

TABLE OF CONTENTS

INTRODUCTION	3
WEBSITE:	5
MEMBER INFORMATION	6
Member Eligibility and Identification Cards	6
Member Rights and Responsibilities	6
Confidentiality of and Access to Medical Records	7
Members' Right to Appeal	8
Member Satisfaction Survey	8
ADMINISTRATIVE PROCEDURES	8
Provider Record Changes	8
Provider Address and Telephone Number Changes	8
Physician Participation in PHO's or Medical Groups	9
Physician Primary Hospital Affiliation Changes/Additional Hospital Affiliations	9
Provider Tax Identification Number Changes	9
Provider Coverage Arrangements	9
PCP Panel Status Changes.....	9
PCP – Removing a Member From the Panel.....	10
COORDINATION OF BENEFITS AND SUBROGATION	11
Coordination of Benefits Guidelines for Members with Other Health Insurance Coverage	11
Coordination of Benefits Guidelines	12
Coordination of Benefits Guidelines for Medicare Recipients when HNE is Secondary.....	12
Coordination of Benefits Guidelines in Automobile Accident Cases, or Where a Third Party is Liable.....	13
Coordination of Benefits Guidelines for Workers' Compensation Injuries.....	13
Subrogation	13
PRIOR APPROVAL PROCEDURES	14
Instructions for Requesting Prior Approval.....	14
Procedures and Services Requiring Utilization Management (UM) Review:	14
Key Contact Telephone and Fax Numbers for Prior Approval Requests	17
Instructions for Completing the HNE Prior Approval Request Form	17
Instructions for Submitting the Prior Approval Request Form.....	19
REIMBURSEMENT AND CLAIMS SUBMISSION	21
Scope of Services	21
Claims Procedure	21
Obstetrical Billing Guidelines	22
Anesthesia Billing Guidelines:.....	23
CPT Modifiers:.....	25
HNE's Policy on HCPCS codes being billed by Physicians and Facilities	26
Claims X-Ten	26
Important Information Regarding All Claims	26
Imaging Claims	27
HNEDirect Provider On-line Services.....	30
HEDIS and the Provider Information Portal (PIP) through HNEDirect.....	30
Explanation of Payment (EOP) and Negative Balances	31
HNE's Vaccine Policy.....	36
PROVIDER APPEAL GUIDELINES AND REVIEW SHEET	38
DURABLE MEDICAL EQUIPMENT (DME)	40
HNE PRODUCTS AND BENEFITS	44
HNE HMO (fully-funded) and Select Exclusive (self-funded)	45
HNE Advantage Plus (fully-funded)	45
HNE Select Preferred (self-funded)	45
PPO Plans	45
HNE Exclusive Provider Organization (EPO) Plan (self-funded).....	46
CPI Physician Review-GIC/CPI product.....	46

HEALTH NEW ENGLAND PROVIDER MANUAL

Emergency Services	47
Infertility Service.....	48
Obstetrical and Gynecological Services	48
Annual Vision Exam	49
Chiropractic Benefit	49
DME (Includes durable medical equipment, specialty medical equipment, medical and surgical supplies, orthotics and prosthetics, oxygen and respiratory supplies).....	49
Laboratory	49
HNE Physician Office Allowable Lab Tests	50
Miscellaneous Services including Pain Management, Biofeedback, Neuropsychological Testing, and Outpatient Electroconvulsive Therapy (ECT).....	55
Provider Collection Policy	55
PHARMACY SERVICES	57
UTILIZATION MANAGEMENT, CASE MANAGEMENT & DISEASE MANAGEMENT.....	61
The purpose of HNE’s Utilization Management (UM)	61
UM Review and Decision Process	61
Case Management	63
High Risk Member Case Management.....	64
Disease Management.....	64
Health Information Line (HIL).....	64
Behavioral Health (BH).....	64
Radiology Management Program	66
Clinical Transition Program	66
Appropriateness of Care Statement	67
Medical Technology Assessment Program	67
PCP Data	68
HIPAA Privacy Requirements and Patient Information Needed for Utilization Management, Case Management and Care Coordination.....	68
HNE CLINICAL GUIDELINES AND STANDARDS	69
Clinical Guidelines and Standards.....	69
Appointment and After-hours Standards	70
Medical Record Standards and Reviews	70
Credentialing/Recredentialing	71
Quality Management Program – <i>(additional detail is available upon request)</i>	72
Serious Reportable Events and Never Events	73
HEDIS	76
NCQA Accreditation	76
PROVIDER REVIEW AND CORRECTIVE ACTION	77
Introduction and Purpose.....	77
Provider Actions Warranting Further Review	77
Further Review and Corrective Action.....	79
Provider Appeals re: Disciplinary Matters	80
Important Note about Suspension and Termination	82
HNE CORPORATE COMPLIANCE PROGRAM (INCLUDING FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM)	83
Compliance Statement and Code of Conduct	83
Reporting Concerns	84
Confidentiality and non-retaliation for good faith reporting:	84
Prompt response and corrective action:	84
Enforcement of Standards through Well-Publicized Disciplinary Guidelines	84
Privacy and Security Program:	84
Fraud, Waste, and Abuse Prevention Program:	85

