

# ADMINISTRATIVE POLICY STATEMENT

## Wisconsin Marketplace

Policy Name & Number	Date Effective
Retrospective Authorization Review-WI MP-AD-1464	04/01/2025-09/30/2025
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 PA cannot be reasonably obtained prior to care, service, or benefit. In these cases, Common Ground Healthcare Cooperative ("CGHC") will conduct a retrospective review of medical services received by members when the request is received within 90 days of the date of initial denial by the plan for dates of service beginning on January 1, 2025 and forward, communicated on an explanation of payment to provider.

For dates of service prior to January 1, 2025 providers shall be eligible for retro authorization reviews for a period of 15 months from the original date of service and for any reason, not limited by paragraph D below.

Retrospective reviews are performed by licensed clinicians who are supported by licensed physicians. A decision is rendered within 30 days of 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 and are provided with their appeal rights.

C. Definitions

- **Clinical Review Criteria** – The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CGHC to determine the medical necessity and appropriateness of health care services.
- **Retrospective Authorization Review** – The process of reviewing and making a coverage decision for a service or procedure that has already been performed (e.g., post service decision).
- **Prior Authorization** – Utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with CGHC's requirement that the health care service or course of treatment, in whole or in part, be approved prior to provision.

D. Policy

- I. CGHC considers retrospective authorization review appropriate when **ANY** of the following circumstances has occurred:
  - A. A CGHC 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.

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

- D. The new service was not known to be needed at the time the original prior authorized service was performed.
  - E. The need for the new service was revealed at the time the original authorized service was performed.
  - F. The service was directly related to another service for which prior approval has already been obtained and that has already been performed.
- II. Effective for dates of service occurring on or after January 1, 2025, retrospective authorization requests must be submitted within 90 calendar days of the date of the initial claim denial for lack prior authorization, communicated to Provider on an explanation of payment.
  - III. Unless the CGHC member is transitioning and qualifies under the retroactive coverage requirements, retrospective reviews, which are requested greater than 90 days past the date of initial denial by the plan, communicated on an explanation of payment to provider, will be administratively denied.
  - IV. For Dates of Service prior to January 1, 2025, Providers shall have 15 months from the date of service to request a retrospective authorization review for any reason not limited to Paragraph D above. Failure to request retro authorization review within that timeframe can and will result in an administrative denial of the authorization and denial of payment of the claim will be upheld.
  - V. In the event of any conflict between this policy and a provider's contract with CGHC, the provider's contract will be the governing document.
- E. Conditions of Coverage  
NA
  - F. Related Policies/Rules  
Medical Necessity Determinations

#### G. Review/Revision History

DATE		ACTION
<b>Date Issued</b>	09/25/2024	New policy. Approved at Committee.
<b>Date Revised</b>	02/26/2025	Revision. Updated background, D. Policy section and reference.
<b>Date Effective</b>	04/01/2025	
<b>Date Archived</b>	09/30/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

#### H. References

1. Common Ground Provider Manual Wisconsin-Marketplace. Accessed February 20,

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Archived