AmeriHealth Caritas Family of Companies
Medicaid Policy and Procedure

Supersedes:	State-specific ACFC Health Plan versions of this policy	**Policy Number:**	UM.200
Subject:	**Post Service Review**		
Department(s):	Utilization Management	**Current Effective Date:**	12/2023
		Last Review Date:	12/2022
		Original Effective Date:	12/27/2022
		Next Review Date:	12/2024

Applicable Lines of Business:

☒**100**: Keystone First
☒ **500**: AmeriHealth Caritas Pennsylvania
☒ **2100**: AmeriHealth Caritas Louisiana
☒ **2400**: Select Health of South Carolina
☒ **2600**: Blue Cross Complete
☒ **5400/5410**: AmeriHealth Caritas District Of Columbia
☒ **6400:** AmeriHealth Caritas Florida
☒ **7100**: AmeriHealth Caritas Delaware
☒ **7200:** Community HealthChoices (KFCHC, ACPCHC)
☒ **900**: AmeriHealth Caritas New Hampshire
☒ **1200:** AmeriHealth Caritas North Carolina
☒ **7700:** AmeriHealth Caritas Ohio

Scope
This policy applies to the following AmeriHealth Caritas Family of Companies (ACFC) business operations.

Member is defined as enrollee, participant,recipient or beneficiary.

As necessary to comply with local state regulations, the contents of this policy may be copied into a stand-alone document for a specific business operation.

Purpose
To outline the process for Retrospective Review of services that require authorization, where an authorization was not obtained prior to delivery of the service.

Policy
At certain times, ACFC conducts Restropective Reviews of medical services received by Members. In these instances, the Member's medical record is reviewed and a determination is madein accordance with the timeframes outlined in the UM.010 Decision Response Time Policy. However, request/information must be received no later than 180 days from the date of service or Member's date of discharge from an inpatient facility. In the case of an adverse determination, the attending or treating health care Practitioner, institutional Provider and/or Member are notified of the decision and the reason for the decision as outlined in Policy UM.010, *Decision Response Time* and, as applicable, Policy UM.017, *Notice of Adverse Benefit Determination*.

A retrospective/post-service review will be performed in the following circumstances:

- When the member obtains retroactive eligibility (as applicable)
- When pertinent coverage information is not available, or incorrect, upon admission or at the time of the service (i.e. member presented as self-pay or with altered level of consciousness).
- When an out-of-state- facility treats the member emergently/urgently.
- When a provider is able to show that attempts were made to submit request prior to the service but the plan did not receive the request.
- Based on specific provider contract terms

Restropective Review is performed by UM staff including licensed clinicians and reviewers who are supported by licensed physicians. Restropective Review decisions are based on nationally accepted guidelines as outlined in Policy UM.008 *Utilization Management Criteria.* UM staff can approve requested services when Utilization Management Criteria have been met. A provider's failure to adhere to ACFC contractual requirements may result in an administrate denial, where applicable, in accordance with policy UM.906 *Administrative Denial.* Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested is made by the ACFC Medical Director, BH Medical Director or designee after evaluating the individual health needs of the Member, characteristics of the local delivery system and, as needed, consultation with the treating physician/practitioner.

Restropective Review determinations are documented in the appropriate medical information system to facilitate claim payment, and are communicated to the requesting Practitioner/Provider in accordance with Policy UM.010, *Decision Response Time and* UM.906 *Administrative Denial.* The UM documentation system generates and stores an authorization number and the effective dates of the authorization to servicing and requesting providers, regardless of contracted status. Any decision to deny or limit coverage is communicated in writing to the facility, attending physician, and/or Member in accordance with Policy UM.017, *Notice of Adverse Benefit Determination*

In the case of an adverse determination, the attending or treating health care Practitioner, institutional Provider and/or Member are notified of the decision and the reason for the decision as outlined in Policy UM.010, Decision Response Time and, as applicable, Policy UM.017, Notice of Adverse Benefit Determination.

All information with PHI is handled in accordance with Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data* and related policies listed in the Related Procedures section, unless otherwise required by Law or regulation.

Definitions

N/A

Procedure

1. Requests for Retrospective Review are submitted electronically, by telephone, fax, or written requiest to the AmeriHealth Utilization Management department. Members may request, orally or in writing, a Retrospective review of initial services, or continuation of previously requested

services, in the event a provider refuses a service or does not request a service within appropriate timelines.

2. Health Care Practitioners/Providers are required to submit the diagnosis and procedure information (applicable codes are preferred but not required) to have the service considered for authorization.

3. The information gathered for use in a Retrospective Review determination includes some or all of the following:
    - Medical history
    - Mental Health and Substance Abuse History
    - History of present illness
    - Presenting symptoms
    - Prior treatment outcomes
    - Current clinical status
    - Plan of care
    - ER treatment
    - Current treatment
    - Discharge Plan
    - Information regarding condition and instructions at prior discharge

4. The UM Reviewermay make a determination that coverage for the requested service(s) is Medically Necessary based on the ACFC's accepted Utilization Management Criteria (See Policy UM.008, *Utilization Management Criteria)*. The requesting Practitioner/Provider is notified of this determination as outlined in Policy UM.010, *Decision Response Time*.

5. If the UM Revieweris not able to approve the requested service(s), he/she will refer the case to the Medical Director, BH Medical Director, or designee for review.

