Retrospective Review Information & Instruction Sheet

What is a Retrospective Review?

A Retrospective Review is the process of determining coverage after treatment has been given. These evaluations occur by:

- Confirming participant eligibility and the availability of benefits
- Analyzing patient care data to support the coverage determination process
- Receiving supporting clinical documentation from providers

Why should a provider/facility submit a retrospective review?

Submitting a retro-review allows the retrospective review team to review coverage requests post service regardless if a claim has been submitted.

When should a provider/facility submit a retrospective review?

Retrospective reviews can be submitted when:

- No previous approvals or non-coverage determinations have been issued for the episode of care identified in the request.
- A provider receives a claims denial with the code DNA indicating “Deny due to No Authorization”
- The request must be received after the participant has ended or has been discharge from the service being requested.
  *If a participant is still receiving services, submit a service authorization form, not a retrospective review request
- The request must be received within 365 days after the last date of service

What documentation is required for a retrospective review?

Please include the following information when requesting a retro-review:

- Retrospective Review Cover Sheet (Please fill out the form completely) found at- Service Authorizations (optum.com)
- Biopsychosocial Assessment and any other assessments applicable
- Treatment plan for dates of service requested
- Medical necessity tool (i.e.: CALOCUS-CASII, LOCUS, ASAM, ECSII)

Please Note: Additional documents may be requested as needed to be able to render a decision

How do providers submit?

Mail or Fax:

Optum Alaska Attn: Retroactive Reviews
911 W. 8th Ave Ste 101
Anchorage, Alaska 99501
Fax# 1-855-508-9353