Health New England
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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.