ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Retrospective Authorization Review-GA MCD-AD-1336	11/01/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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 documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) 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 30 days of the date of service or discharge.

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.

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 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 CareSource's requirement that the health care service or course of treatment, in whole or in part, be approved prior to provision.

D. Policy
I. CareSource considers retrospective authorization review appropriate when **ANY** of the following circumstances has occurred:
   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 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. All retrospective authorization requests must be submitted within 30 calendar days of the date of service or date of discharge or as specified in a provider contract.

III. Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, retrospective reviews, which are 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.

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

G. Review/Revision History

	DATE	ACTION
Date Issued	06/21/2023	New policy. Approved at Committee.
Date Revised		
Date Effective	11/01/2023	
Date Archived		

H. References

1. *CareSource Georgia Provider Manual-Medicaid*. CareSource; 2023. Accessed June 2, 2023. www.caresource.com.

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