KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Down Grading UM Referral Requests	**Policy #**	30.72-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	01/16/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To establish a standardized, compliant framework for KHS Health System (KHS) clinical staff to downgrade expedited Utilization Management (UM) requests to a standard review timeframe for Medicare members, and to ensure clinical appropriateness, regulatory adherence, and clear practitioner communication during the process.

II. POLICY

A. KHS allows the concession of expedited requests to be downgraded when clinical review demonstrates no imminent risk, per Milliman Care Guidelines (MCG) and other appropriate medical necessity criteria.

B. When the request demonstrates no imminent risk, it will be downgraded to a standard review to ensure adherence to Centers for Medicare and Medicaid Services (CMS) and National Committee on Quality Assurance (NCQA) requirements of clear practitioner communication, and comprehensive documentation.

C. The following are possible clinical scenarios and rationales justifying the downgrade of an expedited UM request to standard review for Medicare members.
   1. Stable Hemodynamics
   2. Laboratory Values Within Acceptable Limits
   3. Resolution of Acute Symptoms
   4. Absence of Neurologic Compromise
   5. No Evidence of Active Infection
   6. Existing Interim Authorization
   7. Diagnostic Clarification Completed
   8. Stable Chronic Condition
   9. Scheduling

D. An expedited referral request that is downgraded will require the following elements:

1. Documented rationale
2. Appropriate approvals
3. Member and/or Provider notification

E. KHS UM Staff will ensure that valid verbal and written notifications occur within regulatory timelines.

F. All documentation and audit trails shall be maintained within the UM system.

III. DEFINITIONS

TERMS	DEFINITIONS
Expedited Review	A review requiring a determination within three calendar days (seventy-two (72) hours) when delay could seriously jeopardize health.
Standard Review	A review requiring determination within seven (7) calendar days.
Downgrade	The formal change of a UM request's status from Expedited to Standard.

IV. PROCEDURES

A. When KHS receives an expedited referral request, and the UM staff determines it meets one of the policy criteria to downgrade the request the UM staff will proceed as follows:
   1. UM Coordinator logs incoming requests in the UM system as Expedited.
   2. In turn the system will trigger automate a seventy-two (72)-hour countdown alert to UM Nurse

B. The UM Nurse reviews the submitted clinical documentation.
   1. Accessing the Milliman Care Guidelines (MCG)/criteria.
   2. Evaluating the patient's current clinical data against these criteria, noting any matches or exclusions.
   3. Documenting in the system in which specific guideline sections were reviewed, the criterion outcome (met/unmet), and any relevant notes explaining why the expedited criteria are no longer satisfied.

C. Written Notification to Practitioner occurs within one (1) business day of downgrade
   1. Member Notification within two (2) business days of downgrade

D. If new clinical evidence arises that falls under the expedited definition, UM staff will process and reclassify as Expedited.

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 Chapter 13, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf
Other	NCQA Utilization Management Standards and Guidelines

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.		

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