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| Utilization Management Program: Retrospective Review |  |
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**Retrospective Review Process**

The Payer Compass Utilization Review Department assumes the following responsibilities during the retrospective review process:

* Determine the medical necessity and appropriateness of care after a patient has been discharged and/or for service that has already been administered prior to notification.

### The following outlines the Retrospective Review procedure:

1. The Retrospective Review determination is based on medical information obtained at the time of the Retrospective Review.
2. Retrospective review certifications are subject to the same notification and appeal procedures and notification as the prospective and concurrent review processes.
3. The Payer Compass Clinical Reviewer will certify the length of stay if the patient meets the necessary criteria. The length of stay authorized should equal the number of days patient met criteria.
4. Days not meeting criteria will be subject to the Peer-to-Peer Denial of Authorization Request Policy.
5. The timeframe to complete a retrospective review is 30 Calendar Days from the initial receipt of the request. This timeframe will be extended if one of the following conditions exists:

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| Payer Compass determines extension is necessary because of circumstances beyond its control | Up to 15 additional Calendar Days with patient notified of the reason for the extension prior to the expiration of the initial 30 Calendar Day period |
| Patients fails to submit necessary information | At least 45 Calendar Days from receipt of notice that describes the necessary information |

1. The ordering provider/facility is contacted via telephone or facsimile and given the following information: of the number of days or units of service and the new total number of days or services approved, and the date of admission or onset of services. Upon request, written notification is provided to the ordering physician/provider, the facility rendering the service, and the patient.
2. Pertinent medical information may be obtained from reliable sources when necessary, including the patient’s medical records or treating providers, to provide evidence supporting medical necessity, appropriateness of the admission or extension of stay, frequency, or duration of service. Payer Compass Utilization Review may request the diagnosis and/or procedure codes to assist in the review; however it is not required. If the patient is providing information and is unable to provide enough information to support certification, the reviewer shall contact the provider and/or request medical records.
3. If after any certification has been completed, new information becomes available which is materially different from that which was reasonably available at the time of the original determination, the certification may be reversed (i.e., original approval was based upon fraudulently submitted information materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or provider). If the information does not meet criteria, the new information will need to be referred to the Payer Compass Medical Director or IRO.
4. If prior authorization has already been completed, Payer Compass Utilization Review will not retrospectively review, revise or modify the specific standards, criteria or procedures used for the review of procedures, treatment and services delivered to the insured during the same course of treatment.