Independence

Medicare non-contracted provider payment dispute process

Medicare Advantage Organization

Filing a request for payment review determination

If you believe that the payment amount you received for treating Independence Blue Cross (Independence) Medicare Advantage (MA) members is less than the expected payment, you have the right to dispute that payment by requesting a Payment Review Determination (PRD).

A written request for a PRD, along with any documentation and correspondence that support your position that the Plan's reimbursement is not correct, and a signed Waiver of Liability Statement must be submitted within 120 days from the initial MA payment to have your claim reconsidered.

The PRD request can be sent via fax (1-888-289-3008) or mailed to:

Independence Blue Cross
Medicare Member Appeals Department
P.O. Box 13652
Philadelphia, PA 19101-3652

We will review your request and respond to you within 30 calendar days. If we agree with the reason for the dispute, we will adjust the claim and pay any additional money that is due. We will also inform you if the decision is to uphold the original payment. If you have questions about our PRD, you may contact Provider Services at 1-800-ASK-BLUE.

If you still believe our decision is incorrect, you may request a Payment Dispute Decision (PDD) by Independence.

Filing a request for an independent PDD

A request for a PDD must be submitted to Independence within 180 days of the Plan's PRD notification. The request must be in writing and should be made on a standard PDD form available in the Claims Resources and Guides section of www.ibx.com/providers.

A written request that is not made on the standard PDD form will be accepted if it contains all the required elements, as follows:

- Provider or Supplier contact information including name and address.
- Pricing information, including NPI (and CCN/OSCAR number for institutional providers), ZIP code where services were rendered, physician specialty, the name of the MAO that made the redetermination including the specific Plan name, and whether the provider/supplier is deemed or non-contracted.
- Reason for dispute; a description of the specific issue.
- Copy of the provider's submitted claim with disputed portion identified.
- Copy of the MA Plan's original pricing determination.
- Copy of the MA Plan's redetermination (dispute) pricing decision.
- Copy of the relevant portion of Terms and Conditions or contract and any supporting documentation and correspondence that support your position that the Plan's reimbursement is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare on similar or identical services).
- Appointment of Provider or Supplier Representative Authorization Statement, if applicable.
- The name and signature of the party or the representative of the party.

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Decisions subject to the payment dispute process include any decisions where there is a dispute about the payment amount made by a MAO Plan to a non-contracted provider that is less than the rates of Original Medicare.

Decisions ***not*** subject to the provider payment dispute process are:

- National Coverage Determinations (NCDs)
- Services denied for coverage issues such as Local Coverage Determinations (LCDs)
- Medical necessity determinations (these are not subject to the independent review process and should be sent to the appropriate Qualified Independent Contractor (QIC) for processing)
- Disputes between a contracted network provider and the MA Plan (these are not reviewed by CMS)

Claim payment dispute decision requests may be submitted via the following ways:

- **Fax.** Fax electronic requests for payment dispute decisions to 1-888-289-3008.
- **Mail.** Providers can mail hard copy requests for payment dispute decisions to the following address:

  Independence Blue Cross
  Medicare Member Appeals Department
  P.O. Box 13652
  Philadelphia, PA 19101-3652

Time frame for making a payment dispute decision

Independence will issue a decision within 60 days after receiving a provider payment dispute appeal unless granted an exception by the Plan. The Plan will notify all parties of its PDD or notify all parties that it has dismissed the request for a PDD.

Decision letters

The PDD letter will include the facts of the appeal, arguments made for and against additional reimbursement, the adjudicator’s decision, and the adjudicator’s rationale, and notification to the parties of their right to request a debrief.

Common Abbreviations

CMS: Centers for Medicare & Medicaid Services

MAO: Medicare Advantage Organization; HMO: Health Maintenance Organization;
PPO: Preferred Provider Organization

PDD: An Independent Payment Dispute Decision

PRD: Payment Review Determination

Standard Definitions

Organization Determination: MAO Plan's original claim payment

Payment Dispute: Provider or Supplier disputes the MAO Plan's original claim payment (generally must be disputed within 120 days from the date payment is initially received by the provider or supplier)

Payment Review Determination (PRD): The first-level payment dispute decision made by a MAO Plan (generally provided within 30 days from the time the payment dispute is first received by the Plan)

Payment Dispute Decision (PDD): The Plan’s second-level decision regarding the Payment Dispute.

Request for Independent Payment Dispute Decision: Provider's or Supplier's request for review of the MAO Plan's Payment Review Determination, submitted to the Plan.

Medicare Advantage Organization (MAO) Plans: An entity contracted with CMS to provide Medicare Advantage insurance benefits to enrollees.

Non-Contracted Provider or Supplier: A provider or supplier who has rendered services to a MAO PFFS Plan enrollee on an emergency basis and did not review the PFFS Plan’s Terms & Conditions before rendering services is referred to as a non-contracted provider or supplier. For all other MAO Plans, a provider is considered non-contracted when there is not a signed contract/agreement between the provider and the specific MAO Plan (HMO, PPO, etc). For example, a provider may be contracted under a MAO’s HMO Plan, but be considered non-contracted for services rendered to a PPO Plan member.

Contracted Provider or Supplier: A contracted provider or supplier of services that files a claim for services or items furnished to the enrollee may not request an independent payment dispute decision since these disputes are considered to be matters of contract disputes.