

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 74**

POLICY TITLE: POST- SERVICE/RETROSPECTIVE REVIEW

POLICY STATEMENT: When a request for coverage is made after the care/service has been received and a determination of coverage is required, MAHP Staff will follow the following procedure. Retrospective decisions are now known as post-service decisions.

PROCEDURE:

1. Post-service/Retrospective Review will be initiated at the request of member, practitioner, or upon receipt of claim.
2. Information pertaining to the case may be requested in writing or by phone call and can include all or part of medical records, statements from the attending practitioner, and information obtained by Health Care Services Staff.
3. After all pertinent information is obtained; the MAHP Staff reviews the request. Determination of coverage is made by following appropriate Health Care Services policies and procedures such as but not limited to the following:
 - A. # 7 - Out-of-Plan Referral
 - B. #10 - Approval of Out-of-Area Care/Students/Vacationers/"Snowbirds"
 - C. #11 - Concurrent Hospital Review
 - D. # 9 - Emergency Room Usage
 - E. # 2 - Health Care Services Denial Policy
 - F. #80 - Pre-Certification Policy
4. For **post-service (retrospective review) decisions** the organization must give oral, written, or electronic notification of the decision to practitioners and members within 30 calendar days of the request. Approvals may be given orally, electronically, or written. The initial denial notification must be in writing.

For non-urgent post-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 30 calendar days of the post service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 30 calendar days of the post service request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or the member's authorized representative to provide the information. The member or the member's authorized representative must be given at least 45 days to provide the information.

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The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension, within which a decision must be made by MAHP, begins on the date on which the member's response is received by MAHP ((without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

5. The Case Managers will involve the Director of Health Care Services, Chief Medical Officer or Associate Medical Director, and/or Manager of Claims, as indicated.
6. If approval of the claim(s) is granted, appropriate documentation/communication is completed, i.e., Claims Staff notified of approval, documentation of approval in our information system, notification to Member, as indicated.
7. If an out-of-plan referral has been authorized, Health Care Services will generate a letter notifying member of retrospective review and approval and of need for pre-certification for any additional visits.
8. The Chief Medical Officer and the Associate Medical Director are the only individuals who have the authority to deny Health Plans' coverage for questions of medical necessity.
9. If an adverse determination is made, the appropriate staff generates a denial letter within the established timeframe, i.e., claims for denied claims. If member is not satisfied with the outcome of the retrospective review, the member, practitioner, and/or contracted facility will be offered the right to appeal according to MAHP Administrative Policies #10 through #10E, Appeal/Grievance Procedures.
10. See attached flow sheet.

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Judy Riniker, R.N.
Manager of Health Care Services/Quality Improvement

Date

Mary Leary, R.N.
Director of Health Care Services/Quality Improvement

Date

Original:	04/99	Reviewed:	03/02	Revised:	03/05	Revised:	03/09
Reviewed:	02/00	Reviewed:	11/02	Reviewed:	03/06	Reviewed:	02/10
Revised:	05/00	Reviewed:	03/03	Reviewed:	03/07	Revised:	02/11
Revised:	05/01	Reviewed:	03/04	Revised:	03/08	Reviewed:	01/12

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ISSUES – DENIALS - APPEALS

Preservice non urgent _____ (15 days)
Urgent Preservice _____ (72 hours)
Urgent Concurrent Review _____ (24 hours)
Post Service _____ (30 days)
Extension requested Yes ___ No ___
Member Notified of need for extension _____

Auth # _____ Member Name _____

Member # _____ Contract _____ State _____

Case Manager _____ Plan Type: (HC, HMO, POS, Medicare)

Date Request Received _____ Phone # of Dr. Office _____

Summary of question/issue:

CMO decision:

Signature _____

Date _____

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Date Member/Practitioner Informed of Decision/Denial/Redirect:

Verbal _____ Written _____

Date of Appeal Request: Verbal _____ by: _____ Written _____ by: _____

Expedited _____ (IA/WI 72 hrs) _____ (IL 24 hrs) Standard: _____ (14 days)

Original decision maker _____

Entered into appeals log: _____

Person appointed to review 1st level _____

Copy of notes, emails pertaining to denial/redirect, supporting documents with member's rationale, copy of denial letter.

Date above documents forwarded to decision maker _____

1st Level Decision:

Signature _____

Date _____

Date Member Notified: Verbal _____

Written _____