

# Carolina Complete Health Provider Guide

## Retrospective Review Request Provider Guide

### 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.
- Late eligibility notification from DHHS.

### 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:

- [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).

### 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. If the request lacks clinical information, Carolina Complete Health may extend the retrospective review time frame for up to 15 calendar days (total 45 calendar days for review).

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## 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:

Providers may then file their claim and follow the Claim Reconsideration/Grievance process. (Completion of the retrospective review process as defined above must be completed; a denied authorization must be on file). Upon receipt, the request will be reviewed to determine if the retrospective process and/or beneficiary appeal process was followed.

## Support

Please view the Provider section of our website at [network.carolinacompletehealth.com](https://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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