DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES	**Behavioral Health and Developmental Disabilities (BHDD) Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: January 1, 2025
Policy Number: *305*	**Subject:** Retrospective and Quality Reviews

Retrospective Reviews

(1) The department or its designee may perform retrospective clinical and/or case record reviews for two purposes:

(a) To determine eligibility and/or medical necessity of a provided service; or

(b) As requested by the provider to establish the eligibility and/or medical necessity for payment when the member has become Medicaid eligible retroactively or the provider has not enrolled in Montana Medicaid prior to the admission of the member.

(2) Retrospective reviews may be used to verify any of the following:

(a) There is sufficient evidence of eligibility and/or medical necessity for payment;

(b) The member is receiving active and appropriate services consistent with standards of practice for the diagnosis and circumstances of the member; ~~or~~

(c) The criteria for having a SDMI and/or a SUD have been met~~.~~; or

(d) The service eligibility criteria for TSS have been met.

Quality Reviews

(1) The department or its designee will notify the provider by letter of the following:

(a) The purpose of the review; and

(b) What records are required, if applicable, and the specific period within which the full medical record is due to the department or its designee.

(2) Quality reviews are conducted as determined by the department.

Retrospective Reviews requested by the Provider

(1) A provider may request a retrospective review when the member becomes Medicaid eligible after the admission to the facility or program or when the provider has not enrolled in Montana Medicaid prior to the admission of the member:
   (a) Within 14 days after Montana Medicaid is established if prior to the discharge of the member; or
   (b) Within 90 days after Montana Medicaid is established if after the member has been discharged.

(2) A provider must submit to the department or its designee:
   (a) Documentation that the member has met eligibility and/or medical necessity criteria; and
   (b) A prior authorization and/or certificate of need, if applicable.