blue california Promise Health Plan	POLICY & PROCEDURE Medical Services	
Policy Title: Retrospective Review		
Policy No: 70.2.10	**Original Date: 11/97**	
Effective Date: 12/18	**Revision Date: 9/98, 3/03, 7/04, 4/05, 6/08, 12/18**	**Revision No: 6**
Department Head: Date:	**Medical Services/P&T Committee: Date:**	
P&P Committee: Date:	**Department(s):** **UM**	

PURPOSE:

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

POLICY:

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 within 30 days of receipt of the information necessary to make a determination.

PROCEDURE:

ER CLAIMS:

Since Emergency Services are not subject to prior authorization, ER claims are evaluated retrospectively. Criteria have been established by UM and provided to the Claims Department for their use in evaluating claims for emergency services. The Claims Department automatically pays Professional services and facility claims that meet pre-established criteria. Professional services and facility claims that fail to meet pre-established criteria are sent to UM for retrospective review. The Claims Department will request medical records before sending the case to UM for review.

Once medical records are received the claim is sent to UM for review. The case are sent to a physician reviewer for determination concerning the appropriateness of billed services and the level of care rendered. Based upon the physician reviewer's determination the claim may be authorized or modified.

Cases are then returned to the Claims Department for processing and filing.

NON-EMERGENT SERVICES:

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 Managed Health Care (MHC) system 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.

Once in UM the case will be logged in by a UM Coordinator and distributed to a Case Manager for review. The Case Manager 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 case manager will resolve it making the appropriate notations in the MHC system and return the case to the Claims Department for processing. If the case involves a medical necessity determination, the Case Manager will completely review the medical record comparing it to Milliman Care Guidelines. If the Case Manager determines Milliman Care Guidelines are satisfied, she/he will approve the case making the appropriate notations in MHC and return the case to the Claims Department for processing.

Should the Case Manager determine that Milliman Care Guidelines are not satisfied, she/he shall summarize the case in the MHC system and forward the case to the Chief Medical Officer or physician reviewer for a determination.

The Chief Medical Officer or the physician reviewer will review the medical record and the Case Manager'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. If denied or modified, the UM Coordinator will prepare a denial or modification letter. Notification of the member and provider will occur as described above.

INPATIENTS STAYS:

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 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.

Once in UM the case will be logged in by a UM Coordinator and distributed to a Case Manager for review. If the case involves a medical necessity determination, the Case Manager will completely review the medical record comparing it to Milliman Care Guidelines. If the Case Manager determines that Milliman Care Guidelines are satisfied, she/he will approve the case making the appropriate notations in MHC and return the case to the Claims Department for processing. Should the Case Manager determine that Milliman Care Guidelines are not satisfied,

she/he shall summarize the case in the MHC system and forward the case to the Chief Medical Officer or physician reviewer for a determination.

The Chief Medical Officer or the physician reviewer will review the medical record and the Case Manager'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. If denied or modified, the UM Coordinator will prepare a denial or modification letter. Notification of the member and provider will occur as described above.

REFERENCES/AUTHORITIES:

Health & Safety Code Section 1367.01