Provider Manual

Effective Date 1/1/2021 | Revised Date 11/1/2023

Health New England
Where you matter.

Health New England
Where you matter.

Introduction

Effective Date 1/1/2021 | Revised Date 1/1/2021

Introduction

The Health New England (HNE) Provider Manual contains information, guidelines and procedures to follow when rendering medical service to members and which are common to managed care in general. This edition of the HNE Provider Manual supersedes all previous editions. It includes information and changes for which providers have received written notification throughout the past year. Any additional material changes for which notification has not been provided will take effect 60 days from the distribution of this Manual.

Some of the guidelines and procedures in this Manual are based on requirements of state and federal law and/or accrediting organizations. Thus, the guidelines and procedures are subject to change if the requirements of the law or accrediting organizations change. HNE will notify providers in writing of modifications to this Manual that have a substantial impact on provider rights or responsibilities at least 60 days prior to the effective date of such modifications. Where there is a conflict between this edition of the Manual and a subsequent notification of a modification to a policy or procedure, the information in the subsequent notification shall prevail.

If providers have questions or recommendations about the information in this Provider Manual or wish to obtain a paper copy of the Manual, they should contact Provider Relations at (413) 233-3313 or (800) 842-4464, extension 5000. Representatives are available Monday – Friday, from 8:00 a.m. to 4:00 p.m.

The following two pages are a quick reference guide to important department phone and fax numbers for HNE.

Important Contact Information:

Provider Relations Toll Free	(800)842-4464, extension 5000
Member Services Local	(413) 787-4004
Member Services Toll Free	(800) 310-2835
Member Services Local (Self-Funded)	(413) 233-3060
Member Services Toll Free (Self-Funded)	(800) 791-7944
Member Services Hispanic Toll-Free	(866) 725-8399
Member Services Medicare Local	(413) 787-0010
Member Services Medicare Toll-Free	(877) 443-3314
Member Services Be Healthy	(800) 786-9999
Be Healthy - Behavioral Health	(800) 495-0086
HNE Local calls from Connecticut	(860) 623-1147

Below is a chart showing the extensions for important departments that may be reached by either calling the HNE local or HNE toll-free telephone numbers shown above.

HNE Departments	Extensions	For Questions Regarding…
Provider Relations	5000	Provider Specific Information Provider Requests Reimbursement Issues Complex Claims Educational Visit Requests
Behavioral Health Services	5028	Prior Approval Out-of-Plan Requests
Health Services (Commercial)	5027	Prior Approval, Out-of-Plan Requests and Case Management for our Commercial population
Health Services (Self-Funded)	5033	Prior Approval, Out-of-Plan Requests and Case Management for our Self-Funded population
Member Services/Enrollment	5025	Benefits Eligibility Copayments

Provider Claims Servicing Unit	5026	General Claim Inquiries

Fax Numbers:

HNE Department	**Fax Number**
Behavioral Health Services	(413) 233-2800
Quality Improvement	(413) 233-2866
Health Services	(413) 233-2700
Provider Appeals	(413) 233-2797
Provider Enrollment	(413) 233-2665
Provider Credentialing	(413) 233-2808
Provider Contracting	(413) 233-3175

Address Information:

Health New England

One Monarch Place, Suite 1500

Springfield, MA 01144-1500

Website:

www.healthnewengland.org

Health New England

Where you matter.

Member Information

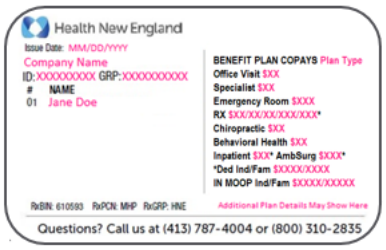
Effective Date 1/1/2021 | Revised Date 11/1/2023

Member Eligibility and Identification Cards

HNE members are issued an identification card (ID card). Members are instructed to present their ID card when seeking medical services. The ID card alone does not guarantee eligibility. You can verify eligibility and benefits by logging on to HNEDirect. If you have not registered already, you can do so by going to https://www.hnedirect.com/login. Refer to the member's ID card to identify any member copay amounts for office visits, urgent/emergency care, prescriptions, etc. Please note that members of a Self-Funded employer group will have an "S" before the group number.

Sample ID cards provided below:

Commercial Fully Funded HMO (small groups will have PCP not Office Visit)



Commercial Fully Funded PPO

Commercial Self Funded HMO

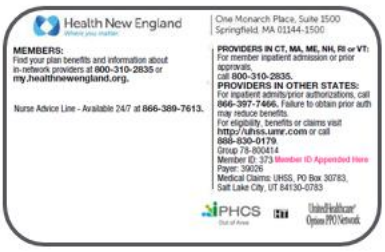
Commercial Self Funded PPO

Member Information

Commercial HMO FF:
(copy and logos at the bottom may change depending on the group/plan)

Commercial PPO FF:
(copy and logos at the bottom may change depending on the group/plan)

Commercial HMO SF:
(copy and logos at the bottom may change depending on the group/plan)



Commercial PPO SF:
(copy and logos at the bottom may change depending on the group/plan)

Care outside of New England:

Health New England PPO plan members have access to the national UnitedHealthcare Options PPO network for care outside of New England (outside of CT, MA, ME, NH, RI and VT).

Care within New England:

Members who require care within New England (within CT, MA, ME, NH, RI and VT) will continue to access care using the Health New England Commercial plan network and MultiPlan's PHCS regional network.

Visit **healthnewengland.org/provider-search** to learn more about our provider network and view participating providers in your plan.

Government Program Identification Cards

Front Side:

Individual Medicare Supplement

Group Medicare Supplement

Medicare Advantage

Medicaid/ACO

Back Side:

Individual Medicare Supplement

Group Medicare Supplement

Medicare Advantage

Medicaid/ACO

Member Rights and Responsibilities

HNE has adopted the following statement of Members' Rights and Responsibilities:

Members of HNE have the right to:

- Receive information on HNE, its services, In-Plan providers, policies, procedures, and their rights and responsibilities. HNE will not release information that by law may not be given to Members or any third party. We will not disclose privileged information about In-Plan providers.
- Be treated with respect and with recognition of their dignity and right to privacy.
- Participate in health care decisions with their doctors or other health care providers.
- Expect that their doctors or other health care providers will fully and openly discuss appropriate, Medically Necessary treatment options, regardless of the cost or benefit coverage. It does not mean that HNE covers all treatment options. If the member is unsure about coverage, they may contact Member Services at (413) 787-4004 or (800) 310-2835.
- Contact us with a grievance or complaint about HNE or an In-Plan provider.
- Refuse a treatment, drug or other procedure that is recommended by their doctor or other health care providers as the law allows. Providers should tell the member about any potential medical effects of refusing treatment.
- Select a Primary Care Provider (PCP) who is accepting new patients. HNE PCPs are listed in the Provider Directory.
- Change their PCP. A member may choose any In-Plan PCP, except those who have notified HNE that they are not accepting new patients.
- Have access during business hours to HNE Member Services Representatives who can answer their questions and help them resolve a problem.
- Expect that medical records and information on their relationship with their doctor will remain confidential in accordance with state and federal law and HNE policies.
- Make recommendations regarding HNE's Member Rights and Responsibilities policies.

Members of HNE have certain responsibilities. These are to:

- Provide, to the extent possible, information to their providers that providers need in order to care for them. This includes their present and past medical conditions, as they understand them, before and during any course of treatment.
- Follow the treatment plans and instructions for care that the member has agreed on with his or her provider.
- Read HNE materials to become familiar with their benefits and services. If members have any questions, they should call Member Services at (413) 787-4004 or (800) 310-2835.
- Follow all HNE policies and procedures.
- Treat In-Plan providers and HNE staff with the same respect and courtesy they would expect for themselves.
- Arrive on time for appointments or give proper notice if they must cancel or will be late.
- Understand their health problems, an important factor in their treatments. If members do not understand their illnesses or treatments, they can talk them over with their doctors.
- Participate in decision-making about their health care.
- Inform HNE of any other insurance coverage they may have. This helps us process claims and work with other payers.
- Notify us of status changes (such as a new address) that could affect their eligibility for coverage.

- Help HNE and In-Plan providers get prior medical records as needed. Members agree that HNE may obtain and use any of their medical records and other information needed to administer the plan.
- Consider the potential effects if they do not follow their providers' advice. When a service recommended by an In-Plan doctor is covered, they may choose to decline it for personal reasons. For example, members may prefer to get care from Out-of-Plan providers rather than In-Plan providers. In these cases, HNE may not cover the substitute or alternate care that the member prefers.

Confidentiality of and Access to Medical Records

HNE is committed to protecting the privacy of HNE members at all times and in all settings. As part of that commitment, HNE requires that all providers protect the confidentiality of member records in accordance with state and federal law. HNE requires that medical records be stored securely, with access granted to only those individuals who are authorized to do so in the performance of their duties; that medical records be organized and stored to allow for easy retrieval; and that the practice periodically conducts training centered on member confidentiality requirements.

HNE uses member information for many different purposes, including:

- For general plan administration purposes, including processing and paying claims, verification of enrollment and eligibility, coordination of benefits with other benefit plans, subrogation, reinsurance, financial auditing, and member satisfaction processes
- For quality management
- For utilization management
- For disease management activities
- To furnish information to providers who are treating HNE members
- When required by law, such as to respond to a court order or subpoena
- For other purposes allowed by law

Please Note:

HNE may release confidential member information to or request information from a member's provider without an individual authorization from the member as described below. In cases where HNE would like to use a member's information for a purpose not specifically described by law, HNE will obtain the member's written authorization to do so.

Some physicians have expressed concern about whether they may disclose medical record information to HNE in light of the Privacy Rule requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows covered entities, which includes physicians and health plans, to use or disclose protected health information (PHI) without an individual authorization from the patient for treatment, payment and some health care operations purposes, and for certain other specific purposes outlined by the HIPAA Privacy Rule (45 C.F.R. §§ 164.502, 164.506). The definition of health care operations includes quality improvement, accreditation and licensing activities (45 C.F.R. § 164.501).

Covered entities may disclose PHI to other covered entities for the other covered entity's treatment, payment and limited health care operations purposes, as defined by the Privacy Rule, as long as the request relates to current or former patients or members [45 C.F.R. § 164.506(c)(4)].

HNE's utilization review activities are considered payment activity, and HNE's quality improvement, accreditation, case management and care coordination activities are considered health care operations activities. Therefore, the disclosure of health information by physicians to HNE without an individual authorization from the patient for these purposes is permissible under the HIPAA Privacy Rule.

HNE recognizes that physicians are concerned with compliance to applicable privacy laws. We at HNE share those same concerns and will proceed only in a manner that is consistent with applicable laws.

HNE may share PHI with third parties outside of HNE, such as consultants and auditors, when necessary to conduct our business. HNE does not release a member's PHI (other than enrollment information) to employer groups. Self-Funded groups, however, need certain information so that they may adequately fund their accounts. Therefore, HNE will release information to certain persons designated by the Self-Funded group as persons who may appropriately have access to the information. HNE also will require that the Self-Funded group sets security measures to prevent unauthorized access.

In addition, under state and federal law, members have a right to obtain a copy of their medical records.

HNE has a detailed policy on privacy. HNE protects members' PHI by requiring that all employees or temporary employees sign a statement that they have read, understand and agree to abide by the policy. The policy addresses internal protection of oral, written and electronic PHI. It requires that use of PHI across HNE be limited to the minimum necessary. HNE also conducts privacy training and sends annual privacy reminders to its employees. HNE will provide a more detailed explanation of its privacy practices to all HNE members and/or providers upon request. Providers may request a copy by calling Provider Relations at (413) 233-3313 or (800) 842-4464, extension 5000.

Members Requesting Copies of Medical Records

HNE and all of its contracted providers agree to give members access to, and a copy of, their medical records upon the member's request. HNE expects contracted providers to allow members to amend their own records, in accordance with applicable state and federal laws.

Members' Right to Appeal

Members have the right to file a grievance concerning any aspect or action of HNE relative to the member, including but not limited to an "adverse determination." An "adverse determination" is a decision to deny, reduce, change or end coverage of a health service for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting, and level of care or effectiveness. A grievance may also be a complaint about quality of care or administration of an HNE plan.

To file a grievance, please go to https://healthnewengland.org/forms, click on Member Complaint/Appeal Request Form. Completed forms may be mailed to Health New England, Attention: Complaints & Appeals, One Monarch Place, Suite 1500, Springfield, MA 01144-1500 or faxed to (413) 233-2685.

Member Satisfaction Survey

HNE conducts an annual survey of randomly selected members to ask them to report on and evaluate their experiences with health care. The survey includes ratings of personal doctors and other health care staff, as well as an overall rating of the health plan. It also asks members to report on their experiences with health care services. The survey compares the actual satisfaction of members with projected measures of their satisfaction.

Health New England

Where you matter.

Administrative Procedures

Effective Date 1/1/2021 | Revised Date 11/1/2023

Provider Record Changes

Based on the requirements of the No Surprise Act of 2022, providers are obligated to verify their provider directory information at least once every 90 days. Failure by providers to confirm current and accurate provider directory information requires the removal of the provider or facility from the Health New England (HNE) directory.

Provider should validate and update their provider directory data in CAQH for distribution to HNE. Please refer to the Provider Directory Validation and CAQH Initiative at http://hnetalk.com/provider for more information

Please notify HNE of changes involving telephone numbers, addresses, hospital affiliations, tax identification numbers, coverage arrangements and panel status by completing the Standardized Provider Information Change Form located at: https://www.hcasma.org/attach/Provider_Information_Change_Form.PDF

Mail:	Health New England Attn: Provider Enrollment One Monarch Place, Suite 1500 Springfield, MA 01144
Fax	(413) 233-2665
Website	https://www.hnedirect.com/login

Provider Address and Telephone Number Changes

Changes of address and telephone number must be communicated to HNE in writing no less than

60 days from the effective date of the change. When informing HNE of an address or telephone number change, providers should specify whether the change is for an office address or phone number, billing address or phone number, or both.

Physician Participation in PHOs or Medical Groups

Physicians that establish or terminate membership(s) in a Physician Hospital Organization (PHO) or Medical Group, or enter into other arrangements that may affect participation status must notify HNE in writing not less than 60 days prior to the effective date of the change. Such change in status may have an impact on payment terms and contractual obligations. The failure of physicians to properly notify HNE of such change in participation status may result in delayed or incorrect payments.

Physician Primary Hospital Affiliation Changes/Additional Hospital Affiliations

If physicians want to add, change or delete their primary hospital affiliation with HNE, the request must be submitted no less than 60 days prior to such change. The notification must indicate the reason for the change and the effective date of the change.

Provider Tax Identification Number Changes

When providers have a change in their Federal Tax ID number, HNE must be notified in writing at least 60 days prior to the change. When notifying HNE of the change, the following information must be provided:

- New Federal Tax ID number
- Need W-9
- The name to which checks should be made payable
- Billing address
- Billing phone number
- Effective date of change

Provider Coverage Arrangements

HNE requires all providers to make arrangements for care for members 24 hours a day. HNE must be notified in writing of any provider coverage arrangements. HNE also must be notified in writing at least 60 days prior to any changes in provider

coverage arrangements. If a physician does not properly notify HNE of coverage arrangements or changes in such arrangements, delayed or incorrect payments may result.

PCP Panel Status Changes

PCPs may change their panel status by notifying HNE in writing. PCPs may change the age restriction placed on their panels and may change restrictions on accepting new patients. If a change places a greater restriction on the PCP's panel, the change will be effective 30 days from the date that HNE received the request. Any change that reduces or eliminates a restriction to a PCP's panel will be effective immediately upon receipt of the request. Categories of PCP panel status are described below:

ALL	Any member who chooses this PCP will be added to the PCP's panel provided the member is within the age restrictions that the PCP has provided to HNE. A PCP with a panel status of "ALL" will appear in the Provider Directory with no asterisk (*) following his or her name.
EXISTING	Only members who are patients of this PCP at the time they became HNE members will be added to this PCP's panel. All HNE members are asked if they are existing patients of the PCP that they have selected. A member who answers Yes will be added to the PCP's panel. If the member answers No, the member will not be added to the PCP's panel. The PCP's name will appear in the HNE Provider Directory with an asterisk (*) to denote that the PCP is accepting existing patients only.
CLOSED	Neither new nor existing patients will be added to this PCP's panel. PCPs with a closed panel will not appear in the HNE Provider Directory. PCPs must not treat HNE members differently from non-HNE members with respect to closed panel status.

PCP – Removing a Member from the Panel

The physician-patient relationship is a personal one that may become unacceptable to either party. If this happens, the PCP may request that a member be transferred to another PCP. The PCP may not request a member's transfer for discriminatory reasons, because of the amount of medical services required or because of a member's physical or mental condition. The PCP's reason for removing a member from his or her panel must be approved by HNE.

To remove a member from a PCP's panel, the PCP must send a letter to the member, with a copy mailed to HNE, requesting that the member choose another PCP and explaining why the PCP is making the request. Once HNE receives the letter, the HNE Member Services Department will contact the member to assist with selecting a new PCP. From the time HNE contacts the member, the member will have 30 days to select a new PCP. After 30 days, HNE will assign the member a new PCP if necessary. HNE will then send a letter to the member advising them of the change. You may not remove a member from your panel until another PCP is selected. You must continue to treat the member during this transition period.

Provider Communications

Material changes to policies and procedures that require provider notification occur at least 60 days in advance of the effective date of the change. These changes are communicated in writing and will be available online. Online provider resources include http://healthnewengland.org/provider, https://www.hnedirect.com/login or http://hnetalk.com/provider/.

Requests for Medical Records

To the extent permitted by state and federal law, HNE may request medical records or other appropriate records of members from providers for the orderly delivery of care, peer review or claims processing. Providers may not charge HNE for the photocopying of medical records or invoices, nor will HNE pay a hospital fee or be required to produce a separate signed patient authorization.

PCP Data

HNE collects and maintains data regarding utilization of services, membership, and financial performance with respect to PCPs. This data is sorted by risk unit, provider group, and individual practitioner. The data is compiled and summarized, and these

reports are presented to physician unit leadership on a regular basis. Reports may contain data that is specific to individual physicians and may pertain to pharmacy utilization, adherence to clinical guidelines, performance within clinical initiatives or individual patterns of utilization. Case mix and efficiency scores also are reported on a regular basis.

