Carolina Complete Health Provider Guide

Retrospective Authorization Review Request

Retrospective Review Definition:

Retrospective review is an initial review of services provided to a beneficiary, but for which authorization and/or timely notification to Carolina Complete Health was not obtained due to extenuating circumstances. Examples of extenuating circumstances include, but are not limited to the following:

- The member was unable or refused to provide eligibility information (i.e., member unconscious).
- Services were authorized by another payer, who subsequently determined the member was not eligible at the time of service or that the services occurred during a transition of care period.
- A catastrophic event/natural disaster interfered with normal business operations.
- A service/procedure change due to unavoidable circumstance.

How should Providers submit retrospective review requests?

Providers may request a retrospective review up to 90 days after the date of service (DOS) or the date of admission (DOA) in the case of an inpatient request.

Retrospective review requests may be submitted to CCH using one of the following prior authorization submission processes:

- Availity Essentials: providers can submit retroactive web authorizations via Availity Essentials when the request is within 30 days post service. An error message displays when a request is more than 30 days post service. If you are submitting a request greater that 30 days post service, please use any of the other methods listed here.
- Secure Provider Portal (Preferred and most efficient method)
- Phone: 1-833-552-3876 (Follow the prompts for Provider Services, then Utilization Management)
- Fax: 1-833-238-7694
- **NOTE**: If faxing, providers should use the Prior Authorization form located online.

What should be included in the Retrospective Request?

Retrospective review requests must contain:

1. Clinical documentation that illustrates specific clinical evidence supportive of the request and demonstrates alignment with the applicable definition of medical necessity

2. Specific details as to why an authorization was not obtained (preferably on the cover page of the request).

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When can the provider expect to hear back from Carolina Complete Health?

The health plan will have 30 calendar days to review and finalize a decision.

How are Retrospective Requests reviewed?

- If the retrospective review request is received after 90 days of the DOS/DOA, the retrospective request will
- not be reviewed and will deny for lack of timely notification.
- If the request is received timely and extenuating circumstances are not clearly defined, the request will not be reviewed and will be denied due to failure to follow authorization procedures (administrative denial).
- If the request is received timely and extenuating circumstances are clearly defined, the request will be reviewed for medical necessity.

If the provider disagrees with the Retrospective Review determination:

Retrospective review denials may be appealed in accordance with the beneficiary (member) appeal process. Please see the Beneficiary (Member) Appeals (Medical Necessity or Authorization Denial Appeals) section of the Carolian Complete Health Provider Manual.

Support

Please view the Provider section of our website at network.carolinacompletehealth.com for additional tools and resources. You may also contact your Provider Engagement Administrator directly for support and education.

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