Independence

December 2022

Independence's post-service appeals and grievance processes

Billing dispute process

Independence Blue Cross (Independence) offers a two-level post-service billing dispute 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:

- bundling logic (integral, incidental, mutually exclusive claim edits);
- modifier consideration and application;
- claim adjudication settlement not consistent with the law or terms of the provider's contract;
- improper administration of an Independence claim payment policy;
- claim coding (i.e., how we processed the codes in the claim vs. the provider's use of the codes);
- unlisted/not otherwise classified (NOC) service pricing determination.

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

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

Submission of billing disputes

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

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

All first-level billing disputes must be filed within 180 days of receiving the Provider Explanation of Benefits (Provider EOB) and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the dispute. Independence will process first-level billing disputes within 30 days of receipt of all necessary information. A billing dispute determination letter will be sent to the provider.

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

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Services. 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.

Provider grievance process

Independence offers a one-level post-service grievance process for professional providers. For services provided to any Independence commercial or Medicare Advantage Independence member, providers may appeal claim denials for Medical Necessity, experimental/investigational, or cosmetic reasons as a provider grievance.

The grievance process does *not* apply to:

- lack of preapproval/precertification/authorization/referral;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the CFID;
- fee schedule concerns;
- billing disputes.

Submission of provider grievances

To facilitate a grievance review, submit to:

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

Please ensure that all applicable medical records, notes, and tests are submitted along with a cover letter explaining the grievance. All grievances must be filed within 180 days of receiving the Provider EOB. 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. Future provider grievances for the same issue are ineligible for servicing as a provider grievance.

Learn more

If you have any questions, providers may call Customer Service at 1-800-ASK-BLUE (1-800-275-2583).