HNE will monitor all data for possible under- or over-utilization of services. Such findings will be presented to practitioners in a manner appropriate to their importance. All measures are compared to peer benchmarks, and confidentiality is maintained at all times.

HIPAA Privacy Requirements and Patient Information Needed for Utilization Management, Case Management and Care Coordination

HNE conducts utilization review, case management and care coordination activities for payment and health care operations purposes. In order to perform these activities, HNE often needs patient information such as office notes, diagnostic results, and treatment plans.

Some physicians have expressed concern about whether they may disclose medical record information to HNE in light of the Privacy Rule requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows covered entities, which includes physicians and health plans, to use or disclose protected health information (PHI) without an individual authorization from the patient for treatment, payment and some health care operation purposes, and for certain other specific purposes outlined by the HIPAA Privacy Rule [45 C.F.R. & 164.506(c)(4)].

Specifically, covered entities may disclose PHI to other covered entities for the other covered entity's treatment, payment and limited health care operation purposes, as defined by the Privacy Rule, as long as the request relates to current or former patients or members [45 C.F.R. & 164.506(c)(4)] .

Under the Privacy Rule, HNE's utilization review activities qualify as both payment and health care operations, and care coordination activities qualify as health care operations. Therefore, the disclosure of health information by physicians to HNE for these purposes is permissible without an individual authorization from the patient under the HIPAA Privacy Rule.

HNE recognizes that physicians are concerned with compliance with applicable privacy laws. We share those same concerns and will proceed only in a manner that is consistent with applicable laws, as outlined above. For more information on HNE Privacy and Compliance, visit https://healthnewengland.org/privacy-and-disclaimer-statement. Providers can contact HNE's Compliance Department as follows:

Email: compliancedepartment@hne.com

Ethics/Compliance Hotline: (800) 453-3959

Concierge Services

A provider may not charge a member a fee as a condition of being part of the provider's panel of patients. Notwithstanding the foregoing, the Massachusetts Division of Insurance requires that physicians provide advance disclosure to HNE that the physician intends to charge members an annual fee as a condition of inclusion in the physician's panel of patients. HNE requires sixty (60) days prior written notice of the establishment of any such fees.

Provider Collection Policy

Provides should submit claims to HNE prior to collecting any portion of a member's deductible and coinsurance. If a provider collects from the member prior to submitting a claim to HNE, providers and members are responsible to coordinate mutually acceptable terms for collection of a member's deductible and coinsurance obligations.

In no event may a provider collect payment from an HNE member for an HNE covered service for more than the member's current estimated remaining deductible obligation as of the date of service.

In the event that an amount in excess of member's actual obligation is inadvertently collected, the provider or facility must promptly remit such excess amount to the member upon verification from the provider's or facility's EOP or member's EOB.

HNE supports the use of standardized disclosure and authorization forms to facilitate dialogue between providers and members regarding financial responsibility and to establish expectations and facilitate collection of member deductible and coinsurance payments. In all cases, HNE expects providers or facilities to apply collection practices that are no more restrictive to HNE members than those applied to members of any other commercial payers.

Sample Statement of Understanding

Use the Statement of Understanding for services that HNE will not cover for which the member intends to accept full financial liability. If your office uses a different Statement of Understanding, it is only valid upon HNE's review and approval. This form is <u>not</u> applicable for Medicare Advantage Members. This form should only be used in one of the four circumstances described on the form:

<u>Member Assumption of Financial Responsibility for Medical Services</u>

<u>Statement of Understanding</u>

I understand that a Health New England provider may not require me to sign this Statement of Understanding as a condition of receiving services unless one or more of the following conditions exist on the date below (date services provided):

1. These services are normally provided by my primary care provider and I have decided to request services from the below named provider who is not my primary care provider.

or

2. These services exceed my benefit limitation.

or

3. These services are not covered services under my plan.

or

4. These services have not received prior approval.

I acknowledge that I have voluntarily sought the services of (name of provider) _____ who is an HNE participating provider. I accept full responsibility for paying for these services provided today by the above named provider. I understand that Health New England will not pay the provider, or reimburse me, for the cost of today's services, or any subsequent or ancillary medical services that the provider may order today on my behalf as a result of today's visit.

I understand that this Statement of Understanding is not an acceptance of financial responsibility for any services other than those services provided or ordered today.

_____ _____

Patient's Name *(please print or type)* Patient's HNE ID Number

_____ _____

Patient's Signature Today's Date

_____

Parent/Guardian Signature
(if under 18 years of age)

Health New England
Where you matter.

Professional Credentialing & Recredentialing

Effective Date 1/1/2021 | Revised Date 08/2022

HNE is dedicated to providing its members with access to effective health care and, as such, requires participating physicians to be board certified or board eligible within certain timeframes. Exceptions will be evaluated on a case-by-case basis.

The credentialing process is completed before a provider is accepted into the network(s). Recredentialing is conducted every two years after the initial credentialing to ensure professional qualifications remain valid and current. HNE is accredited by the National Committee for Quality Assurance (NCQA) and is fully compliant with NCQA standards.

Once approved by HNE's Credentialing Committee, a provider will be sent written notification in the form of a Welcome Letter containing the provider's effective date with HNE and the HNE provider identification number. In some instances, Health New England also delegates credentialing to vendors or provider groups.

Providers Who Require Credentialing

Addiction Medicine Specialists	Advanced Practice Registered Nurses (APRN)
Anesthesiologists within Pain Management Practices	Behavioral Healthcare Practitioners
Certified Nurse Midwives (CNM)	Chiropractors (DC)
Doctoral Level Practitioners	Doctors of Dental Surgery (DDS)
Doctors of Medical Dentistry (DMD)	Medical Doctors
Nutritionists/Registered Dieticians	Optometrists (OD)
Oral Surgeons	Osteopathic Doctors (DO)
Physician Assistants (PA)	Podiatrists (DPM)

Providers Who Do Not Require Credentialing

Providers who practice exclusively within the inpatient setting and who provide care to members only as a result of the member being directed to the inpatient setting do not require credentialing. These practice areas include Anesthesiology, Critical Care, Emergency Medicine, Hospitalists, Pathology, Radiology and Surgical Critical Care.

Additionally, providers who participate exclusively at a credentialed facility (Facility Staff), Physical Therapists, Occupational Therapists, Speech and Language Pathologists, do not require credentialing. Please see "Facility Credentialing and Recredentialing" below for additional information.

Practitioners who will be working on a temporary basis at a practice or facility are deemed locum tenens. If the duration of practice is less than one year, locum tenens will not need to go through the credentialing process; however the locum tenens provider must be enrolled in the HNE system. A fully completed HCAS form must be submitted to Provider Enrollment at penrollment@hne.com, along with a W9. The date range during which the provider will be joining the group must also be included in the submission.

The following are core requirements (as applicable) for all providers who require credentialing with HNE:

- Graduate education
- Residency
- Current, unrestricted license
- Malpractice coverage – $1 million/$3 million (minimum)
- Copy of current DEA Certificate and State Controlled Substance Registration
- Primary hospital affiliation or acceptable arrangements at an HNE contracted hospital
- Board certification and/or eligibility - if board eligible, statement of intent to become board certified if applicable
- References from persons who are knowledgeable about the clinician's competence and ethical character
- Clinician's statement regarding physical and mental health status, lack of chemical or substance impairment, history of loss or limitations of privileges or disciplinary activity
- Attestation to the correctness and completeness of the application
- Attestation to current malpractice coverage and agreement to maintain insurance at the HNE required level
- Five (5) year related work history

Healthcare Administrative Solutions, Inc. (HCAS)

Healthcare Administrative Solutions, Inc. (HCAS) coordinates the credentialing application process and primary source verification for providers participating with or applying to participate with HNE. HCAS provides a single point of credentialing data entry that is shared by all HCAS participating health plans. HNE adds the provider to the HNE roster and sends information from the HCAS forms to the Credentialing Verification Organization (CVO). The CVO verifies this information and then passes the information to HNE for further review by the Credentialing Department and final determination by the HNE Credentialing Committee.

HCAS has entered into an arrangement with Aperture Credentialing, a national CVO and provider data management company, to centralize and streamline components of the credentialing process. Aperture Credentialing partners with the Council for Affordable Quality Healthcare (CAQH) to collect credentialing data through CAQH's Universal Provider DataSource (UPD), a central repository for credentialing information.

Council for Affordable Quality Healthcare (CAQH)

HNE utilizes the CAQH Universal Provider DataSource (UPD) to gather credentialing data. This system enables physicians and other health care professionals to provide credentialing information to multiple health plans through a streamlined process. This eliminates redundancies and the need to print and mail credentialing applications, reduces the need for costly credentialing software, minimizes paperwork by allowing professionals to make changes online, and provides standardization and portability.

Healthcare providers must register with CAQH. You can log on to the CAQH website or contact them directly at 888.599.1771 to begin this process. Before completing the CAQH process, a provider must authorize HNE to view the information submitted. If already registered with CAQH, a provider must re-attest every 120 days to the correctness of the information submitted and update all the necessary information.

Registered providers receive automatic reminders from CAQH to review and attest to the accuracy of their data. CAQH requires providers to review and authorize the data once every four months. This can be done online or by calling the CAQH Help Desk at 888.599-1771. Providers can make changes 24/7 by phone or online. If you attest on a regular schedule, HNE and the CVO will access your most current information/documents from CAQH for timely recredentialing.

Use the links below for assistance in getting started with the credentialing process or for more information if you are recredentialing. You also may contact the HNE Credentialing Department via fax at 413.233-2808 or email at PROVCRED@hne.com.

- www.hcasma.org
- www.caqh.org
- www.healthnewengland.org
- https://proview.caqh.org/Login/Download?filename=PR-QuickRef.v2.pdf

Practitioner's Rights

During the credentialing and recredentialing process, practitioners have the right to:

- Review information submitted to support their credentialing application
- Correct erroneous information
- Receive the status of their credentialing or recredentialing application upon request
- Receive notification of these rights

Facility/Organizational Provider Credentialing and Recredentialing

Successful completion of the credentialing process is a requirement for all facilities prior to participation in HNE's network. Recredentialing is required at a minimum of every three years, or sooner, as deemed necessary thereafter.

The following core criteria (as applicable) will be required of facilities that seek to participate in the HNE network:

- Completed HNE Corporate Provider Application
- Completed Federally Required Disclosures (FRD) Entities form for BeHealthy Partnership/Medicaid participating facilities
- Valid, current, unrestricted state facility license
- General and professional liability coverage for the organization and any employee providing direct or indirect care to patients that meets or exceeds HNE's minimum limits of $1million-$3million
- No evidence of suspension or exclusion from Medicare or Medicaid during the past three years
- Most recent Department of Public Health (DPH) Survey Report (including any follow-up reports for deficiencies or complaint filed within the past year)
- Most recent survey report from an HNE accepted accrediting organization (including decision grid, summary and progress reports):
    - AAAHC: Accreditation Association for Ambulatory Health Care (http://www.aaahc.org) for ambulatory clinics, surgery centers, office-based surgery center practices, urgent and immediate care centers
    - AABB: Advancing Transfusion and Cellular Therapies Worldwide (http://www.aabb.org)
    - AASM: American Academy of Sleep Medicine (http://www.aasmnet.org) for sleep facilities, independent sleep practices, and DME suppliers
    - ABC: American Board for Certification in Orthotics, Prosthetics & Pedorthics (http://www.abcop.org) for orthotic, prosthetic, and pedorthic organizations
    - ACHC: Accreditation Commission for Health Care (http://www.achc.org) for home health, hospice, behavioral health, home infusion, ambulatory care, dialysis, and hospitals
    - ACR: American College of Radiology (http://www.acr.org) for CT, MRI, Breast MRI, Nuclear Medicine and PET, Ultrasound, Breast Ultrasound, and Stereotactic Breast Biopsy
    - BOC: Board of Certification / Accreditation (http://www.bocusa.org) for orthotic and prosthetic practices, and durable medical equipment
    - CAP: College of American Pathologists (http://www.cap.org) for laboratories
    - CARF: Commission on Accreditation of Rehabilitation Facilities (http://www.carf.org) for alcohol and drug rehabilitation programs, sub-acute rehabilitation units, and retirement communities
    - CHAP: Community Health Accreditation Partner (http://www.chapinc.org) for community based health organizations
    - CLIA: Clinical Laboratory Improvement Amendments (https://www.cms.gov/clia) for all laboratories
    - COA: Council on Accreditation (http://coanet.org) for child, youth and family services, behavioral health, aging services, and residential services
    - DNVGL: Det Norske Veritas Germanischer Lloyd DNVGL Healthcare (http://dnvglhealthcare.com) for hospitals
    - HFAP: Healthcare Facilities Accreditation Program (http://www.hfap.org) for hospitals, ambulatory surgical centers, laboratories, and behavioral health
    - IAC: Intersocietal Accreditation Commission (http://www.intersocietal.org) for diagnostic imaging, CT, MRI, nuclear, and PET
    - The Joint Commission (formerly JCAHO: Joint Commission on Accreditation of Healthcare Organizations) (http://www.jointcommission.org) for hospitals, long-term care, home care, and mental health organizations

The facility should complete and submit the HNE Corporate Provider Application (CPA) and supporting documentation. The Credentialing Department reviews the application to determine if the organizational provider meets NCQA and HNE standards.

For those facilities lacking accreditation by a recognized accrediting body, a site review and quality assessment may be required at the time of initial credentialing and recredentialing. HNE may substitute the Centers for Medicare and Medicaid (CMS) or state review in lieu of the required site visit, as long as it meets HNE's standards. To determine whether a site visit will be conducted, HNE reviews and assesses each CMS or state report with regard to the number of deficiencies identified and the scope and severity of the deficiencies, along with any other objective and relevant information.

Accreditation Requirements for Sleep Diagnostic Testing:

As part of Health New England's continued commitment to quality of care for sleep-related disease, we will require that all providers of sleep diagnostic testing services be accredited by the American Academy of Sleep Medicine (AASM). Full accreditation through the AASM ensures that providers are not only fully capable of providing high quality diagnostic sleep testing services but are also meeting high standards for quality sleep medicine care.

Suppliers of the technical component of advanced diagnostic imaging services must be accredited.

> For all lines of business, HNE follows the Centers for Medicare and Medicaid Services (CMS) accreditation requirements for suppliers that provide the technical component of advanced diagnostic imaging. CMS defines advanced diagnostic imaging procedures as including magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). This requirement only applies to the suppliers that furnish the technical component (TC) of advanced diagnostic imaging services, not to the physicians interpreting them. Providers subject to this requirement include physicians, non-physician practitioners, and Independent Testing Facilities. Hospitals are excluded from this requirement.

Provisional Credentialing of Advanced Diagnostic Imaging (ADI) Facilities:

Provisional credentialing for Diagnostic Imaging Technical Component will be granted for 120 days to new locations and/or to enrolled suppliers who wish to purchase additional ADI equipment or expand services by location or modality. A final decision on credentialing the new location or ADI equipment will be made during the 120-day period of provisional credentialing.

Health New England
Where you matter.

Serious Reportable Events and Never Events

Effective Date 1/1/2021 | Revised Date 1/1/2021

The purpose of this HNE policy is to increase patient safety and promote cost-effective, high quality health care by utilizing national and regional guidelines for the reporting, payment and treatment of Serious Reportable Events and Never Events.

Definitions

- **Serious Reportable Event**-(i) An event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and caused by care management (rather than the underlying disease) or (ii) errors that occur from failure to follow standard care or institutional practices and policies.
- **Never Event**-Any wrong procedure(s) performed on the wrong side, wrong body part, or wrong person. These Never Events are not medically necessary as they are not required to diagnose or treat an illness, injury, disease or it symptoms, and are not consistent with generally accepted standards of medical practice. All Never Events involving a wrong procedure performed on the wrong side, wrong body part, or wrong person are considered not medically necessary.

The National Quality Forum (NQF), a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting, has identified 29 Serious Reportable Events and Never Events in one of seven categories: Surgical or Invasive Procedure Events, Product or Device Events, Patient Protection Events, Care Management Events, Environmental Events, Radiologic Events and Potential Criminal Events. A list of these 29 events will follow this section.

Reporting:

- All facilities that are required to report a Serious Reportable Event or Never Event to the Massachusetts Department of Public Health (DPH) shall report that event simultaneously to HNE when the event involves an HNE member. The facility shall accomplish this reporting requirement by faxing a copy of the DPH report currently identified in DPH Circular Letter DHCQ-08-07-496 to the Health New England Utilization Review Specialist at fax number 413-233-2700.
- In order to identify inefficient care and preventable conditions, all facilities must provide Present on Admission (POA) indicators on all inpatient claims. Failure to indicate POA conditions on an inpatient claim may result in delayed reimbursement or denial of the claim.
- HNE will not publicly disclose information reported under this section unless otherwise required to do so by law, statute, or regulation.

Reimbursement:

Effective January 1, 2009, HNE will not reimburse for services associated with the following Serious Reportable Events or Never Events:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgical procedure
- Retention of foreign object
- Incompatible blood-associated injury
- Air embolism-associated injury
- Medication error injury
- Artificial insemination/wrong donor
- Infant discharged to wrong family

These events are based on nationally acceptable definitions and are consistent with those identified by the Massachusetts Hospital Association (MHA) for which member hospitals have voluntarily agreed not to charge patients or insurers. This list may be amended from time to time.

Providers shall not bill HNE members for charges associated with the Serious Reportable Events and Never Events for which HNE denies reimbursement, and for any subsequent care needed to address the events. Providers shall waive any copay or deductible due from the HNE member for the admission during which the Serious Reportable Event or Never Event occurred.

HNE shall retract payment for any services after payment has been made if the claim is identified to have met the requirements for non-reimbursement as a Serious Reportable Event or Never Event.

Scope:

This policy will be in effect for all facilities, such as hospitals, acute rehabilitation centers, skilled nursing facilities, visiting nurse associations, same day surgery centers, offices, and outpatient locations, both in-network and out-of-network, until such time as HNE deems it prudent to expand the policy to encompass all providers. Notwithstanding the foregoing, upon notification of a Serious Reportable Event or Never Event to HNE's Chief Medical Officer, the Medical Director and Health Services Department may review the claim(s) to determine whether to extend non-payment to other service professionals (nurse practitioners, anesthesiologist, etc.) involved in the services of said event.

