Health New England

Where you matter.

Provider Appeal Guidelines

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

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 180 days 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 12 months from the date of services or date of discharge for inpatient services.
- 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 Types

Provider Contractual Appeals, such as:

- Claim denied for no authorization
- Claim denied past filing limit
- Claim denied as billed incorrectly
- Claim denied as duplicate claim
- Claim reimbursement issue, e.g. CPT code(s), disagreement about payment methodology

Provider Adverse Determinations, such as:

- Claim denied for no authorization (when preauthorization is required)
- Claim denied for not being medically necessary
- Claim denied as experimental/investigational

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.