POLICY AND PROCEDURE

DEPARTMENT: Medical Management	DOCUMENT NAME: Retrospective Review For Services Requiring Authorizations
PAGE: 1 of 6	REPLACES DOCUMENT:
APPROVED DATE: 10/12	RETIRED:
EFFECTIVE DATE: 10/12	REVIEWED/REVISED: 10/2013, 8/14, 11/14, 7/15, 7/16. 6/17, 6/18, 6/19, 4/20, 3/21
PRODUCT TYPE: Medicaid	REFERENCE NUMBER: LA.UM.05.01

SCOPE:
Louisiana Healthcare Connections (Plan) Medical Management Department

PURPOSE:
To ensure a consistent and standard approach to retrospective (post-service) review of services delivered without prior authorization, and/or without timely Plan notification. **Retrospective reviews are initial review of services after services have been provided to a members.**

POLICY:
The Plan makes retrospective medical necessity review decisions for the following services delivered without prior authorization (PA), timely or untimely notification to The Plan:

- Inpatient admission for obstetrical delivery
- Inpatient admissions when the member is still hospitalized

For requests regarding PA of services that are untimely and post-discharge of an inpatient admission, or untimely and post-completion of outpatient services, the provider will be advised that the Plan does not retrospectively authorize services that have already been rendered unless the provider is able to present an **extenuating** circumstance as to why the PA was not requested timely. The following circumstances will qualify the provider for a retrospective review:

- The provider has documentation advising that they were informed that no authorization was required, date, time and who provided them the information.
- There was a catastrophic event that substantially interfered with normal business operations of the provider or damage or destruction of the provider's business office or records due to a natural disaster.
- A member has pending or retroactive eligibility. PA is granted in this situation only if one of the following conditions are met:
    - Provider's records document that the member refused or was physically unable to provide the Recipient ID number (RID).
    - Any situation that the physician cannot determine the exact procedure to be done until after the service has been performed; contracted providers are permitted to call 2 days post-procedure to request a PA. Any request outside 2 days post-procedure can only be granted based on an eligibility awareness issue.

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- For all Providers/Facilities – A PA must be submitted telephonically or by fax a minimum of 7 business days prior to the services rendered.

Inpatient Emergent Admissions – the Plan will allow a retrospective PA up to one (1) business day following the admission for participating and non-participating facilities. All medical necessity reviews are conducted according to the process as outlined in policy LA.UM.02.01 - Medical Necessity Review Process.

PROCEDURE:
In cases where a member was transferred from another Managed Care Organization (MCO) or Fee For Service Program (FFS), the Plan will honor the treatment that has been approved by that program for up to 90 calendar days during the transition period. (Emergency Contract 6.29.2.10)

~~Retrospective review guidelines are the same for both participating and non-participating providers. All medical necessity reviews are conducted according to processes as outlined in the LA.UM.02 – Clinical Decision Criteria and Application and LA.UM.02.01 – Medical Necessity Review policies and based solely on the medical~~ .

Requests and supporting clinical information for review may be submitted to the Plan by telephone, fax, or web portal from the servicing/ managing provider or facility

- In order to render an informed and objective review determination, the Plan requires submission of adequate clinical documentation to complete the review and determination.
- All medical necessity reviews are conducted according to processes as outlined in the LA.UM.02 - Clinical Decision Criteria and Application and LA.UM.02.01 - Medical Necessity Review policies, and based solely on the medical information available to the attending physician or ordering provider at the time the care or service was rendered.
- Timeliness and notifications will be made in accordance with LA.UM.05 – Timeliness of UM Decisions and Notifications. For adverse determinations, refer to LA.UM.07 – Adverse Determination (Denial) Notices
- **Retrospective review guidelines are the same for both participating and non-participating providers**

1. Inpatient Admission – Obstetrical Delivery

When the Plan is notified of hospitalization for a routine, uncomplicated vaginal or C-section delivery, regardless of timeliness, the nurse or designee enters all necessary information into the authorization system within 1 business day of receiving the information and approves the PA. If the obstetrical admission is non-routine, requiring additional days or service, a Level I review must be conducted on the additional days of service and authorized as appropriate.

If the member remains inpatient at the time of notification, concurrent decision and notification timelines apply.

If the member has been discharged at the time of notification, retrospective review decisions and notification timelines apply as outlined in LA.UM.05 Timeliness of UM Decisions and Notifications.

2. Timely Notification - Inpatient Admission (non-obstetrical) – Post-discharge

   When a request is made for authorization of hospital services and the member has been discharged, but the request is still within the required inpatient admission notification timeframe of one (1) business day, the applicable appropriate Utilization Management (UM) Clinical Reviewer (CR) will request the information needed and conduct a Level I Review. Post-service decision and notification timelines apply. Retrospective review decisions and notification timelines apply. (Emergency Contract 8.4.5.2)

3. Untimely Notification – Inpatient Admission (non-obstetrical) – Pre-discharge

   When an untimely request is made for authorization of hospital services and the member is still inpatient, days prior to notification are not retrospectively reviewed for medical necessity, but are administratively denied, and medical necessity review applies to date of notification forward. Review and notification will follow LA.UM.05 Timeliness of UM Decisions and Notification and UM.07.01 – Administrative Denials policies.

