Health New England
Where you matter.

Reimbursement and Claims Submission

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

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.

Claims Procedure

All EDI claims must be submitted in accordance with HIPAA 5010 Standards. 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 180 days of the date of service or within the time period specified by contract. 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.

The filing time limit also applies to the resubmission of claims. 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.

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

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.

Consult Codes

Per CMS guidelines, HNE no longer covers consult codes. If we receive a claim with a consult code, we will prompt the provider to submit the claim with an appropriate Evaluation and Management (E&M) code. The codes that will no longer be covered are:

- 99241 through 99245
- 99251 through 99255

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.

Modifier 25

HNE will reimburse a preventive visit with an E&M service when modifier 25 is appended to the E&M service. Reimbursement for the preventive visit will be made at 100% of the contracted rate and reimbursement for the E&M service will be made at 50% of the contracted rate.

According to CPT coding guidelines, when submitting a preventive claim with a modifier 25, the modifier should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service.

Additional information: HNE will conduct random audits of claims where surgical services are billed with modifier 25. Correct coding guidelines suggest that modifier 25 be attached to E&M services performed on the same day as the surgical procedure to indicate that separate reimbursement for E&M services is warranted.

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	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.