Retrospective Request FAQ

Can I gain authorization for services already rendered?

Prior authorization is required for all STRS treatment services.

Retrospective requests will be considered on a case by case basis. Potential reasons for retrospective review may include:

- Retroactive membership eligibility changes
- Fax not received by Cenpatico but was sent by provider (providers are encouraged to keep a copy of fax confirmation sheets with time and date stamp)
- Extenuating circumstances (please include a thorough explanation of extenuating circumstances)
- Services were provided during a transition of care period
- Member has a different primary insurance and the claims were denied by the primary insurance for non-administrative reasons

What is the time frame to submit a retrospective request?

180 days from date of service

Where do I send my retrospective request?

Retrospective requests are processed by the Retrospective Authorization and Appeals Department.

Please fax all retrospective requests to **1-866-714-7991**.

What should I include in my retrospective request?

Requests should include the following:

- Completed Outpatient Treatment Request (OTR) form with specific retrospective dates of services and the number of visits requested
- Evaluation/plan of care
- Signed referring provider's referral/prescription or signed plan of care—that covers the retroactive dates of service requested
- Explanation of the reason for retrospective request if applicable

When can I anticipate a decision on my request?

A decision on the request will be made within **30 calendar days** from the receipt of the request.

Appeals FAQ

What is an appeal?

STRS Retrospective Authorization and Appeals Department can have appeal requests reviewed if the original denial was a medical necessity denial. Administrative denials do not have appeal rights, but providers can pursue reconsideration through the claims appeals or complaint process.

What is the filing deadline for an appeal?

Providers **must** file an appeal within **90 calendar days** of receipt of the adverse action letter.

Where do I send my appeal?

Providers can fax or mail their appeal request to Cenpatico.

Cenpatico Appeals Dept.
12515-8 Research Blvd, Ste. 400
Austin, TX 78759
Fax: 866-714-7991

What should I include in my appeal?

Providers **must** include the member signed Authorized Representative (member consent) Form to begin an appeal. Additional information to support the appeal may include a completed Outpatient Treatment Request (OTR) form, updated plan of care, and/or additional clinical information that supports medical necessity.

When can I anticipate a decision on my appeal?

Appeals will be determined within **30 calendar days**.

I have chosen not to appeal the authorization denial based on medical necessity. When can I request additional services for this member?

Additional services can be requested if any of the following apply:

- There has been a change in the member's condition that would warrant additional therapy
- The member needs therapy for a different condition
- A partial denial was issued with the intent to allow the provider to gather additional information or update the plan of care
- The dates of service requested begin after the end date on the denial that was issued.

*Providers should request these services through the standard process by faxing **866-264-4452**.*