

## Troy Medicare Policy and Procedure



<b>Title:</b> Part C Retrospective Review		<b>Policy Number:</b> UM - 004	
<b>Primary Department:</b> Utilization Management		<b>LOB:</b> Medicare Advantage and DSNP	
<b>Author:</b> J Murphy			
<b>Effective Date:</b> 11/1/2022	<b>Original Date:</b> 11/1/2022	<b>Review Date(s):</b> 12/7/2023	<b>Archive Date:</b>
<b>Interactive Related Department(s)</b>			
<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 Utilization Management applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), TroyPolicies, 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

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.

### 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

- Chief Medical Officer

## DEFINITIONS

1. **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.
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

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### APPROVALS

*Jen Murphy*

Vice President, Medical Management

12 / 21 / 2023

Date:

*J. Scott*

Utilization Management Committee

12 / 20 / 2023

Date

#### Revision History

Revision Date	Revised by Whom	Revisions Made
12.7.2023	J Murphy	Annual review by Utilization Management Committee