KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Retrospective Review Process | **Policy #** | 30.75-P |
| **Policy Owner** | Utilization Management | **Original Effective Date** | 01/01/2026 |
| **Revision Effective Date** | | **Approval Date** | 2/4/2026 |
| **Line of Business** | ☐ Medi-Cal ☒ Medicare ☐ Corporate | | |

## I. PURPOSE

The purpose of this policy is to define the Utilization Management (UM) process for retrospectively reviewing suspended claims and referral requests not authorized prior to date of service. And, to determine if the service would have been authorized, according to medical necessity based on established guidelines and criteria, if the service was requested prior to the date of service.

## II. POLICY

A. Only a physician reviewer can render a denial or partial approval/partial denial determination.
B. Services that do not require prior authorization will not undergo a retrospective review, i.e., preventive health
C. Retrospective review through the Claims Department
    1. Emergency room claims will be paid according to the "prudent layperson" standards.
    2. Emergency services will be covered to screen and stabilize the member without prior authorization.
    3. Coverage of emergency services if an authorized representative acting for KHS has authorized the provision of emergency services.

D. KHS will review and determine a retrospective request decision within fourteen (14) calendar days of the request.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| Retrospective Review: | The process of initial review for medical necessity for services that delivered to a Member, but for which authorization and/or timely Plan notification was not obtained. |
| Timely Request: | Unscheduled Inpatient: Urgent / emergent / post stabilization inpatient services require plan notification within one (1) business day following the admission. |
| Untimely Request: | An authorization request from a provider, facility or Member received: more than one (1) business day after an inpatient admission or more than two (2) business days after outpatient services have been initiated. |

## IV. PROCEDURES

A. Retrospective Service Review

1. At certain times KHS will conduct post service reviews of medical services received by Members when the request is:
    a. Due to Member retrospective enrollment into the plan
    b. When a KHS Member is unable to advise the provider what plan they are enrolled in due to a condition that renders them unresponsive or incapacitated
    c. When urgent service(s) requiring authorization was/were performed and it would have been to the Member's detriment to take the time to request authorization.
    d. The need for the new service was revealed at the time the original authorized service was performed.
    e. The service was directly related to another service for which prior approval has already been obtained and that has already been performed.

2. For services provided to a dual eligible Member and the provider is notified that Medicare benefits have been exhausted after delivery of service a retro review will be conducted.

3. Retro reviews will be conducted if this provision is based on specific provider contract terms.

B. In these instances, the Member's medical record is reviewed, and a decision is rendered within fourteen (14) calendar days of receiving all information reasonably necessary to make the determination.

C. In the case of an adverse determination, the attending or treating health care practitioner, institutional provider and/or Member are notified of the decision and the reason for the decision (additional

information in policy 30.66-P, Adverse Organization Determinations - Fully Denied-Partially Denied.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other Centers for Medicare and Medicaid Services (CMS), Department of Health Care (DHCS), and or Department of Managed Health Care (DMHC) guidance, including applicable All Plan Letters (APLs), Health Plan Management Systems (HPMS) memos, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

## V. ATTACHMENTS

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| Attachment A: | N/A |

## VI. REFERENCES

| Reference Type | Specific Reference |
|---|---|
| Regulatory | Medicare Managed Care Manual Chapter 13, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf |
| Other KHS Policies | 30.92-P Prior Authorization Referrals |
| Other KHS Policies | 30.66-P Adverse Organization Determinations - Fully Denied-Partially Denied. |
| Regulatory | California Code, Health and Safety Code - HSC § 1367.01 |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| Effective | 1/2026 | New policy created to comply with D-SNP | UM |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | Date Reviewed | Date Approved |
|---|---|---|
| Choose an item. | | |