HNE will continue to evaluate and monitor these regulations to determine any additional specifications.

National Quality Forum (NQF) List of Serious Reportable Events and Never Events
Surgical or Invasive Procedure Events
1A. Surgery or other invasive procedure performed on the wrong site Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
1B. Surgery or other invasive procedure performed on the wrong patient Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
1C. Wrong surgical or other invasive procedure performed on a patient Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices
Product or Device Events
2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities
Patient Protection Events
3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
3B. Patient death or serious injury associated with patient elopement (disappearance) Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
Care Management Events
4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4B. Patient death or serious injury associated with unsafe administration of blood products Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers
4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy Applicable in: hospitals, outpatient/office-based surgery centers
4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities
4G. Artificial insemination with the wrong donor sperm or wrong egg Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices
4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
Environmental Events
5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
Radiologic Events
6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices
Potential Criminal Events
7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
7B. Abduction of a patient/resident of any age Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Health New England
Where you matter.

Provider Review and Corrective Action

Effective Date 1/1/2021 | Revised Date 3/1/2022

Introduction and Purpose

Noted below, is HNE's policy that creates a framework to address provider actions affecting the administration of an HNE plan or the quality of health care services provided to HNE members. This policy applies when HNE becomes aware of information concerning a provider (or the office staff working on behalf of the provider) that warrants further review and possible corrective action, including both non-disciplinary and disciplinary action.

The provisions of this policy are incorporated into the contract between HNE and the provider (or the PHO through which the provider is contracted with HNE) ("HNE Agreement"). The remedies set forth in this policy are in addition to, and not in lieu of, those expressly set forth in the HNE Agreement. If the provider engages in conduct, that constitutes a breach of the HNE Agreement, HNE's action or inaction pursuant to this policy shall not affect HNE's rights to enforce the HNE Agreement and shall not be construed as a waiver of that contract.

In the event that a provider engages in conduct that is also addressed by an HNE credentialing policy, the HNE Chief Medical Officer, or designee shall decide, in his or her discretion, whether to proceed under the HNE Agreement, the credentialing policy or both, if appropriate. Such decision shall take into account the nature and severity of the offense and the particular circumstances of the case.

The objective of this policy is to resolve the issues through discussion and cooperation between HNE and the provider. When disciplinary issues arise, this policy is intended to ensure that the quality of care provided to members is not compromised, and to address the improper provider action promptly and effectively.

HNE retains the right to approve, suspend, or terminate providers based on instances of poor quality, without regard to the provider's status as determined by the health plan. Providers have the right to a peer review process in the event that their clinical privileges and provider panel status are restricted, suspended, or terminated.

Disciplinary Matters

Actions that affect a provider's ability to practice medicine, provide quality health care services to members, or to meet certain criteria for participation in the HNE network, or which would subject a provider to discipline pursuant to the regulations of the Massachusetts Board of Registration in Medicine or an equivalent agency of another state, shall be deemed to be Disciplinary Matters. Examples of such Disciplinary Matters are listed below. The following list is not all-inclusive, and HNE reserves the right to determine whether similar conduct not specifically listed shall be treated as a Disciplinary Matter. **If, in the judgment of the HNE Chief Medical Officer, a provider has engaged in conduct that the HNE CMO, or designee, believes to be a Disciplinary Matter, the provider may be immediately suspended from the HNE network, where appropriate, pending resolution of the matter.**

- Failure to maintain a professional relationship with members or with HNE. This refers to professional conduct that is not likely to cause harm to patients but is nonetheless inappropriate, such as insensitive or discriminatory behavior toward HNE members, rude or abusive behavior toward HNE members or employees, failure to cooperate with an HNE investigation under this policy, derogatory or demeaning statements about HNE, or any negative behavior that raises concerns about provider's commitment to working with HNE or its members

- Engaging in unlawful or unethical behavior related to provider's professional conduct or concerning HNE or its members
- Practicing medicine in violation of the law or good and accepted medical practice
- Suspension or revocation of a provider's license to practice medicine in any jurisdiction in which the provider has been licensed
- Voluntary surrender of a provider's license to practice medicine in any jurisdiction in which the provider treats HNE members
- Suspension, revocation or voluntary surrender of the provider's narcotics license
- Adverse action against the provider taken or recorded by a professional society (e.g., initial or renewal membership denied, disciplinary action undertaken)
- Suspension, revocation or voluntary surrender of board certification
- Denial, suspension, reduction, revocation of privileges at any hospital
- Indictment for or otherwise charged with a criminal offense
- Medicare or Medicaid sanctions imposed on a provider
- Sanctions or limitations on license
- Malpractice
- Member complaints
- Giving false or misleading information in connection with HNE or hospital credentialing processes
- Practicing medicine while the ability to practice is impaired by drugs, alcohol, physical disability or mental instability
- Knowingly permitting, aiding, or abetting an unlicensed person to perform activities requiring a license
- Engaging in conduct that has the capacity to deceive or defraud
- Engaging in any conduct that warrants immediate termination of his or her contract with HNE as provided in that contract

Provider Appeals Rights

Should HNE make a decision to restrict, suspend or terminate a provider's participation "for cause", HNE shall notify a provider, in writing, of the corrective or disciplinary action imposed by HNE pursuant to this policy within 30 calendar days. Such notice may be provided via email, Certified US Mail, Return Receipt Requested, or fax. Notices sent under this policy shall be deemed to have been received by a provider or HNE upon the expiration of three days from the date of mailing, or upon completion of a fax or electronic mail transmission.

The procedure set forth below shall be followed by a provider where: (1) a provider disputes the HNE CMO, designee, or Credentialing Committee conclusion that the provider has engaged in conduct warranting further review and corrective or disciplinary action; or (2) a provider disputes that the particular corrective or disciplinary action imposed by the HNE CMO, designee, or Credentialing Committee is appropriate given the nature, severity, frequency or effect of the action, or any other relevant circumstances.

The following appeal procedure shall not be available to a provider who, in the good faith judgment of the HNE CMO, designee, or Credentialing Committee and based on all of the facts available to the CMO or designee at the time, has:

- Lost his or her license to practice medicine (or other discipline) in any jurisdiction
- Been convicted of a crime

At the appeals hearing the provider has the right to:

- Be represented by an attorney or other person of the provider's choice
- To have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation

- To present evidence determined to be relevant by the subcommittee, regardless of the admissibility in a court of law, and to submit a written statement at the close of the hearing

First Level Appeals

- If within (14) calendar days of receipt of a notice imposing corrective or disciplinary action, a provider shall submit a written statement to the HNE Chief Medical Officer, or designee, setting forth the provider's grounds for appeal. Such statement shall include all relevant facts, circumstances and opinions upon which a provider's appeal is based.
- The HNE CMO, or designee, shall respond to the provider's written statement within 30 calendar days of receipt of the provider's written statement.
- If the HNE CMO, or designee, believes that the initial conclusion was correct, the CMO, or designee, shall so notify the provider in writing.
- If the HNE CMO, or designee, believes that the initial conclusion was not appropriate given the facts, circumstances and opinions raised in the provider's written statement, the CMO, or designee, shall so notify the provider in writing and shall include in such written statement the alternative corrective or remedial action, if any, imposed by HNE.

Second Level Appeals

- If a provider who is not satisfied with the result of a First Level Appeal, they may request in writing a review of the matter by the Credentialing Committee (CC), or another standing or ad hoc committee. Such request shall be made within 14 calendar days of receipt of notice of the decision under the First Level Appeal. The matter shall be brought to the Committee at the next regularly scheduled meeting or as soon thereafter, as is reasonably possible. Any provider on the Committee, who is in competition with the appealing provider, shall be excused from serving on the Committee, unless the two providers and HNE agree otherwise. In addition, the HNE Chief Medical Officer or designee shall be recused from serving on the Committee during Second Level Appeal proceedings.
- At the provider's option, his or her attorney may present the matter to the Committee on the provider's behalf. If the provider chooses to have an attorney, the provider must give at least 14 days advance written notice to HNE and must state in such notice the attorney's name and address. If an attorney appears on behalf of a provider, HNE may choose to have its attorney present the matter to the Committee on HNE's behalf. HNE shall give the provider written notice of its attorney's name and address at least five days prior to the date of the Committee meeting.
- At the Committee meeting, each party shall initially be given 30 minutes to address the Committee. HNE shall address the Committee first, followed by the provider. Each party shall then be given 10 minutes to respond to the statements made by the other party. The time limits may be extended upon agreement of each party and a majority vote of the members of the Committee.
- Within 30 days of the Committee meeting, the Committee shall notify the provider, in writing, of its decision. The Committee may affirm the decision of the HNE Chief Medical Officer, or designee, reverse the decision of the HNE Chief Medical Officer, or designee, or modify the decision of the HNE CMO, or designee, and order additional or alternative corrective action.

Third Level Appeals

If a provider or HNE is not satisfied with the result of a Second Level Appeal, the dispute will be submitted to an arbitrator. The arbitrator will conduct the proceeding in Springfield, Massachusetts, in accordance with the rules of the American Arbitration Association. The arbitrator's authority shall be limited to either affirming or denying the decision of the Credentialing Committee (CC), or another standing or ad hoc committee, and the arbitrator shall not have any authority to modify the decision of the Committee, unless HNE and the provider agree otherwise in a particular case. The decision of the arbitrator will be binding upon the parties and may be enforced by any court of competent jurisdiction. All costs and expenses of arbitration, excluding attorneys' fees, witness fees, and consultants' fees, will be shared equally by the parties.

1st Level Appeal		
Notification	**Time Frame**	**Method**
HNE notification to provider of corrective action	Within 30 calendar days of imposed corrective action	Written statement*
Provider appeal notification to HNE	Within 14 calendar days of receipt of corrective action notification	Written statement*
The HNE CMO response to provider 1st Level Appeal	Within 30 calendar days of receipt of the provider's written statement	Written statement*
2nd Level Appeal		
Notification	**Time Frame**	**Method**
A provider who is not satisfied with the decision of a 1st Level Appeal, may seek further review	Within 14 calendar days of receipt of the 1st level appeal decision	Written statement*
The HNE Committee Response to Provider 2nd Level Appeal	Within 30 calendar days of the Committee's 2nd Level Appeal decision	Written statement*

** Notifications can be corresponded via email or Certified U.S. Mail, Return Receipt Requested or Fax*

Important Note about Suspension and Termination

Please note: If HNE determines that the health, safety, or welfare of HNE members is endangered by the conduct of any participating provider, or if the participating provider's license, or is limited, suspended, or revoked, HNE, or, if applicable, the PHO or similar organization through which the provider participates, may immediately terminate the provider from participation with HNE. HNE may also suspend such provider's participation pending any appeal to which the provider is entitled under the policy set forth in the above section or applicable agreements with HNE.

Health New England
Where you matter.

CARE MANAGEMENT

Effective Date 1/1/2021 | Revised Date 11/1/2023

CARE MANAGEMENT

HNE is committed to improving the overall health and wellbeing of our members by creating an integrated health care network. The HNE Care Management (CM) program strategy has four foundational elements: (1) improve member experience (2) improve provider engagement (3) improve the health of populations and (4) ensure quality and affordability of care.

Care management is one of the most effective tools HNE has to manage the health of a defined population. Unlike our previous disease management model, which tended to be disease-centric, HNE's CM program addresses the whole individual and includes appropriate interventions for a member along the entire continuum of care, thereby reducing health risks and decreasing care costs. This team-based, member-centered approach supports systems to effectively and efficiently manage populations, their medical conditions and social determinants of health. CM also encompasses the care coordination activities needed to help manage complex chronic illnesses.

The HNE CM team is comprised of licensed registered nurses and social workers acting as clinical advocates to provide member education, care management, and coordination of care services across the continuum of care.

HNE identifies populations and subpopulations of members who may benefit from CM by using a variety of data elements and referrals (including member self-referral) it receives. Predictive modeling supports the identification of members with modifiable risks that can be managed in ways that will help members achieve their health and wellbeing goals, improve their overall quality of life, and mitigate healthcare costs, leading to an enhanced member experience.

The Quality Management Committee, Population Health Review Committee, and the Clinical Care Advisory Committee review the CM Program at least annually. Practitioners, including specialists on these committees, are responsible for the review and revision of all Care Management Programs.

Instructions on how to access the information about the CM program is included in the orientation packet for newly credentialed practitioners. Existing providers receive an annual reminder. Practitioners are notified via mail, e-mail, phone and/or fax when revisions are made to the CM Program. A paper copy of the CM Program is available upon request.

A Care Manager may focus on certain diagnosed disease states or conditions such as Diabetes, Asthma, Heart Disease, Chronic Obstructive Pulmonary Disease, High Risk Pregnancy, and Behavioral Health conditions (Depression) when the identified diagnoses have a substantial impact on the member's health and quality-of-life.

HNE CM program is primarily conducted over the telephone. Member participation is completely voluntary. Members are made aware of the CM program in a number of ways:

- benefit program materials
- employer communications
- provider referrals
- Utilization Management process
- HNE web-based materials; including information about the how to enroll

HNE monitors its CM program engagement monthly to ensure appropriate Care Manger to member ratio, identify trends in internal and external coordination of services, and identify trends in types of services and referral sources. The data is analyzed (qualitatively and quantitatively) to address opportunities for improvement in the CM process. Data analysis and observations are shared to the Clinical Care Advisory Committee to obtain additional feedback and recommendations from our local provider network on addressing the four foundational elements of the CM Program.

We survey all members enrolled in CM to help us understand how our CM program impacts our members' health and wellbeing. We analyze the survey results related to the member experience with CM quantitatively to identify trends and collect qualitative information, such as member success stories and anecdotal information. This data is used to make appropriate modifications to our program, address Care Manager training or make changes in our member or provider materials about our CM program.

Providers may refer a member to receive Care Management Services by calling HNE Health Services at (413) 787-4000, extension 3940, or (800) 842-4464, extension 3940.

Complex Care Management

Complex Care Management is a proactive approach to managing HNE's high-risk members. High-risk members are those who are likely to become hospitalized or require multiple health care services. The goal is to improve members' understanding of their overall health, reduce hospital admissions, and reduce medical costs.

If providers have questions or would like to refer a member to this program, they can contact Care Management by calling (413) 787-4000, extension 3940, or (800) 842-4464, extension 3940.

Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN) Population Health Management

ProgenyHealth, a national company dedicated to population health management for infants admitted to the neonatal intensive care unit (NICU) or special care nursery (SCN), partners with Health New England on the care management and utilization management for medically complex newborns in our Commercial business lines. Their care coordination team includes neonatologists, pediatricians, nurses, and social workers. This team has a deep understanding of the evidence-based protocols needed to support outcomes, and supports families from initial NICU or SCN admission through first year of life.

Kidney Health Management (KHM)

Health New England is partnering with Healthmap Solutions to provide care that is more comprehensive for our Medicare members with Chronic Kidney Disease (CKD), Stage 3, 4, 5 and End Stage Renal Disease (ESRD). Healthmap' s KHM program integrates into your existing practice workflow to reduce additional office work, while enhancing communication. To learn more go to https://healthnewengland.org/Providers/Resources. Click Kidney Health Management.

Nurse Advice Line

The Nurse Advice Line provides health information and resources to HNE members 24-hours a day. It is not intended to replace or question the diagnosis of a physician or health care provider, nor provide specific follow-up care for treatments prescribed. For triage situations, the nurse directs the member to the type of care most appropriate based on the symptoms and situation conveyed by the member. The Nurse Advice Line notifies HNE about member activity on a daily basis for quality and utilization purposes. The Nurse Advice Line is accessible by calling (866) 389-7613.

Health New England
Where you matter.

UTILIZATION MANAGEMENT

Effective Date 1/1/2021 | Revised Date 11/1/2023

The purpose of HNE's Utilization Management (UM) Program

The purpose of HNE's UM program is to assess medical necessity, enable and encourage use of contracted providers and facilitate claims payment. This involves collaborating with practitioners, members, facility staff and other providers to ensure timely and appropriate decision making and to understand and/or resolve barriers. This is accomplished through:

1. Pre-Service Review
   Review of a case or service that must be approved, in whole or in part, in advance of the member obtaining medical or behavioral health care or services. Prior authorization and pre-certification are defined as pre-service review. Pre-service review also includes confirmation of member eligibility, coverage and assessment of medical necessity. HNE will make an initial determination within two days of obtaining all information necessary to the determination. **It is the responsibility of the provider to submit complete and accurate information to HNE prior to the treatment or facility stay. Failure to submit the information in a timely manner may result in non-payment for administrative reasons.**

2. Concurrent Review
   This includes review of urgent/emergent admissions and elective admissions that were not prior approved; ongoing review of a member's inpatient stay; and review of requests for extension of the length or number of previously approved ongoing courses of treatment. Any request to extend the member's length of stay or treatment beyond the initial authorization must be reviewed and approved by HNE. HNE will make an initial determination within one day of obtaining all information necessary to the determination. **It is the responsibility of the provider to submit complete and accurate information to HNE by the last day of authorized treatment or facility stay. Failure to submit the information in a timely manner may result in non-payment for administrative reasons.**

3. Post-Service Review
   This includes review for care or services that have already been received (i.e., retrospective review). "Post-Service Review" is appropriate under defined circumstances, and we will consider when the request meets the following Health New England (HNE) retrospective review criteria.
   1. When the member has been added retrospectively to HNE after services have been provided or during a course of continuing treatment; or
   2. The member has been referred or received same day services; or
   3. The service was urgent or emergent in nature; and/or;
   4. Enrollment with HNE/eligibility and/or member benefit unable to be verified

   Otherwise, HNE will not perform a retrospective review when a claim processed for services is on file.

There may be times when a service is not approved. A denial may be due to failure to follow appropriate administrative procedures, lack of medical necessity or appropriateness, or benefit exclusion under the terms of the member's plan.

UM Review and Decision Process

All UM decisions are made in accordance with the terms of the member plan document and in a fair and consistent manner. When making a determination of coverage based on medical necessity or appropriateness, HNE will render the decision in accordance with defined UM criteria and will evaluate all relevant clinical information, including the individual member's particular health care needs and the capability of the local delivery system.

The HNE UM Decisions policies set forth the timeframes for UM decision-making and the process for notification of UM decisions. It is HNE's policy to meet both state and federal regulatory requirements as well as to meet or exceed NCQA standards and requirements. These policies are reviewed at least annually. HNE will notify providers in writing of changes or modifications to the UM program that have a substantial impact on the rights or responsibilities of the providers and the effective date of such modifications. To request a copy of HNE's UM Decisions policies, providers may call Provider Relations at (800) 842-4464, extension 5000.

