the decision-making time frame for urgent pre-service, non-urgent pre-service, and post-service decisions for reasons other than a lack of necessary information or matters beyond KHS's control such as an evaluation by a certain specialist.

2. Members may voluntarily agree to additional extensions of urgent pre-service, non-urgent pre-service and post-service decisions beyond the prescribed time frames listed under the extension period in the ICE Timeliness grids.

E. Part B Drugs Defined
1. Generally, Part B covers drugs that usually aren't self-administered. These drugs can be given in a doctor's office as part of their service. In a hospital outpatient department, coverage generally is limited to drugs that are given by infusion or injection.

F. Part B Drug Requests Processing TATs:
1. Part B drugs, timeframes for a Standard Organization Determination (SOD), is seventy-two (72) hours.

2. For an Expedited Organization Determination (EOD), it is twenty-four (24) hours.

3. EOD processing timeframe begins when the appropriate department receives the request.
a. In all circumstances for requests for a Part B drug, KHS will notify the enrollee, and the physician, or other prescriber involved, of its decision as expeditiously as the enrollee's health condition requires but no later than the time frames set forth above.

G. Notification

1. KHS will notify Members of any decisions to deny services, to include reason for denying the services and inform the member of the right to file a reconsideration or appeal . The date in the notification notice is the date the notice is sent out. If there is a failure to provide the member with timely notice of a determination, this failure itself constitutes an adverse organizational determination and may be appealed. For electronic notification, the date when the notification was posted in the electronic system is the confirmation of sending.

H. KHS must include the appropriate Notice of Language Assistance with the following Non-Standardized Vital Documents when issued in English:
    1. UM denial notifications, including denial, modification, or delay in service.
    2. UM delay notifications for additional information or expert reviews, and
    3. Specialist termination letters to Members.

I. Procedures are to be in place for ongoing review of urgent concurrent care if approved initially. For ongoing reviews, the notification period begins on the day of the review KHS documents the date of the ongoing review and the decision notification in the UM denial file.

J. For favorable standard decisions, on a pre-service request, notice may be provided verbally or in writing to the requesting party.
    1. Verbal notification is considered delivered on the date/time the staff directly speak or leave a voicemail.
    2. If a successful verbal notification (speaking directly or leaving a voicemail) occurs a written notification must be sent within three (3) calendar days of the verbal notice.
    3. Verbal or written notice of a favorable decision will explain any conditions of the approval, such as the duration of the approval.
    4. A written notice of favorable decisions will be provided to members and providers.

K. If KHS is unable to successfully provide verbal notice, such as when the member's telephone number on file is incorrect, out of service, or unanswered with no available voicemail-a written notification will be sent within the applicable timeframe.

    Expedited favorable (approval), partially favorable, or adverse (denial) determinations must include notification to the enrollee and the prescribing or ordering Practitioner, as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours after receipt for items or services.

L. For Part B drugs:
    1. KHS must notify the enrollee, and the prescribing Practitioner, of its decision as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request. This seventy-two (72)-hour timeframe may not be extended.
    2. KHS must make its determination and notify the enrollee, and the prescribing Practitioner of its decision as expeditiously as the enrollee's health condition

requires, but no later than twenty-four (24) hours after receipt of the request. This twenty-four (24)-hour timeframe may not be extended.

M. Concurrent Review decisions and notifications are made in a timely manner in accordance with federal, state regulations and accreditation standards. Where regulatory and accreditation standards differ, the strictest or shortest timeframe is used to assure compliance with all requirements.
    1. In accordance with CA H&S Code § 1367.01(h) 3, for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within twenty-four (24) hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision

N. Initial Organization Determinations and Expedited Determinations
    1. Members and providers may request services verbally by contacting the KHS UM Department. All verbal requests will be documented and logged.
    2. If the UM Department receives an oral authorization request, the UM staff will process for determination by coordinating with the PCP/Provider as applicable.

O. A Prior Authorization Nurse shall review authorization requests utilizing.
    1. Medicare Coverage Guidelines – CMS National and Local Coverage Determinations are utilized for decision-making.
    2. If Medicare Guidelines do not exist for service requested, Milliman Care Guidelines ("MCG") or other contracted Health Plan guidelines will be utilized.

P. The medical director, or their clinical designee, will review all authorization requests when criteria are not clear or if the authorization request does not meet clinical criteria.

Q. The medical director or physician reviewer makes all medical necessity denial decisions.

R. Post-service Organization Determination (Retrospective) TATs.
    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)

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 Systems (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	CMS § 422.568 Standard timeframes and notice requirements for organization determinations.
Regulatory	CMS Part 44 Subpart M and Part 423 Subpart M
Regulatory	CA H&S Code § 1367.01(h) 3
Regulatory	CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)

VII. REVSION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	1/1/2026	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.		