



Title:	Medicare Provider Claims Processing and Redeterminations				
Department/Line of Business:	ICSW Medicare MAPD SWHP Medicare Cost (CTX – SeniorCare)				
Approver(s):					
Location/Region/Division:	Scott & White Health Plan				
Document Number:					
Effective Date:	1 Dec 2016	Last Review/ Revision Date:	1 Dec 2016	Origination Date:	1 Dec 2016

LINE OF BUSINESS

This document applies to the following line(s) of business:
 ICSW Medicare MAPD (NTX- VitalTraditions)
 SWHP Medicare Cost (CTX- SeniorCare)

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.

Recoupment: The recovery of previously paid expenses for a legitimate reason through a written request to the provider or facility OR a reduction or withholding of part or all of an owed amount to a provider or facility.

Explanation of Coverage (EOC) – The document that describes the covered benefits for the member under their health insurance plan

Evidence of Payment (EOP) – The document transmitted to provider that summarizes payment for claims submitted.

Scott and White Health Plan and Insurance Company of Scott and White – will be referred to as SWHP in this policy.

POLICY

Provider Claims Processing, Redetermination Policy for Senior Care & Medicare Advantage Claims Payment

PROCEDURE

I. Provider/Facility Claims Submission, Processing & Payment:

1. Claims Submission / Timely Filing: The provider/facility has **1 year** from the date of service to submit a claim. If not submitted within **1 year** from date of service the claim will be denied for non-timely filing.
2. Process and Payment of a Claim:
 - a. **Claims Payment:**
 1. Claim will be processed according to the members Benefit Schedule as outlined in the EOC (Policy & Procedures are subject to specifics of provider contract.).
 2. Benefit schedules will be outlined in the Explanation of Coverage (EOC) document.

3. Medicare Members referred to an OON Provider by an In-Network Provider will be paid for service rendered at the In-Network Medicare fee schedule.
4. Claim will be processed in accordance to the designated fee schedule.

b. Prompt Payment

SWHP must comply with the following prompt payment of claims provisions for claims that have been submitted by providers for services and supplies rendered to Medicare members when these services and supplies are furnished by contracted and non-contracted providers.

- SWHP will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, a member.
- Interest will be paid on all claims paid after the 30th day as designated by contract or as prescribed in regulatory guidelines.
- All other claims must be paid or denied within 60 calendar days from the date of the request for payment.

II. Provider/Facility Request for Redetermination (Refer to Policy SWHP.CLM.043P for specifics):

Provider / Facilities may a single (one time) request for a redetermination of previously processed claim based on the following criteria:

1. Providers are required to submit a Redetermination Request Form or a written request with sufficient information to identify the claim issue, and should include any pertinent supporting documentation (i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records).
2. Providers are only allowed one (1) redetermination request per claim. See SWHP Claims Operations policy **SWHP.CLM.043.P**. Subsequent requests for a provider redetermination of the same claim will be returned/ rejected back to the provider/facility.
3. Requests for Redeterminations must be submitted within **120 days** from the initial adverse determination date unless contract states otherwise. Receipt of the notice of initial determination is presumed to be 5 days after the date of the evidence of payment (EOP). When the filing deadline for a redetermination ends on a Saturday, Sunday, legal holiday, or any other non-work day, the Plan shall apply a rollover period that extends the filing deadline to the first working day after the Saturday, Sunday, legal holiday, or other non-work day. For example, if the filing deadline for a redetermination falls on the Saturday before Columbus Day, the filing deadline is extended to the first working day after the Columbus Day holiday. (240-A, 310.2)
4. When necessary documentation has not been submitted, the reviewer advises the provider to submit the required documentation. In some situations, a provider may inform the reviewer that it is having trouble obtaining supporting documentation from another provider (e.g., an ambulance supplier who is requested to submit hospital admission records). If the additional documentation that was requested is not received within 14 calendar days from the date of request, the reviewer conducts the redetermination based on the information in the file. The reviewer must consider evidence that is received after the 14-day deadline but before having made and issued the redetermination. (310.4.D.2)
5. Processing time for redeterminations is **60 days** from date of receipt (310.4-A)
6. Payment is made within **60 days** from date of receipt.

III. Requests for provider or facility recoupment and refunds actions:

1. Provider Recoupments / Corrected Claims:
 - a. Recoupment actions for overpayment of claims may occur for corrected claim submissions. No refund request will be sent to the provider, since the submission of a corrected claim is considered a request from the provider/facility to reprocess the claim with the corrected claim.

2. Provider Refund Requests:
 - a. Medicare requires Request to a Provider for refunds of overpayment of a claim will be requested in writing within 180 days from the payment date.
 - b. Providers have **45 days** from the date of receipt of the refund request to dispute or make arrangements to refund the overpayment to the Health Plan.
 - c. If no action is taken to dispute or refund the overpayment within the **45 day period, recoupment actions will be taken.**
 - d. BSW contract requires that a written request for overpayment be presented and no offsetting of member accounts is permitted.

ATTACHMENTS

None.

RELATED DOCUMENTS

Redetermination Policy **SWHP.CLM.043.P**
Provider Claim Redetermination Request Form - Final 11-15-16

REFERENCES

Medicare Claims Processing Manual:
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf>

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.

Attachment Name:	(Required for this section Font - Arial 9)		
Attachment Number:		Last Review/Revision Date:	