6. The UM Reviewer is prohibited from denying, altering or approving a lower or different level of care or scope of services than requested; any such denial or downgrade must be made by the Medical Director, BH Medical Director or physician designee.

7. The Medical Director/BH Medical Director or physician designee reviews the clinical information submitted in support of the request and documents the determination in the medical management information system. He/She may also consult a specialty Practitioner/Provider for input into the determination (Policy UM.315 *Independent Consultant Review*).

8. The UM Reviewer is responsible for communicating the determination to the requesting Practitioner/Provider as outlined in Policy UM.010, *Decision Response Time.*

9. If the determination is to deny, alter or approve a lower or different level of care or scope of services than requested, the requesting Practitioner/Provider and/or Member are notified of the determination and applicable appeal rights as outlined in Policy UM.017, *Notice of Adverse Benefit Determination.*

10. ACFC reimburses Health Care Providers for the cost of providing medical information, including copying, only in those situations where there are explicit provisions for such payment in the Health Care Provider's participation agreement with ACFC.

Related Policies
See also - Policy UM.001 *Glossary of Terms*
See also - Policy UM.010*Decision Response Time*
See also - Policy UM.008*Utilization Management Criteria*
See also - Policy UM.017 *Notice of Adverse Benefit Determination*
See also - Policy 168.235 *HIPAA Privacy Definitions*
See also - Policy 168.200 *Authorization to Use or Disclose PHI*
See also - Policy 168.212 *Facsimile Machines and Transmission of Protected Health Information*
See also - Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*
See also - Policy 168.227 *Use and Disclosure of Protected Health Information without Member Consent or Authorization*
See also - Policy 591.001 *Records Retention Policy & Schedule*

Source Documents & References
MCO Standards for Accreditation - National Committee for Quality Assurance (NCQA), Utilization Management Standards

Attachments

Approved by

Vanessa Johnson
Vice President, Utilization Management Operations
Date: December 2023

Lenaye Lawyer
Vice President, Medical Affairs
Date: December 2023

Revision Date	Revision
12/2023	Annual Review. No changes to the policies scope or intent.

AmeriHealth Caritas Family of Companies

Medicaid Policy Addendum

Territory: Louisiana

Addendum Number: UM-A.200.LA

Subject: Post-Service Review

Department(s): Utilization Management

Current Effective Date: 11/12/2024

Last Review Date: 11/12/2024

Original Effective Date: 11/13/2023

Next Review Date: 11/2025

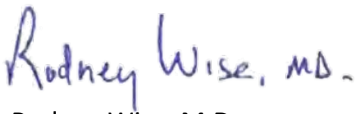
Service/Program	ACDE State Distinction	Reference/Source
Review Timeframe	ACLA shall make retrospective review determinations withing thirty (30) Calendar Days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) Calendar Days from the date of receipt of request for Service Authorization.	*2.12.6.3.1- 2.12.6.3.2*
Retroactive Enrollment	• For Enrollees who are retro-enrolled into the Plan, post service reviews will be completed for services provided within the Enrollee's retrospective enrollment period. • Retrospective enrollment period is identified as the time between when the Enrollee becomes eligible and when they are linked to ACLA. • An Enrollee may be retroactively enrolled up to twelve (12) months before the Enrollee's linkage add date. Providers have three hundred sixty-five (365) calendar day from the date of service or one-hundred eighty (180) calendar days from the Enrollee's MCO linkage add date in the Enrollee's 834 file, whichever is later, to submit claims to the plan for services with dates of service during the retrospective enrollment period.	*Louisiana Medicaid Managed Care Organization (MCO) Manual – Retroactive Enrollment*

	• In the case of an adverse determination, the attending or treating health care practitioner and institutional provider are notified of the decision and the reason for the decision. • ACLA shall not deny these claims for timely filing, prior authorization or precertification edits. The provider shall not be required to submit the enrollee's eligibility determination award letter. • ACLA may conduct post-service reviews for medical necessity, and if it is determined that the service was not medically necessary, ACLA may deny the claim. The provider will have the right to appeal the denial.	
Retro-Enrollment Verification	• In the instance a Health Care provider indicates the Enrollee was retro-enrolled into ACLA, or submits a request for authorization for services already rendered, UM staff will verify the Enrollee's eligibility within our documentation system, with enrollment and reference the LDH website for Enrollee eligibility verification (MEVs) to determine the Enrollee's retrospective review eligibility period. Once the eligibility is verified the request is sent for medical necessity review.	*Louisiana Medicaid Managed Care Organization (MCO) Manual -Enrollee Retroactive Reimbursement*

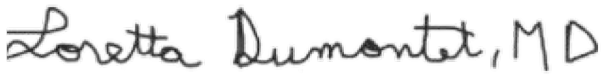
Reference:

Louisiana Medicaid Managed Care Organization (MCO) Manual
Louisiana Medicaid Managed Care Organization Attachment A: Model Contract 2.12.6.3

Approved By:



Rodney Wise, M.D.
Market Chief Medical Officer



Loretta Dumontet, MD
Behavior Health Medical Director

Revision Date	Revision
10/2/2023	Annual review: Transitioned policy from plan policy 153.200 to corporate base policy UM.200 Post-Service Review with state specific addendum to meet plan requirements.
10/2024	Added retrospective review timeframe.