Independence

Independence's post-service appeals and grievance processes

Billing dispute appeals process

Independence offers a two-level post-service billing dispute appeals process for professional providers. For services provided to any commercial or Medicare Advantage Independence member, providers may appeal claim denials related to general coding and the administration of claim payment policy as billing disputes.

Examples of billing disputes include:

- modifier consideration and application;
- improper administration of a claim payment policy;
- claim coding (i.e., how we processed the codes in the claim vs. the provider's use of the codes).

The provider billing dispute appeals process does *not* apply to:

- utilization management determinations (e.g., claims for services considered not Medically Necessary, experimental/investigational, cosmetic);
- precertification/authorization/referral requirements;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the Corporate and Financial Investigations department;
- fee schedule concerns.

Submission of billing dispute appeals

To facilitate a first- or second-level billing dispute review, submit inquiries to:

Provider Billing Dispute Appeals
P.O. Box 7930
Philadelphia, PA 19101-7930

All first-level billing dispute appeals must be filed within 180 days of receiving the SOR or Provider EOB and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the appeal. Independence will process first-level appeals within 60 days of receipt of all necessary information. A billing dispute appeal determination letter will be sent to the provider.

If a provider disputes the first-level provider billing dispute appeal determination, he or she may then submit a second-level provider billing dispute appeal by sending a written request within 60 days of receipt of the decision of the first-level provider billing dispute appeal. The appeal will be reviewed by an internal Provider Appeals Review Board (PARB) consisting of three members, including at least one Medical Director. The decision will then be communicated to the provider and will include a detailed explanation. The decision of the PARB will be the final decision of Independence.

If a member appeal, or provider appealing on behalf of the member appeal, is filed before or during an open provider appeal for the same issue, the provider appeal will be closed and addressed under the member appeal.

Provider grievance process

Independence offers a one-level post-service grievance process for professional providers. For services provided to any commercial or Medicare Advantage Independence member, providers may appeal claim denials related to services that denied as not Medically Necessary, experimental/investigational, or cosmetic.

The grievance process does *not* apply to:

- precertification/authorization/referral requirements;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the Corporate and Financial Investigations department;
- fee schedule concerns;
- billing dispute appeals.

Submission of provider grievances

To facilitate a grievance review, submit to:

Provider Grievances
P.O. Box 7930
Philadelphia, PA 19101-7930

All grievances must be filed within 180 days of receiving the SOR or Provider EOB and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the grievance. All grievances will be processed within 60 days of receipt of all necessary information. A preliminary review will be conducted. If the determination is to pay the claim, a claim adjustment will be processed and a determination letter will be sent to the provider. All other grievances will be sent to an Independent Review Organization (IRO) for a matched specialty review. A determination letter will be sent to the provider containing the IRO decision and detailed explanation. The decision of the IRO is final.

If a member grievance, or provider filing on behalf of the member grievance, is filed before or during an open provider grievance for the same issue, the provider grievance will be closed and addressed under the member grievance.

For more information

For claim explanation, providers may call Customer Service at 1-800-ASK-BLUE.