ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Retrospective Authorization Review-IN MCD-AD-1335	04/01/2025
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 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 where a PA cannot be reasonably obtained. In these cases, CareSource will conduct a retrospective review of medical services received by members in accordance with Indiana Administrative Code 405 IAC 5-3-9.

Retrospective reviews are performed by licensed clinicians who are supported by licensed physicians. A decision is rendered following receipt of all necessary documentation to make a determination. In the event of an adverse benefit 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 its provision.

D. Policy

I. CareSource conducts retrospective authorization reviews after services have begun or supplies have been delivered only under the following circumstances:
   A. Pending or retroactive member eligibility. The prior authorization request must be submitted within 12 months of the date of the issuance of the member's Medicaid card.
   B. Mechanical or administrative delays or errors by the office. The prior authorization request must be submitted within 30 calendar days of the date of service or date of discharge.
   C. Services rendered outside Indiana by a provider who has not yet received a provider manual. The prior authorization request must be submitted within 30 calendar days of the date of service or date of discharge.
   D. Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within 12 months of the date of service.

E. The provider was unaware that the member was eligible for services at the time services were rendered. The prior authorization request must be submitted within 60 calendar days of the date of service or date of discharge prior authorization will be granted in this situation only if the following conditions are met:
   1. The provider's records document that the member refused or was physically unable to provide the member identification (RID) number.
   2. The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
   3. The prior authorization request must be submitted within 60 calendar days of the date of service or date of discharge.

II. Requests for retrospective authorization review are submitted via telephone, fax, in writing, or electronically through the provider portal to the CareSource Utilization Management Department. Members may request, orally or in writing, a post service review of initial services or continuation of previously requested services in the event a provider does not request a service within appropriate timelines. Practitioners/ providers must submit a request for post service review in writing via telephone, fax, in writing, or electronically through the provider portal.

III. Healthcare practitioners/providers are required to submit the diagnosis and procedure/product codes in order for the service to be considered for authorization.

IV. Healthcare practitioners/providers should indicate/notate that they are requesting a retrospective authorization review.

V. Supporting documentation of the exception circumstance for which the member/healthcare practitioners/providers believe they meet applicable criteria for must be provided with the Retrospective Authorization Review Request. If supporting documentation is not provided, the Prior Authorization Request Form will be administratively denied for timeliness.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	05/24/2023	New policy. Approved at Committee.
Date Revised	11/06/2024	Periodic review. Updated reference. Approved at Committee.
Date Effective	04/01/2025	
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

1. *CareSource Provider Manual Indiana Medicaid*. CareSource; 2024. Accessed October 21, 2024. www.caresource.com.
2. Indiana General Assembly. Indiana Administrative Code Medicaid Services: 405 IAC 5-3-9. Accessed October 21, 2024. www.iag.iga.in.gov.