

Care N' Care Insurance Company of North Carolina, Inc.
POLICY

Policy Title: Retrospective Authorization Request Policy			
Department Responsible: Utilization Management	Policy Code 9.13	Effective Date: 10/01/2026	Next Review Date: 8/19/2027
Title of Person Responsible Medical Director	Approval Council Medical Oversight Committee		Approved Date 8/19/2026

PURPOSE

To establish guidelines for the submission and review of retrospective authorization requests and to define the appropriate post-service review processes for participating and non-participating providers.

DEFINITIONS, INITIALS, ACRONYMS

Retrospective Prior Authorization: A request for authorization submitted after a healthcare service has been rendered and completed for a member when prior authorization was required but was not obtained before the service was provided. Retrospective prior authorization requests are reviewed to determine whether the service met applicable medical necessity criteria, coverage requirements, and Plan guidelines as of the date the service was rendered.

POLICY

Policy Statement

The Medicare Advantage Plan permits retrospective prior authorization requests from in-network providers under limited circumstances when prior authorization was not obtained before services were rendered. Retrospective prior authorization requests must be submitted within seven (7) calendar days of the date of service and before a claim is submitted for the same service.

Out-of-network providers are not eligible to submit retrospective prior authorization requests and must utilize the claims appeal process when seeking reconsideration of claim determinations.

Policy

1. In-Network Providers

In-network providers may submit a retrospective prior authorization request when all of the following criteria are met:

- The service has already been rendered/completed.
- Prior authorization was required but was not obtained before the service was provided
- A retrospective prior authorization request is required to be submitted within seven (7) calendar days following the date of service, except where an alternative timeframe is expressly provided in the provider's contract with HTA
- A claim has not already been submitted to the Plan for the same service.

Retrospective prior authorization requests received more than seven (7) calendar days after the date of service will not be accepted for review.

When the seven-day submission window has expired, the provider must submit the claim for payment. Once a denial has been issued, the provider may pursue reconsideration through the Plan's Post-Service Review process, subject to all applicable filing requirements and deadlines.

2. Out-of-Network Providers

Out-of-network providers are not eligible to submit retrospective prior authorization requests. The provider must submit the claim for payment. Once a claim denial has been issued, the provider may pursue reconsideration through the Plan's Claim Appeal process and must comply with all applicable appeal requirements and filing deadlines.

3. Claims Already Submitted

Retrospective prior authorization requests will not be accepted when a claim has already been submitted to the Plan for the same service.

Providers must utilize the appropriate post-payment or post-adjudication process:

- **In-Network Providers:** Submit a Post-Service Review for medical necessity within 120 days from the date of the explanation of payment.
- **Out-of-Network Providers:** Submit a Claim Appeal.

4. Review of Retrospective Prior Authorization Requests

Accepted retrospective prior authorization requests will be reviewed by the Utilization Management Department and may include evaluation of:

- Medical necessity of the service provided.
- Member eligibility on the date of service.
- Benefit coverage and exclusions.
- Applicable clinical criteria and guidelines.
- Supporting medical records and documentation.

Approval of a retrospective prior authorization does not guarantee reimbursement or payment. Payment remains subject to member eligibility, benefit limitations, claims processing requirements, provider contract provisions, and other applicable Plan policies.

5. Provider Responsibilities

Providers submitting retrospective prior authorization requests must:

- Submit complete and accurate clinical documentation.
- Provide all records necessary to support medical necessity and coverage requirements.
- Submit the request within seven (7) calendar days of the date of service.
- Ensure that a claim has not been submitted for the same service prior to the retrospective authorization request.

Summary of Provider Requirements

Provider Type	Retrospective Prior Authorization Allowed?	Submission Timeframe	If Timeframe Expires	If Claim Already Submitted
In-Network	Yes	Within 7 calendar days of date of service	Submit Post-Service Review	Submit Post-Service Review

Out-of-Network	No	Not applicable	Submit Claim Appeal	Submit Claim Appeal
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RESPONSIBILITIES

REFERENCE DOCUMENTS/LINKS

N/A

PREVIOUS REVISION/REVIEW DATES

Date	Reviewed	Revised	Notes
8/19/2026	N/A	N/A	This is a new policy.
8/19/2026	X		Reviewed and approved by HTA/Cone Medical Oversight Committee
9/30/2026		x	Updated language alternative timeframe based on contract and updated verbiage for post service review to occur within 120 days