ADMINISTRATIVE POLICY STATEMENT TrueCare	
Policy Name & Number	**Date Effective**
Retrospective Authorization Review TrueCare-AD-1341	07/01/2025
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 2
E. Conditions of Coverage 3
F. Related Policies/Rules 3
G. Review/Revision History 3
H. References 3

A. Subject
Retrospective Authorization Review

B. Background
A retrospective review is a request for an initial review for authorization of care, service or benefit for which a prior authorization (PA) is required but was not obtained prior to the delivery of the care, service or benefit. Occasionally, situations arise where a PA cannot be reasonably obtained. In these cases, TrueCare will conduct a retrospective review of medical services received by members when the request is received within the timeframes stated below. Retrospective reviews are performed by licensed clinicians who are supported by licensed physicians. In the event of an adverse determination, TrueCare will provide written notice to the hospital administrator, the attending physician, the Medicaid agency, the beneficiary and if necessary, the next of kin or sponsor of the decision and supporting rationale.

C. Definitions
- **Clinical Review Criteria –** The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by TrueCare to determine the medical necessity and appropriateness of health care services.
- **Retrospective Authorization Review –** The process of reviewing and making a coverage decision for a service or procedure that has already been performed (eg, post service decision).
- **Prior Authorization** – A determination to authorize a Provider's request, pursuant to services covered in [TrueCare], to provide a service or course of treatment of a specific duration and scope to a member prior to the initiation or continuation of the service.

D. Policy
I. TrueCare considers retrospective authorization review appropriate when **ANY** of the following circumstances have occurred:
   A. A TrueCare member is unable to advise the provider what plan they are enrolled in due to a condition that renders them unresponsive or incapacitated;
   B. The member is retrospectively enrolled and covers the date of service.
   C. Urgent service(s) requiring authorization was/were performed and it would have been to the member's detriment to take the time to request authorization.
   D. A prior authorization had been issued, however a new service/procedure was needed and/or performed that was not known to be needed at the time of the original prior authorization request.

   Note: It is a provider's/facility's responsibility to attempt to obtain insurance information and submit authorization request if/when the member is able to provide that information prior to discharge.

II. All retrospective authorization requests must be submitted within 60 calendar days of the date of service, date of discharge, or as specified in a provider contract.
   A. Determination and notification of an authorization involving post service authorization hospital reviews and transplant reviews is made as soon as

possible but in no event later than twenty (20) business days after receipt of the request for service.

B. Determination and notification of an authorization involving post service authorization for all other reviews is made as soon as possible but in no event later than thirty (30) calendar days after receipt of the request for service.

III. Retrospective reviews which are requested greater than 60 days past date of service or date of retrospective enrollment will be administratively denied. Administrative denials do not require a review by a TrueCare Medical Director.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/09/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	07/01/2025	
Date Archived		

H. References

NA

DOM approved - DOM061026.04A