Policy Title	**Part C Retrospective Review**
Policy Department	**Utilization Management**
Effective Date	**1/1/21**
Revision Date(s)	
Next Review Date	**1/1/22**

Disclaimer:

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

Purpose:

To establish consistent and compliant processing of Retrospective Reviews if Clover'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 Clover Health Utilization Management.

Policy:

Utilization Management will issue timely and accurate organization determinations for all pre-service medical necessity review requests. Prior authorization reviews allow Clover Health to ensure care/services are medically necessary, performed in the appropriate setting and by the appropriate provider. Clover Health follows CMS guidance of timeframes for review and determination of prior authorization requests. In accordance with CMS regulations, Clover Health maintains processes to receive prior authorization requests 24 hours a day, 7 days a week (including holidays). Authorization requests may be submitted to Clover Health via phone, fax or online. Failure to obtain authorization for care or services prior to their provision may not be covered by the plan. Clover Health does not require prior authorization for emergency services.

Requests for an organization determination from the Utilization Management department after care or services have been provided may result in a dismissal for untimely notification. Prior authorization review cannot be completed for a service that has already been provided to a member. Providers who receive a dismissal of a retrospective authorization request may submit a claim to Clover Health for the services provided. 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 requires authorization then the initial organization determination will be made through claims processing.

Providers contracted with Clover 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.

Definitions:

An **Appeal** 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.

A Dismissal is 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 is 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 is the request for coverage determination made after the care or services have been provided to a member.

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

Organization Determinations are 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.

Receipt Date is the delivery date/time to the Company. This includes; mail date/time stamp, Fax transmittal date/time, portal submission date/time, and date/time of phone request.

Start of Care is the date the beneficiary's initial visit to a provider or the date services are initially delivered.

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