Section (Primary Department) **Utilization Management**		**SUBJECT (Document Title)** **Post-Service Clinical Claims Review - CA**	
Effective Date 12/01/1995	**Date of Last Review** 04/25/2024	**Date of Last Revision** 04/25/2024	**Dept. Approval Date** 04/25/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross Medicaid provides a mechanism that monitors services that have been rendered. Post-service review is done to determine the medical necessity and/or level of care for services that had been rendered without obtaining pre-service authorization. Only qualified licensed, clinical Registered Nurse (RN) staff are utilized to perform post-service reviews.

Denials for medical necessity or benefit determination can only be made by a Physician Peer Clinical Reviewer (PCR).

DEFINITIONS:

Medically Necessary: Procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society

recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Peer Clinical Reviewer (PCR)/Medical Director: A physician who is employed by or contracted with Anthem Medicaid to carry out utilization review. PCRs must meet job description requirements that include education, training or professional experience in medical or clinical practice, board certification in his/her specialty, and must have a current license to practice without restrictions.

Post-service Request: Any request received for the care or services which was already rendered; including, a request for coverage of an acute inpatient stay after the member's discharge.

PROCEDURE:

I. Request for Post-service Review

A. Post-service review is performed for services that were rendered without obtaining pre-service authorization due to circumstances which prevented timely authorization; i.e., member eligibility, or a medical emergency; including, a request for coverage of an acute inpatient stay after the member's discharge.

B. Operations receive the claim with imaged medical records, and if a medical necessity review is required, routes the claim for retrospective review to the appropriate Post Service Clinical Claims Review (PSCCR) queue in the claims system. Operations documents in the claims system, the specific information related to reviewing the claim.

II. Review of Medical Necessity

A. The PSCCR RN reviews the relevant medical record information in conjunction with the claim as applicable including but not limited to: diagnoses, medical treatment needs and any social/environmental factors that impacted the member's medical condition, and makes a determination of medical necessity, length of stay, level of care, etc., using Anthem Medicaid-approved Medical Policies, adopted Clinical and Review guidelines.

B. Services approved are documented in the claims system and routed to the Operations queue for processing.

C. Services rendered that do ***not*** meet criteria for medical necessity, are sent to an Anthem Medicaid PCR using the Anthem Care Management Platform (ACMP) Medical Management system. The FileNet document control number is included along with a documentation of the review of the service(s) rendered in accordance with the PCR referral process. The PCR has sufficient expertise to evaluate the specific clinical issues involved in the health care services requested by the provider.

D. The PCR documents approval, modified or denial decision in ACMP and tasks the case to the PSCCR associate. The PSCCR associate documents the decision in ACMP and Mainframe system, and routes the determination to the Operations queue for processing (i.e., for payment, partial payment, or denial).

E. Refer to CA_UMXX_013 for denials of services & CA_UMXX_117 for decision and notification timeframes.

REFERENCES:

- CA_UMXX_013 Non-Authorization of Medical Services
- CA_UMXX_117 Decision and Notification Timeframes
- Central Valley/ Bay Area, Sacramento, Stanislaus, Tulare Tri-County, Kings, Fresno, Madera county contracts. Amendment 18, Exhibit A, Attachment 5
- Health & Safety Code Section 1367.01
- National Committee for Quality Assurance (NCQA) UM Standards
- PSCCR Job Aids

RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management

Secondary Department(s):
Post Service Clinical Claims Review (PSCCR)

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
04/25/24	• Annual Review

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Utilization Management	**Post-Service Clinical Claims Review - CA**

Review Date	Changes
	• Updated Anthem reference under Policy section, per recent rebranding guidelines
05/31/23	• Annual Review • Added Medical Director to PCR definition under Definitions section
05/26/22	• Annual Review • Updated language on reviewers
05/27/21	• Annual Review, no changes
05/27/20	• Annual Review, no changes
05/15/19	• Annual Review, Changed WMDS to ACMP
05/14/18	• Annual Review, no changes
05/02/17	• Annual Review, no changes
05/30/16	• Annual Review, no changes
06/30/15	• Removed Blue Cross
09/04/14	• Removed Healthy Families • Changed header to Government Business Division
09/20/13	• Per Stephanie Everett, verbiage added to I.A. to include circumstances which prevented timely authorization. • Per Stephanie Everett, I.B. was reworded for clarity and included new verbiage “if a medical necessity review is required.”
12/07/12	• Changed reference from Anthem Blue Cross State Sponsored Business to Anthem Medicaid. • Added statement about referring to CA_UMXX-013 and CA_UMXX_117 policies. • Expanded acronyms where applicable. • Changed reference from Care Management to Medical Management • Updated references • Added revision history to policy
12/01/95	• Policy created