Physician Reviewers

The Chief Medical Officer, Medical Director, Associate Medical Director, Associate Medical Director for Behavioral Health or an HNE pharmacist is the final decision-maker for any denial based on medical necessity or appropriateness.

UM Decisions, Criteria and Definition of Medical Necessity

The medical necessity criteria utilized by HNE in making coverage determinations are:

- Developed with input from practicing physicians national-wide or in HNE's service area
- Evidence-based and developed in accordance with the standards adopted by national accreditation organizations
- Updated annually or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice.

In applying such guidelines, HNE considers the individual health care needs of the member. HNE will notify members and providers 60 days prior to the effective date of any material changes to HNE's criteria.

Many of these medical necessity criteria sets are commercially purchased. These commercially purchased criteria sets are licensed and are the PROPRIETARY and CONFIDENTIAL property of the licensing company. HNE makes the specific portion of the criteria used available to the treating provider and the member where required by law or by applicable accreditation requirements.

HNE has also developed criteria sets for other select procedures, treatments, and services. These HNE-developed criteria are available at http://healthnewengland.org/Providers/Resources

Please note: Some HNE members are enrolled in a health benefit plan under which HNE only provides administrative services (i.e., a Self-Funded plan). In some instances, the plan sponsor/payer has reserved the right to decide certain appeals of benefit denials. In those cases, HNE must adhere to the benefit coverage determination of the plan sponsor/payer.

Appropriateness of Care Statement

It is the policy of HNE that decisions regarding patient care are made based upon medical necessity, the appropriateness of care, and the services rendered. If a service is not medically necessary or is not a covered benefit, coverage may be denied. In cases where services are covered but are not being provided, such as preventive care services and prenatal care, it is HNE's policy to encourage appropriate treatment.

Affirmative Statement Regarding Incentives

- HNE makes utilization decisions based on the appropriateness of care and service and the existence of coverage.
- There are no specific rewards to practitioners or other individuals conducting utilization review for denials of coverage or service care.
- HNE does not provide financial incentives for UM decision-makers that encourage or result in under-utilization.
- Practitioners are ensured independence and impartiality in making referral decisions that will not influence: hiring, compensation, termination, promotion, or any other similar matters.
- This statement covers any practitioner, provider, staff member, or delegate who is subject to financial incentives for UM decisions.
- This statement appears at a minimum in the HNE Provider Manual, HNE Intranet and in ALL editions of ALL HNE member newsletters.

Clinical Transition Program

HNE has established a Clinical Transition process to ensure the continuity of care for

- members new to HNE;

- members who have reached their benefit maximum for coverage;
- continuation of coverage following provider disenrollment; and
- departing members without new coverage.

If providers have questions concerning transitional coverage availability, contact Health Services by calling (413) 787-4000, extension 5027, or (800) 842-4464, extension 5027.

Inquiring about the Status of a UM Decision

Practitioners have direct access to UM staff regarding specific cases and discussion of UM decisions. In general, if a provider requests a service that requires HNE's prior authorization and would like to know its status or outcome, the provider should contact Member Services at (413) 787-4000 or (800) 842-4464, extension 5025, between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Practitioners may also call HNE UM Department delegated entities directly as follows:

- High Cost Radiology and Imaging, Genetic Testing and Sleep Studies - **eviCore healthcare at (888) 693-3211**
- Chiropractic Services - **OptumHealth at (888) 676-7768**
- Pharmacy Issues - **OptumRx at (800) 282-3232**
- Medical injectable drug program - **MagellanRx Management at (800) 424-8325**
- **NICU – ProgenyHealth at (888) 832-2006**

Reconsideration of Adverse Determinations at Treating Provider's Request

A treating provider shall have an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. Said reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to MGL c. 176O. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by MGL c. 176O. Any request for a peer-to-peer discussion between the treating provider and the HNE clinical reviewer shall be treated as a request for reconsideration of an adverse determination under MGL c. 176O. HNE delegated entities shall provide such opportunity to seek reconsideration.

Arranging a Telephone Conference for a Reconsideration

To arrange a telephone conference time for a reconsideration by an HNE clinical reviewer, the requesting provider should call Health Services at (413) 233-4000, extension 3470, or (800) 842-4464, extension 3470. Health Services will obtain the relevant plan information for the case and arrange a teleconference between the requesting provider and the HNE clinical reviewer or designated clinical peer reviewer.

In-Office Denial for Medicare Members

Providers have an obligation to notify HNE of an in-office denial for Medicare Members. When a provider fully or partially denies a Medicare Advantage enrollee's referral or request, or if there is a reduction of a requested service for the enrollee, it is the responsibility of the provider to contact HNE so a written notification, including the member's appeal rights, can be sent to the enrollee.

If a Network provider furnishes a non-covered service, the enrollee must be clearly advised prior to furnishing the service of the enrollee's financial responsibility for the full cost of the service.

Medical Technology Assessment Program

The Medical Technology Assessment Committee (MTAC) is responsible for systematically evaluating new healthcare technologies, new applications of existing technologies, and new uses of existing healthcare diagnostic and therapeutic

technologies, pharmaceuticals, medical devices, and medical/surgical/behavioral health services and procedures. This process is intended to afford all members with access to safe, high quality, cost effective healthcare.

MTAC uses evidence-based information for reviews, which focus on recently developed technologies and evolving applications of established modalities, particularly those that are most relevant to the clinical care of our members. Technologies include diagnostic tests, procedures, treatments, and devices for both medical and behavioral health that have implications for patient coverage. Decisions are made by a majority vote of MTAC voting members. New technologies approved by MTAC are presented to the Clinical Care Assessment Committee (CCAC). CCAC makes the final determination on new technologies and policies.

Medical technology evaluation criteria, in general terms, include:

- Final approval from appropriate governmental regulatory bodies;
- Scientific evidence that permits conclusions concerning the beneficial effect of the technology on health outcomes;
- Evidence that the technology improves the net health outcomes while outweighing any harmful effects;
- Evidence that the technology is as beneficial and cost effective as any established alternatives that achieve a similar health outcome;
- That the improvement is attainable outside investigational settings (i.e. in a standard clinical setting) to a degree comparable in the published, scientifically derived and evidence-based investigations.

If providers have questions about this program or would like HNE to consider coverage for a new or existing technology, they should contact HNE's Process Supervisor, at (413) 787-4000, extension 3457, or (800) 842-4464, extension 3457.

Health New England

Where you matter.

Behavioral Health

Effective Date 1/1/2021 | Revised Date 1/1/2021

This section applies to **Commercial and Medicare Advantage** members **only.**

HNE has partnered with Massachusetts Behavioral Health Partnership (MBHP) to manage behavioral health (BH) services for HNE Be Healthy members. Providers treating HNE Be Healthy members can access MBHP's Provider Manual at https://masspartnership.com/HNE/default.aspx.

HNE covers both inpatient and outpatient behavioral health and substance use disorder services that are medically necessary or in accordance with the member's plan or state law. Covered services may include inpatient, community-based acute residential and partial hospitalization services, inpatient detox including acute treatment services (ATS), inpatient rehabilitation, clinical stabilization services (CSS), community crisis stabilization (CCS), intensive outpatient program services, and outpatient behavioral health services. Where required by HNE, all determinations of medical necessity are based upon the most current edition of the InterQual Level of Care Criteria or HNE's Clinical Review Criteria. A telephonic review of single criteria may be conducted by contacting the Health Services Department at (413) 787-4000, extension 5028, or (800) 842-4464, extension 5028.

With respect to substance use disorder services, the BH Department conducts concurrent reviews of ongoing substance use disorder services, as permitted by state law, to ensure continued medical necessity.

Inpatient BH Hospitalization Services

HNE covers inpatient BH hospitalization services. HNE requires notification following admission. HNE recommends, but does not require, screening by an Emergency Screening Program (ESP) prior to admission.; The BH Department conducts concurrent reviews of ongoing hospitalization services, as allowed by state law, to ensure continued medical necessity.

BH Services Requiring Prior Authorization

The following BH services, procedures or treatments require prior authorization:

- Applied Behavioral Analysis
- Crisis Stabilization Unit
- Acute Residential Treatment
- Day Treatment
- Partial Hospitalization Program
- Family Stabilization Treatment
- Intensive Outpatient Therapy
- Repetitive Transcranial Magnetic Stimulation
- Neuropsychological Testing

See below for detailed Instructions for Completing and Submitting the Standard Prior Authorization Request Form.

What is not covered:

Services that are not covered under the behavioral health/substance use disorder benefit include:

- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Services for problems of school performance
- Faith-based counseling
- Social work for non-mental health care
- Christian Science practitioner and sanitarium stays
- Services required by a third party or court-ordered residential/custodial services (including residential treatment programs and halfway houses)

Instructions for Completing the Standardized Prior Authorization Request Form

When submitting the Standardized Prior Authorization Request Form to HNE Health Services, providers should be very specific. Fill out the form as completely as possible and attach copies of additional pertinent clinical information (e.g., a statement of medical necessity, office notes, lab results, x-ray report and other consultation reports) so that Health Services can make an informed determination within standardized decision-making timeframes. If the required information is not submitted with the initial request, Health Services may need to request additional information, delaying the review process. Once all necessary information is received, Health Services will make a coverage determination. Health Services will then send a written confirmation of the decision to all appropriate parties (e.g., the requesting physician, the provider rendering the service, the member and the member's PCP). If the determination is a Medical Necessity denial, the referring provider will also receive a phone call.

The Standardized Prior Authorization Request Form should be received at HNE at least seven days prior to the scheduled service date. The requesting provider is responsible for submitting the Standardized Prior Authorization Request Form to HNE.

Choose the Service Type Category:

Provider Information:

- Requesting Provider Name, Phone Number and Fax
- Servicing Provider Name, Phone Number and Fax
- Servicing Facility Name (if indicated)
- Name of Contact Person, Phone Number and Fax

Member Information:

- Name of Member
- Date of Birth
- HNE ID Number
- Diagnosis
- Procedure Description and Code
- Units/Days/Visits Requested
- Service Start and End Date

Instructions for Submitting the Standardized Prior Authorization Request Form

To request prior authorization, the requesting physician's office must submit a Standardized Prior Authorization Form to Health Services. Standardized Prior Authorization Forms are located on the HNE website. In addition to this general prior authorization form, there are additional forms pertaining to specific services such as Behavioral Health, Infertility Treatment and Enteral Nutrition. For assistance, please contact the HNE Provider Relations Department at (800) 842-4464 extension 5000, or Health Services at (413) 787-4000 extension 5027, or (800) 842-4464 extension 5027.

You can access the format at http://healthnewengland.org/forms.

Prior Authorization requests for Medical and Behavioral Health Services should be sent to:

Health New England
Attention: Health Services
One Monarch Place, Suite 1500
Springfield, MA 01144
Fax: (413) 233-2700

Health New England
Where you matter.

PROCEDURES, TREATMENTS AND SERVICES REQUIRING UTILIZATION MANAGEMENT (UM) REVIEW (NON-BEHAVIORAL HEALTH):

Effective Date 1/1/2021 | Revised Date 1/1/2021

IMPORTANT INFORMATION:

This section includes examples of non-behavioral health services, procedures and treatments that require prior authorization. Examples are included to demonstrate what information is needed for various types of requests. The examples are not a comprehensive list of services, procedures and treatment that require prior authorization, as this list is subject to change and may differ according to the member's individual benefit package. To verify if a service, procedure or treatment requires prior authorization, contact Provider Relations at (413) 233-3313 or (800) 842-4464, ext. 5000. Providers also may contact HNE Health Services directly at (413) 787-4000, extension 5027, or (800) 842-4464, extension 5027, or HNE Member Services at (800) 310-2835. **For information on behavioral health utilization management, see "Behavioral Health" section here.**

Procedures and Services Requiring Prior Authorization or Pre-Service Review – Performed by HNE:

To request prior authorization for the following services/treatments/procedures, fax the Standardized Prior Authorization Request Form to Health Services at (413) 233-2700 or mail it to Health New England at One Monarch Place, Suite 1500, Springfield, MA 01144.

1. All requests for Out-Of-Plan providers for HMO plans
2. All elective admissions to an Out-Of-Plan facility for PPO/POS plans
3. All admissions to a skilled nursing facility or inpatient rehabilitation facility
4. Transplants
5. Designated Surgical Procedures and Treatments/Services, including:
    - Abdominal Panniculectomy
    - Biofeedback
    - Autologous Chondrocyte Transplant
    - Blepharoplasty
    - Cardiac Monitoring
    - Clinical Trials
    - Cochlear Implants
    - Dermal Injections
    - Durable Medical Equipment for Home Infusion and Sleep Studies (all other DME is approved by Northwood, see list of HNE Delegates noted below):
        - When Home Infusion, Home Care and Specialty RX providers are billing for medical supplies and equipment related to infusion/parenteral/tube-fed nutrition, Health New England manages/pays for those supplies and/or equipment. Prior Authorization is obtained through Health New England's Health Services at (800) 842-4464, extension 5027 or by faxing the Standardized Prior Authorization Request Form to (413) 233-2700.
        - When Sleep Study providers are billing for professional studies supporting sleep service, Health New England manages/pays for those services. Prior Authorization is obtained from eviCore.
        - If the service is managed through HNE, the AELK Master List should be consulted to determine if the item is covered
    - Formula and Enteral Nutrition
    - Gastric Electrical Stimulation
    - Infertility Treatment and Services (See "OB/GYN Services Requiring Prior Authorization from HNE: below for more details.)
    - Laser-Assisted Uvulopalatoplasty
    - Lyme Disease Treatment
    - Mandibular Advancement Device for treatment of Obstructive Sleep Apnea
    - Orthognathic Surgery
    - Outpatient Hyperbaric Oxygen Therapy
    - Positive Airway Pressure Devices
    - Reduction Mammoplasty

- Rhinoplasty
- Sacral Nerve Stimulation
- Scleral Lens
- Speech Generating Devices
- Speech Therapy (outpatient except when provided as part of the Home Health Care benefit)
- Spinal Cord Stimulation
- Surgical Management of Morbid Obesity
- Therapeutic Shoes and Orthotics
- Total Hip Resurfacing
- Upper Limb Prosthetic

See below for detailed Instructions for Completing and Submitting the Standard Prior Authorization Request Form.

Procedures and Services Requiring Prior Authorization – Performed by HNE Delegates:

High-Cost Imaging Studies, Genetic Lab Testing and Sleep Studies: contact eviCore healthcare at (888) 693-3211. For more information, see "eviCore: Radiology, Sleep Studies, Genetic Testing" here.

Chiropractic Care: contact OptumHealth at (888) 676-7768. For more information, see "Chiropractic Benefit" below.

Durable Medical Equipment: contact Northwood at (877) 807-3701. (To view the list of codes managed by Northwood please visit http://healthnewengland.org/Providers/Resource). For more information on Northwood's DME process, see "Durable Medical Equipment" section here.

Non-Emergency (Scheduled) Transport Services: contact American Medical Response (AMR) at (866) 585-6438. **Please note: not all scheduled transportation is covered.**

Medical Injectable Drugs: contact Magellan Rx Management at (800) 424-8325. For more information on medical injectable drug program, see "Pharmacy Services" section here.

Services Requiring Notification to HNE:

- **Emergency Admissions**: fax notifications to (413) 233-2700 or call Health Services at (413) 787-4000, extension 5027 or (800) 842-4464, extension 5027.
- **Pregnancy**: following the first prenatal visit, the ACOG Antepartum Record Form or Obstetrical Pre-Registration Form should be mailed to Health Services at One Monarch Place, Suite 1500, Springfield, MA 01144 or faxed to (413) 233-2700. (See "OBGYN Services Requiring Prior Authorization from HNE" below for more details.)

Procedures or Services Subject to Concurrent Review:

- Inpatient admissions
- After hour and weekend inpatient admissions
- Ongoing services beyond the initial authorization period such as skilled home care services, infusion therapy or outpatient speech therapy
- Discharge Planning

Services Subject to Retrospective Review

- Emergency Services

OB/GYN Services Requiring Prior Authorization from HNE:

- Pregnancy – Following the first prenatal visit, the American College of Obstetricians and Gynecologists (ACOG) Antepartum Record Form or Obstetrical Pre-Registration Form should be mailed to Health Services or faxed to (413) 233-2700. The ACOG or Obstetrical Pre-Registration form should be completed again and resubmitted if a risk factor is identified at a subsequent pre-natal visit. Send the original forms to Health Services and keep a copy for the member's file. This form will serve as authorization for claims payment, including the projected inpatient admission based on the estimated date of confinement (EDC). The Obstetrical Pre-Registration form can be found on the HNE website at http://healthnewengland.org/forms under the Provider tab in the Clinical Request Forms section or by calling Health Services at (800) 842-4464, extension 5027, or (413) 787-4000, extension 5027.
- All Infertility Treatment: AI, IUI, IVF, GIFT, ZIFT and FET requires Prior Authorization. Prior Authorization forms for infertility treatment can found on the HNE website at http://healthnewengland.org/forms under the Provider tab in the Clinical Request Forms section or by calling Health Services at (800) 842-4464, extension 5027, or (413) 787-4000, extension 5027.

  Infertility services are mandated benefits in Massachusetts for Massachusetts residents only and in Connecticut. This means that Fully Funded plans must cover these services according to state law and where medically indicated. Self-Funded plans may choose not to cover them. Infertility services require prior approval. For detailed information, please refer to the Infertility Protocol Policy at http://healthnewengland.org/Providers/Resources

Instructions for Completing the Standardized Prior Authorization Request Form

When submitting the Standardized Prior Authorization Request Form to HNE Health Services, providers should be very specific. Fill out the form as completely as possible and attach copies of additional pertinent clinical information (e.g., a statement of medical necessity, office notes, lab results, x-ray report and other consultation reports) so that Health Services can make an informed determination within standardized decision-making timeframes. If the required information is not submitted with the initial request, Health Services may need to request additional information, delaying the review process. Once all necessary information is received, Health Services will make a coverage determination. Health Services will then send a written confirmation of the decision to all appropriate parties (e.g., the requesting physician, the provider rendering the service, the member and the member's PCP). If the determination is a Medical Necessity denial, the referring provider will also receive a phone call.

