| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Concurrent Review Utilization Management | **Policy #** | 30.81-P |
| **Policy Owner** | Utilization Management | **Original Effective Date** | 01/01/2026 |
| **Revision Effective Date** | | **Approval Date** | 01/20/2026 |
| **Line of Business** | ☐ Medi-Cal ☒ Medicare ☐ Corporate | | |

## I. PURPOSE

The purpose of the KHS Concurrent Utilization Management Review policy is to assure that the care provided to the member is medically appropriate and necessary, provided effectively and efficiently, provided in the appropriate setting and level of care while monitoring the member closely for post discharge care needs.

KHS is required to receive notification of urgent/emergency admissions and process requests for health care services on a concurrent basis according to the Center for Medicare and Medicaid Services (CMS), state/federal regulations and accreditation agency standards. KHS utilizes evidence-based criteria to provide outcome determinations to support medical necessity and appropriateness of continued inpatient services.

Services that do not require precertification will not undergo a retrospective review, i.e., preventive health.

UM review will occur upon receipt of the request for a retrospective review made directly to the UM Department or has been forwarded by the Claims department for a request within thirty (30) days.

The UM clinical reviewer will verify if:

1. Services were Emergent or Urgent in nature. If so, UM clinical reviewer will document and approve based on Emergency/Urgent criteria.

2. If services were not emergent or urgent in nature the KHS evidence of coverage will be applied and services not deemed emergent or urgent in nature may be subjected to administrative denial.

KHS must take into consideration Dual Special Needs Plan (D-SNP) members whose benefits will differ from the non-DSNP members. CMS regulatory guidance outlines how to apply D-SNP member benefits as it applies to Fully-Integrated Dual Eligible (FIDE) and Highly Integrated Dual Eligible (HIDE) plan coverage guidelines (see MA Integrated Plans Job Aid).

## II. POLICY

The continued stay review process requires an ongoing team approach that will involve the Kern Health Systems (KHS) Concurrent Review Utilization Manager (UM) nurses, non-clinical personnel and Medical Directors. Review descriptions include the acute inpatient and continued stay as well as retrospective acute inpatient reviews. A retrospective acute inpatient review is when a timely notification of the admission was performed by the provider. However, the member was discharged prior to the completion of an initial concurrent review by the health plan.

The Concurrent UM nurse will conduct electronic, telephonic, or onsite initial reviews and subsequent concurrent reviews on all inpatient admissions. Every attempt will be made to complete the initial review within one working day of receipt of the notification of the admission and then regularly throughout the member's hospital stay.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| CMS | Centers for Medicare and Medicaid Services, the Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations. |
| Continued Stay (Concurrent) Review | Process of reviewing the medical necessity and appropriateness of continued inpatient services. Continued Stay review is synonymous with Concurrent Review. |
| D-SNP/SNP | Dual Special Needs Plan or Special Needs Plan. Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS. |
| Fully-Integrated Dual Eligible (FIDE) | Fully Integrated Dual Eligible (FIDE) SNPs are D-SNPs that meet the following five elements:<br>• Enrolls special needs individuals entitled to medical assistance under a Medicaid State plan;<br>• Provides dual eligible beneficiaries access to Medicare and Medicaid benefits under a single Managed Care Organization (MCO);<br>• Has a CMS-approved Medicare Improvements for Patients and |

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| | Providers Act (MIPPA) - compliant contract with an SMA that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing;<br>• Coordinates the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and<br>• Employs policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement. |
| Highly Integrated Dual Eligible (HIDE) | CMS created a definition for a new D-SNP category, the Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP). To be considered a HIDE-SNP, a plan must provide, either directly or through a companion Medicaid managed care plan, either Long-term Services and Supports (LTSS) or behavioral health services as well as other Medicaid services to its dual eligible members. This contrasts with a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) which provides virtually all Medicaid services including both LTSS and behavioral health. |
| Post-Stabilization Care | Covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 422.113 (c)(2)(iii) of this section, to improve or resolve the enrollee's condition. |
| Retrospective (Post Service) Decisions | Any review for care or services that have already been received by the member, e.g., retrospective. |

## IV. PROCEDURES

A. For services provided to a dual eligible member and the provider is notified that Medicare benefits have been exhausted after delivery of service a retro review will be conducted.

B. Retro reviews will be conducted if this provision is based on specific provider contract terms.

C. In these instances, the member’s medical record is reviewed, and a decision is rendered within thirty (30) calendar days of receiving all information reasonably necessary to make the determination.

D. In the case of an adverse determination, the attending or treating health care practitioner, institutional provider and/or member are notified of the decision and the reason for the decision.

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 (APL)s, 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

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| **Attachment A:** N/A |
| **Attachment B:** |

## VI. REFERENCES

| Reference Type: | Specific Reference: |
|---|---|
| Regulatory | MMCM- Chapter 13, Section 40: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf |
| Regulatory | Medicare Claims Processing manual, Chapter 30, Section 400- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf |
| Regulatory | Medicare Outpatient Observation Notice (MOON)- https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CR9935-MOON-Instructions.pdf |
| Regulatory | eCFR- §422.152 & 405.1206- Expedited determinations for IP Hospital Care https://www.ecfr.gov/422.152 & https://www.ecfr.gov/405.1206 |
| Regulatory | eCFR §422.113 (c)(2)(iii) |
| Other | UM Program Description |
| Other KHS Policies | 30.82-I Medical Director Review Policy |
| Other KHS Policies | 30.80-P Discharge Planning Policy |

## 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. | | |
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