SMSO Policy Manual
RETROSPECTIVE REVIEW OF SERVICES

Executive Sponsor: Chief Medical Officer

Issuing Department: Clinical Management

Gate Keeper: Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement: All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.

Review Schedule: This policy will be reviewed and updated as necessary and no less than every two years.

Monitoring and Auditing: The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.

Documentation: Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare Apex
- ☐ Summa Management Service Organization (SMSO)
- ☒
- ☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups Medicare
- ☐ Medicare Supplemental On-
- ☒ Off-Exchange Self-Funded
- ☒
- ☒ Exchange
- ☒

1.0 Purpose:

1.1 To assess medical necessity and payment of services rendered.

1.2 To ensure members and providers that the Plan follows and adheres to all federal and state guidelines pertaining to utilization and prior authorizations.

2.0 Policy:

2.1 Retrospective review will occur for all unauthorized services that require a review of records and clinical information to determine approval or denial of inpatient services.

2.2 Retrospective Review is defined as the process of determining certification for payment after services have been rendered. Retrospective Review may also be applied for the purpose of:

- 2.2.1 Ensuring that claims are properly billed;
- 2.2.2 Negotiating large out-of-network claims; and
- 2.2.3 Analyzing aggregate data to identify utilization issues.

2.3 Retrospective review is not available for outpatient services that require prior authorization, unless otherwise specified by the provider's contract or is a SummaCare Medicare network provider that has not submitted a claim at the time of the retrospective request.

2.4 For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.

2.5 For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate

3.0 Procedure:

- 3.1.1 Authorization is entered into the Care Manager system with a pend status.
- 3.1.2 Request the medical record and review for medical necessity, appropriateness of services and determination of benefits. The review is documented per procedure.
- 3.1.3 Make retrospective review determinations within 30 days of the request.
- 3.1.4 The plan makes reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If the determination requires medical necessity review and there is not enough information provided to make a determination, 1 attempt are made to obtain the necessary information. Requests for clinical information will be made by different methods (telephone, fax, email, mail). SummaCare staff make at least 1 attempt to obtain the missing information from the appropriate provider(s) or to verify that the needed information is not available. When there is still lack of response, SummaCare will contact the member, when appropriate, for records or assistance in reaching the provider. When efforts have been exhausted and a decision is required to meet timeliness, the determination will be made according to the information available and the member's available benefits.

3.1.5 Retrospective Reviews will be completed on:

3.1.5.1 Benefit plans that have it specified in their contract;

3.1.5.2 SummaCare Medicare network providers for whom we do not have a claim (if claims have been denied it will go to Providers services for dispute process); and

3.1.5.3 Commercial Non-Par providers for whom we do not have a claim. (If claims have been denied it will go to provider services for dispute process).

3.1.5.4 The Claims department requests additional information from provider.

3.1.5.5 Incorrect Prior Authorization requirement quoted to Provider.

3.1.5.6 Plan directed Care

3.1.5.7 SummaCare Medicare non-network provider if claim has not been processed.

3.1.5.8 The above criteria exists for eviCore's Managed services in which Plan will review. eviCore is not contracted for retro reviews.

3.2 Director, HSM Clinical Management, has the authority and responsibility for the activities in this policy or procedure.

3.3 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

3.3.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, and internal standard)

4.1.1 NCQA UM 6; Code of Federal Regulations (CFR) 422.101; CFR 422.202; CFR 422.101; CFR 422.138

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 None

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 None

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 Medical Necessity: Services, supplies or drugs that are needed for prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

5.2 Plan Directed Care: Occurs when SummaCare or its contracting network providers who are responsible for ensuring that ordered or referred care services are covered by the members plan.

5.3 Retro Review: Is the process of determining certification for payment after services have been rendered

6.0 Key Words or Aliases (Optional):

6.1 Retrospective review of inpatient services
6.2 Inpatient stays

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