Introduction

The Health New England (HNE) Provider Manual contains information, guidelines, and procedures that should be followed 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. This edition of the Manual may also be found on the HNE secure website at HNEDirect@hne.com.

Some of the guidelines and procedures in this Manual are based on requirements of State and Federal law as well as 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 ext. 5000. Representatives are available Monday-Friday from 8:00 am to 4:00 pm.

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

HEALTH NEW ENGLAND PROVIDER MANUAL

Important HNE Telephone Numbers:

Provider Relations Local	(413) 233-3313
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 HNE Be Healthy	(800) 439-2370
HNE Be Healthy-Behavioral Health	(800) 495-0086
HNE for calls from Connecticut	(860) 623-1147

Below is a chart showing the extensions for important departments that may be reached whether 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 Co-Payments
Provider Claims Servicing Unit	5026	General Claim Inquiries

HEALTH NEW ENGLAND PROVIDER MANUAL

Fax Numbers:

HNE Departments	Fax Numbers
Provider Relations & Credentialing	(413) 233-2808
Behavioral Health Services	(413) 233-2800
Health Services	(413) 233-2700
Member Services	(413) 233-2655
Provider Claims Servicing Unit	(413) 731-7498
Provider Contracting	(413) 734-3356
Director of Quality Operations	(413) 233-2607

Address Information:

Health New England
One Monarch Place – Suite 1500
Springfield, MA 01144-1500

Website:

www.hne.com

Member Information

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 hne.com and clicking on [HNEDirect](#). Refer to the member's ID card to identify any member co-payment 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.

A sample ID card is provided below:



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, Plan Providers, policies, procedures, and their rights and responsibilities. HNE will not provide to Members, or to any third party, information that it is not allowed to disclose under the law. HNE will not disclose information about Plan Providers that would constitute information that is privileged.
- Be treated with respect and with recognition of their dignity and right to privacy.
- Participate with their doctor or other health care provider in decisions on their health care.
- Expect that their doctor or other health care provider will fully and candidly discuss treatment options for their condition that are appropriate or Medically Necessary, regardless of the cost or benefit coverage. It does not mean that all treatment options are covered by HNE. If they are unsure about whether a treatment is covered, they should contact HNE Member Services.
- Bring a grievance or complaint about HNE, or care that is provided by a Plan Provider, to the attention of HNE. The procedure for this is outlined in Section II.E.
- Make recommendations regarding HNE's members' rights and responsibilities policies.
- Refuse a treatment, drug, or other procedure that is recommended by their doctor or other health care provider to the extent permitted by law. They are to be informed of the potential medical consequences of refusing such treatment.
- Select a PCP who is accepting new patients. HNE PCPs are listed in the Provider Directory.
- Request to change their PCP. The newly-chosen PCP must not have notified HNE that he or she is no longer accepting new patients.
- Have access, during HNE's business hours, to HNE Member Services Representatives who can answer their questions and help them to resolve a problem.
- Expect that information from their medical records and on their relationship with their doctor and their hospital will be kept confidential. This is in accordance with State and Federal law and as provided by HNE policies and rules.

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 giving the provider information on their present and past medical conditions, as they understand them, before and during any course of treatment.
- Follow the plans and instructions for care that they have agreed on with their provider.
- Become familiar with their HNE benefits and services by reading the materials that HNE gives them. They should also call HNE Member Services with any questions on these.
- Abide by all HNE policies and procedures.
- Treat Plan Providers and HNE staff with the same respect and courtesy they would expect for themselves.
- Arrive on time for a scheduled appointment or to give adequate notice if they must cancel or will be late.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible. If they do not understand their illness or treatment, they should talk it over with their doctor. It is very important to the success of the treatment for them to understand their health problems.
- Participate in decision-making on their health care.
- To inform HNE of any other insurance coverage they may have. This is so HNE may appropriately administer claims payment and coordinate with other payers.
- Inform HNE of any changes in status that could affect their eligibility for coverage, such as a change of address.
- Assist HNE and Plan Providers to obtain prior medical records when asked to do so. They agree that HNE may obtain and use any of their medical records and other information that it requires to administer the Plan.
- Consider the potential consequences of not following the advice of their health care practitioner. When a service recommended by a Plan Doctor is covered, they may choose to decline it for reasons personal to them. For example, they may prefer to get care from Non-Plan Providers rather than Plan Providers. In these cases, HNE is not obligated to cover substitute or alternate care based on their preference.

