POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Retrospective Review For Services Requiring Authorization
PAGE: 1 of 6	**REPLACES DOCUMENT:** N/A
APPROVED DATE: 11/12/14	**RETIRED:**
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PRODUCT TYPE: All	**REFERENCE NUMBER:** SC.UM.51

SCOPE:
Absolute Total Care (ATC) Medical Management Departments

PURPOSE:
To ensure a consistent and standard approach to retrospective (post-service) review of services delivered without prior authorization (PA) and/or timely ATC notification.

POLICY:
ATC Medical Management Department makes retrospective medical necessity review decisions for the following:

- Inpatient admission for obstetrical delivery delivered *without PA and/or without timely notification.*
- Inpatient admissions or observation settings when the member is *still hospitalized, without PA and/or without timely notification.*
- Outpatient services when the patient is *still receiving* the out-patient services requiring authorization *without PA and/or without timely notification.*
- Inpatient admissions when the member has already been discharged, *with timely notification.*
- Provider contractual exceptions to SC.UM.O5 Timeliness of UM Decisions and Notifications

Note: Timelines for Provider Notification and Standards & Guidelines for UM Decision & Notifications are referenced in the following P&P: *SC.UM.05 Timeliness of UM Decisions and Notifications.*

For requests regarding PA of services that are untimely and post-discharge of an inpatient admission/observation setting stay, or untimely and post-completion of outpatient services, the caller will be advised that ATC **will not** make retrospective determinations for 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. Examples:

- The provider has documentation advising that they were informed that no authorization was required; must include the date, time and who provided this 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 pending or retroactive eligibility issues exists, and the provider is able to provide documentation of the earliest date that ATC eligibility was identified following the start date of the services.
- Provider was unaware that the member was eligible for services at the time services were rendered. 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 ATC member ID number.
    - Any situation that the physician cannot determine the exact procedure to be done until after the service has been performed; contracted providers are permitted up to two (2) business days to call post procedure to request a PA. Any request outside of two (2) business days post-procedure can only be granted based on an eligibility awareness issue.

For telephonic inquiries regarding procedures for authorization of services that do not meet the criteria described above, the caller is advised that ATC does not retrospectively authorize services that have already been rendered, and informed of the proper procedures to follow when requesting a pre-service decision.

Written requests that are received regarding the authorization of services that are *untimely* and *post discharge* of an inpatient admission or *untimely* and *post completion of* outpatient services, will be handled as formal requests with the appropriate procedures, per SC.UM.05.

PROCEDURE:

A. In order to render an informed and objective review determination, ATC requires submission of a complete inpatient chart for review. No submission is considered complete for any type of post-discharge review without the complete hospital medical record, which includes the discharge summary as well as any other relevant clinical information.

B. 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 *Clinical Decision Criteria and Application (SC.UM.02)* and *Medical Necessity Review (SC.UM.02.01)* 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.

C. Requests and supporting clinical information for review may be submitted to the Medical Management Department by phone, facsimile or web portal from the servicing/managing provider and/or the facility. Medical necessity review decisions and time-frames will occur as follows for the following request types:

1. **Timely OR Untimely Notification - Inpatient Admission - Obstetrical Delivery:**
   When ATC 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 **one (1) business day** of receiving the information and *approves* the authorization.

   If the obstetrical admission is non-routine, requiring additional days of service, a Level I review is conducted on the additional dates of service and authorized as appropriate. If the member remains inpatient at the time of notification, urgent concurrent decision and notification timelines apply. If the member has been discharged at time of notification, post-service review decisions and notification timelines apply.

2. **Untimely Notification - Inpatient Admission (Non-Obstetrical) - Member Still Hospitalized:**
   When an untimely request is made for authorization of an inpatient admission or post stabilization service more than **one (1) business day** after the admission date and the member is still hospitalized, the Concurrent Review Nurse performs a Level I Review. Urgent concurrent and post stabilization review decision and notification timelines apply.

3. **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 Concurrent Review Nurse requests the information needed and conducts a Level I Review. Post-service decision and notification timelines apply.

4. **Untimely Notification – Outpatient/Ancillary Services - Member Still Receiving Services:**
   When a request for PA of outpatient/ancillary services is made after initiation of the services and the member is still receiving the services, the Prior Authorization Nurse reviews the information and makes a determination. Non-urgent, pre-service decision and notification timelines apply.

5. **Untimely Notification – Post Discharge Inpatient Admission (Non-Obstetrical); Untimely Notification – Post Completion Outpatient Services**
   When a provider or facility makes an untimely request for authorization of inpatient services after the member has been discharged or outpatient services after the services have been rendered, the Referral Specialist or UM Nurse (i.e., Concurrent Review or Prior Authorization Nurse) informs the requesting provider that ATC does not retrospectively authorize services that have already been rendered. The provider is instructed to submit the claim for processing (refer to ***CC.MRU.12.07- A1 Denial Work Process***) and informed of the proper procedures to follow when requesting a pre-service decision.

D. Documentation:

1. The Referral Specialist/UM Nurse makes a notation in the *Notes* section within the clinical documentation system when a telephonic post-service inquiry from a provider/facility has been received. ATC staff document the education provided to the caller regarding proper ATC procedures to be followed when requesting pre-service decisions.

2. Upon receipt of a formal request for post-discharge authorization of services, the UM Nurse reviews the submission for completeness of medical record information.

3. If any piece of the medical record is missing, including the discharge summary, the UM Nurse attempts to, within the contractual timeframes, obtain the additional information from the provider/facility. The discharge summary is required in lieu of a summary from the attending physician or a peer-to-peer review of the case.

4. If there is no response or continued lack of required information, the UM Nurse documents the request for Advisor Review in the clinical documentation system, and forward to the physician reviewer for determination.

5. The physician reviewer completes the review based on the available information and documents the decision and rationale in the Advisor Review section of the clinical documentation system.

6. A denial for lack of medical record information is only made if there is *no* clinical information available; otherwise the determination is made based on the available clinical information.

7. Should the physician reviewer decision result in a denial, the UM Nurse sends a denial letter to member/provider/facility, as outlined in the following policy: SC.*UM.07 Adverse Determination (Denial) Letters*.

REFERENCES:
SC.UM.05 - Timeliness of UM Decisions and Notifications
SC.UM.07 - Adverse Determination (Denial) Letters
CC.MRU.12.07 - A1 Denial Work Process
SC.UM.02 - Clinical Decision Criteria and Application
SC.UM.02.01 - Medical Necessity Review
NCQA Health Plan Standards & Guidelines

ATTACHMENTS:

DEFINITIONS:

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REVISION LOG	**DATE**
Revised Reference Section.	11/17/14
Annual Review; updated job titles of UM/nursing staff	11/11/15
Annual Review; minor grammar edits.	11/3/16
Annual review; minor grammatical edits.	11/1/17

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.