blue california
Promise Health Plan

Policy Title: Retrospective Review		POLICY #: 10.2.32 Line of business: MCAL	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 5/19	**Revision Date** 12/18, 11/21, 3/22, 9/22
Department Head: Sr. Director, UM		Date of Approval: 10/22	
Medical Services/P&T Committee: (If Applicable) PHP CMO		Date of Committee Review: 10/22	

A. PURPOSE

To establish and define mechanisms for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management (UM) Department to retrospectively review, approve, deny, or modify services.

B. Definitions
N/A

C. POLICY

I. Blue Shield Promise reserves the right to perform retrospective review of care provided to its member for any reason. Care is subject to retrospective review when claims are received for services that were not authorized. All retrospective reviews are to be completed within 30 (thirty) calendar days of obtaining all necessary information. Notification of retrospective review determinations will be made in writing to the provider and the member within 30 days of receipt of the information necessary to make a determination.

II. Communications will be made in the members preferred language and the necessary accommodations for the communication needs of all qualified members with disabilities, including authorized representatives, and be prepared to facilitate alternative format requests for Braille, audio format, large print (no less than 20 point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate.

D. PROCEDURE

I. **NON-EMERGENT SERVICES:**

a. The Claims Department will check non-emergent service claims for prior authorization. Non- emergent service claims include outpatient services, home health, DME, ancillary services etc. if prior authorization was obtained, the system of record will contain information regarding the services authorized. If non-emergent service claims are for services other than those previously authorized, the claim will be sent to the UM department for review.

b. Once in UM the case will be logged in by a UM Coordinator and distributed to a UM Clinician for review. The UM Clinician may determine that a discrepancy exists between the services being billed and the services authorized. If the discrepancy does not involve a medical necessity determination, the UM Clinician will resolve it making the appropriate notations in the system of record and return the case to the Claims Department for processing. If the case involves a medical necessity determination, the UM Clinician will completely review the medical record comparing it to UM Criteria hierarchy. If the UM Clinician determines if UM Criteria are satisfied, she/he will approve the case making the appropriate notations in Medhok Auth Accel and return the case to the Claims Department for processing.

c. Should the UM Clinician determine that UM Criteria are not satisfied, she/he shall summarize the case in the Medhok Auth Accel system and forward the case to the Chief Medical Officer or physician reviewer for a determination.

d. The Chief Medical Officer or the physician reviewer will review the medical record and the UM Clinician's summary and make a determination to approve, deny, or modify the requested services. If approved, the case will be returned to the Claims Department for processing and the UM Clinician will prepare an approval letter. If denied or modified, the UM Clinician will prepare a denial or modification letter. Notification of the member and provider will occur as described above.

II. **INPATIENTS STAYS:**

a. Inpatient stays may be subject to retrospective review when they were not previously authorized or when there was insufficient information upon which an authorization determination could be made. When the Claims Department receives an inpatient claim that has not been authorized
b. or has been pended/deferred, they will request a copy of the medical record from the provider. When the record is received, the case will be sent to the UM department for review.

c. Once in UM the case will be logged in by a UM Coordinator and distributed to a UM Clinician for review. If the case involves a medical necessity determination, the UM Clinician will completely review the medical record comparing it to UM Criteria s. If the UM Clinician determines that UM Criteria hierarchy are satisfied, she/he will approve the case making the appropriate notations in Medhok Auth Accel and return the case to the Claims Department for processing. Should the UM Clinician determine that UM Criteria are not satisfied, she/he shall summarize the case in the Medhok Auth Accel system and forward the case to the Chief Medical Officer or physician reviewer for a determination.

d. The Chief Medical Officer or the physician reviewer will review the medical record and the UM Clinician's summary and make a determination to approve, deny, or modify the requested services. If approved, the case will be returned to the Claims

Department for processing and UM Clinician will prepare an approval letter. If denied or modified, the UM Clinician will prepare a denial or modification letter. Notification of the member and provider will occur as described above.

E. MONITORING

N/A

F. REPORTING

N/A

G. REFERENCES & ATTACHMENTS

Health & Safety Code Section 1367.01
APL 21-011

H. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-Filing Number