Ambetter Provider Reconsiderations, Disputes and Complaints				
Definition	**Submission Process**	**Filing Timeframe**	**Timeframe for Response**	**Next Level Available?**
PRE-SERVICE and CONCURRENT*				
Authorization Has Been Denied, Re-Review				
Provider did not submit Medical Records timely and would like to submit them and have the Health Plan re-review authorization.	Complete and **fax Re-Review Request Form** as cover sheet along with Medical Records. Inpatient Physical Health: 855-218-0587 Pre-Service Physical Health: 855-219-0592 Behavioral Health: 833-286-1086 Biopharmacy/Buy&Bill: 855-678-6980	Inpatient Concurrent Review • 5 business days from decision. Retain right for peer to peer Pre-Service • 45 days from denial notification. Waives right to a peer to peer.	Inpatient Concurrent Review: • Members still admitted - 1-3 business days • Member already discharged - 5 business days Pre-Service: • 5-14 calendar days	Inpatient Concurrent Review Peer to Peer Pre-Service Only a Claim Dispute
Medical Records were submitted timely, however, Provider believes denial was based on incomplete clinical information. OR At time of review by Health Plan there were pending diagnostics, procedures, or laboratory results.	Complete and **fax Re-Review Request Form** as cover sheet along with Medical Records. Inpatient Physical Health: 855-218-0587 Pre-Service Physical Health: 855-219-0592 Behavioral Health: 833-286-1086 Biopharmacy/Buy&Bill: 855-678-6980	Inpatient Concurrent Review • 10 business days from decision. Retain right for peer to peer Pre-Service • 45 days from denial notification. Waives right to a peer to peer.	Inpatient Concurrent Review: • Members still admitted - 1-3 business days • Member already discharged - 5 business days Pre-Service: • 5-14 calendar days	Inpatient Concurrent Review Peer to Peer or Claim Dispute Pre-Service Only a Claim Dispute
Provider disagrees with authorization denial and wants to speak with Health Plan MD to discuss the case.	Call Peer to Peer line to schedule meeting at 1-833-661-0642	10 business days from decision	Peer to peers are scheduled by urgency of the requested service. Cases where the member is still admitted or receiving the denied service may be scheduled as soon as same day.	Only a Claim Dispute

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POST CLAIM SUBMISSION **Claim Payment Reconsideration / Claim Dispute**				
Provider is uncertain of the basis for the original claim outcome (payment amount, denial reason, etc.) or has other questions about the claim.	Ambetter - 877-687-1197	24 months from date of claims processing	30 days from Plan's receipt of Recon/Dispute	Request for reconsideration
Provider disagrees with the claim outcome and is submitting medical records or other documentation to support the disagreement.	Submit via portal or mail with *Reconsideration Form* to: Ambetter Attn: Claim Dispute PO Box 5000 Farmington, MO 63640-5000 **Disputes of Denials for Lack of Medical Necessity**: Disputes must include an explanation outlining why the original decision is incorrect. Simply sending in records will not result in further review. **Disputes of Denials for Failure to Pre-Authorize:** Disputes must include documentation of the extenuating circumstance preventing a prior authorization from occurring. Simply sending in records will not result in further review. The documentation of the extenuating circumstance will be compared to the Retrospective Review policy	24 months from date of claims processing	30 days from Plan's receipt of Recon/Dispute	Yes**

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	(CC.UM.05.01) to see if the case qualifies for medical necessity review. **Disputes of Denials for Code Editing Policy** (e.g., NCCI edits, MUE edits, bundling edits, modifier 25/59, etc.): Disputes must include an explanation of why the provider disagrees with the code editing policy. Medical records are usually also required to support the dispute.			

* Administrative denials for lack of timely notification do not apply to the UM re-review process; these must be submitted as a claim dispute

** Next Level Claim Dispute for Post-Claims Submission Disputes: A second claim dispute of an upheld denial is allowed, but must be received within the standard 24 months from date of claims processing. A second dispute of an upheld denial will be considered only if further information or explanation is provided. Submitting the same explanation a second time will not result in further review. Two reviews are the maximum that will be completed.