<table>
<tr><td colspan="2">Subject: Processing Retrospective Review Request</td><td>Accountability: Utilization Management</td><td>Effective Date: 1/15/2016</td><td>Pages: 3</td></tr>
<tr><td colspan="3">Associated Policy: SWMBH Operating Policy 4.8 Retrospective Review</td><td>Last Reviewed Date:
9/1/18</td><td>Past Reviewed Dates:
3/1/16</td></tr>
<tr><td>LINE OF BUSINESS:
☒ Specialty Waiver (B/C)
☐ 1115 Waiver
☒ Healthy Michigan Plan
☒ SUD Medicaid
☒ SUD Block Grant
☒ MI Health Link
☐ OTHER: ________</td><td colspan="2">APPLICATION:
☒ SWMBH Staff and Ops
☒ Participant CMHSPs
☐ SUD Providers
☐ MH / DD providers
☐ Other:_______</td><td>Last Revised Date:
9/1/18</td><td>Past Revised Dates:
3/1/16</td></tr>
<tr><td colspan="3">Approved : Elizabeth Guisinger
Date: 10/11/2018</td><td colspan="2">Required Reviewer:
Manager of Utilization Management</td></tr>
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I. Purpose

To describe a clear method for requesting and completing a retrospective administrative authorization service determination process for urgent/emergent services provided without pre-authorization. Any request for retrospective review in which an authorization decision had been previously made, will follow Southwest Michigan Behavioral Health Policy 6.4: Customer Grievance Systems and Second Opinions.

II. Scope

This retrospective review procedure requires prior authorization/coverage determination decisions for all services SWMBH directly funds before delivery of services. For a narrow category of services provided in urgent or emergent situations a retrospective review process shall apply when:

- Southwest Michigan Behavioral Health (SWMBH) or its designee is identified as the reviewing entity to make the determination and
- Obtaining pre-authorization for and/or discharging from an identified setting would have jeopardized the health or safety of the individual or
- Inaccurate County of Financial Responsibility (COFR) or insurance information is provided to the provider or
- The individual presents in such a disorganized state that insurance or residency information is not attainable or
- The individual was not Medicaid or Healthy Michigan Plan eligible at the time of service and became retroactively enrolled

III. Procedural Steps

A. Upon receipt of a retrospective review request, the utilization department shall determine:

1. If the request has been sent to the appropriate entity for retrospective review, as defined in SWMBH Policy 4.8: Retrospective Review. If the request has been sent to the incorrect organization, the entity that received the review request shall promptly return the review request to the sending entity and inform sender of correct entity to review.
2. If the request is for a service that was previously denied authorization. In the event that the service was previously denied, the request will be managed as an appeal request and will follow the process as indicated in SWMBH Policy 6.4 Customer Grievance Systems and Second Opinions.
3. If the entity has financial responsibility based on Michigan Department of Health and Human Services (MDHHS) COFR Technical Requirements. In the event the retrospective authorization request is for an individual that is deemed to not meet criteria for review by the organization that received the request according the COFR Technical Requirements, the entity shall notify the requesting provider/facility and return the records to the sending entity.
4. If the request adequately explains the reason for the retrospective request for authorization, supports the reasoning prior authorization was not sought, and provides clinical documentation to support the request. In the event that there is not enough information to process the request, the responsible entity shall notify the requesting provider/entity of what information is missing and the timelines in which they have to provide the missing information.
5. If the individual is uninsured, the Community Mental Health Service Provider (CMHSP) shall determine if General Fund dollars will be used to authorize and pay for the service, in the event the service is deemed to be medically necessary.

B. Upon determining eligibility for review, the entity's Utilization Management (UM) Department shall review the clinical documentation to determine if the individual meets medical necessity criteria for the service requested. The authorization determination and notice of the authorization determination must be made within 30 calendar days from the date of the request, unless a 15 day extension is warranted as defined in SWMBH Policy 4.3 Service: Authorization- Outlier Management.

1. If the information indicates any part of the services were medically necessary and the individual meets criteria, UM staff shall:
    a. Document the clinical information used in making the determination and complete an authorization for the eligible and medically necessary portion of the Episode of Care in the individual's electronic record.
    b. Provide the Service Determination Authorization and notification letter to the provider and member as applicable.
    c. Notify the claims department of the completed decision. A signed authorization in the individual's electronic medical record serves as notification.
    d. Clearly document and maintain all decisions (including the time and date of the request and determination) along with justification in the electronic health record (EHR) or managed care information system (MCIS) so as to be available to the

individual at their request. Supporting documents available from the request should be stored in the customer's electronic record.

2. If the information indicates any part of the services were not medically necessary and the individual does not meet criteria, UM staff shall:
   a. Make a determination for services within scope of practice or consult with the senior practitioner, who will, within his/her scope of practice, review all pertinent and relevant documentation and render a service determination decision.
   b. Document the clinical information used in making the determination and complete a denial determination for any of the dates of service deemed to not meet medical necessity criteria for any portion of the episode of care in the individual's electronic record.
   c. Assure that the Service Determination denial and notification letter are provided to the member and/or provider.
   d. Notify the SWMBH claims department and applicable CMH of the completed decision. The signed denial in the individual's electronic medical record serves as notification.
   e. Clearly document and maintain all decisions (including the time and date of the request and determination) along with justification in the EHR or MCIS so as to be available to the individual at their request. Supporting documents available from the request should be stored in the individual's electronic record.
   f. Notify the SWMBH Customer Services department to initiate any applicable Grievance and Appeals notification process.

IV. Definitions

A. None

V. References

A. SWMBH Policy 4.3: Service Authorization- Outlier Management

B. SWMBH Policy 6.4: Customer Grievance Systems and Second Opinions

VI. Attachments

A. None