HAP CareSource™

ADMINISTRATIVE POLICY STATEMENT
Michigan Coordinated Health

Policy Name & Number	Date Effective
Retrospective Authorization Review-MI Coordinated Health-AD-1605	11/01/2026
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 prior authorization (PA) cannot be reasonably obtained prior to care, service, or benefit. In these cases, HAP 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 HAP 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 (eg, post service decision).

D. Policy

I. HAP CareSource considers retrospective authorization review appropriate when **ANY** of the following circumstances has occurred:
   A. A HAP 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 PA was/were performed, and it would have been to the member's detriment to take the time to request PA.
   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 HAP 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 HAP CareSource Medical Director.

IV. In the event of any conflict between this policy and a provider's contract with HAP 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	07/16/2025	New policy. Approved at Committee.
Date Revised	07/29/2026	Annual review. Changed 90 days timeframe to 30 days. Approved at Committee.
Date Effective	11/01/2026	
Date Archived		

H. References

NA