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 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.
- 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).

HEALTH NEW ENGLAND PROVIDER MANUAL

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 employers. Self-funded employers, 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 employer as persons who may appropriately have access to the information. HNE will also insist that the self-funded employer 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 subscribers and/or providers upon request. Providers may request a copy by calling Provider Relations at (413) 233-3313 or (800) 842-4464, ext. 5000.

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.

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 and 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.

Administrative Procedures

Provider Record Changes

Please notify HNE of changes involving telephone numbers, addresses, hospital affiliations, tax identification numbers, coverage arrangements and panel status.

Mail:	Health New England Attn: Provider Enrollment One Monarch Place Springfield, MA 01144
Fax	(413) 233-2665
Website	Hnedirect.com

Provider Address and Telephone Number Changes

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

HEALTH NEW ENGLAND PROVIDER MANUAL

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 PHO's or Medical Groups

Physicians that establish or terminate membership(s) in a 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 a physician would like to add, change or delete his or her primary hospital affiliation with HNE, the request must be submitted no less than 60 days prior to such change. The notification should indicate the reason for the change and the effective date of the change.

Provider Tax Identification Number Changes

When a provider has a change in his or her 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
- The name to which checks should be made payable
- Billing address
- Billing phone number
- Effective date of change

Provider Coverage Arrangements

HNE requires all PCPs to make arrangements for care for members listed on their panels twenty-four 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

PCP's may change their panel status by notifying HNE in writing. PCPs may change the age restriction placed on their panels and may also change restrictions on accepting new patients. If a change places a greater restriction on the PCP's panel, the change will be effective thirty (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 an existing patient 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 (*) following his or her name to denote that the PCP is accepting existing patients only.
- CLOSED** No members may be added to this PCP's panel. 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 which 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 their panel must be approved by HNE.

In order to remove a member from his or her panel, the PCP must send a letter to the member, with a copy mailed to HNE, requesting that the member choose another PCP. The letter must explain why the PCP is removing the member from his or her panel. Once HNE receives the letter, HNE Member Services Department will contact the member to assist them with selecting a new PCP. From the time HNE contacts the member, the member will have 30 days to select a new PCP. If they do not choose a new PCP within 30 days, HNE will assign them a new PCP. 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.

Coordination of Benefits and Subrogation

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 HNE 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 which 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 is issued and may not describe current amendments*. There are other COB rules between a group health plan and Medicare described further in this chapter in Section C.

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 covers 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 pays 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 twelve months of the date of payment or denial by the other health insurer.

If HNE receives a claim from a provider for services which 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 pay providers 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 (413) 233-3256, (413)233-3407 or (800) 842-4464 and ask for extension 3256 or 3407.

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 which 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 spouse¹ is secondary. If the spouse of an HNE member has coverage through his or her employer, that insurance is the primary insurer for him/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 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.

Coordination of Benefits Guidelines for 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. 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 (413) 233 -3256, (413) 233-3407 or toll-free at (800) 842-4464 and ask for extension 3256 or 3407.

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 copayment.

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 1 calendar year from the date of the service.

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.

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 and medical payment coverage. When the PIP and medical payment 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 twelve months of the date of payment or denial from the primary carrier. You should provide any information pertaining to the accident, for example: 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, they should contact HNE's COB staff at (413) 233-3256, (413) 233-3407 or toll-free at (800) 842-4464 and ask for extension 3256 or 3407.

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 copayment.

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 pay 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's compensation denial within twelve months of the date of payment or denial from the primary carrier. You should provide any information pertaining to the case, for example: 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 (413) 233-3256, (413) 233-3407 or (800) 842-4464 and ask for extension 3256 or 3407.

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 copayment.

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 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 (413) 233-3256, 233-3407, 787-4000, or (800) 842-4464 and ask for extension 3256 or 3407.

Prior Approval Procedures

Instructions for Requesting Prior Approval

IMPORTANT INFORMATION:

These instructions include examples of services, procedures and treatment that require prior approval. 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 approval 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 approval, providers should contact Provider Relations at (413) 233-3313 or (800) 842-4464 ext. 5000. Providers may also 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.

