Troy Medicare Policy and Procedure

Title: Part C Retrospective Review
Policy Number: UM - 004

Primary Department: Utilization Management
LOB: Medicare Advantage and DSNP
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Effective Date: 11/1/22
Original Date:
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Archive Date:

Interactive Related Department(s)

☐ All Departments
☐ Compliance
☒ Medical Management
☐ Provider Operations
☐ Sales and Marketing
☐ Appeals and Grievances
☐ Pharmacy
☐ Member Services
☐ Quality Management
☒ Utilization Management
☐ Care Management
☐ Enrollment
☐ Plan Administration
☐ Claims
☐ Other _____________

Disclaimer: Troy Utilization Management applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Troy Policies, and MCG for determining medical necessity. Troy Health Policies are intended to provide a standard guideline but are not used to preempt providers’ judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

POLICY PURPOSE

Troy Health, Inc. is committed to comply with all regulations and requirements for Medicare Advantage Plans.

The purpose of this policy is to establish consistent and compliant processing of Retrospective Reviews if Troy’s Utilization Management department receives an authorization request from a provider or member after a service or item has been furnished by the provider.

SCOPE

Part C Retrospective Authorization Requests submitted to Troy Health Utilization Management.

REFERENCES

- Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

RESPONSIBLE PARTIES

- Vice President Health Services
DEFINITIONS

1. **Appeal:** The is the process used when a party (beneficiary, provider, or supplier) disagrees with an initial determination or a revised determination for a health care item or service.

2. **Dismissal:** The decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage requirements.

3. **Precertification or Prior Authorization:** The process of authorizing a medical service or item. It is the Plan’s opportunity to ensure that a service/item is medically necessary and performed in the appropriate setting by an appropriate provider. Precertification is required for several services before the service is provided.

4. **Retrospective (Retro) Request:** The request for a coverage determination made after the care or services have been provided to a member.

5. **The Centers for Medicare and Medicaid Services (CMS):** The federal agency that administers the Medicare program.

6. **Organization Determinations:** Any decision made by a Medicare health plan regarding: Authorization or payment for a health care item or service; The amount a health plan requires an enrollee to pay for an item or service; or a limit on the quantity of items or services.

POLICY

The Troy Medicare Utilization Management department will issue timely and accurate organization determinations for all pre-service medical necessity review requests. Prior authorization reviews allow Troy to ensure care/services are medically necessary, performed in the appropriate setting, and by the appropriate provider. Troy follows CMS guidance of timeframes for review and determination of prior authorization requests. Authorization requests may be submitted to Troy via secure email, fax or mail. **Failure to obtain authorization for care or services prior to their provision by contracted providers may not be covered by the plan and are not eligible for retrospective review.** Troy Health does not require prior authorization for emergency services.

PROCEDURE

1. **Retrospective Authorization Requests**
   a. Requests for an organization determination from the Utilization Management department after care or services have been provided will result in a dismissal for untimely notification/invalid request.

2. **Retrospective Review Request Dismissals**
a. If an initial organization determination has not been issued by the Utilization Management department through prior authorization and a claim is received for care or services that require authorization, then the initial organization determination will be made through claims processing.

3. Appeals

a. Providers contracted with Troy Health that provide a service without submitting a prior authorization will not have appeal rights and should refer to their contract regarding payment denial. All non-contracted providers may be allowed applicable appeal rights for adverse determinations in accordance with CMS guidance.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- APPROVALS

[Signature]

Chief Medical Officer

10 / 31 / 2022

Date: