



Troy Medicare Policy and Procedure

Title: Part C Retrospective Review		Policy Number: UM - 004	
Primary Department: Utilization Management	LOB: Medicare Advantage and DSNP	Author: J Murphy	
Effective Date: 11/1/2022	Original Date: 11/1/2022	Review Date(s): 12/7/2023, 11/05/2024, 11/6/2025	Archive Date:
Interactive Related Department(s)			
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input checked="" type="checkbox"/> Medical Management <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing	<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input checked="" type="checkbox"/> Utilization Management	<input type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input type="checkbox"/> Claims <input type="checkbox"/> Other	

Disclaimer: Troy Medicare Utilization Management applies CMS criteria and guidelines, National and Local Coverage Determinations (NCD/LCD), Clinix Internal Review Guidelines, Troy Utilization Review Policies, and MCG (Milliman Criteria Guidelines) Criteria. This suite of guidelines covers the spectrum of inpatient, outpatient, and rehabilitation, and care for medical, surgical, and behavioral health issues. In addition, Troy partners with vendors who provide clinical expertise for specific services.

POLICY PURPOSE

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.

Troy Health, Inc. is committed to complying with all regulations and requirements for Medicare Advantage Plans, and applicable federal and state laws, including health care fraud and identity theft laws.

SCOPE

Medicare Part C retrospective authorization requests submitted to Troy Health Utilization Management, or its delegate.

REFERENCES

- [42 C.F.R. Part 422, Subpart M](#)
- [Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#)

RESPONSIBLE PARTIES

- Chief Clinical Officer
- Chief Medical Officer

DEFINITIONS

Appeal: 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.

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.

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.

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

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

Organization Determinations: Any decision made by a Medicare health plan regarding: authorization or payment for a health care item or service.

POLICY

The Troy Medicare Utilization Management department, or its delegated entity, 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, or its delegated entity, via secure email, fax, mail, electronic means or phone. 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, or its delegated entity, 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, or its delegated entity, 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

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APPROVALS

Jennifer Murphy
Jennifer Murphy (Nov 24, 2025 09:31:54 EST)

Chief Clinical Officer

11/24/2025

Date

Sally Scott
Sally Scott (Nov 23, 2025 22:39:21 EST)

UM Committee

11/23/2025

Date

Revision History

Revision Date	Revised by Whom	Revisions Made
12.7.2023	J Murphy	Annual review by Utilization Management Committee
11.5.2024	J Murphy	Revised definitions. Updated disclaimer. Annual review by Utilization Management Committee.
11.10.2025	J Murphy	Revised purpose, policy and procedure, references added. Annual review by Utilization Management Committee