

**Government Business Division  
Policies and Procedures**

<b>Section (Primary Department)</b> Health Care Management – Utilization Management	<b>SUBJECT (Document Title)</b> Retrospective Review – LA
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<b>Effective Date</b> January 26, 2010	<b>Date of Last Review</b> <del>April 23, 2019</del> April 2, 2020	<b>Date of Last Revision</b> <del>April 23, 2019</del> April 2, 2020	<b>Dept. Approval Date</b> <del>April 23, 2019</del> April 2, 2020
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**Department Approval/Signature :**

**Policy applies to health plans operating in the following State(s). Applicable products noted below.**

**Products**

- |  |   |   |  |  |
|--|---|---|--|--|
| <input checked="" type="checkbox"/> Medicaid | <input type="checkbox"/> Arkansas             | <input type="checkbox"/> Indiana              | <input type="checkbox"/> Nevada            | <input type="checkbox"/> Tennessee     |
| <input type="checkbox"/> Medicare/SNP        | <input type="checkbox"/> California           | <input type="checkbox"/> Iowa                 | <input type="checkbox"/> New Jersey        | <input type="checkbox"/> Texas         |
| <input type="checkbox"/> MMP/Duals           | <input type="checkbox"/> Colorado             | <input type="checkbox"/> Kentucky             | <input type="checkbox"/> New York – Empire | <input type="checkbox"/> Virginia      |
|  | <input type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Louisiana | <input type="checkbox"/> New York (WNY)    | <input type="checkbox"/> Washington    |
|  | <input type="checkbox"/> Florida              | <input type="checkbox"/> Maryland             | <input type="checkbox"/> North Carolina    | <input type="checkbox"/> Wisconsin     |
|  | <input type="checkbox"/> Georgia              | <input type="checkbox"/> Minnesota            | <input type="checkbox"/> South Carolina    | <input type="checkbox"/> West Virginia |

**POLICY:**

To outline the process of retrospective [utilization](#) review.

[Physical health retrospective reviews are completed by the health plan. Behavioral health retrospective reviews are completed by a dedicated corporate clinical team.](#)

**DEFINITIONS:**

[Retro-Eligible Member](#) – An enrollee who was retroactively enrolled or certified for Medicaid benefits. [Retroactive enrollment in a Managed Care Organization \(MCO\) is limited to twelve \(12\) months.](#)

**Retrospective ~~or Post-Service~~ Review** – The review of a request for a service or care that has already been rendered by the provider, [and the member has been discharged. Also referred to as post-service review.](#)

**Service Authorization** – A utilization management ([UM](#)) activity that includes ~~prospective~~, concurrent, or [retrospective post](#)-review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by the member. Service authorization activities consistently apply review criteria.

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**Utilization Review (UR)** – Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

**PROCEDURE:**

**Retroactive Eligibility**

- 1) Individuals may be retroactively eligible for Medicaid. Retro-eligible individuals may be retroactively enrolled with Healthy Blue for a period not to exceed twelve (12) months.
- 2) In cases of retroactive eligibility, the effective date of enrollment may occur prior to either the individual or Healthy Blue being notified of the person’s enrollment.
- 3) Healthy Blue is not liable for the cost of any covered services prior to the effective date of enrollment. Healthy Blue is responsible for the costs of covered core benefits and services obtained on or after 12:01 am CST on the effective date of enrollment.
  - a) This includes reimbursement to a member for payments already made by the member for Medicaid payable services rendered during the retroactive eligibility period.
- 4) The Louisiana Department of Health (LDH) shall make monthly capitation payments to Healthy Blue from the effective date of a member’s enrollment.
  - a) Claims for dates of service prior to the effective date of enrollment shall be submitted by providers directly to the Medicaid Fiscal Intermediary for payment.
- 5) Except for applicable Medicaid cost sharing, Healthy Blue shall ensure members are held harmless for the cost of covered services provided as of the effective date of enrollment with Healthy Blue.
- 6) Healthy Blue shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within one hundred and eighty (180) days from the member's linkage to Healthy Blue.
  - a) The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted by the latter of three hundred and sixty-five (365) calendar days from the date of service or one hundred and eighty (180) days from the member’s linkage to Healthy Blue. [S1][W]L2
- 7) A member may be retroactively enrolled up to twelve (12) months before the member’s Healthy Blue linkage date. Providers have up to twelve (12) months from the linkage date

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to submit claims for services with dates of service during the retrospective enrollment period. [SJ3][WJL4]

- a) The linkage date is reported on the 834 file header.
- b) The provider shall not be required to submit the member’s eligibility determination award letter.
- c) Healthy Blue shall not deny claims for timely filing, prior authorization, or precertification edits.
- d) Healthy Blue may conduct post-service reviews for medical necessity and if it is determined the service was not medically necessary, Healthy Blue may deny the claim. The provider will have the right to appeal the denial.

**Inpatient Retrospective Review Activity**

- 1) Providers are instructed to notify the National Customer Care (NCC) Department within one (1) business day of an urgent/emergent inpatient admission for admission review. Elective admissions must be precertified prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.
- 2) Once notification is received and the request is entered in the medical management system, the admission appears on the census report and is reviewed by the assigned UM clinician.
- 3) If notification of the inpatient admission was made after the member was discharged, a post-service (retrospective) review is completed. A decision to approve the admission is based on company policy, medical necessity criteria, and/or discussion with the health plan/regional Medical Director (or appropriate practitioner). Refer to the *Medicaid Non Notification Grid (NNG)* and processing instructions.
  - a) If notification was not received timely, and the member is still inpatient at the time of notification (not yet discharged), the request is considered concurrent and held to concurrent review processing standards (refer to *Concurrent Review (Telephonic and On-Site) – LA*). Coverage of services may be denied as result of the facility’s non-compliance with notification requirements in accordance with company policy, the Contract, and applicable law.
  - b) When notification and/or initial clinical is sent after discharge, the request is considered a retrospective review (it does not fall into the concurrent review category). The services have already been provided and Healthy Blue has no ability to impact the stay.
- 4) Retrospective review determinations are made within thirty (30) calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred and eighty (180) calendar days from the date of service.
- 5) For service authorization approval, the provider (whether a healthcare professional,

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facility, or both) is notified verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination, and documented confirmation of such notification is provided to the provider within two (2) business days of making the determination.

- a) Healthy Blue shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.
- b) Healthy Blue shall not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.
- 6) For a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested, the provider (whether a healthcare professional, facility, or both) is notified verbally or as expeditiously as the member's health condition requires but no more than one (1) business day of making the initial determination. The member, requesting provider, and servicing provider are notified in writing within two (2) business days of making the adverse determination (refer to *Health Care Management Denial – LA*).

**Outpatient Retrospective Review Activity**

- 1) If the provider contacts Healthy Blue after non-emergent outpatient care has been rendered and precertification was required, the following applies:
  - a) The provider is advised that precertification must occur prior to the procedure or service being rendered.
  - b) The request is routed to a UM clinical associate for administrative denial for lack of notification; medical necessity review is completed for current and/or future dates of service (refer to *Precertification of Requested Services – LA*).
  - c) The requesting provider is informed of appeal and payment dispute options included as part of the claims review process.
- 2) If an outpatient procedure requires notification only (no medical necessity review), the NCC associate enters and completes the notification in the medical management system. The provider is advised no precertification is required, and claims may be submitted for payment.

