Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management - Utilization Management**		**SUBJECT (Document Title)** **Retrospective Review**	
Effective Date 01/26/2010	**Date of Last Review** 07/25/2019	**Date of Last Revision** 12/18/2019	**Dept. Approval Date** 12/18/2019
Department Approval/Signature :			

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

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☒ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☒ **MMP/Duals**	☐ Colorado	☒ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

To outline the process of retrospective review for providers.

DEFINITIONS:

Post-Service Review (Retrospective Review): The review of a request for a service/care that has already been rendered by the provider.
Note: If a physical health service has been initiated by the provider, but treatment/episode of care is not yet complete at the time of the request, the request is forwarded to the health plan/region for a decision. For behavioral health, the case is reviewed by the dedicated clinical team who will review the case from the date of the call and request provider send in any un-covered days to be reviewed by the health plan concurrent reviewer.

Post-Stabilization Care Services: Services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition. These services may be provided in order to maintain the stabilized condition or to improve or resolve the member's condition. The following clinical scenarios are excluded: Admission to NICU level III (level IV for those markets where the state does not recognize level III), admission to ICU, direct admission to the operating/recovery room, direct admission to telemetry (a setting of intense monitoring for cardiac arrhythmias.)

Pre-Service Review (Pre-Certification Review): The review of a request for a service/care that has not yet been rendered by the provider.

PROCEDURE:

1) **Inpatient Activity:**
   a) Providers are instructed to notify the National Customer Care Department (NCC) within one business day (Monday – Friday, not including weekends or weekdays that fall on a federal holiday) of an urgent/emergent inpatient admission for admission review. Elective admissions must be pre-certified a minimum of seventy-two (72) hours prior to

the scheduled admission. Failure to comply with notification rules will result in an administrative denial. DRG facilities who fail to notify within the designated time frames will receive an administrative denial for the entire stay.

b) The member appears on the health plan/regional census report and/or facility-specific census and is reviewed by the Utilization Management (UM) clinician assigned to that facility.
   i) If the UM clinician is notified of the urgent/emergent inpatient admission after the member is discharged, the health plan/region may perform a post-service (retrospective) review on the medical record (initiated by the health plan/region). A decision to approve the admission is based on company-approved medical necessity criteria and discussion with the health plan/regional Medical Director (or appropriately licensed practitioner). Please refer to the Medicaid Non Notification Grid (NNG) and Processing Instructions.
   ii) If the NCC does not receive timely notification of the urgent/emergent admission as outlined in 1) a) and the member is still inpatient at the time of notification, the health plan/region begins their review for medical necessity from the point of notification forward and notifies the provider that the timely filing denial, for the days prior to notification, may be appealed through the appropriate medical necessity or provider payment dispute appeal process.
      (1) The health plan/region may administratively deny coverage for post-stabilization care services as a result of the facility non-notification in accordance with its notification policies and applicable law. If the post-stabilization care services are administratively denied as a result of non-notification, the denial letter includes language explaining if the ordering/admitting physician believes the member was not stable at the time services were rendered/admitted, the ordering/admitting physician or facility acting on his/her behalf may submit medical records for review, and the decision will be reconsidered. (**Reference: Coverage for Post Stabilization Policy**)

c) Retrospective review decisions are completed within thirty (30) calendar days of receipt of request.
   i) If the review does not meet the designated medical criteria guidelines and it is determined by the health plan/regional Medical Director (or appropriately licensed practitioner) that coverage of the service will not be authorized, the appropriate denial of coverage letter is issued to the requesting provider and the member (if required by applicable law) with appeal information included.

d) If the inpatient stay was an elective admission, and the NCC is not notified until after the member has been discharged/received the care, the provider is advised that precertification must occur prior to the procedure being completed and the health plan/region is unable to review.

i) The appropriate administrative denial for lack of notification letter is issued to the requesting provider with the payment dispute information included as part of the claims review process.

2) **Outpatient Activity:**
   a) If the outpatient procedure requires notification only (no medical necessity review), the NCC enters the notification into the medical management system. (See below for OB notification rule.)
   b) If the provider contacts the health plan/region after non-emergent care has been rendered to the member and pre-certification was required, the following applies:
      i) The provider is advised that precertification must occur prior to the procedure being completed and the health plan is unable to review.
         (1) The appropriate administrative denial letter for lack of notification is issued to the requesting provider with the payment dispute information included as part of the claims review process.
   c) If the provider contacts the health plan/region after the care has been rendered and the procedure was emergent (emergency services), the provider is advised that no pre-certification is required for emergency services, and that he/she should submit the claim for payment.

3) **Postnatal Requests:**
   a) If the NCC receives notification/request for OB global pre-certification after the mother has delivered, the NCC enters the pre-certification for the delivery only, and the case is routed to the applicable health plan to assign the days. Every effort is made by the NCC to obtain the newborn information to complete the assessment at the time the precertification is created.
   b) If an OB claim is received and there is no pre-certification in the claims payment system, the NCC enters the pre-certification so that the claim pays accordingly.
   Note: This process is not performed for OON providers in the Texas health plan. The case is routed to the health plan.