The Standardized Prior Authorization Request Form should be received at HNE at least seven days prior to the scheduled service date. The requesting provider is responsible for submitting the Standardized Prior Authorization Request Form to HNE.

Choose the Service Type Category:

Provider Information:

- Requesting Provider Name, Phone Number and Fax
- Servicing Provider Name, Phone Number and Fax
- Servicing Facility Name (if indicated)
- Name of Contact Person, Phone Number and Fax

Member Information:

- Name of Member
- Date of Birth
- HNE ID Number
- Diagnosis
- Procedure Description and Code
- Units/Days/Visits Requested
- Service Start and End Date

Instructions for Submitting the Standardized Prior Authorization Request Form

To request prior authorization, the requesting physician's office must submit a Standardized Prior Authorization Form to Health Services. Standardized Prior Authorization Forms are located on the HNE website. In addition to this general prior authorization form, there are additional forms pertaining to specific services such as Behavioral Health, Infertility Treatment and Enteral Nutrition. For assistance, please contact the HNE Provider Relations Department at (800) 842-4464 extension 5000, or Health Services at (413) 787-4000 extension 5027, or (800) 842-4464 extension 5027.

You can access the format http://healthnewengland.org/forms.

Prior Authorization requests for Medical Services should be sent to:

Health New England
Attention: Health Services
One Monarch Place, Suite 1500
Springfield, MA 01144
Fax: (413) 233-2700

Chiropractic Benefit

The HNE chiropractic benefit is managed by OptumHealth, an experienced health and wellness company specializing in chiropractic management. When the member receives chiropractic services, prior approval is not required, but the chiropractor must notify OptumHealth when treatment has been initiated or continuing care is expected. OptumHealth works with the chiropractor to determine the appropriate level of covered services to treat the member's condition. OptumHealth will notify both the member and the chiropractor of coverage decisions.

Please note: X-rays are not covered in chiropractic office. OptumHealth providers are directed to refer members to their PCPs or other treating physicians for coordination of these services.

To find a participating chiropractor, call OptumHealth Care Solutions directly or use the OptumHealth Care Solutions online Provider Locator. OptumHealth contact information is as follows:

Mailing Address:
OptumHealth Care Solutions
P.O. Box 5600
Kingston, NY 12402

Web Address:
https://www.myoptumhealthphysicalhealth.com/providerlocator.asp

Health New England

Where you matter.

Radiology, Sleep Studies, Genetic Testing

Effective Date 1/1/2021 | Revised Date 1/1/2021

eviCore healthcare performs utilization management services for outpatient imaging services, sleep studies and genetic lab testing. Advanced Diagnostic Imaging services require prior authorization when performed in an outpatient setting. This policy **does not apply to** emergency room, observation or inpatient imaging procedures. **Failure to obtain prior authorization for the listed procedures may result in denial of payment**. This policy is applicable **to all HNE products**.

Procedures That Require Prior Authorization

- CT Scan
- MRI/MRA
- PET Scan
- Nuclear Cardiology
- Sleep Studies
- Genetic Lab Testing

Prior Authorization Process

- The **ordering physician** is responsible for obtaining the prior authorization from eviCore healthcare for the service requested. Patient symptoms, past clinical history and prior treatment information must be available at the time of the request. eviCore healthcare can accept requests online via a secure web application at https://www.evicore.com/ or by phone (see below). The web application is available 24 hours per day, seven days per week.
- **Call center hours of operation are Monday through Friday, 8 a.m. to 9 p.m. EST**. Providers can obtain prior authorization by calling (888) 693-3211. (Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact eviCore healthcare within 48 hours of the next business day to obtain proper authorization for the studies, which will still be subject to medical necessity review.)
- The **facility providing radiological services** is responsible for ensuring that authorization has been obtained prior to rendering service. Facility providers can confirm authorizations at eviCore healthcare's website, https://www.evicore.com/. Providing services without prior authorization may result in denial of payment.

Important Notes:

- If the ordering provider is not satisfied with eviCore healthcare's decision, the provider may request a reconsideration by contacting eviCore healthcare at (888) 693-3211. If the provider is still not satisfied with the outcome after a reconsideration, the provider may, with the member's consent, initiate a member appeal on behalf of the member by contacting HNE's Member Services Department at (800) 310-2835 or (800) 842-4464, extension 5025. Appeals are managed through HNE.
- The provider may submit a provider appeal for post-service denials once a claim has been denied. See Provider Appeal Guidelines for information on how to file a provider appeal.

Accreditation Requirements for Advanced Diagnostic Imaging Facilities

Suppliers of the technical component of advanced diagnostic imaging services must be accredited.

For all lines of business, HNE follows the Centers for Medicare and Medicaid Services (CMS) accreditation requirements for suppliers that provide the technical component of advanced diagnostic imaging. CMS defines advanced diagnostic imaging procedures as including magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). This requirement only applies to the suppliers that furnish the technical component (TC) of advanced diagnostic imaging services, not to the physicians interpreting them. Providers subject to this requirement include physicians, non-physician practitioners, and Independent Testing Facilities. Hospitals are excluded from this requirement.

Health New England

Where you matter.

Pharmacy Services

Effective Date 1/1/2021 | Revised Date 1/1/2021

Pharmacy Services

HNE's pharmacy utilization and therapeutic intervention programs help ensure that members have access to quality care through clinically sound and cost-effective medication utilization. Our clinical pharmacists oversee the pharmacy and therapeutics program and work with HNE's Pharmacy Benefit Manager.

Pharmacy and therapeutics management consists of a formulary, generic medication substitution, targeted benefit restrictions, medication utilization review, prior authorizations, and a pharmacy network. Below are overviews of each program component.

Prescription Benefit

Most HNE members are covered for prescription medications obtained at in-plan pharmacies. HNE ID cards indicate if a member has prescription drug coverage and detail copay structure (for example, RX$10/20/35). The retail prescription drug benefit is typically limited to up to a 30-day supply.

HNE Pharmacy Network

Members can fill prescriptions at any pharmacy that participates in our national network, such as, but not limited to, CVS, Walgreens, and Walmart. HNE's Pharmacy Benefit Manager maintains the network by negotiating contracts and engaging in ongoing analysis to monitor quality of care and service.

Over the Counter Medications

HNE covers a number of over the counter (OTC) products, such as allergy medications. HNE covers these products as a cost saving measure to our members. These products are typically covered at a Tier 1 copay.

Compounded Medications

Coverage for compounded medications varies based on ingredients and frequently requires prior authorization. Approved compounds are covered with a Tier 3 copay. For questions regarding coverage, please call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Maintenance Medications

HNE's Access 90 program allows members to receive up to a 90-day supply of maintenance medications at participating retail pharmacies. A copay will apply to each 30-day supply. The Access 90 program does not apply to prescriptions filled at HNE's specialty vendor or if prohibited by law. For a listing of participating pharmacies, visit http://healthnewengland.org/Pharmacy/Access-90 or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Members may obtain up to a 90-day supply of maintenance medications through HNE's mail order vendor. Copays will vary based on member's copay structure. For information regarding HNE's in-plan mail order pharmacy, please visit https://healthnewengland.org/pharmacy/mail-order-pharmacy or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Specialty Medications

HNE's in-plan specialty pharmacy covers certain specialty medications for complex conditions such as cancer, multiple sclerosis, and rheumatoid arthritis. These medications, which may be taken orally, by injection, or through infusion, are generally not available through a retail pharmacy or home delivery because they require special storage and handling. More information can be found at http://healthnewengland.org/pharmacy/specialty-pharmacy or by calling HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Magellan Management Program

MagellanRx assists HNE in managing injectable and infusion medications. This program applies to HNE's Commercial, Medicare Advantage, and Medicaid members. To determine if a medication is part of this program, visit http://healthnewengland.org/pharmacy/find-medication or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

This program consists of pre-service prior authorizations and post-service claim edits. For the pre-service prior authorization program, visit the MagellanRx secure website at http://ih.magellanrx.com/ and click on the "Providers and Physician" icon to access your provider account page or call MagellanRx directly at (800) 424-8325 (Monday – Friday, 9a.m. to 6 p.m. Eastern) for urgent requests.

The post service claim edit portion of the program reviews claims after they are billed for appropriate units and diagnosis codes. Certain medications in this program may also require pre-service prior authorization.

Clinical Trials

Clinical trials are not a part of this program. The provider should contact HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711 for clinical trial information.

Retrospective Requests

HNE recognizes that, in some cases, therapy may be initiated prior to the provider submitting a request for a prior authorization. To streamline the authorization and claims process, HNE and MagellanRx have created a retro-authorization process. To request an up to 60-day retro - authorization, please contact MagellanRx directly at (800) 424-8325 (Monday – Friday, 9a.m. to 6 p.m. Eastern). For retrospective requests beyond 60 days after the authorization approval date, providers must contact HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

HNE Formulary

The Pharmacy Benefit Manager supports HNE's Pharmacy and Therapeutics Committee (P&T) in evaluating and recommending therapeutically effective and safe medications. HNE's P&T Committee meets at least four times per year to evaluate changes to the formulary. New medications are reviewed and evaluated by HNE's Pharmacy Department in collaboration with our Pharmacy Benefit Manager. HNE gathers appropriate clinical literature, contacts specialists as needed, and obtains unbiased information from peer review journals, government agencies, clinical associations, and recognized commissions. Additional factors including, but not limited to, whether the medication has been approved by the Food and Drug Administration (FDA) and whether the medication represents breakthrough therapy, are also considered. All medication classes are reviewed annually.

As part of the formulary evaluation process, HNE also considers safety, efficacy and cost. All formulary recommendations are discussed at the HNE Clinical Care Advisory Committee (CCAC), which acts as our P&T Committee. This provides a forum for additional local practicing physician involvement.

The formulary is reviewed annually and as necessary throughout the year. Providers can receive a formulary listing upon request. Medications added or deleted from the formulary during the year are communicated through periodic mailings to providers and members, and are posted on http://healthnewengland.org/pharmacy/find-medication.

Generic Medications

Generic substitution is mandated in Massachusetts and HNE supports and encourages the use of generic equivalent pharmaceuticals. Approved generic equivalent medications contain the same active ingredients as brand name medications, are equally as safe and effective, and typically cost less.

In order to obtain coverage for a non-covered brand name drug, a prior authorization request providing medical necessity rationale must be submitted to HNE by the provider for medical exception.

HNE encourages providers to go to the FDA website and complete a MedWatch Adverse Event Reporting Form if the member had a serious adverse event.

If allowed for medical exception, the non-covered drug will be approved at the highest copay level and terms allowed under the terms of the member's plan. In addition, after review and at the reviewer's discretion, quantity limitations may be applied to the approved brand medication.

Newly Approved Medications

HNE does not cover new-to-market medications for at least six months after they are approved by the FDA. This is called the Clinical Review Period. Depending on the member's plan, he or she may be subject to 50% cost-share for the drug if approved during the Clinical Review Period. If a medical exception was made for coverage of the drug during the Clinical Review Period and a determination was later made by CCAC to exclude the drug from coverage, the drug may no longer be covered for the member.

For information regarding new-to-market medications, refer to the HNE formulary at http://healthnewengland.org/pharmacy/find-medication or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Excluded Medications

For information regarding excluded medications, refer to the HNE formulary at http://healthnewengland.org/pharmacy/find-medication or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Medications Requiring Prior Approval

HNE utilizes a number of pharmacy programs to promote the safe and appropriate use of prescription medications. Medications that belong to a program have clinical guidelines that must be met before we cover them.

Covered medications must be medically necessary. If a provider believes it is medically necessary for a member to use a medication that is

- not covered
- being used for an off-label indication, or
- being used for new indications that have not yet been reviewed by HNE,

the provider should request a prior authorization from HNE.

For information regarding medications requiring prior authorization, refer to the HNE formulary at http://healthnewengland.org/pharmacy/find-medication or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Medications with Quantity Limits

HNE's Quantity Limit Program is an approach to medication management designed to encourage appropriate medication use, ensure patient safety, and avoid misuse, waste and abuse. The quantity limits are based on FDA approved recommendations, generally accepted pharmaceutical guidelines, and efficient dosing regimens.

For information regarding medications with quantity limits or quantity-based copays, refer to the HNE formulary at http://healthnewengland.org/pharmacy/find-medication or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Step Therapy Program

Step Therapy is an approach to medication management and is part of HNE's prior authorization program. HNE requires that a member try certain medications to treat his or her medical condition (known as first line drugs) before covering another medication for that condition. If it is medically necessary for a member to use a Step Therapy drug before trying a first line drug, providers should request a prior authorization from HNE.

For information regarding medications with step therapy requirements, refer to the HNE formulary at http://healthnewengland.org/pharmacy/find-medication or call HNE Member Services at (413) 787-4004 or (800) 310-2835, TTY 711.

Health New England
Where you matter.

Durable Medical Equipment (DME)

Effective Date 1/1/2021 | Revised Date 1/1/2021

Northwood, Inc. (Northwood), HNE's Durable Medical Equipment Partner

Northwood will manage a full range of services in order to administer our DMEPOS benefit, including:

- Prior Authorization
- Claims Processing and Adjudication
- Member and Provider Services
- Data Reporting
- Provider Contracting, Credentialing and Management
- Provider Inquiries, Grievances and Appeals

Examples of equipment and supplies that Northwood will manage include wheelchairs, oxygen and other kinds of respiratory equipment, nebulizers, prosthetics, orthotics, wigs, speech devices and other medical supplies (diabetic, ostomy, urological, incontinence and wound care). Some equipment and supplies will still be managed by HNE.

Please note that it is the health care provider's responsibility to prescribe, get authorization and make any other necessary arrangements with Northwood or HNE for medically necessary equipment and supplies.

For more about Northwood, visit https://www.northwoodinc.com/

For a list of codes managed by Northwood, click here.

Information pertaining to coverage and reimbursement guidelines should be referenced at https://www.northwoodinc.com

The information in the AELK Master List applies only to HNE's contracted network, specifically those whose contracts reference the AELK Master List or the DME Reference Log, which has been replaced by the Master List. Questions or clarification regarding coverage by non-DME vendors should be directed to Provider Relations at (800) 842-4464, extension 5000, or (413) 233-3313.

Provider Types Managed by Northwood
(Phone: 1-877-807-3701; Fax: 1-877-552-6551

- Durable Medical Equipment providers
- Emergency response providers
- Wig providers
- Breast prosthesis providers
- Medical Supply providers
- Pharmacy providers (who distribute/dispense DMEPOS)
- Orthotics/Prosthetic providers
- Oxygen/respiratory equipment providers
- Speech generating device providers
- Ocular prosthetic providers
- Mobility providers
- Home Infusion Providers*
- Home Care Providers* (Home Health)
- Specialty pharmacy providers*
- Sleep DME providers

***Exception:** When Home Infusion, Home Care and Specialty RX providers are billing for medical supplies and equipment related to infusion/parenteral/tube-fed nutrition, Health New England manages/pays for those supplies and/or equipment.

Provider Types Managed by HNE
(Phone: 1-800-842-4464, extension 5027; Fax: 1-413-233-2700)

- Acute, sub-acute/intermediate-care and rehabilitation hospitals/facilities
- Hearing Aid providers
- Physician and mid-level clinicians and corresponding locations
- Allied health practitioners (including podiatrists, physical therapists, occupational therapists, speech therapists and optometrists)
- Outpatient facilities (including outpatient hospitals, ambulatory surgery centers, labs, emergency rooms and urgent care centers
- Cardiac monitoring providers
- Behavioral health providers
- Ambulance providers

NOTE: These providers may dispense and bill DMEPOS items to HNE which manages those supplies/services from these provider types.

Health New England
Where you matter.

