Cotiviti
<<<Address Line 1>>>
<<<Address Line 2>>>
<<<City, State Zip>>>

<<<Date>>>

CCV - Reconsideration Response – Upheld

<<<Provider Name>>>
<<<Provider Address 1>>>
<<<Provider Address 2>>>
<<<City, State Zip>>>

Dear <<< Provider Name >>>:

Thank you for your letter requesting a reconsideration of our audit determination for the following claim:

Patient Account #:	XXXXXXXXXXXXXXXXX	**Patient Name:**	<<< Last Name, First Name >>>
Facility:	XXXXXXXXXXXXXXXXX	**Patient DOB:**	99/99/9999
Date of Admission:	99/99/9999	**Date of Discharge:**	99/99/9999
Recon Received:	99/99/9999	**Recon Review Date:**	99/99/9999

This case, along with any additional documentation submitted, has been carefully reviewed. Based on the information provided, the original audit determination is upheld. This is supported by the explanation as found on page two.

If you have any questions regarding this reconsideration process, please contact Cotiviti Provider Services at <<< (XXX) XXX-XXXX >>>, Monday – Friday from 7:00 AM to 4:00 PM CST/CDT. Thank you for your cooperation with this claim review.

Sincerely,

Cotiviti

<<<Date>>>

CCV - Reconsideration Response – Upheld

Patient Account #:	XXXXXXXXXXXXXXXXX	**Subscriber ID:**	XXXXXXXXXXXXX
Facility:	XXXXXXXXXXXXXXXXX	**Dependent ID:**	XXXXXXXXXX
Tax ID:	99-99999999	**Patient Name:**	<<< Last Name, First Name >>>
Provider ID:	999999	**Patient DOB:**	99/99/9999
Payer Name:	<<< Payer >>>	**Patient Gender:**	X
Payer Claim #:	XXXXXXXXXXXXXXXXX	**Date of Admission:**	99/99/9999
Cotiviti ID #:	999999999999	**Date of Discharge:**	99/99/9999
Recon Received:	99/99/9999	**Recon Review Date:**	99/99/9999

Reconsideration Determination: <<<Original audit determination upheld>>>

Reconsideration Explanation: <<<Insert reconsideration determination explanation here>>>

Agreement with Determination

If you agree with this decision, please sign and submit a claim adjustment form with a copy of this letter and Reconsideration Response within 45 calendar days of this letter date to: <<< Cotiviti >>>, <<< Address Line 1 >>>, <<< Address Line 2 >>>, City, State Zip >>>. If no adjustment request is received within this timeframe, the claim will be denied. Any further opportunity for payment of the claim is waived by the provider for failure to respond timely.

Claim adjustment forms specific to DRG Validation Coding Audits can be found at:
https://www.bcbsnd.com/providers/news-resources/forms-documents

Printed Name	**Signature of Representative**	**Title**	**Date**

Disagreement with Determination

If you disagree with this decision, you have a right to request a second reconsideration. Please mail your written request, and additional supporting documentation, within 45 calendar days of this letter date to BCBSND at the second reconsideration address below. **Note: Reconsideration instructions enclosed.**

IMPORTANT INFORMATION ABOUT YOUR RECONSIDERATION RIGHTS

Cotiviti conducts audits on behalf of Blue Cross Blue Shield of North Dakota (BCBSND) in accordance with current industry standards and practices. The mission of the Cotiviti clinical and coding auditor team is to provide complete and accurate results with fair perspective.

Second Reconsideration

If you received an unfavorable decision on the first reconsideration, you may file a request for second reconsideration. To exercise this right, file your written request, along with any new supporting documentation to support reimbursement of the claim as originally billed, within 45 calendar days of this letter date. All requests for second review must be in writing and sent to:

Manager of SIU/Provider Audit
Blue Cross Blue Shield of North Dakota
4510 13th Avenue S
Fargo, ND 58121

BCBSND will issue a decision within 45 calendar days of this letter date. In order to ensure that the second review receives a fair and impartial review, the second review will be made by clinicians and/or specialists who did not conduct the original audit of the claim.

This is the final determination; no further review or reconsideration will be accepted by Cotiviti or BCBSND.