HEALTH PLANS
UNIVERSITY OF UTAH

Administrative Policy

Retrospective Service Reviews

Related Policies:
ADMIN-021 Dismissal: Failure to Follow Filing Procedures
ADMIN-023 Administrative Denials

Policy ADMIN-022

Origination Date: 05/26/2021

Reviewed/Revised Date: 05/24/2023

Next Review Date: 05/24/2024

Current Effective Date: 05/24/2023

Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Description:

Prior Authorization or pre-authorization is a process used by U of U Health Plans to assure health benefits are administered as designed, that members receive treatments that are safe and effective for the condition being treated, and that the treatments used have the greatest value. Prior authorization may also be used as a tool to flag members who are using high cost services, for care management to assist in optimizing care. Prior Authorizations require the contracted provider to receive pre-approval for coverage of a particular treatment in order for the service to be covered by the U of U Health Plans benefit.

A request for coverage is sometimes submitted by providers after the service has already been performed but prior to claim submission. This is considered a retrospective review request.

Policy Statement and Criteria

1. Commercial Plans

U of U Health Plans considers coverage of a request for retrospective authorization in *limited circumstances*.

Circumstances in which a retrospective authorization will be considered:

A. A claim has not yet been received and ONE of the following:

   i. Initial inpatient requests will not be accepted after the date of discharge. If health plans has authorized the initial request subsequent requests will be reviewed up to 72 hours after discharge.

   ii. For outpatient medical services – the request must be received within 5 business days of the service.

   iii. For Pharmacy Services – the request must be received within 72 hours of the date of service.

   iv. Member is in transition and provider not aware of coverage change.

B. The request precedes a claim, is received after the timeframes listed above, and meets one of the following extenuating circumstances:

   i. Additional services needed- The service is directly related to another service for which prior approval has already been obtained, but need for the new service was revealed at the time the original authorized service was performed.

   ii. An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

A review meeting the criteria for a retrospective review but failing to meet the above standards will be considered a dismissal per the Dismissal Policy (Admin-021 Dismissal: Failure to Follow Filing Procedures).

Circumstances not meeting the criteria for a retrospective review, may be denied for failure to obtain prior authorization and result in an administrative denial of the services without review, claim non-payment and provider write off. In certain instances, when no authorization is on file, and the claim cannot be denied for not obtaining authorization, the claim may receive the denial code 252 and/or M127. These denial codes indicate we do not have the necessary clinical records to process the claim. The provider has the option to submit records supporting medical necessity and upon receipt of those clinical records the services will be reviewed for claim payment.

Contractual obligations take precedence over this policy.

2. Medicaid Plans

Healthy U Health Plan considers for coverage a request for retrospective authorization in *limited circumstances*.

Circumstances in which a retrospective authorization will be considered:

A. A claim has not yet been received and ONE of the following:

   i. Initial inpatient requests will not be accepted after the date of discharge. If U of U Health Plans has authorized the initial request subsequent requests will be reviewed up to 72 hours after discharge.

   ii. For outpatient medical services – the request must be received within 5 business days of the service.

   iii. For Pharmacy Services – the request must be received within 72 hours of the date of service.

   iv. Member is in transition and provider not aware of coverage change.

B. The request precedes a claim, is received after the timeframes listed above, and meets one of the following extenuating circumstances:

   i. Additional services needed- The service is directly related to another service for which prior approval has already been obtained, but need for the new service was revealed at the time the original authorized service was performed.

   ii. An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

A review meeting the criteria for a retrospective review but failing to meet the above standards will be considered a dismissal per the Dismissal Policy (Admin-021 Dismissal: Failure to Follow Filing Procedures).

Circumstances not meeting the criteria for a retrospective review, may be denied for failure to obtain prior authorization and result in an administrative denial of the services without review, claim non-payment and provider write off. In certain instances, when no authorization is on file, and the claim cannot be denied for not obtaining authorization, the claim may receive the denial code 252 and/or M127. These denial codes indicate we do not have the necessary clinical records to process the claim. The provider has the option to submit records supporting medical necessity and upon receipt of those clinical records the services will be reviewed for claim payment.

Contractual obligations take precedence over this policy.

Clinical Rationale

Prior authorization is a tool used by U of U Health Plans to assure areas of potential high cost, which may reflect on costs back to the purchasers of health care, thus increasing the cost burden of health care for plan members. The process of prior authorization is an accepted and well-established tool to manage costs. Failure to abide by this process may result in unnecessary costs to plan members. U of U

Health Plans has contractual obligations with those who pay for the insurance coverage provided by U of U Health contracted providers. These providers also have contracts requiring adherence to U of U Health Plans policies.

Errors or miscommunication and such may occur in the authorization process which may result in services requiring prior authorization to have unintentionally been omitted by provider or member from obtaining necessary prior authorization for coverage. Retrospective review affords a limited opportunity for providers and members to obtain necessary authorization so services provided can be reimbursed without opening U of U Health Plans to abuse or misuse of this process maintaining the integrity of U of U Health Plans contractual obligations.

Applicable Coding

CPT Codes

Too numerous to List

HCPCS Codes

Too numerous to List

References:

1. U of U Health Plan Internal Policy: Dismissal for Failure to follow filing procedures
2. U of U Health Plan Internal Policy: Administrative Denial