Procedures and Services Requiring Utilization Management (UM) Review:

Inpatient Activities

1. Pre-Service Review (Pre-certification):
 - All admissions to an out-of-plan facility for HMO plans
 - All admissions to a skilled nursing facility or inpatient rehabilitation facility
 - Human organ transplants
2. Concurrent Review:
 - Inpatient admissions
3. Discharge Planning
4. Retrospective Review:
 - After-hour and weekend inpatient admissions

Outpatient Activities:

1. All requests for out-of-plan providers for HMO plans
2. Pre-Service Review of outpatient Diagnostic Radiology procedures (CT, MRI, MRA and PET Scans) is **performed by MedSolutions at (888) 693-3211**. Emergency Room, Observation and Inpatient imaging procedures do not require MedSolutions' prior approval.
3. Pre-Service Review for Chiropractic care is **performed by OptumHealth at (888) 676-7768**
4. Pre-Service Review of Surgical Procedures and Treatments/Services:
 - Abdominal Panniculectomy
 - Autologous Chondrocyte Transplant
 - Blepharoplasty
 - Bone Growth Stimulators
 - BRCA testing
 - Cochlear Implants
 - Continuous Glucose Monitoring Systems
 - Growth Hormone
 - High Frequency Chest Wall Compression
 - Home Care services
 - Hospice Services
 - Hospital and anesthesia services for certain dental procedures required by members with a serious medical condition
 - Infertility treatment, Assisted Reproductive Technology (ART) procedures (such as IVF, GIFT, ZIFT, ICSI, Donor Egg and FET services) and related ART medications (pre-service review not required for evaluation, artificial insemination/intra-uterine insemination (AI/IUI) services and related AI/IUI medications although residency requirements must be met for coverage of any infertility services and medications)
 - Insulin Pumps (supplies do not require prior approval if obtained from a participating provider)
 - Laser-Assisted Uvulopalatoplasty or Uvulopalatopharyngoplasty
 - Lower/Upper Limb Prosthesis

HEALTH NEW ENGLAND PROVIDER MANUAL

- Mandibular Advancement Device for treatment of obstructive sleep apnea
 - Nutritional support (special formulas and low protein foods)
 - Ongoing outpatient mental health or substance abuse services
 - Orthotics and therapeutic shoes
 - Outpatient hyperbaric oxygen therapy
 - Positive Airway Pressure (PAP) Devices (CPAP and Bi-level Positive Airway Pressure Devices)
 - Pulmonary Rehabilitation
 - Reduction Mammoplasty
 - Rhinoplasty
 - Selected durable medical equipment (DME)
 - Self-monitoring of Anti-Coagulant Therapy
 - Skilled home care services including skilled nursing, physical, occupational and speech therapy, perinatal monitoring and infusion therapy
 - Speech Therapy (outpatient)
 - Spinal Cord Stimulator
 - Surgical Management of Morbid Obesity
 - Total Hip Resurfacing
5. Retrospective Review:
- Emergency services
6. Concurrent Review:
- Ongoing services beyond the initial authorization period such as skilled home care services, infusion therapy or outpatient speech therapy

Durable Medical Equipment (DME) Requiring Prior Approval from HNE:

- DME does not require a referral; however HNE does require DME vendors to receive a prescription from a physician or ordering practitioner prior to dispensing an item to ensure that it is medically necessary.
- The vendor is not required to submit the prescription to be reimbursed. HNE may request to see the physician's prescription order.
- The AELK Master List should be consulted to determine if the item is covered
- Very few DME items require prior approval by Health Services prior to dispensing. This information is available on the AELK Master List as well.
- Prior approval can be obtained by calling Health Services at (800) 842-4464, extension 5027 or (413) 787-4000, extension 5027 or by faxing the Prior Approval Request Form to (413) 233-2700.

OB/GYN Services Requiring Prior Approval from HNE:

- Pregnancy – 1st 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, for all pregnant members. 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 copies 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).
- Infertility Treatment: AI, IUI, IVF, GIFT and ZIFT
- Prior approval forms for infertility treatment can be found on the HNE Provider website at www.hne.com or by calling Health Services at (800) 842-4464, extension 5027 or (413) 787-4000, extension 5027.

Emergency (Non-Scheduled) Transport Services:

Emergency transportation is a covered benefit for all HNE plans.

Non-Emergency (Scheduled) Transport Services Requiring Prior Approval by HNE:

- Providers should call HNE's transport benefit manager, American Medical Response at (866) 585-6483.

HNE's Non-Emergency Transport Benefit and Procedure:

HNE's transport benefit manager, American Medical Response (AMR), administers HNE's non-emergency transportation benefit. **Please note: not all scheduled transportation is covered.** Members should call HNE's Member Services Department at (800) 310-2835 with any questions regarding benefits or covered services.

HNE covers ambulance or wheelchair van services for a member from a hospital setting to the member's home or to a skilled nursing facility in the event that the member cannot be safely transferred without endangering their health.

If providers need to schedule non-emergency transport services for an HNE member, they should follow these steps:

- STEP 1** Before the provider calls to order a non-emergency transport, he or she should have the following information available:
- Patient's name
 - Patient's member ID number
 - Pick-up location address
 - Pick-up location (i.e. room #, ICU, ER)
 - Destination location address
 - Destination location (i.e. room #, ICU, ER)
 - Reason for transport (chief complaint)
 - Any special equipment required for the transport
 - Any medications required en route
- STEP 2** Providers may call AMR at the following toll-free phone number, anytime 24 hours a day / 7 days a week:
- 1-866-585-6438**
- STEP 3** Providers will be directed to follow several brief prompts.
- STEP 4** Staff at the AMR Communications Center will ask for the above information and any other pertinent clinical information to determine the level of transport required and schedule pick up time.

To ensure on-time pick up by an appropriate level of transport vehicle, AMR may dispatch an AMR vehicle or direct another transport provider in its network to respond.

If providers have any questions regarding this service and procedure, they should call Provider Relations at (413) 233-3313 or (800) 842-4464 ext. 5000.

Key Contact Telephone and Fax Numbers for Prior Approval Requests

For Notification of Emergency Admissions, providers should fax notifications to (413) 233-2700 or call Health Services at (413) 787-4000, extension 5027 or (800) 842-4464 ext. 5027.

For High-Cost Imaging Studies, providers should call MedSolutions at (888) 693-3211.

For Chiropractic Care, providers should call OptumHealth at (888) 676-7768

For Pregnancy -The 1st Prenatal Visit, The ACOG Antepartum Record Form or Obstetrical Pre-Registration Form should be mailed to Health Services at 1 Monarch Place, Springfield, MA 01144 or faxed to (413) 233-2700.

For Non-Emergency (Scheduled) Transport Services, providers should call American Medical Response (AMR) at (866) 585-6483.

All other services/treatments/procedures requiring prior approval, providers should fax the HNE Prior Approval Request Form to Health Services at (413) 233-2700 or mail it to Health New England at One Monarch Place, Springfield, MA 01144.

Instructions for Completing the HNE Prior Approval Request Form

When submitting the Prior Approval 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 notify the provider requesting the service of its decision via telephone and 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).

The Prior Approval Request Form should be received at HNE at least seven days prior to the admission or scheduled procedure date. The admitting physician performing the procedure is responsible for submitting the Prior Approval Request Form to HNE.

Information required on the Prior Approval Request Form for All Requests

- Today's date
- Patient name
- Patient's ID number
- Patient's Date of Birth

Requesting Physician's information, include:

- Name and Provider Number
- Address (Health Services needs this information especially for providers with multiple office sites)
- Name of a Contact Person, telephone and fax number

Additional Information required on the Prior Approval Request Form by Type of Request

Hospitalizations

- Type of Request: Check “Inpatient Admission”, “Surgical Day” or “Observation”
- Admit date
- Procedure code(s)
- Admitting physician's name, phone and fax number
- Hospital/Facility name, address, phone and fax number
- Type of Facility: “In-plan” or “Out-of-plan” Pre-op or Post-op days

In-Plan Outpatient Services

To verify if a procedure requires prior authorization, please contact Health Services at (413) 787-4000, extension 5027 or (800) 842-4464, extension 5027.

- Specialty physician’s name and address, telephone and fax number
-
- Place of Service: “In office” or “Other” = Hospital/Facility name
- Service/CPT code(s)
- Attach separate medical necessity documentation if needed. Please specify any failed treatments

Durable Medical Equipment

To verify if a DME item requires prior authorization, please contact Health Services at (413) 787-4000, extension 5027 or (800) 842-4464, extension 5027.

- Type of Request: Check “Other”
- Provider name, ID number, address, telephone and fax number
- HCPC cod(s) along with number of units
- Ordering physician orders
- Rationale for the request if using an out-of-plan provider

Out-Of-Plan Outpatient Services

All out-of-plan services require prior authorization.

- Type of Request: Check “Second Opinion Only”, “Evaluation”, “Follow-up” or “Student/Travel”
- Rationale for request
- In-plan treating specialist name
- Requested provider name, specialty, address, telephone and fax number
- Procedure CPT code(s)
- Date(s) of service

New Technology and Procedures

Providers, who intend to implement the use of a new technology or procedure, or implement a new use for an existing technology or procedure, must provide written notification to HNE not less than 60 days prior to such implementation. HNE will determine coverage and reimbursement guidelines, including but not limited to payment rates and authorization requirements, for such new technology or procedure for the intended site of service. These requests should be faxed to Provider Contracting at (413) 734-3356.

Medical Benefit Drugs

Please refer to the HNE on-line formulary on www.hne.com

Instructions for Submitting the Prior Approval Request Form

To request prior approval the requesting physician's office must submit a Prior Approval Request Form to Health Services in the main Springfield office. Prior Approval Request Forms are located on the HNE website. For assistance please contact the HNE Provider Relation Department at (413) 233-3313 or (800) 842-4464 ext. 5000 or Health Services at (413) 787-4000 ext. 5027 or (800) 842-4464 ext. 5027.

To request prior approval the requesting physician's office must submit a Prior Approval Request Form to Health Services as specified below. You can access the form on www.hne.com.

Prior Approval requests for Medical Services should be sent to:

Health New England
1 Monarch Place
Springfield, MA 01144
Attention: Health Services

Fax: (413) 233-2700

Prior Approval Requests for Behavioral Health Services for all members should be sent to:

Health New England
1 Monarch Place
Springfield, MA 01144
Attention: Behavioral Health

Fax: (413) 233-2800

Sample Prior Approval Request Form

A sample Prior Approval Request Form is shown on the next page. When completing the HNE Prior Approval Request Form, it is extremely important that all information be provided. Incomplete forms may cause delays in determination by Health Services.



One Monarch Place - Suite 1500
 Springfield, MA 01144-1500
 413-787-4000 - 800-842-4464
 UM fax number: 413 233-2700
 hne.com - hnewhizkidz.com

PRIOR APPROVAL REQUEST

MEMBER INFORMATION	DIAGNOSIS(ES)	REQUESTING PHYSICIAN (Must be in plan)
Today's Date: _____ / _____ / _____		Name: _____ Provider #: _____
Name: _____		Address: _____
Date of Birth: _____ / _____ / _____		Name of Contact: _____
ID#: _____		Telephone Number of Contact: _____

CHOOSE YOUR REQUEST TYPE:

<input type="checkbox"/> HOSPITALIZATIONS ___ Inpatient Admission ___ Surgical Day ___ Observation Admit Date: _____ / _____ / _____ Procedure/CPT Code(s): _____ _____ Admitting Physician: _____ Address: _____ _____ Phone: _____ Fax: _____ Facility: _____ Address: _____ _____ Phone: _____ Fax: _____ ___ In-plan ___ Out-of-Plan _____ # of Pre-Op _____ # of Post-Op	<input type="checkbox"/> DURABLE MEDICAL EQUIPMENT Provider: _____ Provider # _____ Address: _____ _____ Phone: _____ Fax: _____ HCPC _____ # of Units _____ HCPC _____ # of Units _____ HCPC _____ # of Units _____ HCPC _____ # of Units _____ Prescribing Physician: _____ Phone: _____ Orders: _____ ___ Out-of-Plan Rationale for utilizing an out-of-plan provider: _____
---	---

OUT-OF-PLAN OUTPATIENT SERVICES – Please note: HNE does not verify the credentials of Non-Plan Providers. Any Imaging services (MRI, CT, PET) must be performed in-plan.

___ Second Opinion Only: Submit office notes from the in-plan treating specialist related to request

___ Evaluation: Submit office notes from the in-plan treating specialist related to request

___ Follow-Up: Submit office note from the last visit. Procedure Name: _____

___ Student/Travel: Submit any pertinent documentation. CPT Codes: _____

Rationale: _____

Member's in-plan treating specialist: _____ Date of Visit: _____ / _____ / _____ # of Visits

Physician Requested: _____

Specialty: _____

Address: _____ Comments: _____

Phone: _____ Fax: _____

IN-PLAN OUTPATIENT SERVICES

Provider: _____ Provider #: _____

Specialty: _____

Address: _____

Phone: _____ Fax: _____

Service/CPTCode(s): _____

In office

Other: _____

Number of Visits: _____ Frequency: _____

* Note: Submit office notes from inplan Doctor related to request

PLASTIC SURGEONS ONLY: Will this be the only surgery being performed?
 YES or NO

Prior approval is not a guarantee of payment. All payment of claims is contingent upon verification of: (1) The member's eligibility on the date of service, (2) The medical necessity of the care, and (3) Coordination of Benefits/Subrogation status. For information regarding timeframes please contact the Health Services Department at 413-787-4000 or 800-842-4464, extension 5027.

10001194

Reimbursement and Claims Submission

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. The request will be reviewed in consideration of the needs of membership for such services in the provider's geographic area, site of service, and the existing availability of similar services in that area. The approval for expansion of scope of services will be made at the discretion of HNE and is subject to change with not less than 60 days prior notification to the provider.

