Retrospective review requests
Policy and Procedure

Policy and Procedure Information

Scope	Medicare Advantage Plan-ISNP, DSNP & IESNP	Effective Date	1/1/23
Department	Utilization Management	Revision Date	10/14/2025
Owner	Koby Mitchell, MSN, RN	Version	1.2
Executive Sponsor	Clare Hays, MD, CMD	Status	Active
Exceptions to Scope	Non-Participating Providers		

Purpose of Policy and Procedure

To outline Associated Care Ventures (ACV) process for accepting and reviewing retrospective reviews for medical necessity. The scope of this policy does not include review of retrospective services for which claims have been submitted. This procedure refers to retrospective reviews for medical necessity and appropriateness of health care services provided for which prior authorization is required but not obtained. In addition, retrospective review does not include subsequent review of services for which prospective or concurrent review for medical necessity and appropriateness were previously conducted.

Guidelines

- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, § 40.6
- HIPAA Privacy Rule protections, 45 CFR Part 164, especially §164.501

Policy Statement

Associated Care Ventures (ACV)/Simpra Advantage Utilization Management evaluates the medical necessity of select services as communicated to providers and members. Participating providers must adhere to requirements for authorization of covered services. If a service is eligible for retrospective review, Utilization Management (UM) will evaluate medical necessity based upon the presenting condition of the member against evidence-based criteria applicable to the time the services were rendered. This policy applies only to contracted providers. Retrospective review requests submitted by non-contracted providers will not be processed through Utilization Management. Instead, the provider will be instructed to file a post-service claim accompanied by a waiver of liability in accordance with CMS requirements.

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Procedure

Generally, UM does not review requests for services requiring prior authorization retrospectively, however the following procedure describes the circumstances for when UM will accept and review requests for authorization retrospective to the services being rendered. Any retrospective review request for services received in UM that does not meet the requirements listed below will be dismissed (see UM-013_Dismissals & Withdrawals).

1. In the event the service was provided to the member emergently, providers have two (2) business days to notify ACV of emergent services rendered. The prudent layperson standard (as described in 42 CFR §422.113(b)(1)) will be applied when making determinations regarding emergency services.
2. A review request received within two (2) business days of the initiation and completion of emergent services occurring over a weekend or legal holiday will be accepted and reviewed by UM.
3. When a service requiring prior authorization is unanticipated, Simpra will accept the prior authorization request within two (2) business days. Authorization will be granted based on the request meeting medical necessity criteria or Simpra guidelines for the service requested.
4. An authorization request submitted for review because of a member's retroactive eligibility with Simpra will be accepted and reviewed by UM.
5. Services provided to a member which at the time-of-service eligibility was not known will be accepted and reviewed by UM.

Non-emergent and Elective Services:

1. Non-emergent/elective services do not qualify for retrospective review. To be considered for prospective review, non-emergent and elective service requests should be submitted through UM within (5) business days of the intended service date.

Review of Eligible Retrospective Review Requests:

1. The UM nurse reviews the request for eligible retrospective review using the applicable evidence-based criteria once the clinical information has been received by Simpra.
2. Simpra may administratively deny the request if it does not receive the information needed to make a decision within 30 days of receipt of the request.
3. Simpra UM offers healthcare providers a reasonable opportunity to discuss the services under review with a healthcare provider of same or similar specialty during normal business hours, and no less than five (5) days prior to issuing a retrospective utilization review adverse determination.
4. A determination is made, which could include physician review if criteria for approval are not met, and an electronic and/or written notification is given to the member, member's physician, or healthcare provider of record within 30 calendar days of receipt of the request for retrospective review. Additional information may be considered at the request of the provider.

5. A written response of an adverse determination of a retrospective review is sent to the member and the member's physician or healthcare provider of record explaining the resolution of the determination. The letter shall include:
    a. Statement of the specific medical, dental or contractual reasons for the resolution in easily understandable language
    b. the clinical basis for the decision
    c. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
    d. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based upon request specialization of any physician or provider consulted during the review process notice of
    e. the appealing party's right to seek review of the denial by an independent review organization, and procedures for obtaining that review [as applicable]
    f. notice of the complaint or appeals process as applicable
6. When a retrospective review of the medical necessity or appropriateness, or the experimental or investigational nature of the health care services is made in relation to health coverage, Simpra does not require the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of a member's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude requiring submission of:
    a. A member's mental health medical record summary; or
    b. Medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.
7. Appeal of retrospective review adverse determinations
    a. ACV maintains and makes available a written description of the appeal procedures involving an adverse determination in a retrospective review.
    b. A member, an individual acting on behalf of the member, or the provider of record may appeal the adverse determination in writing.
    c. Procedures for all appeals are addressed in the ACV Appeals policies.

Extension of Retrospective Review Timeframe

1. The review period of retrospective requests may be extended once by Simpra for a period not to exceed 14 days, if Simpra:
    a. Determines that an extension is necessary to receive the needed clinical information and in the interest of the member to approve the request;
    b. Extensions are also granted if requested by the provider or member/representative wishing to submit additional clinical or information for consideration of medical necessity.

2. If the extension is required because of the failure of the provider of record, member/representative to submit information necessary to reach a determination on the request, the notice of extension will be provided to the provider and member before the 30-day review timeframe expires and will include:
    a. A description of the circumstances requiring the extension and the date by which Simpra UM expects to make the determination
    b. A description of the required information necessary to complete the request; and
    c. Give the provider of record and the member/representative at least 44 days from the date of receipt of the request to provide the specified information. For example, request received 10/1 (due by 10/31); however, extension applied 10/20, new due date of 11/14.
3. Under 42 CFR § 422.572(b) and CMS Chapter 13 § 40.10, when an MA plan grants an extension (up to 14 days), the extension doesn't pause indefinitely waiting for the provider/member. The 14-day extension is an additional timeframe added to the original 30-day review period, allowing a total of up to 44 calendar days from the date the request was received:
    a. If the requested information is received before the end of the 44-day period, Simpra will issue a determination as soon as possible upon receipt, without waiting for the full extension to elapse.
    b. If no information is received by the end of the specified response period, Simpra will make a determination based on the information available within the remaining days of the 44-day timeframe.

Document Approval

Date	Approver	Role	Approved
7/3/2023	Clare Hays, MD, CMD	Chief Medical Officer	Yes
12/22/2023	UM Committee	UM Committee	Yes
12/27/2024	UM Committee – annual review	UM activity oversight	Yes
12/15/2025	UM Committee- annual review	UM activity oversight	Yes

Review & Revision History

Date	Revision Summary	Author	Approval Required?
1/2/2024	Annual review complete	K. Mitchell	No
11/25/24	Annual review completed. Clarification added that prior authorization requirements apply to Participating providers. Added clarification regarding the scope of this P&P and exclusion of non-contracted provider retrospective review requests.	K. Mitchell	UMAC annual review. Choose an item.

10/14/25	Annual review completed. Clarification added for when the process for extensions – specifically on what date the extension is applied (date of the original receipt date).	K. Mitchell	UMAC annual review.