

Provider Claim Reconsideration Guide

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Purpose



- This document can serve as a guide for providers to understand VA Premier's standards for claims reconsiderations and appeals, and assist in navigating VA Premier resources when a claim issue has been identified.

Reconsideration Defined



- A claim reconsideration is defined as any payment dispute (Paid or Denied) that the provider wants VA Premier to review.
- All Reconsiderations must be submitted in writing on the VA Premier Claims Adjustment Form.

Reconsideration Defined (cont.)



- Reconsiderations for denied claims must be sent within 60 days of the original date of the denial remittance.
- If a response is not received on a reconsideration form within 30 days, a provider can contact their Provider Services Representative to escalate.

Reconsiderations (cont.)



- All providers are encouraged to contact Claims Customer Service as soon as a disputed claim is identified at 1-800-727-7236, Option 4. Customer service can assist with the following claims questions:
 - Verifying claim status
 - Researching claim issues and denials
 - Status of submitted reconsiderations
 - Identifying if a claim issue can be resolved on the phone

Tiered Process for Reconsiderations



- VA Premier has a three-tiered process for escalating rejected claims reconsiderations. After an initial escalation by the provider, the provider is entitled to a review by the Claims Manager, and (if necessary) by the Claims Director.

Tiered Process (cont.)



- Each subsequent escalation will reset the 60-day time period for submitting an additional reconsideration.
- All additional escalations must be submitted in writing on the Claims Adjustment Form, noting level of escalation.

Tiered Process (cont.)



- Responses from VA Premier Claims Manager and Director will be sent in writing to the provider within 30 days.
- All providers are encouraged to contact their Provider Service Representative for assistance when any claims issues are escalated, or if a provider identifies a unique or persistent issue.

Appeals vs. Reconsiderations



- Medical Necessity Appeals are handled by Medical Management department. Provider Services does not address Medical Appeals, but providers can find more information by contacting Medical Management at 888-251-3063.
- Denials subject to reconsiderations are considered administrative (non-medical) denials. Some examples include timely filing, duplicate claims, ungroupable codes, coordination of benefits, and bundled services.

Next Steps



- If a provider issue cannot be resolved by Claims Customer Service, or the provider has additional questions on the submission or standards for reconsiderations, the provider should contact their Provider Service Representative.