



Retrospective Authorization Review

LOB(s): <input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Medicare	State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Oregon

Commercial Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing procedural processes. Each policy contains a list of sources (references) and applicable regulations that serves as the summary of evidence used in the development and adoption of procedures. The evidence was considered to ensure the procedures promote clinical benefits, patient safety and/or access to appropriate care. Each policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Guideline only applies to PacificSource Health Plans in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Guideline and the Member's policy, the Member's policy language shall control. Guidelines do not constitute medical advice nor guarantee coverage.

Background

Prior authorization is the process by which providers verify coverage and receive authorization from PacificSource before specific services or supplies are rendered. Services requiring prior authorization are posted on our external website under the provider and member pages. It is the responsibility of both the provider of the services and the member receiving the services to obtain prior authorization for services under the member's specific coverage.

Retrospective review, also known as post service, is any review for care or services on the prior authorization list that have already been provided.

Retrospective authorizations will be reviewed when the requirements below are met. Determinations will be based solely on the medical information available at the time the service was provided. Results from subsequent testing/procedures will not be considered.

Criteria

PacificSource will review retrospective requests for authorization when **ALL** of the following conditions are met:

- Is made within 60 days from the date of service

- Is due to circumstances beyond the provider's control (e.g., need for second procedure is identified while performing an approved primary procedure or member is new to the plan and efforts were made to obtain authorization from the prior insurer).
 - Request must include documentation of the reason the request for authorization was not requested pre-service.
 - Scheduling or clerical error is not an acceptable reason.
- The provider has not already billed for the service and/or received a denial citing lack of authorization as the reason. In this case, the provider may submit an appeal for reconsideration.

PacificSource will not require an additional prior authorization when an additional or related surgical health care procedure is **identified during an approved surgical procedure** if **ALL** of the following occur:

- A medical condition, disease or ailment is identified by the provider during an approved surgical procedure, which was not identified in the initial prior authorization request **AND** the provider determines that performing a related health care procedure, instead of or in addition to the approved surgical procedure, is medically necessary and within generally accepted standards of medical practice, **AND** it is in the provider's judgment, to interrupt or delay the provision of care in order to obtain prior authorization for the additional or related health care procedure would not be medically advisable;
- The additional or related health care procedure is a covered benefit under the member's health benefit plan;
- The additional or related health care procedure is not experimental or for investigational purposes.

All retrospective requests for authorization are completed within thirty (30) calendar days from receipt of request.

It is the responsibility of the admitting facility and/or the admitting practitioner to obtain prior authorization for inpatient services that require prior authorization.

Ancillary providers (e.g., anesthesia, radiology, pathology) will not have payment withheld for failure to obtain prior authorization, unless the specific service provided was subject to prior authorization.

Members may not be billed for services, if an in-network or participating provider's services are denied because a prior authorization was not obtained. Members may be responsible for charges, if an out-of-network (non-participating) provider's services are denied because a prior authorization was not obtained.

If PacificSource receives a grievance or appeal based on a claims denial reason for failing to obtain a prior authorization within the above timeframes, the request will not be reviewed clinically for medical necessity. The grievance or appeal may be reviewed for extenuating circumstances which prevented timely prior authorization, such as primary coverage disputes.

Related Policies

Timeliness of UM Decisions and Notifications of Decisions

Utilization Management Clinician Determination of Non-Coverage

Utilization Management Program Description

Appendix

Policy Number:

Effective: 8/1/2020

Next review: 7/1/2027

Policy type: Commercial

Author(s):

Depts.: Claims, Provider Network, Health Services, Legal/Compliance

Applicable regulation(s): NCQA UM 5, Element A & B, Factor 6, Oregon HB 3134; MCA 33-32-211(6)(a); WAC 284-43-2000(7)(b)

OPs Approval: 5/2026