Allowable Labs

Effective Date 1/1/2021 | Revised Date 7/1/2022

Allowable Labs

CPT #	Procedure Description
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease (COVID-19) includes titer(s) when performed
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA) 22 targets including severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2) qualitative RT-PC nasopharyngeal, swab, each pathogen reported as detected or not detected
36400	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture-femoral or jugular vein
36405	Venipuncture, under age 3 years-scalp vein
36406	Venipuncture, under age 3 years-other vein
36410	Venipuncture, age 3 or older, necessitating physician's skill, for diagnostic or therapeutic purposes
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
36540	Collection of blood specimen from a completely implantable venous access device
36550	Declotting by thrombolytic agent of I implanted vascular access device or catheter
36600	Arterial puncture, withdrawal of blood for diagnosis
38220	Bone marrow-aspiration only
80047	Basic metabolic panel (calcium, ionized)
80048	Basic metabolic panel (calcium, total)
80050	General health panel

80051	Electrolyte panel
80053	Comprehensive metabolic panel
80061	Lipid panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitative-multiple drug classes chromatographic method, each procedure, each
80101	Drug screen, qualitative-single drug class method (e.g., immunoassay, enzyme assay), each drug class
80104	Drug screen, qualitative-multiple drug classes other than chromatographic method, each procedure
80162	Digoxin
80185	Phenytoin-total
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, capable of being read by direct optical observation only (e.g. Utilizing immunoassay) (e.g. Dipsticks, cups, cards, or cartridges), including sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, read by instrument assisted direct optical observation (e.g. Utilizing immunoassay) (e.g., dipsticks, cups, cards,, or cartridges) includes sample validation when performed, per date of service
80307	Drug test(s) presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g. Utilizing immunoassay (e.g. EIA, ELISA, EMIT, FPIA, IA, KMS) chromatography (e.g. GC, HPLC), and mass spectrometry either with or without chromatography (e.g. Dart, desi, GC-MS, GC-MS/MS, LC-MS, LC-MSMS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
81000	Urinalysis, non-auto w/scope
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non automated, without microscopy
81003	Urinalysis, automated without microscopy

81005	Urinalysis-qualitative or semiquantitative, except immunoassays
81007	Urinalysis-bacteria screen
81015	Urinalysis-microscopic only
81025	Urine pregnancy test, by visual color comparison methods
82040	Albumin-serum, plasma or whole blood
82044	Albumin-urine, microalbumin, semiquantitative (e.g., reagent strip assay)
82150	Amylase
82247	Bilirubin, total
82248	Bilirubin, direct
82270	Blood, occult, by peroxidase activity (e.g. guaiac), qualitative-feces, consecutive collected specimens with single determination for colorectal neoplasm screening
82272	Blood, occult, by peroxidase activity (e.g. guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82274	Blood , occult, by fecal hemoglobin determination my immunoassay, qualitative, feces, 1-3 simultaneous determinations
82310	Calcium-total
82374	Carbon dioxide (bicarbonate)
82378	Carcinoembryonic antigen (CEA)
82435	Chloride-blood
82465	Cholesterol, serum or whole blood, total
82550	Creatine kinase (CK, (CPK)-total

82553	Creatine kinase (CK), (CPK) – MB fraction only
82565	Creatinine-blood
82607	Cyanocobalamin (vitamin B-12)
82670	Assay of estradiol
82728	Ferritin
82746	Folic acid-serum
82800	Gases , blood, PH only
82803	Gases, blood, any combination of PH, PCO2, PO2, CO2, HCO3 (including calculated 02 saturation)
82805	Gases, blood, any combination of PH, PCO2, PO2, CO2, HCO3 (including calculated 02 saturation) with 02 saturation, by direct measurement, except pulse oximetry
82810	Gases, blood, 02 saturation only, by direct measurement, except pulse oximetry
82947	Glucose-quantitative, blood (except reagent strip)
82948	Glucose-blood, reagent strip
82950	Glucose-post glucose dose (includes glucose)
82951	Glucose-tolerance test (GIT), 3 specimens (includes glucose)
82952	Glucose-tolerance test, each additional beyond three specimens (list separately in addition to code for primary procedure)
82962	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use
82977	Glutamyltransferase, Gamma (GGT)
83001	Gonadotropin-follicle stimulating hormone (FSH)

83002	Gonadotropin-luteinizing hormone (LH)
83013	Helicobacter pylori-breath test analysis for urease activity, non-radioactive isotope (e.g. C-13)
83014	Helicobacter pylor-drug administration
83036	Hemoglobin-glycosylated (A1C)
83037	Hemoglobin-glycosylated (A1C) by device cleared by FDA for home use
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen-qualitative or semiquantitative, single step method (e.g. reagent strip)
83519	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen-quantitative, by radioimmunoassay (e.g. RIA)
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen-quantitative, not otherwise specified
83540	Iron
83550	Iron binding capacity
83615	Lactate dehydrogenase (LD), (LDH)
83690	Lipase
83718	Lipoprotein, direct measurement-high density cholesterol (HDL cholesterol)
83721	Lipoprotein, direct measurement-direct measurement, LDL cholesterol
83735	Magnesium
83874	Myoglobin
83880	Natriuretic peptide
83912	Molecular diagnostics-interpretation and report

84075	Phosphatase, alkaline
84100	Phosphorus inorganic (phosphate)
84132	Potassium-serum, plasma or whole blood
84144	Progesterone
84146	Prolactin
84152	Prostate Specific Antigen (PSA)-complexed (direct measurement)
84153	Prostate Specific Antigen (PSA)-total
84154	Prostate Specific Antigen (PSA) - Free
84155	Protein, total, except by refractometry-serum, plasma or whole blood
84165	Protein-electrophoretic fractionation and quantitation, serum
84203	Protoporphyrin, RBC-screen
84295	Sodium-serum, plasma or whole blood
84436	Thyroxine-total
84439	Thyroxine-free
84443	Thyroid stimulating hormone (TSH)
84450	Transferase (AST) (SGOT)
84460	Alanine Amino (ALT) (SPGT)
84478	Triglycerides

84479	Thyroid hormone (T3or T4) uptake or thyroid hormone binding ratio (THBR)
84484	Troponin, quantitative
84520	Urea nitrogen-quantitative
84525	Urea nitrogen – semiquantitative (e.g., reagent strip test)
84550	Uric acid-blood
84702	Gonadotropin, chorionic (HCG) quantitative
84703	Gonadotropin, chorionic (HCG) qualitative
84704	Gonadotropin, chorionic (HCG) free beta chain
85002	Bleeding time
85004	Blood count-automated differential
85007	Blood count-blood smear, microscope examination with manual differential wbc count
85009	Blood count-manual differential wbc count, buffy coat
85013	Blood count-spun microhematocrit
85014	Blood count-hematocrit (HCT)
85018	Blood count-hematocrit (HGB)
85021	Blood count-hemogram, automated (RBC, WBC, HGB, HCT and indices only)
85023	Blood count-hemogram and platelet count, automated, and manual differential WBC count (CBC)
85024	Blood count-hemogram and platelet count, automated and automated partial differential WBC count (CBC)

85025	Blood count-complete (CBC), automated (HGB, HCT, RBC, WBC, and platelet count) and automated differential WBC count
85027	Blood count-complete (CBC), automated (HGB, HCT, RBC, WBC and platelet count)
85044	Blood count-reticulocyte, manual
85045	Blood count-reticulocyte automated
85060	Blood smear, peripheral, interpretation by physician with written report
85097	Bone marrow, smear interpretation
85379	Fibrin degradation products, D-dimer; quantitative
85585	Platelet-estimation on smear, only
85595	Platelet-automated count
85610	Prothrombin time
85651	Sedimentation rate, erythrocyte-non automated
85652	Sedimentation rate, erythrocyte-automated
85730	Thromboplastin time, partial (PTT)-plasma or whole blood
86140	C-reactive protein
86308	Heterophile antibodies-screening
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86318	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (e.g., reagent strip)
86320	Immunoelectrophoresis-serum

86328	Immunoassay for infectious agent antibody (IES), qualitative or semi quantitative, single step method (e.g.. reagent strip), severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease (COVID-19)
86403	Particle agglutination-screen, each antibody
86430	Rheumatoid factor-qualitative
86480	Tuberculosis test, cell mediated immunity antigen response measurement-gamma interferon
86481	Tuberculosis test, cell mediated immunity antigen response measurement-enumeration of gamma interferon-producing T-cells in cell suspension
86485	Skin test-candida
86580	Skin test-tuberculosis, intradermal
86585	Skin test-tuberculosis, tine test
86586	Skin test-unlisted antigen, each
86592	Syphilis test, non-treponemal antibody-qualitative (e.g., VDRL, RPR, ART)
86677	Antibody-helicobacter pylori
86769	Antibody; severe acute respiratory syndrome Coronavirus 2 (SAES-CoV-2) Coronavirus disease (COVID-19)
87070	Culture, bacterial-any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87071	Culture, bacterial-quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
87077	Culture, bacterial-aerobic isolate, additional methods required for definitive identification, each isolate
87081	Culture, bacterial-aerobic isolate, additional methods required for definitive identification, each isolate
87086	Culture, bacterial-quantitative colony count, urine
87088	Culture, bacterial-with isolation and presumptive identification of each isolate, urine

87210	Smear, primary source with interpretation-wet mount for infectious agents (e.g., saline, india ink KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87426	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay) ELISA, immunochemiluminometric assay, MCAI, qualitative or semiquantitative, multiple-step method, severe acute respiratory syndrome coronavirus (e.g., SARS, -CoV-2, COVID 19, (Coronavirus disease)
87430	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method-streptococcus, group A
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplexamplified probe technique, first 2 types or sub-types
87631	Infectious agent detection by nucleic acid (DNA or RNA)-respiratory virus (e.g. adenovirus, influenza virus, corona virus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplexreverse transcription and amplified probe technique, multiple types or subtypes, 3-5 targets
87634	Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique
87635	Infectious agent detection by nucleic acid (DNA or RNA), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) Coronavirus disease (COVID-19), amplified probe technique
87651	Infectious agent detection by nucleic acid (DNA or RNA)-streptococcus group A, amplified probe technique
87804	Infectious agent antigen detection by immunoassay with direct optical observation-influenza
87807	Infectious agent antigen detection by immunoassay with direct optical observation-respiratory syncytial virus
87880	Infectious agent detection by immunoassay with direct optical observation-streptococcus, Group A
87905	Infectious agent enzymatic activity other than virus (e.g., sialidase activity in vaginal fluid)
88738	Hemoglobin (HGB), quantitative, transcutaneous
89060	Crystal identification by light microscopy with or without polarizing lens analysis, tissue or body fluid (except urine)
89300	Semen analysis-presence and/or motility of sperm including Huhner Test (post coital)
89310	Semen analysis-motility and count (not including Huhner Test)
89320	Semen analysis-volume, count, motility and differential

89321	Semen analysis-sperm presence and motility of sperm, if performed
89322	Semen analysis-volume, count, motility, and differential, using strict morphologic criteria (e.g., Kruger)
89331	Sperm evaluation for retrograde ejaculation, urine (sperm concentration, motility and morphology as indicated
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
G2023	Specimen collection for severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease (COVID-19), any specimen source
G2024	Specimen collection for severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2) Coronavirus disease (COVID-19) from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source
G0431	Drug screen, qualitative; multiple drug classes by high complexity test method (e.g. immunoassay, enzyme assay), per patient encounter
G0434	Drug screen, other than chromatographic-any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
G0477	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
G0478	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
G0479	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC MASS spectrometry), includes sample validation when performed, per date of service
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers to identify individual drugs and distinguish between structural isomers (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods
G0481	Drug test(s) definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers) including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods
G0482	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers to identify individual drugs and distinguish between structural isomers (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods
G0483	Drug test(s), definitive, utilizing (1) drug identification methods able identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods

U0001	CDC 2019 Novel Coronavirus (2019-NCOV) real-time RT-PCR diagnostic panel
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID 19) using any technique, multiple types or subtypes (includes all targets)
U0003	Infectious agent detection by nucleic acid (DNA or RNA), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease COVID 29), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) any technique, multiple types or subtypes (includes all targets) non-CDC, making use of high throughput technologies as described by CMS-2020-01-R

Health New England
Where you matter.

HNE Clinical Guidelines and Standards

Effective Date 1/1/2021 | Revised Date 1/1/2021

The HNE Clinical Care Assessment Committee (CCAC) and/or the Behavioral Health Assessment Committees (BHAC) are responsible for developing, disseminating and coordinating activities intended to define good medical practice and develop improved quality. Activities include establishing and maintaining a criterion-based system including standards and guidelines in relation to patient care and developing pre-treatment and pre-admission medical protocols.

Physician participation plays an important role in the development of clinical guidelines and standards. Participating physicians serve on the CCAC/BHAC and HNE welcomes and invites the comments of other participating physicians. If providers have comments, questions, or concerns about a clinical guideline or standard, they should contact the Health Services Supervisor at (413) 787-4000, extension 3457, or (800) 842-4464, extension 3457.

Unless new scientific evidence or revised national standards warrants review and update sooner, clinical guidelines and criteria are reviewed annually. Preventive health recommendations are reviewed annually.

All clinical guidelines, standards and criteria used for rendering decisions regarding the appropriateness of medical services are available to participating providers upon request by calling Health Services at (413) 787-4000, extension 3457, or (800)842-4464, extension 3457. In addition, clinical guidelines are available on the HNE website at http://healthnewengland.org/Providers/Resources and the physician information portal (https://www.hnedirect.com/login).

Appointment and After-Hours Standards

ACCESS STANDARDS

On average, 85% of members are able to access (type of appointment) within (stated time).

PRIMARY CARE PRACTITIONER

Appointment Type	Appointment Standard		Exception
	Non-Medical Home	Medical Home	Product-Specific Standards
Routine/Regular (includes Preventive)	Within 1 month of request		Medicaid: Within 45 days of request*
Non-Urgent Symptomatic	Within 7 business days of request	Same day of request	Medicaid: Within 10 days of request
Urgent	Within 24 hrs of request		Medicaid: Within 48 hrs of request
Emergency	Immediate or refer to emergency room		
After-Hours Care	24-hrs-a-day/7-days-a-week on-call system (answering service/ pager) for after-hours emergencies. PCP or covering MD returns call within 60 minutes		

- ***-Children in the Care or Custody of the Department of Child and Family Services (DCF):** A healthcare screening within seven calendar days after you or the DCF worker asks for it.
- A full medical exam within 30 calendar days after you or the DCF worker asks for it (unless a shorter time is required by Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services schedule.

HIGH-VOLUME SPECIALTY PRACTITIONERS

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards
Routine/Regular	Within thirty business days of request	
Non-Urgent Symptomatic	Within thirty business days of request	Medicaid: Within 30 days of request
Urgent	Same day of request	Medicaid: Within 48 hrs of request
Emergency	Immediate or refer to emergency room	
After-Hours Care	24-hrs-a-day/7-days-a-week on-call system (answering service/ pager) for after-hours emergencies. PCP or covering MD returns call within 60 minutes	

HIGH-IMPACT SPECIALTY PRACTITIONERS

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards
Routine/Regular	Within thirty business days of request	
Non-Urgent Symptomatic	Within thirty business days of request	Medicaid: Within 30 days of request
Urgent	Same day of request	Medicaid: Within 48 hrs of request
Emergency	Immediate or refer to emergency room	
After-Hours Care	24-hrs-a-day/7-days-a-week on-call system (answering service/ pager) for after-hours emergencies. PCP or covering MD returns call within 60 minutes	

BEHAVIORAL HEALTH PROVIDERS

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards
Routine/Regular	Within 10 business days of request	
Life Threatening Emergency Services	Requires immediate face-to-face medical care. The member or representative should call 911. Care should be provided within 6 hours. Member referred to the nearest hospital-based psychiatric emergency service crisis team for immediate treatment. Member with an established relationship, may call provider directly for urgent care. The urgent care request must be provided within 48 hours.	•Immediately…..
Urgent	Requires immediate face-to-face medical care. The member or representative should call 911. Care should be provided within 6 hours. Member referred to the nearest hospital-based psychiatric emergency service crisis team for immediate treatment. Member with an established	•Medicaid: Within 48 hrs of request

	relationship, may call provider directly for urgent care. The urgent care request must be provided within 48 hours.	
Non-life Threatening	Requires immediate face-to-face medical care. The member or representative should call 911. Care should be provided within 6 hours. Member referred to the nearest hospital-based psychiatric emergency service crisis team for immediate treatment. Member with an established relationship, may call provider directly for urgent care. The urgent care request must be provided within 48 hours.	• Medicaid: Within 10 business days of your request
Follow-up After Hospitalization for Mental Illness	After discharge from a hospital stay, members are scheduled for the first follow-up visit within 7 days of discharge, and a second follow-up visit within 30 days of discharge.	
Follow-up Routine Care	Within 30 days from the routine care visit	
After-Hours Care	24-hrs-a-day/7 days-a-week on-call system must be in place for member emergencies after hours	

	Exception Product Specific Standard
Non 24-Hour Diversionary Services Discharges	• Medicaid: within 2 calendar days • Medicaid: Medication management within 14 calendar days • Medicaid: Other outpatient services within 7 calendar days Medicaid: Intensive Care Coordination (ICC) services within 24 hours of Referral, including self-Referral offering a face-to-face interview with the family

Medical Record Standards and Reviews

The following medical record standards have been adopted by the CCAC and BHAC:

Criteria	**Benchmark**
1. Each page in the record contains the patient's name or ID number.	95%
2. Personal biographical data include the address, employer, home and work telephone numbers, and marital status.	95%
3. All entries in the medical record contain author identification. Author identification may be hand written, stamped, or electronic.	95%
4. All entries are dated.	95%
5. The record is legible by someone other than the writer. A second surveyor examines any record judged to be illegible by one physician surveyor.	95%
6. Significant illnesses and medical conditions are indicated on the problem list,	95%
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.	100%
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses,	95%
9. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history.)	95%

10. The history and physical exam records appropriate subjective and objective information pertinent to the patient's presenting complaints.	95%
11. Laboratory and other studies are ordered as appropriate.	100%
12. Working diagnoses are consistent with findings.	100%
13. Treatment plans are consistent with diagnoses.	100%
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return in noted in weeks, months, or as needed,	95%
15. Unresolved problems from previous office visits are addressed in subsequent visits,	100%
16. Review for under- and over-utilization of consultants,	95%
17. If a consultation is requested, is there a note from the consultant in the record?	95%
18. Consultation, lab, and imaging reports filed in the chart are initialed by primary care practitioner to signify review. If the reports are presented electronically, or by some other method, there is also representation of practitioner review,	100%
19. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.	100%
20. There is no evidence that the patient is placed at inappropriate risk by diagnostic or therapeutic procedure.	100%
21. An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults.	95%
22. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.	100%
23. Advance Directive documented in a prominent area in the medical record.	92%
24. Medication list is present in the medical record.	95%

Medical records are assessed against the 24 standards listed above. A provider will be deemed fully compliant when the compliance score is equal to or greater than 90 percent for the medical records reviewed.

If after the review, a Provider does not meet compliance requirements, the office is presented with a report outlining any deficiencies and a corrective action plan for improvement. A follow-up appointment is scheduled to review medical records again within six months.

Office Site Standards

The office practice environment is assessed in the following categories:

- Physical accessibility
- Physical appearance
- Medical record keeping practices
- Safety measures
- Appointment availability
- Adequacy of waiting and exam rooms and patient privacy

Physical Accessibility and Appearance

- Clean, well lit
- Poses no safety hazards
- Building and office should have accommodations for the disabled.
- Building ramp or elevator should be present if office is not on the first floor.
- If no accommodations for the disabled, then office must have arrangements in place to accommodate disabled patients.

Adequacy of Waiting Room and Examining Room Space

- Waiting / reception areas neat and clean. These areas appear to be cleaned regularly and are free of excessive clutter.
- There should be an adequate number of examination rooms to accommodate patient volume. Standard: Two (2) examination / treatment rooms per MD in office per day.
- Adequate number of seats to accommodate patient volume. Standard: Three (3) chairs per physician.

Safety Measures:

- Fire exits are clearly labeled, and free of any obstacles.
- Emergency evacuation response plan is posted or staff can describe the plan.
- Office has evidence of personal protective equipment, tuberculocidal surface disinfectant.

Medical Record Standards and Reviews

Medical record reviews may be conducted during practice site evaluations or initiated as a result of quality concerns, and during HEDIS medical record reviews.

When appropriate, the auditing of medical record keeping practices of participating providers will be assessed against the following categories:

- Confidentiality of medical records
- Medical record documentation standards
- Organization of medical records
- Availability of medical records
- Quality of medical record keeping

Confidentiality of all medical record information will be protected in accordance with state and federal regulations and HNE's guidelines.

