ADMINISTRATIVE POLICY		
Post-Service Pre-Payment Review		
Original Date Approved	Effective Date	Revision Date
7/22/2026	10/1/2026	
Applies to Products:		
☒ Senior Care Options FIDE-SNP	☒ One Care FIDE-SNP	

ADMINISTRATIVE POLICY STATEMENT:

A retrospective review is a request for an initial review for an authorization of care, service, or benefit for which a prior authorization (PA) is required but was not obtained prior to the delivery of care, service, or benefit. Occasionally, situations arise in which a PA cannot be reasonably obtained prior to care, service, or benefit. In these cases, Commonwealth Care Alliance (CCA) will conduct a retrospective review of medical services received by members or providers when the request is received within 30 days of the date of service or discharge.

Retrospective reviews are performed by licensed clinicians who are supported by licensed physicians. A decision is generally rendered within 30 days of receipt of all necessary documentation. In the event of adverse determination, the provider and/or member are notified of the decision and supporting rationale.

DEFINITIONS:

Clinical Review Criteria – The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CCA to determine the medical necessity and appropriateness of health care services.

Post Service Pre-payment Review – The process of reviewing and making a coverage and/or payment decision for a service or procedure that has already been performed (e.g. post service decision).

Prior Authorization – Utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with CCA's requirement that the health care service or course of treatment, in whole or in part, be approved prior to provision.

AUTHORIZATION REQUIREMENTS (If applicable):

I. CCA considers post service pre-payment review appropriate when any of the following circumstances have occurred:

A. A CCA member is unable to advise the provider of plan enrollment due to a condition that renders the member unresponsive or incapacitated.
B. Urgent service(s) requiring prior authorization was/were performed, and it would have been to the member's detriment to take the time to request prior authorization.
C. The new service was not known to be needed at the time the original prior authorized service was performed.
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.

II. All post service pre-payment review requests must be submitted within 30 calendar days of the date of service or date of discharge or as specified in a provider contract.

III. Unless the CCA member is within their continuity of care period and qualifies under the retroactive coverage requirements, a post service pre-payment review, which is requested greater than 30 days past the date of service or date of discharge, will be administratively denied. Administrative denials do not require a review by a CCA Medical Director.

IV. In the event of any conflict between this policy and a provider contract with CCA, the provider's contract will be the governing document. In the event a regulator – CMS or EOHHS - informs CCA of a retroactive eligibility update; CCA will adhere to the regulator's guidance.

AUDIT and DISCLAIMER:

Administrative Policies contain supplemental information regarding standard benefit administration and coverage details. Administrative Policies do not guarantee authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage/Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document(s). Reasonable discretion may be used in interpreting and applying this Administrative Policy to services provided in a particular case, and the policy may be modified by CCA at any time. Administrative Policies may be superseded by federal and state laws and regulations, as applicable.

Consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA), coverage for mental health and substance use disorder services is not subject to financial requirements or treatment limitations that are more restrictive than those applied to comparable medical/surgical benefits.

REFERENCES:

1. **CCA Senior Care Options & One Care Provider Manual. Commonwealth Care Alliance; 2026. Accessed July 2026. www.commonwealthcarealliance.org**

REVISION LOG:

REVISION DATE	DESCRIPTION
7/22/2026	New Administrative policy approved by Medical Policy Committee

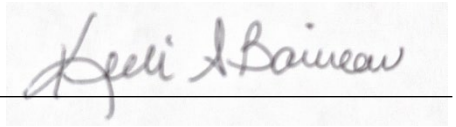
APPROVALS:

Kelli A Barrieau

CCA Senior Clinical Lead [Print]

VP, Clinical Operations

Title [Print]



Signature

July 28, 2026

Date

Jeffrey Sedlack

CCA CMO or Designee [Print]

Senior Medical Director Utilization Review and Medical Policy

Title [Print]

Signature

July 22, 2026

Date

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