Title:	Provider Claim Redetermination				
Department/Line of Business:	Claims				
Approver(s):	Director of Claims				
Location/Region/Division:	FirstCare Health Plans				
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LINE OF BUSINESS

This document applies to the following line(s) of business:
All Lines of Business

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the BSWH P&P Definitions document.

Redetermination – The review of a previously adjudicated/processed claim at the request of a provider to assess if the original determination/decision was correct or should be adjusted based on additional information not previously available during the original determination.

POLICY

FirstCare Claims Adjustment team performs a review of processed claims when a provider payment inquiry is received.

PROCEDURE

Provider payment inquiries are submitted two ways:

- Electronically – provider goes to the SWHP web portal and enters the inquiry online. The provider can also attach any supporting documentation for services performed.
- Paper – providers have the option of mailing in their inquiry. Providers are required to submit an inquiry (redetermination form is located on FirstCare website) with supporting documentation.

Criteria/Limitations* for Redetermination Requests:

- Providers or inquiring parties will have one (1) opportunity to submit a redetermination request on a claims. Multiple requests submitted on a single claims will not be processed and will be returned as previously reviewed.
- Provider must complete a Provider Claims Redetermination Request Form (online or paper) to provide all necessary information to appropriately identify the claim in question (i.e. member name, member number, date of service, total billed amount, and claim number.) Failure to do so will result the request being returned to the requestor for completion.
- Provider should attach ANY pertinent supporting documentation (i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records.)

- Requests for Redeterminations must be submitted within 90 days from the original determination date for Commercial claims, 120 days for Medicare Advantage claims, and 1 year for Out-of-State claims.

Review Process:

- Processing time for redeterminations is 30 days from date of receipt.
- Payment within 15 days of decision (45 days from date of receipt of request).
- Requests are processed first in first out based on received date.
- Upon review of the additional information, a decision is made to “Uphold” or “Overturn” the original decision.
    - Upheld decisions – If the original processing and the additional information/documentation does not support a change in the original decision, then the original decision is “Upheld” and the claim is not adjusted. The provider is sent a resolution letter stating that the original decision is “Upheld” and the claim will not be adjusted based on the information provided.
    - Overturn decisions – the claim is adjusted accordingly and the provider is advised by the Explanation of Payment (EOP) and the adjusted payment. Overturned decisions are communicated in the regular EOP and Payment process.

***Policy & Procedures are subject to specifics of provider contract and regulatory agency guidelines for specific member’s coverage.**

ATTACHMENTS

None.

RELATED DOCUMENTS

Provider Claim Redetermination Request Form

REFERENCES

None