ADMINISTRATIVE POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Retrospective Authorization Review-NV MP-AD-1558	01/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Retrospective Authorization Review

B. Background

A retrospective review is a request for an initial review for an authorization of care, service, or benefit for which a prior authorization (PA) is required but was not obtained prior to the delivery of the care, service, or benefit. Occasionally, situations arise in which a review cannot be reasonably obtained prior to care, service, or benefit. In these cases, CareSource will conduct a retrospective review of medical services received by members when the request is received within 30 days of the date of service or discharge.

Retrospective reviews are performed by licensed clinicians supported by licensed physicians. A decision is rendered within 30 days of the receipt of all necessary documentation. In the event of an adverse determination, the provider and/or member are notified of the decision and supporting rationale.

C. Definitions

- **Claim Dispute Process** – A dispute is the first formal review of the processing of a claim by CareSource, excluding denials based on medical necessity, submitted when the provider disagrees with payment of any other post-service claim denial. Providers should submit corrected claims if it is considered that a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim. A dispute or appeal does not have to be filed.
- **Clinical Review Criteria** – The written screening procedures, decision abstracts, clinical protocols, and practice guidelines used to determine the medical necessity and appropriateness of health care services.
- **Coordination of Benefits (COB)** – The process used for determining which health plan or insurance policy pays first, and/or determining the payment obligations of each health plan, medical insurance policy, or third-party resource when 2 or more resources cover the same benefits for the same member.
- **Explanation of Benefits (EOB)/Explanation of Payment (EOP)** – A written explanation of benefits summarizing the benefits a member receives.
- **Retrospective Authorization Review** – The process of reviewing a request for Medical Review that is submitted after the Health Care Service has been received.

D. Policy

I. CareSource considers retrospective authorization review appropriate when **ANY** of the following circumstances occur:
   A. A CareSource member is unable to advise the provider of plan enrollment due to a condition that renders the member unresponsive or incapacitated.
   B. The member is retrospectively enrolled, which covers the date of service.
   C. Urgent service(s) requiring authorization was/were performed, and it would have been to the member's detriment to take the time to request authorization.

D. The new service was not known to be needed at the time the original prior authorized service was performed.
E. The service was directly related to another service that received PA and was provided.
F. The provider discovered that CareSource is the member's primary insurance.

II. All retrospective authorization requests must be submitted within 30 calendar days of
A. date of service
B. date of discharge
C. as specified in a provider contract
D. discovery of CareSource as primary

III. In the event of the discovery that CareSource is the primary insurance, providers are required to submit the EOB/EOP with an authorization request.

IV. Claim Dispute Process for Providers
A. Claim disputes must be submitted in writing or via the CareSource Provider Portal.
B. The dispute must be submitted within 90 calendar days after the provider's receipt of the written determination of the claim.
C. If CareSource fails to render a determination for the dispute within 30 days after receipt, an appeal may be submitted.

V. Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, retrospective reviews requested greater than 30 days past date of service or date of discharge will be administratively denied. Administrative denials do not require a review by a CareSource medical director.

VI. In the event of any conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations
CareSource Marketplace 2026 Evidence of Coverage Nevada

G. Review/Revision History

	DATE	ACTION
Date Issued	08/27/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

H. References

NA