BIENVIVIR SENIOR HEALTH SERVICES

MEDICAL DEPARTMENT

MED: 2.06	EFFECTIVE DATE:	10/8/2024	REVISED DATE: -	CORRELATE: YES

SUBJECT: Retrospective Review

POLICY:

All services provided to Bienvivir participants require authorization and/or approval from the Interdisciplinary Team prior to delivery of services unless treatment meets the definition of emergent. This function is required to ensure appropriate care coordination consistent with §460.102(c)(2)(ii) and §460.92(a)(3). Service authorization and approval will be based on the participant's current medical, physical, emotional, and social needs and current clinical practice guidelines and professional standards of care applicable to the particular service consistent with §460.92(b)(1)(2). Consistent with §460.98(b)(4), authorized and approved services must be provided as expeditiously as the participant's health condition requires, considering the participant's medical, physical, emotional, and social needs.

When a claim is received for an item or service and no authorization on file has approved the service for which the claim is received, Bienvivir will deny the claim because it was not approved prior to the item being delivered or service being provided.

Additionally, when a claim is received, that does not match the authorization (for example, the authorization was for outpatient care, and the claim requests an inpatient level of care), it will be denied and will need to be resubmitted as a corrected claim to be processed.

Beginning 10/14/2024, all claims for non-emergent services submitted to Bienvivir without a matching authorization will be denied upon receipt.

The following exceptions will allow for a retrospective review and must be provided to Bienvivir for the claim to be processed:

1. Incorrect insurance information provided at the time of service by the Bienvivir participant.
2. A prior authorization was obtained, but changes occurred regarding (a) the service rendered, (b) the setting of care changed, or (c) the date of care changed. When these circumstances are present, it is the responsibility of the Provider to submit supporting clinical documentation as soon as they are known.
3. Service was obtained out of network, and the provider was not aware of the prior authorization requirement.

4. The service rendered was considered “emergent.”

DEFINITIONS:

Participant: the individual enrolled in and covered by Bienvivir.

Medical Necessity:

1. Reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
2. In accordance with generally accepted standards of medical practice

Emergent§460.100(b):

1. Services are needed immediately because of an injury or sudden illness.
2. The time required to reach Bienvivir or a network provider could permanently damage the participant’s health.
3. May include inpatient and/or outpatient services furnished by a qualified emergency services provider (other than Bienvivir or one of its contracted providers)
4. These may occur either in or out of the Bienvivir’s service area and are needed to evaluate or stabilize an emergency medical condition.

Post-stabilization care: services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.

Retrospective Review:

1. The request for authorization and claims payment *after service or care has been delivered.*
2. Examples:

a. The confinement (inpatient or observation) has already occurred, and the participant has been discharged or has been in the hospital beyond the required notification of admission (NOA) timeframe.
b. The service has already been performed (i.e. issuance of a DME item, completion of an outpatient procedure/surgery, administration of testing such as high-tech imaging, the administration of any medication).

PROCEDURE:

All contracted (and non-contracted) providers must obtain approval from Bienvivir before performing a requested procedure or billing for said equipment or service. Please refer to ***MED***

2.01 Prior Authorization (Excludes Post Acute) for further details regarding the process for obtaining prior authorization.

Services provided without prior authorization may be subject to non-payment or may be allowed to undergo a retrospective review. When retrospective review is allowed, providers must include all necessary clinical information to perform a medical necessity review and a summary of why preauthorization was not obtained.

All Claim submissions must be made within 180 days of the date of service if the provider is in-network and one year from the date of service if the provider is not contracted. Claims received after this time will be denied regardless of reason.

A retrospective review will be allowed under the following circumstances:

1. Incorrect insurance information was provided at the time of service by the Bienvivir participant.
    a. As soon as the correct insurance information is received by the servicing provider, the claim must be submitted with supporting clinical documentation for the service(s) rendered.
    b. Submission must include information explaining what occurred.
2. A prior authorization was obtained, but changes occurred regarding (a) service rendered, (b) setting of care delivery, or (c) date of care.
    a. If the Prior Authorization was not adjusted at the time services were rendered and the claim does not match the authorization, the claim will be pended.
    b. For Prior Authorizations, if the date the care was rendered differs by 3 days or less, the claim will be approved and processed. Discrepancies greater than 3 days will require supporting clinical documentation.
    c. If supporting clinical documentation is not received at the time of claim submission, the missing clinical information will be requested from the servicing provider for review for appropriateness by the Bienvivir Utilization Management (UM) Nurse. Three attempts will be made to obtain the needed documentation within a 7-day period.
    d. If the requested information is not received within 45 days from the date of the initial claim submission, the claim will be processed as a denial due to being an unclean claim.

3. Service was obtained from an out-of-network provider who was unaware of the Prior Authorization requirement.
    a. Claim submission must be accompanied by supporting clinical documentation demonstrating medical necessity for the service(s) rendered.

b. In addition to a review for medical necessity, out-of-network providers must agree to Single Case Agreement terms for payment to be processed. This includes the participant not being billed for any of the charges.
c. If the out-of-network provider believes the care delivered met the definition of "emergent," that should be noted in the submission.
d. Upon receipt of all supporting documentation, the request will be reviewed for medical necessity.
e. If the out-of-network claim is not accompanied by supporting clinical documentation, the Bienvivir UM Nurse will request this information. A total of three requests will be made within a seven-day (7) timeframe.
f. If the requested information is not received by day 45 following the initial claim receipt, the claim will be denied for lack of supporting documentation.

4. The service rendered was considered "emergent."
   a. All in-network providers are required to notify the Bienvivir UM Nurse of any admissions (Inpatient or Observation) within 24 hours or by 10 AM the next working day.
   b. Bienvivir is required to cover emergency services provided both in and out of the network per PACE regulation 460.100(e)(3).
   c. Post-stabilization care will be reviewed for medical necessity, and notification timelines will apply.
   d. Requests for retrospective approvals for post-stabilization care delivered by the out-of-network providers will require the submission of supporting clinical documentation and are subject to the UM Nurse's review as defined above in (3).

Procedure Reviewed: _____ Date: 10/8/2024
Medical Director

Procedure Reviewed: _____ Date: 10/8/2024
Chief Executive Officer

Review/Revision History

Designated Committee Approval	Procedures Revised	Statement Amended	Attachment Titles	Correlates
P&P - 10/8/2024				MED 2.01
CCI - 9/5/2024				
-				
-				
-				

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Approval: _____ Date: 10/8/2024
Committee with Community Input Chair

Approval: _____ Date: 10/8/2024
Chief Executive Officer

Approval: _____ Date: 10/8/2024
Medical Director