**Post-Service Authorization**

- 1) ~~Healthy Blue shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.~~

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~~2) — Healthy Blue shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member’s health condition made by the provider.~~

~~3) — For service authorization approval for a non-emergency admission, procedure or service, Healthy Blue shall notify the provider verbally or as expeditiously as the member’s health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.~~

~~4) — For service authorization approval for extended stay or additional services, the Healthy Blue shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member’s health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.~~

~~Healthy Blue shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action defined by the contract.~~

~~The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 for member written materials, and any agreements that LDH may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.~~

~~Healthy Blue shall notify the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested.~~

~~Healthy Blue shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member’s health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.~~

**Exceptions to Authorization Requirements**

The MCO shall not require service authorization for:

- ~~1) Emergency services or post-stabilization services whether provided by an in-network or out-of-network provider;~~

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- ~~a) Authorization is required for emergency air ambulance transportation services; however, the authorization process is done during post-payment review and not prior to service delivery.~~
- ~~2) Non-emergency inpatient admissions for normal newborn deliveries;~~
- ~~3) EPSDT screening services;~~
- ~~4) Continuation of medically necessary covered services of a new member transitioning into Healthy Blue, regardless of whether such services are provided by an in-network or out-of-network provider. Prior authorization of services beyond thirty (30) calendar days may be required.~~

**EXCEPTIONS:**

- 1) Healthy Blue may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. Healthy Blue is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify of the inpatient emergency admission within one (1) business day of admission.
- 2) Healthy Blue shall not require service authorization for emergency services or post-stabilization services as described in the Contract, whether provided by an in-network or out-of-network provider.
- 3) Healthy Blue shall not require service authorization or referral for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program screening services.
- 4) Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the health plan, regardless of whether such services are provided by an in-network or out-of-network provider, however, prior authorization of services may be required beyond thirty (30) calendar days.
- 5) Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.
- 6) Healthy Blue shall not require a primary care physician (PCP) referral for in-network eye care and vision services.
- 7) Healthy Blue shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the plan for routine and preventive women's healthcare services and prenatal care.
- 8) Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.
- 9) Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.

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10) Healthy Blue may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours is denied.

11) Healthy Blue may require notification by the provider of obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours is denied.

**Obstetrical Admissions**

1) If the NCC receives notification/request for obstetric (OB) global precertification after the mother has delivered, the NCC enters the precertification for the delivery only, and the case is routed to the health plan to assign the days. Every effort is made by the NCC to obtain the newborn information to complete the newborn assessment at the time of notification.

2) If an OB claim is received and there is no authorization in the medical management system, the NCC enters the authorization so that the claim pays accordingly.

**Notification of Emergency Admission and Obstetrical Care**

Healthy Blue may require notification by the provider of:

~~1) — Inpatient emergency admissions within one (1) business day of admission.~~

~~a) — Healthy Blue is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify of the inpatient emergency admission within one (1) business day of admission.~~

~~2) — Obstetrical care at the time of the first visit of the pregnancy.~~

~~3) — Obstetrical admissions exceeding forty eight (48) hours after vaginal delivery.~~

~~a) — Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding forty eight (48) hours after vaginal delivery. In this case, Healthy Blue is allowed to deny only the portion of the claim related to the inpatient stay beyond forty eight (48) hours.~~

~~4) — Obstetrical admissions exceeding ninety six (96) hours after Caesarean section.~~

~~a) — Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding ninety six (96) hours after Caesarean section. In this case, Health Blue is allowed to deny only the portion of the claim related to the inpatient stay beyond ninety six (96) hours.~~