REFERENCES:

42 CFR §438.114 Emergency and post-stabilization services
42 CFR §438.404
Kentucky Revised Statutes (KRS) 304.17A-607(1)(h)(i); 304.17A-611, KRS 304.17A.600, 304.17A-603, 304.17A-005
Virginia Medallion 4.0 Contract, Sections 8.1.D.a, 8.1.D.b, 8.2.Q
Commonwealth Coordinated Care Plus Contract, Sections 4.6, 6.2.10.1 & 6.2.10.2
Kentucky Medicaid Managed Care Contract Sections 21.2 and 27.8
NCQA Accreditation Standards and Guidelines: Timeliness of UM Decisions

New Jersey Managed Care Contract: 4.2.1.K.3a
Washington Apple Health Managed Care Contract 2724 (AHMC)
Washington Integrated Managed Care Contract K2729 (IMC)

Related Policies or Procedures
Coverage for Post-Stabilization Care Services
Retrospective Review - DC
Retrospective Review - LA

Desktop Processes
Post Service Reviews (Retrospective)
Denial Late Notification

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management - Utilization Management

Secondary Department(s):
Behavioral Health
Claims Department
National Customer Care - Clinical Services

EXCEPTIONS:

Kentucky:
Health Care Service: means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

Medically Necessary or Medical Necessity: Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Medically Necessary Health Care Services: means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
(a) In accordance with generally accepted standards of medical practice; and
(b) Clinically appropriate in terms of type, frequency, extent, and duration.
When a member is determined to be retro eligible, post-service review requests shall be completed within fourteen (14) days or, if the Member or the Provider requests an extension or

the health plan justifies a need for additional information and how the extension is in the Member's interest, may extend up to an additional fourteen (14) days.

Kentucky Medicaid does not allow reconsiderations.

Retrospective review of an emergency admission where the member is still hospitalized at the time the request is treated as an inpatient concurrent review.

Utilization review decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been given (unless the approval was based on fraudulent, materially inaccurate, or misrepresented information submitted by the member, authorized person, or the provider).

Kentucky Medicaid shall also be responsible for providing coverage to individuals who are retroactively determined eligible for Medicaid. Retroactive Medicaid coverage is defined as a period of time up to three (3) months prior to the application month. Kentucky Medicaid shall cover all medically necessary services provided the Member during the retroactive coverage without a Prior Authorization. Kentucky Medicaid shall allow a provider to submit a claim outside of the timely filing period when the provider is notified after the end of the Contractor's timely filing period of a retroactive change in MCO by receipt of a recoupment letter, and Kentucky Medicaid shall not deny the claim based on timely filing.

Kentucky Medicaid is not responsible for retroactive coverage for SSI Members who are newly enrolled. The Department shall be responsible for previous months or years in situations where an individual appealed a SSI denial, and were subsequently approved as of the original application date and was not already assigned to Kentucky Medicaid.

Precertification is not required for births or the inception of NICU services and shall not be required as a condition of payment.

Urgent health care services include all participating requests for hospitalization and outpatient surgery.

Any medical necessity decision (Medical or Behavioral Health), to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a licensed physician who is of the same specialty and subspecialty, when possible, as the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and consistent with state and federal regulations and state contracts.

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REVISION HISTORY:

Review Date	Changes
10/14/2013	• Rebranded for VA Medicaid Migration. Remove company specific references. Remove OH exception due to market departure.
01/01/2014	• Added Kentucky health plan
02/28/2014	• Approved by PPOC and MOC.
04/01/2014	• Added Wisconsin as applicable health plan
06/17/2014	• Added Desktop Processes to References Section
06/02/2015	• Remove LA as applicable market. Remove LA exceptions.
12/03/2015	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
02/25/2016	• Annual review by PPOC and MOC • Added region(al) to process responsibilities • Added KY and VA references • Revised Medicare, KY, NJ & WA exception language; • Added TX exception language
12/01/2016	• Off-cycle edit to add New York - Western as an applicable market.
01/23/2017	• Off-cycle edits to add IA contract reference and revise IA exception language
04/27/2017	• Annual review • Updated Definitions • Updated Inpatient Activity timeframes • Questions for NCC to address regarding retro review and Postnatal Requests • Updated TN and VA Exceptions
05/30/2017	• Off-cycle edit to add MMP as an applicable product
11/08/2017	• Off-cycle edits to add IN as an applicable market and add IN exception language
02/02/2018	• Off cycle review • KY specific language updated to reference section and exceptions section
06/28/2018	• Annual review • Wordsmithing to Procedure section • Revised References section • Revised exception language for IA, IN, NJ, VA & WA
08/10/2018	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
01/14/2019	• Off-cycle edit to add AR as an applicable market.

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07/25/2019	• Annual Review • Placed on updated template • Added DC as an applicable market • Updated Policy Section • Updated References • Updated KY, MN, NJ, TN, VA & WA exceptions
12/18/2019	• Off-cycle review • Revised KY exception language