The AmeriHealth post-service appeals and grievance processes

Billing dispute appeals process

AmeriHealth offers a two-level post-service billing dispute appeals process for professional providers. For services provided to any AmeriHealth Pennsylvania members, providers may appeal those 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;
- claims adjudication settlement not consistent with the law or the terms of the provider's contract;
- improper administration of an AmeriHealth 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 appeal

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 Statement of Remittance (SOR) or Provider Explanation of Benefits (Provider EOB) and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the appeal. First-level appeals will be processed within 30 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.

If a member appeal, or provider appealing on behalf of the member appeal with the members consent, 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

AmeriHealth offers a one-level post-service grievance process for professional providers. For services provided to any AmeriHealth Pennsylvania members, providers may appeal claim denials related to services (i.e., those considered not medically necessary, experimental/ investigational, or cosmetic) as grievances.

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 containing the IRO decision and detailed explanation will be sent to the provider. 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

If you have any questions, please call Customer Service at **1-800-275-2583**.

**As of January 1, 2014, and continuing through mid-2015, we are in the process of migrating AmeriHealth Pennsylvania members to a new operating platform. Once a member has been migrated to the new platform, providers will no longer receive the current SOR. Professional providers will receive what will be called the Provider EOB. Once all AmeriHealth Pennsylvania members are migrated in 2015, you will only receive the new Provider EOB for these members.*