Medical record documentation will include:

- History and Physicals
- Allergies and Adverse Reactions
- Problem list
- Medication list
- Documentation of clinical findings and evaluation for each visit
- Preventative services / risk screening
- Documentation of Advance Directives in a prominent part of the medical record
- Documentation in regards to whether or not a member has executed an advance directive

Medical records must be organized and stored in a manner for easy retrieval and in a secure environment which allows access by authorized personnel only.

A summary report, indicating compliance with HNE standards, identified deficiencies, and a suggested action plan will be communicated to the provider.

Providing Care in a Culturally Competent Manner

Here are some useful references for developing cultural competence and links to training materials for your consideration. The training materials include ideas and assistance about how to provide care in a culturally competent manner. Providers can access educational materials through the following websites:

Physician Toolkit and Curriculum:
http://minorityhealth.hhs.gov/assets/pdf/checked/toolkit.pdf

Physicians's Practical Guide:
https://cccm.thinkculturalhealth.hhs.gov

Provider's Guide to Quality and Culture:
http://erc.msh.org/mainpaige.cfm?file=1.0htm&module=provider&language=English

HRSA Cultural Competence Resources for Health Care Providers:
http://www.hrsa.gov/CulturalCompetence/research.html

Health New England

Where you matter.

Quality Improvement Program

Effective Date 1/1/2021 | Revised Date 1/1/2021

The HNE Quality Improvement Program is a coordinated, comprehensive and ongoing effort to assess the access to and effectiveness of all care and service provided. All efforts focus on achieving optimum outcomes with continuous incremental improvements over time. The HNE Board of Directors has designated the Quality Management Committee (QMC) as the body charged with development and direct oversight of the Quality Improvement Program.

HNE annually reviews the scope and effectiveness of its Quality Improvement Program. Based on results of the evaluation of each year's Quality Improvement Program, the HNE Quality Improvement team develops the current year's program. The evaluation includes a description of completed and ongoing activities that address quality and safety of clinical care and quality of service, trending of measures to assess performance; analysis of results of initiatives, including barrier analysis; and the evaluation of the overall effectiveness of the Quality Improvement Program. If you would like a copy of either last year's evaluation or the current Quality Improvement Program, contact the HNE' Manager of Healthcare Quality Improvement at (413) 233-3360.

The program addresses the quality of operations and programs in the following broad areas:

- Prevention and Wellness
- Care Management
- Patient Safety
- Transitions of Care / Care Coordination
- Utilization Management
- Pharmacy Management
- Access to Care
- Member and Provider Experience and Satisfaction

Indicators and thresholds that help demonstrate patterns of care, safety, and member services are systematically tracked and trended in order to identify opportunities to improve individual and group practice performance.

Participation in the Quality Improvement Program

As specified in provider contracts, all practitioners, hospitals and other health care providers are expected to fully participate in quality program activities, such as:

- HEDIS®1 clinical data collection and reporting efforts
- Electronic Medical Record access or support of medical records to support quality reporting
- Credentialing/recredentialing site visits and record review
- Quality of care concerns or complaints

Participation may also include providing evidence related to encouraging preventive health care and demonstrating evidence of adherence to standards and measures. Providers may be asked to review and provide feedback for proposed or ongoing clinical activities.

The Quality Improvement Program provides information and education in several ways, including the following:

- Availability of Quality Improvement Program description upon request
- Provider Manual
- HNE Talk
- Special mailings
- Committees with practitioner participation
- Provider and practitioner meetings
- Audit and survey results.
- Note: All information collected for quality-monitoring purposes is maintained as strictly confidential.

Health New England
Where you matter.

NCQA Accreditation

Effective Date 1/1/2021 | Revised Date 1/1/2021

NCQA Accreditation

HNE's commercial HMO and POS products are currently "Accredited" by the National Committee for Quality Assurance (NCQA). NCQA was founded in 1979 by the Group Health Association of America and the American Managed Care and Review Association. It is an independent, nonprofit organization, located in Washington D.C., and is made up of health care quality experts, employers, labor union officials, and consumer representatives. NCQA began accrediting managed care organizations (MCOs) in 1991 in response to the need for standardized, objective information about the quality of these organizations. (Note of Interest: On January 17, 1991, HNE became the first MCO in the country to undergo an NCQA accreditation survey.) NCQA's accreditation program is voluntary and has been embraced by purchasers, consumers and health plans as an objective measure of the quality of these organizations.

Accreditation is a rigorous and comprehensive evaluation process through which NCQA assesses the quality of the key systems and processes that make up a health plan. NCQA's primary focus is to assess the organization's quality improvement structures and processes utilizing more than 50 standards in five categories:

- Quality Management and Improvement
- Population Health Management
- Network Management
- Credentialing and Recredentialing
- Utilization Management
-
- Member Experience

Accreditation also includes an assessment of the care and service that plans are delivering in important areas measured through HEDIS, such as immunization rates, mammography rates and member satisfaction.

Health New England
Where you matter.

HEDIS

Effective Date 1/1/2021 | Revised Date 1/1/2021

HEDIS

Health Plan Employer Data and Information Set (HEDIS) is the most widely used set of performance measures in the managed care industry. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), a nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems. HEDIS was originally designed for private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators, and consumers.

Quality improvement activities, health management systems and provider profiling efforts have all used HEDIS as a core measurement set. HEDIS also is used as an element of NCQA accreditation, and is considered the consumer report card for managed care organizations.

HNE collects HEDIS data from three major sources. The first source is administrative data gathered from claims, encounter and enrollment systems. The second source is the medical record. HNE generally requests copies of medical records for HEDIS reviews during March, April, and May. The third source is survey information. For some measures, administrative and medical record data are commonly combined in a standardized manner known as the hybrid method. Data derived purely from administrative sources reflect rates that consider every eligible member and occurrence. All other data are based on samples of members and services. These samples must be drawn in a systematic fashion that has been specified by NCQA. NCQA publishes summary data in its annual *State of Management Care Quality* report and at its website: www.ncqa.org.

See current HEDIS measures.

Health New England
Where you matter.

HNE Products and Benefits

Effective Date 1/1/2021 | Revised Date 1/1/2021

HNE is a Health Maintenance Organization licensed in Massachusetts. HNE's Commercial service area covers members who live or work in the four counties of Western Massachusetts (Berkshire, Franklin, Hampden and Hampshire) and Worcester County in Central Massachusetts. In these counties, we provide health care benefits to Fully Funded groups, which are employer groups who pay a premium to an insurance company or managed care organization for their employee health coverage. .

We also provide administrative services to health benefit plans sponsored and funded by employers themselves. These "Self-Funded" plans have members in Western Massachusetts and in parts of Litchfield, Tolland and Hartford counties in Connecticut and in southern Vermont. The benefits available under the terms of a Self-Funded plan can vary significantly from those available under a Fully Funded plan because the Self-Funded plans are designed by each plan sponsor/employer. You can identify a Self-Funded member by the group number, which can be found on the HNE ID card. Self-Funded group numbers always start with an "S."

HNE also offers health benefit plans to individuals and Small Employer Groups (fewer than 50 employees) through the Massachusetts Health Connector at https://www.mahealthconnector.org/. All HNE plans offered through the Connector are an extension of our Commercial line of business and should be treated as such. Some eligible Connector members may receive subsidies on premium payments. ID cards for this product will have "Massachusetts Health Connector" on the front of the card. Detailed benefit designs can be found on the Connector website.

It is important to know that our Fully Funded plans cover Massachusetts and Federal Health Care Reform mandated benefits. However, Self-Funded plans can choose whether to cover these mandated benefits. Also, HNE's Fully Funded plans include many standard benefits, such as free preventive care and free allergy shots, that are not always standard among our Self-Funded groups. HNE has a separate phone number dedicated to Self-Funded groups. If you have any Self-Funded eligibility or benefit questions that cannot be answered through our Private Portal at HNEDirect, please call (413) 233-3060 or (800) 791-7944.

HNE offers several types of products described below. Detailed product benefit designs are available through HNEDirect, HNE Member Services or the Summary of Benefits found on our website at http://healthnewengland.org/plans.

HMO Plans (Fully Funded and Self-Funded)

HNE currently offers many types of HMO plans. Our HMO plans offer comprehensive health care coverage within our contracted network. Services are provided through our extensive network of doctors and health care professionals in Western and Central Massachusetts, as well as parts of Connecticut and Vermont. HNE has several types of HMOs in which member cost sharing may include copays, deductibles and coinsurance. HNE also offers High Deductible Health Plans (HDHPs), which may be paired with a Health Savings Account (HSA).

HMO plans require that each member select a primary care provider (PCP). PCPs will either provide medically necessary care or refer the member to an HNE specialty provider. Any referral to a non-participating provider requires prior authorization by HNE Health Services. The PCP can be either a physician, physician assistant or a nurse practitioner. HNE members may see participating specialists without being referred; however, we strongly encourage communication between the member's PCP and specialist whenever possible. Specialists can also refer members to other HNE specialists.

A comparison of HNE's most popular HMO Benefit Plans can be viewed through our website at http://healthnewengland.org/plans.

PPO Plans (Fully Funded and Self-Funded)

HNE currently offers three categories of PPO plans. The following are the general plan descriptions.

- **HNE PPO National:**
  The majority of our PPO members are under this type of plan. Under this plan, members can obtain medically necessary treatment from HNE participating providers, PHCS Multiplan participating providers and non-participating providers. Members' copays are the same when using HNE and PHCS Multiplan participating providers. Services from non-participating providers are subject to coinsurance and deductibles. If the non-

participating provider's charges are greater than HNE's maximum allowable fee, the provider may bill the member for the balance. Authorization is required for some services, whether provided in or out of network. For a list of procedures or services requiring prior authorization, see [link to PA section]. The member is not required to select a PCP.

- **HNE PPO Local:**
  Members enrolled in PPO plans may be seen by participating providers as well as non-participating providers. When receiving care, members will be subject to coinsurance and deductibles, which are higher when care is received outside the network. If the non-participating provider's charges are greater than HNE's maximum allowable fee, the provider may bill the member for the balance. Authorization is required for some services, whether provided in or out of network. For a list of procedures or services requiring prior authorization, see [link to PA section]. The member is not required to choose a PCP.

- **HNE PPO Premier:**
  Under this plan, members can obtain medically necessary treatment from HNE participating providers, PHCS Multiplan participating providers and non-participating providers. The member's co-pay is higher when using PHCS Multiplan providers than when using HNE providers. Service from non-participating providers is subject to coinsurance and deductibles. If the non-participating provider's charges are greater than HNE's maximum allowable fee, the provider may bill the member for the balance. Authorization is required for some services, whether provided in or out of network.. The member is not required to select a PCP.

A comparison of HNE's most popular PPO Benefit Plans can be viewed through our website at http://healthnewengland.org/plans.

HNE Advantage Plus (Point of Service) Plan (Fully Funded)

The benefits and guidelines for the HNE Advantage Plus plan are similar to HMO plans. The member is required to select a PCP. However, in a point of service (POS) plan, members may elect to receive care from non-participating providers and hospitals. PCPs will either provide medically necessary care or assist in coordinating care with specialists. Medically necessary services received from participating providers do not require a referral. Authorization is required for some services, whether provided in or out of network.

Medically necessary services received from non-participating providers are subject to an annual deductible and coinsurance. If the non-participating provider's charges are greater than HNE's maximum allowable fee, the member may be billed for the balance.

HNE Select Preferred Plan (Self-Funded)

The Select Preferred plan is also POS plan, which allows the member to receive care from non-participating providers. This plan requires each member to select a PCP.

The services received from non-participating providers must be medically necessary and are subject to an annual deductible and coinsurance. If the non-participating provider's charges are greater than HNE's maximum allowable fee the member may be billed for the balance. The deductible and coinsurance applies to all services the member receives from non-participating providers, including lab tests. For example, if a provider sent a specimen to a non-participating lab facility, the HNE Select Preferred plan would pay the claim for the lab test subject to the member's annual deductible and coinsurance.

All non-emergency inpatient stays must be approved in advance by HNE Health Services. The member is responsible for submitting the paperwork required to obtain prior approval when being admitted by a non-participating provider.

Massachusetts Health Connector Plans

HNE also offers health benefit plans to individuals and Small Employer Groups (fewer than 50 employees) through the Massachusetts Health Connector (https://www.mahealthconnector.org/). All HNE plans offered through the Connector are an extension of our Commercial line of business and should be treated as such. Some eligible Connector members may receive subsidies on premium payments. ID cards for this product will have "Massachusetts Health Connector" on the front of the card. Detailed benefit designs can be found on the Connector website or https://healthnewengland.org/connector.

Group Insurance Commission (GIC)

HNE offers self-funded benefit plans through the Group Insurance Commission to Active Employees/Employees without Medicare and Medicare Enrolled Retirees. Active employees must use the HNE Provider Network. Medicare Enrolled Retirees are covered by a Group Medicare Supplement Plus plan which supplements Medicare and uses Medicare Providers.

ID cards for this product will have "Group Insurance Commission" on the front of the card. Detailed benefit designs can be found on the GIC website or https://healthnewengland.org/GIC

The Active Employee GIC plan has different levels (or tiers) of copays for office visits with specialist physicians. Copay amounts are based on the tier assignment of the doctor. Tier assignments are included in the provider listings in the HNE Provider Directory.

Tier 1: Specialists other than those who are at Academic Medical Centers (AMC)

Tier 2: Specialists at Academic Medical Centers (AMC)

(An AMC has two components: a teaching or university-based hospital and a medical school)

Health New England
Where you matter.

Claims Submission and Reimbursement

Effective Date 1/1/2021 | Revised Date 11/1/2023

CLAIMS SUBMISSION

Claims Procedure

HNE accepts the electronic delivery of claim information two ways: through HNEDirect (provider portal) or electronic data interchange (EDI). All EDI claims must be submitted in accordance with HIPAA 5010 Standards. Submitting through HNEDirect requires registration. Paper claims must be submitted on either CMS1500 (professional) or CMS1450 (UB04-institutional). All PCPs, specialists and ancillary providers must submit itemized claims to the HNE Claims Department. Claims must be submitted to HNE within the guidelines of the Timely Filing Payment Policy. - or within the time period specified by contract. Unless otherwise noted in the "Claim Past Filing Time Limit Denial policy as an exception, if HNE does not receive a claim within the specified time period, it will be denied for exceeding the claims filing limit. Providers may not bill members for services that were denied payment for untimely submission.

We also accept Medicare crossover claims electronically, if HNE is a secondary payer.

Resubmission of Claims (CMS 1500 professional and CMS 1450 UB04 institutional)

A resubmission of a previously processed claim (changes or corrections to charges, procedure codes, dates of services, member information, etc.), is considered a replacement. When submitting a replacement claim, include all service lines along with the corrections. The original claim is then retracted and the information on the replacement submission takes the place of the prior processed claim (retracted claim).

Resubmission of claims must fall within our filing limits as documented within the Timely Filing Payment Policy or within the time period specified by contract. For example, if a claim is denied for incorrect code, etc., and the provider resubmits the claim with the correct information, HNE must receive the corrected claim within the filing limit of the original date of service. Providers also should be aware that the filing limit applies when utilizing the services of a billing agent.

To indicate a resubmission/replacement or retracted/void claim, use Claim Frequency Type 7 (replacement of prior claim) or 8 (void/cancel prior claim).

Type	Professional Claims	Institutional Claims
EDI	To indicate the claim is a resubmission/ replacement claim: • In Element CLMO5-3 "Claim Frequency Type Code" • Use Claim Frequency Type: 7 or 8 To confirm the claim that is being replaced: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer claim number in REF02.	To indicate the claim is a resubmission/replacement claim: • In Element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type: 7 or 8 To confirm the claim that is being replaced: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer claim number in REF02.

Paper	To indicate the claim is a resubmission/replacement claim: • In Item Number 22: Use Claim Frequency Type 7 or 8 under "Resubmission Code" and under Original Reference Number" use (original payer claim number)	To indicate the claim is a resubmission/replacement/ void claim: • In Form Locator 04: "Type of Bill" / Use Claim Frequency Type: 7 or 8 (third character of Bill Type) • FL 64 (original payer claim number)

If COB is involved and HNE is secondary, a copy of the EOB from the primary insurer should be attached to the claim.

Important Information Regarding All Claims

All claims must include this information:

- Patient name (as it appears on the member's HNE ID card)
- HNE member ID number (including applicable letter prefix and two-digit number suffix as it appears on the member's HNE ID card)
- Most current ICD-CM codes, using appropriate three, four or five digit codes (If there is more than one diagnosis, it is important to include all appropriate ICD-CM codes.)
- Date(s) of service
- Standard place of service code
- Description of service(s), using, as appropriate, the most current CPT procedure code(s), UB-92 revenue code(s), HCPCS code(s), or unique codes previously agreed upon by HNE
- Provider name, payment address, HNE provider number (if possible), provider signature, and provider federal tax identification number and provider NPI number
- Information regarding other insurance coverage
- Name of the referring or ordering physician
- Units
- Amount billed for each procedure
- Total of all amounts billed
- Reports (if applicable to describe unusual services or services for which a coding methodology does not exist)

Imaging Paper Claims

HNE uses an imaging and capture process for paper claims. To ensure accurate and timely claims imaging, please follow the rules below:

- Type all fields completely.
- Submit all claims on an original red and white form.
- Complete all claims in black or blue ink only.
- Include the word 'continue' when submitting a multi-page paper claim with the total amount on the last page. (Do not 'subtotal' the first page.)
- Do not use highlighter on any claim form field.
- Do not submit photocopied claim forms.
- Do not submit claim forms via fax.
- Do not submit unnecessary attachments.

HNE will accept claim submission in the following formats:

Electronically:

- HIPAA compliant professional (CMS1500)
- HIPAA compliant institutional (UB-04)

Paper claim:

- CMS 1500 for professional
- UB-04 for facility or technical

EDI Claims Submission

For more detailed information, please go to: http://healthnewengland.org/provider

Place of Service Codes

Code	Narrative	Code	Narrative
02, 10	Telehealth	41	Ambulance - Land
11	Office	51	Inpatient Psych Facility
12	Home	52	Psychiatric Facility/Partial Hospitalization
21	Inpatient Hospital	53	Community Mental Health Center
22	Outpatient Hospital	54	Intermediate Care Facility/Mentally Retarded

23	Emergency Room - Hospital	61	Comprehensive Inpatient Rehab Facility (CIRF)
24	Ambulatory Surgical Center	65	End Stage Renal Disease Treatment Facility
25	Birthing Center	71	Public Health Clinic
31	Skilled Nursing Facility	81	Independent Lab
32	Nursing Facility	99	Other
34	Hospice		

The above table is a partial listing of the code set referenced under HIPAA. The most recent version of this code set can be found online https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Non-participating providers can use any valid place of service code. Contractual agreements with participating providers may include/exclude codes from this code set.