Claims Procedure

All claims must be submitted to HNE on either a CMS-1500 form (formerly HCFA-1500 form) or a UB-04 form, formerly UB-92. 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 date of discharge from a facility (or, in the case of a claim subject to COB with another payer, within six months of the date of payment or denial by the primary carrier) or within the time period specified by contract. If a bill is not received by HNE 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 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, it must be received at HNE 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. Section IV of this Manual provides information on COB.

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. If an E&M during the post-operative period is due to complications, exacerbations, recurrence, or the presence of other diseases or injuries, Modifier 24 should be appended to the service code for the E&M.

HNE follows CMS guidelines for the global period. A claim must be submitted for every encounter.

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 Evaluate 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 in regards to 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 reduce reimbursement by 50% for any preventive or E&M line billed with modifier 25. For example, if a claim is billed with a modifier 25 on one line reimbursement for that line will be reduced by 50%. If a claim is billed with a modifier 25 on two lines, reimbursement for both lines will be reduced by 50%.

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.

Obstetrical Billing Guidelines

Global Obstetric Care:

Health New England reimburses obstetrical services to obstetrical providers using 25 weeks gestation to distinguish between global and non-global reimbursement. These services include antepartum care, intrapartum care and postpartum care.

Antepartum Care:

- The initial visit to determine whether or not the member is pregnant should be billed with the appropriate E & M CPT code along with the code for the pregnancy test. Once the pregnancy is confirmed, visits are typically scheduled monthly up to 28 weeks gestation, biweekly up to 36 weeks gestation followed by weekly visits until delivery. Per The American Congress of Obstetricians and Gynecologists this amounts to approximately 13 - 15 antepartum visits (see www.acog.org). Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, initial glucose tolerance test, venipuncture or specimen collection performed in the office. (For extensive complications or unusual circumstances, HNE will consider payment on any of the above services outside the global reimbursement on an individual consideration basis after review of medical notes). There may be instances in which a member may see her obstetrician for a non-pregnancy related condition. These services will be paid on an individual basis when billed with the appropriate E & M CPT code and ICD-9 diagnosis code.

Intrapartum Care:

- Intrapartum care is the care rendered at the time of delivery. Delivery services include the admission to the hospital, admission history and physician examination, management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean delivery.

Postpartum Care:

- Postpartum care includes hospital and outpatient visits that are routine following a vaginal or cesarean section delivery up to six weeks post delivery.

When billing for global delivery, submit one claim for delivery with the appropriate CPT procedure codes:

- 59400 (vaginal delivery)
- 59510 (Cesarean delivery)
- 59610 (vaginal delivery after a previous Cesarean delivery)
- 59618 (Cesarean delivery after vaginal delivery attempt after a previous Cesarean delivery)

Multiple-Birth Deliveries:

Multiple vaginal or cesarean deliveries are reimbursed under the single global payment. When two different delivery methods are used, bill the first line with the appropriate CPT code for global obstetrical care and the second with the appropriate delivery only CPT code and modifier 59. HNE will reimburse the global obstetrical code at 100% of the

HEALTH NEW ENGLAND PROVIDER MANUAL

provider's contracted rate and the delivery only code at 50% of the contracted rate. Please submit documentation when billing two different delivery methods.

Assistant Delivery:

HNE will reimburse assistant surgeons for cesarean deliveries based on 20% of the services paid to the delivering physician. The appropriate assistant surgeon modifier is required.

Services that are not included in the global fee include but are not limited to:

- CBC with differential/blood typing Rh antibody screening
- Hepatitis B, Rubella, Syphilis, HIV
- AFP – Alpha-fetoprotein screening
- Fetal Echocardiography
- Rho(D) immune globulin or administration of
- Fetal non-stress tests
- Obstetrical Ultrasound
- Cervical Cerclage
- Amniocentesis, CVS – chorionic villus sampling
- External cephalic version
- Circumcision
- Tubal Ligation

Please bill with the appropriate CPT codes for these services.

Non-Global Obstetrical Services:

The provider may not follow the member for the duration of her pregnancy. These reasons may include the member moving to another physician (not associated with your practice), moving away prior to delivery, losing the pregnancy, or changing insurance. The billing must reflect the actual services rendered. Claims should be submitted for non-global services with the appropriate CPT procedure codes:

- 59425-59426 (antepartum visits)

If the provider does not follow the member for the duration of her pregnancy, the billing must reflect the actual services that the provider has rendered. An example is if a member received prenatal care, but did not deliver, with that same provider. If the member had a total of 4-6 antepartum visits, the global CPT code 59425 with 1 unit should be used, and the last date of service reported. If the member has 7 or more visits, the code 59426 should be billed.

