Retroactive Authorization Requests Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

Authorization is required for all elective admissions. Authorization is also required for services such as (but not limited to) infertility services, genetic testing, high-tech radiology, certain surgical procedures, and certain DME items. Authorization is also required for any service rendered by a provider who is non-participating with the Plan. Providers may refer to our Procedure Code Look-up Tool to determine which codes require prior authorization.

Prior to January 1, 2025, Fallon Health allowed a provider (participating or non-participating) who was unable or otherwise failed to obtain prior authorization, to submit a request for retroactive review and possible authorization to the Plan up to 120 days after the date of service.

Effective January 1, 2025, to align with industry practice, Fallon Health will be eliminating our retroactive authorization policy. We will no longer allow authorization requests after the service is rendered for all Fallon Health products, except Summit ElderCare.

What you need to know:

- Providers must submit authorization requests in advance to ensure an authorization decision is received prior to the service date.
- If a prior authorization is not obtained in advance of the service, the claim will be denied.
- A provider appeal will only be granted for extenuating circumstances, such as enrollment/ eligibility mismatch or technology malfunctions.
- For a continuation of services such as DME, or infusion, providers should submit additional clinical information prior to future service dates for authorization of continued services.

Please refer to the “Changes to prior authorization requirements” in the July 2024 and October 2024 Connection newsletters for additional information.

If you have questions about this change, please contact your Provider Relations Representative.

Place of service

This policy applies to services requiring prior authorization rendered in all settings.

Policy history

Origination date:	April 1, 2017
Previous revision date(s):	N/A
Connection date & details:	May 2017 – Introduced policy. July 2018 – Annual review, no updates. July 2019 – Annual review, no updates.

January 2025 – Updated to include notification of elimination of retroactive authorization request

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.