Clean Claim Requirements

The following fields are required for UB-04 & CMS-1500 claim forms.

CMS-1500 (Physician Claims)

Patient Name		Service Date(s): To and From
Patient HNE ID Number		Place of Service (CMS Codes)
Patient's DOB and Gender		Procedure Code (CPT-4; HCPCS - Current, valid codes)
Patient's Address		Diagnosis Codes (ICD-up to fifth digit if applicable)
Other Insurance / Workers' Compensation / MVA		Units
Insured's Policy Group or Number		Amount Billed for Each Procedure
Insured's Name and Address		Attending Physician
Provider's Name and HNE's Provider ID Number		Patient Account Number (optional)
Provider's Address		Total of All Amounts Billed
Practice Tax ID Number (EIN)		Provider's Telephone Number
Provider's NPI Number		Modifier Codes (CPT-4, HCPCS - Current, valid codes)

UB-04 (Facility Claims)

Patient Name		Service Date(s): To and From for Entire Statement
Patient HNE ID Number		Service Date(s) for Each Service Outpatient Only
Patient's DOB and Gender		Revenue Codes (Current, valid codes)
Patient's Address		Procedure Code (CPT-4; HCPCS - Current valid codes) Outpatient Only
Other Insurance / Workers' Compensation / MVA		Units: Anesthesia Claims require Minutes
Insured's Policy Group or Number		Amount Billed for Each Service
Insured's Name and Address		Total of All Billed Amounts
Date		Principal Diagnosis Code (ICD-up to fifth digit if applicable) (Current, valid codes)
Provider's Name and HNE's Provider ID Number		Secondary/Other Diagnosis Code(s) (ICD-up to fifth digit if applicable) (Current, valid codes)
Provider's Address		Attending Physician
Provider's Telephone Number		ICD Procedure Code(s)—Principal and All Other Applicable Codes
Practice Tax ID Number (EIN)		Admission Date (optional for outpatient; required for inpatient)
Type of Bill		Admission Hour (optional for outpatient; required for inpatient)
Claim Statement Dates		Discharge Hour
Provider's NPI Number		Discharge Status
POA Indicators		

Include ALL services to be considered for payment when submitting a corrected claim. This includes services that may have already been paid on the original claim submission.

REIMBURSEMENT

Scope of Services

The scope of services for which a provider will be reimbursed is limited by the type of provider agreement and the terms of that agreement. Reimbursement may be restricted to services within the provider specialty, to services provided at a specific location, and to services provided pursuant to a particular HNE product.

The scope of covered services provided by physicians and allied health providers is limited to the provision of professional services, unless otherwise specified in the provider agreement. Thus, providers will only be paid for the professional component of their services, unless the provider agreement expressly authorizes payment for technical or other services. Physicians and allied health providers may request an expansion for the provision of additional covered services by sending a letter of interest to the attention of the Provider Relations Manager. HNE will review such requests using the following criteria: 1) the needs of membership for such services in the provider's geographic area, 2) the site of service, and 3) the availability of similar services in that area. Decisions on requests for an expansion of scope of services will be made at HNE's sole discretion and is subject to change with not less than 60 days prior notification to the provider.

Reimbursement

Health New England reimburses providers under the terms of its provider agreement or the terms of agreements a provider may have with the supplemental network indicated on the members ID card, such as United Health Care and Multiplan/PHCS.

For non-contracted, out of network providers, HNE may reimburse providers for Covered Services and pursuant to the member's plan benefit: the established and applicable Qualified Payment Amount (QPA), Usual and Customary Rates, or State/Federal publically available reimbursement amounts without a single case agreement, other written agreement, or prior authorization.

For non-contracted, out of network providers, certain HNE Plans require prior authorization for out of network Covered Services and will require a single case agreement in advance of rendering services.

In no event, unless otherwise contracted, will HNE reimburse providers for Covered Services in excess of billed charges.

Charges for non-Covered Services are not reimbursable by HNE and are the sole responsibility of the member.

Global Period

The "global period" is the number of days during which all necessary services normally furnished by a physician (before, during and after the surgical procedure) are included in the reimbursement for the procedure performed.

Copays should not be collected from HNE members for any services that are not separately reimbursable. Please note that a claim must still be submitted for every encounter regardless of whether it is reimbursable or not.

In situations where an office visit during the post-operative period is due to complications, exacerbations, recurrence, or presence of other diseases or injuries, Modifier 24 should be appended to the service code for the office visit and a copay, if applicable, may be collected.

HNE follows CMS guidelines for the global period.

Assistant Surgeon Claims

HNE follows CMS guidelines for assistant surgeon services. HNE does not reimburse assistant surgeon services for procedures that do not allow for assistant surgeon services. The member cannot be held financially responsible for these services.

Code 99000

HNE no longer reimburses for this code. HNE will follow CMS rules regarding B Bundled Code status. Unless otherwise specified, CPT code 99000 is considered a B Bundled code and is not a reimbursable service, regardless of whether it is billed alone or in conjunction with other services on the same date.

Health New England
Where you matter.

Coordination of Benefits and Subrogation

Effective Date 1/1/2021 | Revised Date 11/1/2023

Coordination of Benefits (COB) occurs when HNE arranges for payment from an alternative insurance, which may either be "primary" or "secondary" for the claim. When a member is covered under two different plans, HNE coordinates benefits under each plan according to rules issued by the Massachusetts Division of Insurance. For example, an HNE member may also be covered as a dependent on his/her spouse's health insurance plan. In addition, an HNE member's auto insurance may provide personal injury protection (PIP) or medical payment benefits that cover medical expenses incurred as a result of injuries sustained in an automobile accident.

The information in this section ***describes the rules in effect at the time this document was issued and may not describe current amendments.*** There are other COB rules between a group health plan and Medicare described further in this chapter.

Workers' Compensation Insurance provides coverage for medical care received as a result of a work-related injury or condition. There is no primary or secondary insurer for workers' compensation claims; Workers' Compensation Insurance pays if the claim results from a work-related condition. HNE processes claims for services covered by the member's benefit plan when claims are denied by the workers' compensation insurer.

"Subrogation" occurs when HNE assumes a member's right to recover from a third party who caused the member's injury or illness. In this case, HNE processes our member's claims and files legal documents to collect funds from the third party's insurer.

Proceed to each section in this chapter to find additional information about HNE's COB and subrogation processes.

Coordination of Benefits Guidelines for Members with Other Health Insurance Coverage

When a provider determines that an HNE member has other insurance coverage, a determination must be made as to which is primary and which is secondary. If HNE is the primary insurer, the provider must bill HNE first. If HNE is the secondary insurer, the provider must bill the primary insurer and should not submit a claim to HNE until after the claim has been processed by the primary insurer. The claim must be submitted to HNE's Claims Department with an explanation of payment or denial within 90 days.

If HNE receives a claim from a provider for services that HNE determines is the primary responsibility of another insurer, HNE will deny payment on the claim and notify the provider of the reason for denial.

HNE guidelines with regard to prior approvals must be followed even when another insurer is primary. As a secondary insurer, HNE will process provider claims in accordance with the provider's contract. If providers have questions about how COB will affect their claims, providers may call HNE's COB staff at (800) 842-4464.

Coordination of Benefits Guidelines

COB rules determine which health plan is primary (pays first) and which health plan is secondary (pays second). Under HNE COB rules, the plan that covers the person as an employee (subscriber) is primary. HNE subscribers (member number ending with *01) have HNE as the primary insurer and any coverage carried by a spouse[1] is secondary. If the spouse of an HNE member has coverage through his or her employer, that insurance is the primary insurer for him or her and HNE is secondary.

The health plan that covers a person as an employee (subscriber), or as a spouse of that employee, is primary if another plan covers that employee as a laid-off or retired employee.

If a person is a subscriber under two plans, the plan that has covered the person longest is the primary insurer.

If two or more plans cover an HNE dependent child whose parents are not divorced, the "birthday rule" is used to determine order of payment. The plan of the parent whose birthday falls earlier in the year is primary. The word "birthday" refers only to

[1] The same rule applies in the case of an ex-spouse or domestic partner. HNE guidelines *(prior approvals, etc.)* should be followed by HNE members involved in an auto accident. HNE will pay for services covered by the member's benefit plan after PIP coverage has been exhausted or if the auto insurance claim is denied.

the month and day in a calendar year, not the actual year that the parents were born. If both parents have the same birthday, the plan that has covered the parent longest is primary.

If two or more plans cover an HNE dependent child whose parents are divorced, the order of payment is as follows:

1. The plan of the parent responsible for the health care expenses of the dependent child by court decree, if any.
2. The plan of the parent with custody of the dependent child.
3. The plan of the spouse of the parent with custody of the dependent child.
4. The plan of the parent who does not have custody of the dependent child.

Please note that regardless of whether the member has HNE as the primary insurance or the secondary insurance, the rules of your contract with HNE still apply. Members cannot be billed for anything other than their deductible, coinsurance or copay.

Coordination of Benefits Guidelines for Original Medicare Recipients When HNE is Secondary

COB for individuals enrolled in Medicare depends on federal rules determining when Medicare is the primary payer and when Medicare is secondary to commercial health insurance coverage. If Medicare is the primary payer, submit the member's claim to Medicare first, and then bill HNE as secondary payer, with Medicare's explanation of benefit information. The claim must be submitted to Health New England's Claims Department with an explanation of payment or denial within 90 days. If providers have a question about whether Medicare or HNE is the primary payer for an HNE member, providers should call HNE's COB staff at (800) 842-4464.

Effective January 1, 2010, the Patient Protection and Affordable Care Act (PPACA) amended the provision relative to the time period for filing Medicare fee-for-service claims. Effective January 1, 2010, claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. The following rules apply to claims with dates of service prior to January 1, 2010, and after January 1, 2010.

- Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules.
- Claims with dates of service from October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.
- Claims with dates of service on and later than January 1, 2010, must be submitted no later than one calendar year from the date of the service.

Coordination of Benefits Guidelines in Automobile Accident Cases, or Where a Third Party is Liable

If an HNE member is involved in an auto accident, the auto insurer is the primary insurer. In most circumstances there is coverage available under personal injury protection (PIP) benefits through the auto insurer. The auto insurer pays medical bills under this PIP coverage. When the PIP coverage has been exhausted, the provider should submit any outstanding medical claims with a copy of the third party EOP to the HNE COB Department with third party insurance information within 90 days. You should provide any information pertaining to the accident, such as: the date of the accident, the auto insurance carrier, the claim number and the claim adjuster's information.

When medical payments coverage is available (~~such as~~ from automobile or homeowners insurance policies), providers should call HNE's COB/Subrogation staff so that HNE can coordinate coverage with the insurer. If the provider has a question, he or she should contact HNE's COB staff at (800) 842-4464.

Please note that regardless of whether the member has HNE as the primary insurance or the secondary insurance, the rules of your contract with HNE still apply. Members cannot be billed for anything other than their deductible, coinsurance or copay.

Coordination of Benefits Guidelines for Workers' Compensation Injuries

The term "workers' compensation" refers to compensation for an injury incurred by a person while performing his or her job. HNE does not cover any services that are the legal liability of Workers' Compensation Insurance.

HNE guidelines should always be followed by a member even if the case is potentially covered by Workers' Compensation Insurance. In the event the workers' compensation claim is denied, HNE will process claims for services covered by the member's benefit plan. When billing HNE for services that the workers' compensation denied, the provider should submit medical claims to the HNE COB Department with the worker' compensation denial within 90 days. You should provide any information pertaining to the case, such as: the workers' compensation carrier, the claim number and the claim adjuster's information.

If providers have questions about a workers' compensation claim, they should call the COB staff at (800) 842-4464.

Please note that regardless of whether the member has HNE as the primary insurance or the secondary insurance, the rules of your contract with HNE still apply. Members cannot be billed for anything other than their deductible, coinsurance or copay.

Subrogation

HNE may pay medical bills for which another person (or his or her insurer) is legally responsible. HNE then has the right to make a claim against the third party to recover payment for the benefits and services provided. In most cases, based on State laws or Employee Retirement Income Security Act (ERISA) laws, HNE has the right to put a legal hold or "lien" on any court judgment or settlement.

Funds collected from third party payers, like funds received from COB, are added to the HNE health service fund, which funds provider reimbursement and return of withhold.

If providers are aware that a third party is liable for the cost of an HNE member's services, they should notify HNE's COB/Subrogation staff at (800) 842-4464.

Health New England
Where you matter.

Provider Appeal Guidelines

Effective Date 1/1/2021 | Revised Date 11/1/2023

NOTE: These guidelines do not apply to the submission of an amended claim to a previously processed claim within 180 days from date of service. An amended claim submitted within the timeframes specified in the Timely Filing Payment Policy or your agreement is an 'On Time Corrected Claim' and not a Provider Appeal. Please note on the claim form that it is an On Time Corrected Claim and mail it to: Health New England, Attn: Claims Department, One Monarch Place, Suite 1500, Springfield, MA 01144. Faxed on Time Corrected Claims will not be accepted.

Providers have the right to file a Provider Appeal if they disagree with how HNE processed a claim.

- Provider Appeals arising from initial claim adjudication must be submitted to HNE within 6 months from the date of services or date of discharge for inpatient services or within the terms of your agreement.
- Appeals arising from payment adjustments due to audits of charges or payments performed by HNE must be submitted to HNE within sixty days from the date of such adjustment.
- Appeals arising from payment adjustments due to an audit by an HNE vendor must be submitted directly to that vendor. See "Vendor Partnership Appeals" below.

HNE will not review any appeals submitted after the time limits set forth herein. Providers may not assert a claim against HNE, in arbitration or otherwise, for any recovery based on HNE's adjudication of a claim or HNE's adjustment of payment of a claim after audit unless the Provider has appealed such adjudication or payment adjustment within the time limits set forth herein.

Appeal Process

- Submit Provider Appeals using the Request for Claim Review form, which is found on HNE's website at this link.
- Mail the completed Request for Claim Review form, and all supporting documentation (see below), to Health New England, One Monarch Place, Suite 1500, Springfield, MA 01144, Attn: Provider Appeals, or fax to (413) 233-2797.
- Include the control number (the 12-digit number on the HNE EOP) on the Request for Claim Review form.
- Include in your submission the EOP and all supporting documentation, such as operative and office notes, authorizations, invoices, other pertinent information, rationale for appeal and desired resolution.

  PLEASE NOTE: If you are disputing a denial of a Prior Authorization Request and the service has not yet been rendered, your appeal will be treated as a Member Appeal and processed in accordance with HNE's Member Appeal Guidelines.

Second Level Appeal Process

If there is additional information to substantiate a second level appeal, a provider may submit a second level appeal if HNE upheld the original claim denial or reimbursement decision. HNE must receive a second level appeal within 90 business days of the date of the original appeal resolution letter. HNE will not review second level appeals received more than 90 days after the original appeal resolution letter.

Required Supporting Documentation

- A completed Request for Claim Review Form or a detailed letter
- Previous Appeal number (if available)
- Supporting documentation that specifically substantiates the reason for the second level appeal

If HNE reviews a second level appeal, it will make a determination within 45 days of receipt of the appeal.

Appeals after Submission to an Alternate Payer

HNE may grant an exception to the timely filing guidelines when an alternate payer has retracted payment of a claim. If an alternate payer retracts payment of a claim because it has determined that HNE is the primary payer, HNE will accept an appeal within six months from the alternate payer's retraction date.

The submission should include:

- The Explanation of Payment (EOP) from the alternate payer that is dated within six months of retraction date. The EOP should indicate payment amount and retraction date.
- Documentation that the provider checked member eligibility with the alternate payer on the date of service.

NOTE: HNE has the right to deny claims billed to the wrong insurance. It is the responsibility of the provider to check member eligibility. At its sole discretion, HNE may review such cases only if the submission includes the documentation listed above.

Vendor Partnership Appeals

Claims with the following EX codes must be appealed to the designated HNE vendor:

ZR: Pay: Paid in accordance to Zelis Adjustment. Contact Zelis directly at (866) 489-9444.

XZ: Priced by DataIsight. Questions? Call (866) 835-4022.

[Link to Payment Policies page]

- Anesthesia services
- Audit program
- Autism professional services
- Bilateral and multiple professional and facility services
- Claims editing
- Counseling and/or risk factor reduction intervention services
- COVID-19 vaccination
- Discarded drugs and biologicals
- Diabetic care
- Drug testing
- Emergency department services
- Evaluation and management
- Genetic testing
- Hospice services
- Immediate post-concussion assessment and cognitive testing (impact) testing
- Individual consideration services (applies to Medicaid only)
- Inpatient hospital services
- Laboratory professional services new effective 9/1/20
- Mammography services
- Mid-level practitioners
- Modifier new effective 9/1/20
- Newborn and neonatal care
- Non-covered, experimental & investigational services
- Non reimbursed revenue codes
- Neuropsychological and psychological testing
- Nutritional counseling
- Observation services
- Obstetrical care
- Preventive services
- Provider based billing
- Readmission to inpatient level of care
- Routine supplies and equipment
- Serious reportable events / provider preventable conditions
- Skilled home health care
- Skilled nursing facility
- Sleep studies
- Telehealth (telemedicine) services
- Timely Filing
- Transportation services
- Treatment room
- Unlisted procedures
- Urgent, extended care & walk-in care
- Vaccines and immunizations

Health New England
Where you matter.

HNEDirect Provider Online Services

Effective Date 1/1/2021 | Revised Date 1/1/2021

HNE Providers can now view up-to-date information online including claim status, member eligibility and member benefits. HNEDirect is an online system that allows providers to get immediate answers to managed care questions 24 hours a day, seven days a week. Once registered with HNEDirect, a provider can:

- Check eligibility
- Obtain the patient's HNE copay amount to ensure collection of the correct copay at the time of service
- Check the status of claims submissions
- Check the status of prior approval requests
- Submit claims electronically
- Access Provider reports
- Access explanation of payment

Providers who have questions about this service or are interested in registering for HNEDirect may contact Provider Relations at (800) 842-4464, extension 5000 or HNEDirect technical support at (413) 233-3313.