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**Retroactive Eligibility**

- ~~1) Individuals may be retroactively eligible for Medicaid. Individuals retroactively eligible for Medicaid may be retroactively enrolled with Healthy Blue. However, retroactive enrollment is limited to 12 months.~~
- ~~2) In cases of retroactive eligibility, the effective date of Healthy Blue enrollment may occur prior to either the individual or Healthy Blue being notified of the person's enrollment.~~
- ~~3) Healthy Blue shall not be liable for the cost of any covered services prior to the effective date of enrollment, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of enrollment.~~
- ~~4) LDH shall make monthly capitation payments to Healthy Blue from the effective date of an enrollee's enrollment. Claims for dates of services prior to the effective date of enrollment shall be submitted by providers directly to the Medicaid Fiscal Intermediary payment.~~
- ~~5) Except for applicable Medicaid cost sharing, Healthy Blue shall ensure members are held harmless for those cost of covered services provided as of the effective date of enrollment with Healthy Blue.~~
- ~~6) Healthy Blue shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claims is submitted within one hundred and eighty (180) days from the member's linkage to Healthy Blue.
  - ~~i) The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted by the latter of three hundred and sixty five (365) calendar day from the date of service or one hundred and eighty (180) days from the member's linkage to Healthy Blue.~~
  - ~~ii) A member may be retroactively enrolled with a plan up to twelve (12) months before the member's Healthy Blue linkage date. Providers have up to twelve (12) months from the member's linkage date to submit claims for services with dates of service during the retrospective enrollment period.
    - ~~• The linkage date is reported on the 834 file header.~~
    - ~~• Healthy Blue should accommodate this policy and not deny claims for timely filing, prior authorization, or precertification edits. The provider shall not be required to submit the member's eligibility determination award letter.~~~~
  - ~~iii) Healthy Blue may conduct post-service reviews for medical necessity and if it is determined the service was not medically necessary, Healthy Blue may deny the claim. The provider will have the right to appeal the denial.~~~~

**REFERENCES:**



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[Associates Performing Utilization Reviews – LA](#)  
[42-CFR Title 42](#)  
[Clinical Criteria for Utilization Management Decisions – Core Process](#)  
[Clinical Information for Utilization Reviews – LA](#)  
[Concurrent Review \(Telephonic and On-Site\) – LA](#)  
[Emergency and Post-Stabilization Services – LA](#)  
[Louisiana Medicaid Hospital Services Provider Manual](#)  
[Coverage for Post Stabilization Care Services](#)  
 Louisiana State Contract  
 Health Plan Advisory 16-31  
~~Health Plan Advisory 17-6~~ [Informational Bulletin 12-28](#)  
[Medicaid Non Notification Grid \(NNG\)](#)  
 NCQA Accreditation Standards and Guidelines  
[Non-Covered and Cost-Effective Alternative Services – LA](#)  
[Precertification of Requested Services – LA](#)  
~~Retrospective Review~~

**RESPONSIBLE DEPARTMENTS:**

**Primary Department:—**  
 Health Care Management – Utilization Management

**Secondary Department(s):—**  
 Behavioral Health, [Claims](#),  
 National Customer Care [Organization](#)—~~Clinical Services~~

**REVISION HISTORY:**

Review Date	Changes
<a href="#">06/02/2015</a>	<ul style="list-style-type: none"> <li>Revised corporate version to remove LA and create Louisiana specific policy</li> </ul>
<a href="#">05/19/2016</a>	<ul style="list-style-type: none"> <li>Annual review</li> <li>Definitions updated</li> <li>Procedures section updated</li> <li>Claims removed as a secondary department</li> </ul>

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	<ul style="list-style-type: none"> <li>• Definitions placed in alphabetical order</li> </ul>
<u>06/19/2017</u>	<ul style="list-style-type: none"> <li>• For annual review</li> <li>• Definitions updated</li> <li>• Procedure section updated with current contract language</li> <li>• References placed in alphabetical order</li> </ul>
<u>05/21/2018</u>	<ul style="list-style-type: none"> <li>• For annual review</li> <li>• Definitions updated</li> <li>• Added verbiage to reflect current RFP with Amendment 11</li> </ul>
<u>04/23/2019</u>	<ul style="list-style-type: none"> <li>• Annual review</li> <li>• Policy section updated</li> <li>• Definition section updated</li> <li>• Procedure section updated with current contract language</li> </ul>
<u>03/19/2020</u> <u>04/02/2020</u>	<ul style="list-style-type: none"> <li>• <u>Annual review</u></li> <li>• <u>Edits to the policy, definitions, and procedure sections</u></li> <li>• <u>References updated</u></li> <li>• <u>Claims added as a secondary department</u></li> <li>• <u>“Clinical Services” removed from the secondary department</u></li> <li>• <u>National Customer Care Organization– Clinical Services</u></li> <li>• <u>Exception language added</u></li> </ul>