Mental Health Parity and Addiction Equity Act Disclosure
Retrospective Review Frequently Asked Questions

This document includes standard responses to questions related to Mental Health Parity (MHP) and Non-Quantitative Treatment Limitations (NQTL). This communication is not intended, nor should it be treated as legal advice. Federal and state laws and regulations are subject to change. The content provided is for informational purposes only and is not medical advice. Decisions about medical care should be made by the doctor and patient. Please note, your plan documents govern all benefit determinations and in the case of conflict with this document your plan controls. Always refer to your Plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

The following explanations apply to both medical/surgical benefits and mental health/substance use disorder benefits unless stated otherwise.

What is retrospective review?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Retrospective review means your Plan reviews services after they have happened. This happens in two different ways: • A **pre-claim retrospective review** when notified of a completed inpatient stay or outpatient service before a claim is submitted. • A **post-claim retrospective review** for an inpatient stay or outpatient service after a claim has been submitted.	

Why does my Plan conduct retrospective reviews?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Retrospective reviews are used to make sure that your benefits are being used correctly. Medical Directors and other clinical staff review outpatient services, hospitalizations, and other inpatient admissions to make sure that: • The benefit is not being over-utilized or under-utilized. • The services that were provided are consistent with your coverage, medically appropriate, and consistent with evidence-based guidelines.	

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What is the process for retrospective reviews?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Pre-Claim: Your Plan does a retrospective review when you or your provider tell us that you had an inpatient stay or received an outpatient service after it happened, and there is a valid reason for not providing notification of the care or stay before. **Post-Claim:** Your Plan checks if the service was necessary when there was no prior authorization received before the service. A retrospective review may also be performed on services that do not require prior authorization after a claim has been submitted to confirm that the service was medically necessary. In all cases, you will be notified of the outcome of any retrospective review as required by applicable laws and other standards.	

What guidelines are used in performing the retrospective review?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Your Plan uses clear, fact-based clinical rules and well-known health guidelines, like InterQual and ASAM to review services. They also use special guidelines for different age groups, like LOCUS for adults and CALOCUS-CASII for kids. Sometimes, they use other trusted sources if there are special guidelines from national health organizations. Your Plan also follows federal and state requirements. If it is decided that the admission or service was not medically necessary, and will not be covered by your benefits, you and the provider will be notified as required by state and federal law. You and your provider will be given information about how to appeal the decision.	

What are the qualifications of those that will be performing the retrospective review?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Clinical, non-clinical, and administrative personnel may participate in the Retrospective Review process. All clinical reviews are made by clinical staff (i.e., nurses, physicians, etc.).	Clinical, non-clinical, and administrative personnel may participate in the Retrospective Review process. All clinical reviews are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.). All inpatient denials are made by Medical Directors. All outpatient denials are made by Medical Directors or psychologists.

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How long does the Plan have to complete a retrospective review?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
In all cases, your Plan follows laws and other accreditation timeframe requirements.	

What factors and sources are used in a retrospective review?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
When doing retrospective reviews, your Plan makes sure that all the services are clinically appropriate. This means that we check to see if the service helps get better health results. We rely on clinical rules from trusted sources like InterQual or ASAM. We also have committees who review evidence-based medical policies and guidelines from professional health associations, like the American Medical Association.	

When the Plan performs a retrospective review, does the Plan treat mental health/substance use disorder differently than medical/surgical "as written?" Are mental health/substance use disorder decisions made any differently than medical/surgical decisions "in operation?"

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. Your Plan found that the rules and steps used to review mental health and substance use disorder services after they happen are comparable to those used for medical or surgical services "as written" and "in operation." The process for reviewing services after they happen is not stricter for mental health or substance use services.	

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