



<b>Title:</b>	Provider Claim Redetermination				
<b>Line of Business:</b>	All SWHP				
<b>Approver(s):</b>	Vice President of Operations				
<b>Location/Region/Division:</b>	Scott & White Health Plan				
<b>Document Number:</b>	SWHP.CLM.043.P				
<b>Effective Date:</b>	5/21/16	<b>Last Review/ Revision Date:</b>	11/30/2016	<b>Origination Date:</b>	5/21/16

## LINE OF BUSINESS

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

## DEFINITIONS

**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 reversed based on additional information not previously available during the original determination.

## POLICY

Provider Claim Redetermination Policy for SWHP

## PROCEDURE

**Criteria / Limitations\* for Redetermination Requests:**

1. Providers or inquiring parties will have only one (1) opportunity to submit a redetermination request on a claim. Multiple requests submitted on a single claim will not be processed and will be returned as “previously reviewed”.
2. Providers must complete a Provider Claims Redetermination Request Form or 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.
3. 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)
4. Requests for Redeterminations must be submitted within **90 days** from the original determination date. (120 days for Medicare Advantage Claims; 1 year for Out-of-State Providers)
5. Processing time for redeterminations is 30 days from date of receipt
6. Payment within 15 days of decision (45 days from date of receipt of request)

**Redetermination submissions:**

Providers are required to submit their redetermination requests via mail. Providers need to complete the Provider Claims Redetermination Request Form or provide all necessary information needed to appropriately identify the claim in question (i.e. member name, member number, date of service, total billed amount, and claim number), attach any pertinent supporting documentation (i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records) and provide a description / narrative stating why they believe the original determination is incorrect.

**Review Process:**

- 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 adjust 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 - Final 11-15-16

**REFERENCES**

None.

The information contained in this document should not be considered standards of professional practice or rules of conduct or for the benefit of any third party. This document is intended to provide guidance and, generally, allows for professional discretion and/or deviation when the individual health care provider or, if applicable, the “Approver” deems appropriate under the circumstances.

<b>Attachment Name:</b>	Provider Claim Redetermination		
<b>Attachment Number:</b>		<b>Last Review/Revision Date:</b>	