Special Bulletin

For professional and facility providers

Updated: June 10, 2025
June 05, 2025

Updated Information: Submitting Retrospective Review Requests

Effective March 14, 2025, providers can submit retrospective review requests for authorization via Predictal in the Availity Essentials® portal. This enhancement was communicated in a March 18 Special Bulletin.

Since that time, there has been some confusion regarding procedures for retrospective review requests and claim inquiries. **Note:** *The original June 5 communication contained incorrect codes, which have since been updated.*

Retrospective Review Requests

Retrospective reviews are requests for post-service authorization. The service has already been performed, but an authorization — which is required — has **NOT** been requested prior to treatment. There are two types of requests:

- **Retrospective Claim Review:** Care was delivered, a claim was submitted and rejected with a rejection code *indicating that an authorization is required*. For step-by-step instructions on submitting retrospective reviews, click **here**.
- **Retrospective Pre-Claim Review:** Care was delivered, a claim was not submitted, but prior authorization was required and not requested before service. **NOTE:** For care that was delivered **more than 30 days ago**, providers should submit a claim. Once the claim is rejected and you receive a rejection code, follow the Retrospective Claim Review process.

How do you know if you may need to submit a retrospective review request?

Key words on the claim rejection may include one of the following terms: *Prior Authorization, Authorization, Precertification*, and/or *Retrospective*.

Also, look for one of these rejection or denial codes:

- E5560, E5719, E5793, E5857, E6168, E6334
- T5695
- T6035, T6039
- T6103, T6104, T6111, T6112, T6113, T6122, T6123, T6126, T6182, T6183
- T6277, T6282, T6285, T6288
- T6326, T6337
- T6437, T6441

- T6503, T6513, T6547, T6549
- T6639, T6641
- T9115, T9165, T9158, T9171, T9189, T9190, T9194, T9197
- T9238, T9239
- T9391
- T9429
- V6960, V9911
- X5137, X5216

What happens after the retrospective request is submitted?

If the retrospective auth request is approved, Highmark will initiate an adjustment on your behalf. We ask that you allow for **up to 30 days** for the adjustment to be completed. *Please do not submit a separate inquiry to Highmark for claim adjustment.*

If the retrospective authorization request is denied, you will receive a letter with the decision, along with directions on filing an appeal. The claim would remain in **the original rejected status**.

Claim Inquiries

A claim inquiry is the ordinary means providers use to communicate their questions regarding pending, paid, or denied claims. To submit a claim inquiry, providers must use **Message this Payer** in Availity:

- Sign into Availity.
- Choose **Claims & Payments > Claim Status.**
- Locate the claim when using **Claim Status**, and then click **Message this Payer** to send your inquiry to Provider Service.

For more information on submitting claim inquiries, use **this guide** on the Provider Resource Center.