   If an **extenuating** circumstance prevented the provider of services from notifying the Plan within the one (1) business day notification timeframe, the provider will be instructed to submit the request for retrospective review. The provider must be notified of the failure to follow plan processes and the proper procedures to be followed for future service requests. Review and notification will follow LA.UM.05 Timeliness of UM Decisions and Notification policy.

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4. Untimely Notification – Outpatient Services – Services Ongoing

   When an untimely request is made for outpatient services is received and the services are still being received, services received prior to the date of notification are not retrospectively reviewed for medical necessity, but are administratively denied, and medical necessity review applies to date of notification forward. Non-urgent, pre-service decision and notification timelines apply. Review and notification will follow LA.UM.05 Timeliness of UM Decisions and Notification and LA.UM.07.01 – Administrative Denials policies.

   If extenuating circumstances prevented the provider of services from notifying the Plan within the two (2) business day notification timeframe, the provider will be instructed to submit the request for retrospective review. The provider must be notified of the failure to follow plan processes and the proper procedures to be followed for future service requests. Review and notification will follow LA.UM.05 Timeliness of UM Decisions and Notification policy.

5. Untimely Notification – Post-Discharge Inpatient Admission (non-obstetrical), or Untimely Notification – Post-Completion of Outpatient/ Ancillary Services

   When a provider or facility makes an untimely request for PA of inpatient services after the member has been discharged or outpatient/ancillary services after those services have been rendered, the Referral Specialist/ UM Clinical Reviewer informs the requesting provider that the Plan will not retrospectively authorize services that have already been rendered prior to the date of notification. The request will be administratively denied. Retrospective review and notification timelines apply.

REFERENCES:

LA.UM.02 Clinical Decision Criteria and Application
LA.UM.02.01 Medical Necessity Review Process
LA.UM.07 Adverse Determination (Denial) Notices
LA.UM.07.01 Administrative Denials
LA.UM.05 Timeliness of UM Decisions and Notifications
CC.UM.05.01 Retrospective Review For Services Requiring Authorization
Current NCQA Health Plan Standards and Guidelines

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LA MCO RFP Amendment 11, Section 6 – Core Benefits and Services, Section 8 – Utilization Management

ATTACHMENTS:

DEFINITIONS:
Retrospective Review: the initial review for medical necessity for services that delivered to a member, but for which authorization and/or timely Plan notification was not obtained.
Timely Request – Unscheduled Inpatient: Urgent / emergent / post stabilization inpatient services require plan notification within one (1) business day following the admission. (Emergency Contract 8.4.5.2)
Timely Request – Scheduled Services: For all non-hospital services and elective or pre-scheduled hospital based services requiring pre-service authorization, the provider must notify the Plan within 2 business days prior to the requested service date.
Untimely Request: An authorization request from a provider, facility or member received: more than one (1) business day after an inpatient admission or more than two (2) business days after outpatient services have been initiated.

REVISION LOG	**DATE**
In Procedure Section, 3 and 4,as the phrase relates to Untimely Notification-deleted the phrase “if extenuating circumstances prevented the provider of services from notifying The Plan within the 2 business day notification timeframe”; bolded font for extenuating	10/12
No Revisions	10/2013
Grammatical changes. NCQA reference added	08/14
LA Procurement 2015 Policy Update	11/2014
Reference updated to current NCQA standards and guidelines. Job titles corrected to reflect contract. Time line updated for untimely notification for administrative denials.	7/2015
Policy section update: removed bullets on Outpatient services and Untimely notification of non-obstetrical Procedure section update: Updated RFP reference #3 & #4 removed rfp reference and added references to LA.UM.05 policy	7/2016
Changes made to reflect Corp. Policy accordingly	06/2017

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Grammatical changes Addition to References - LA.UM.02 Clinical Decision Criteria and Application, LA.UM.07 Adverse Determination (Denial) Notices, LA.UM.07.01 Administrative Denials Updated LA MCO RFP Amendment 11 References & Citations	06/2018
Changed 'Nurse Reviewer' to 'Clinical Reviewer' to be consistent with BH & PH integration Removed section related to Retro Acknowledgement Letter & Timeliness- referred to LA.UM.05 Timeliness of UM Decisions and Notifications for specifics	6/2019
Changed RFP references to Emergency Contract Changed PA/CCR Nurse to UM Clinical Reviewer Changed outpatient services timeframe to 2 Business Days	4/2020
Added statement *"Retrospective reviews are initial review of services after services have been provided to a member"* to Purpose section, **Added statement *"Retrospective review guidelines are the same for both participating and non-participating providers"***	**03/2021**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a signature.