Document Title: *Policy and Procedure # MBH 25: Retrospective Review*
Department: Clinical Services, Claims

Purpose: Outlining steps for performing retrospective review of inpatient admissions or continued stay requests.

Responsibility: The initial clinical reviewer or designee, the clinical peer reviewer (CPR) or designee, the Claims Department

Policy and Procedure:

1. Requests for coverage after care is rendered are subject to the same review as if requested prior to services being rendered (See *Policy and Procedure # MBH 13: Prospective Review....*)

2. The Claims Department may request a retrospective review after a claim is cleared administratively (i.e. verification of benefits and/or eligibility.)

3. The outcome of a retrospective review is based solely on the medical information available to the attending physician or ordering provider at the time the care was provided.

4. Reversal of a certification determination occurs only when information provided to the Clinical Services Department is different from that which was reasonably available at the time of the original determination.

5. Claims subject to retrospective review are unauthorized services that have not been reviewed before or after the services were rendered.

6. The initial clinical reviewer or designee receives the request for retrospective review from the consumer, the provider or the claims payor.

7. Upon receipt of the request for a retrospective review, the initial clinical reviewer or designee reviews the case or claim.

8. The initial clinical reviewer or designee speaks by telephone with the provider and/or consumer if necessary.

9. If additional information is needed, the initial clinical reviewer or designee may request to review the medical records. (See *Policy and Procedure # MBH 26: Requesting Medical Records.)*

10. The initial clinical reviewer or designee reviews the claim upon receipt of all pertinent information.

11. If appropriate, the initial clinical reviewer or designee issues an authorization and notifies the claims payor.

12. If the initial clinical reviewer or designee is unable to approve the case or claim for payment, it is referred to the CPR for review.

13. The decision regarding certification of the claim for payment is based solely on the medical information available to the attending physician or ordering provider at the time medical care was provided.

14. If the CPR issues a non-certification, the initial clinical reviewer sends a notification letter via fax or postal mail to the ordering physician, facility and consumer within applicable regulatory timeframes. (See *Policy and Procedure # MBH 911: Turnaround Timeframes.*)

15. The total time taken in processing a retrospective review will not exceed the applicable regulatory timeframe. (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)