# ADMINISTRATIVE POLICY STATEMENT
# Wisconsin Marketplace

| Policy Name & Number | Date Effective |
|---|---|
| Retrospective Authorization Review-WI MP-AD-1464 | 10/01/2025 |
| **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, CareSource will conduct a retrospective review of medical services received by members when the request is received within 90 days of the date of service, of retrospective enrollment into the plan, or in compliance with a specific provider contract. Post service reviews requested greater than 90 days past the date of service or date of retrospective enrollment are administratively denied.

For dates of service prior to January 1, 2025, providers shall be eligible for retrospective 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. 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 CareSource medical director, behavioral health (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. In the event of an adverse determination, the provider and/or member are notified of the decision and supporting rationale and are provided with appeal rights.

C. Definitions

- **Clinical Review Criteria** – The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CareSource to determine the medical necessity and appropriateness of health care services.
- **Retrospective Authorization Review** – The process of reviewing and making a coverage decision for care or services that have already been received (e.g., post service decision) or any review of a request for a benefit that is not a prospective review request.

D. Policy

CareSource considers retrospective authorization review appropriate based on specific contract terms or when the request is received within 90 days of the date of service or retrospective enrollment into the plan.

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

I. 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 service.

II. Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, retrospective reviews which are requested greater than 90 days past the date of service will be administratively denied.

III. 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 the payment of the claim will be upheld.

IV. 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
42 CFR 438.210
29 CFR 2560.503-1(f)(2)(iii)(B)

## G. Review/Revision History

| | DATE | ACTION |
|---|---|---|
| **Date Issued** | 09/25/2024 | New policy. Approved at Committee. |
| **Date Revised** | 02/26/2025<br><br>07/02/2025 | Revision. Updated background, D. Policy section and reference.<br>Periodic review. Updated background, definitions, section D, F and reference. |
| **Date Effective** | 10/01/2025 | |
| **Date Archived** | | |

## H. References

1. *Common Ground Provider Manual Wisconsin-Marketplace*. Accessed June 11, 2025. www.commongroundhealthcare.org

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