This also should be submitted with 1 unit, and the last date of service reported.

- If 1-3 antepartum care visits only have been performed, bill each date of service separately. Claims should be submitted with the most appropriate E&M CPT procedures codes and the appropriate pregnancy diagnosis.
- 59409, 59514, 59612 or 59620 (delivery only)
- 59410, 59515 or 59614 (the delivery and postpartum care only)
- 59430 (postpartum only)

Anesthesia Billing Guidelines:

Effective August 1, 2008 HNE has required that all participating providers (including Oral Surgeons) bill anesthesia claims according to criteria contained in this document.

Claims Submission Guidelines

- Codes from the Anesthesia section of the CPT Coding Guide
- Anesthesia modifiers and minutes information.
- The appropriate modifier in the first modifier position for services performed directly by a physician.

HNE Guidelines

- Regardless of the location, anesthesia services provided as part of a procedure do not require referrals or prior authorizations.
- HNE generally will follow Medicare guidelines for payment of CRNA and physician anesthesiology claims:
 1. Up to 100% of the fee schedule allowed amount when a physician service only is billed for anesthesia, with the appropriate modifier.

2. Generally a 50-50 split of the physician fee between the billed CRNA service and the billed physician service, when a service is billed by a CRNA supervised by a physician. This is dependent on actual number of minutes reported for each. Services provided by a CRNA and the supervising anesthesiologist are billed during the course of a procedure as separate services with the appropriate modifier in the first modifier position and minutes appropriate for each.
 3. Anesthesia services may be billed in combination with modifiers for CRNA supervised by a physician and additional physician services billed for anesthesia with other additional procedures.
- Moderate Conscious Sedation codes 99144 and 99145 are denied as part of global service. Other CPT codes within the subsection “Moderate (Conscious) Sedation” are pending for determining coverage consideration.
 - Qualifying Circumstances for Anesthesia codes 99100 – 99140 are denied as part of global. These codes are used when anesthesia is provided in situations that make the administration of the anesthesia more difficult. They are considered adjunct codes (add-on) which should not be used alone but must be used in addition to the anesthesia procedure code.

Anesthesia for Obstetrical Services

- HNE applies a 270 minute limitation on anesthesia services for procedure codes 01967 and 01968.

The following anesthesia modifiers denote whether procedures were personally performed, medically directed or medically supervised:

Modifiers	Description	Allowable
AA	Anesthesia service personally performed by physician	100% of anesthesia rate
AD	Medical supervision by a physician, more than 4 concurrent anesthesia procedures	100% of anesthesia rate
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50% of anesthesia rate
QX	CRNA service with medical direction by a physician	50% of anesthesia rate
QY	Medical direction of one Certified Registered nurse Anesthetist by an Anesthesiologist	50% of anesthesia rate
QS	Monitored anesthesia care service	Pend IC determining coverage
QZ	CRNA service: without medical direction by a physician	In plan deny Non plan pend IC determining coverage

The following anesthesia modifiers may be used but do not impact the payment of the service:

Modifiers	Description	Allowable
P1	Physical Status Modifier: A normal healthy patient	100% of anesthesia rate
P2	Physical Status Modifier : A patient with mild systemic disease	100% of anesthesia rate
P3	Physical Status Modifier: A patient with severe systemic disease	100% of anesthesia rate
P4	Physical Status Modifier: A patient with severe systemic disease that is a constant threat to life	100% of anesthesia rate
P5	Physical Status Modifier: A moribund patient who is not expected to survive without the	100% of anesthesia rate

HEALTH NEW ENGLAND PROVIDER MANUAL

	operation	
P6	Physical Status Modifier: A declared brain-dead patient whose organs are being removed for donor purposes	100% of anesthesia rate

CPT Modifiers:

Modifier	Description	Reimbursement Impact
21	Prolonged evaluation and management services	Modifier use will not impact reimbursement. Modifier DELETED in 2009.
22	Increased Procedural services	Requires Letter of explanation and operative report for review.
23	Unusual Anesthesia	Modifier use will not impact reimbursement
24	Unrelated evaluation and management service by the same physician during a postoperative period	Modifier use may impact reimbursement
25	Significant, Separately Identifiable Evaluation and Management Service by the same Physician on the same day of the Procedure or Other service	Documentation should validate usage of this modifier. Outcome may impact reimbursement.
26	Professional component	For procedures subject to 26 modifier as defined by CMS. Based on fee schedule/allowance amount
27	Multiple outpatient hospital E&M encounters on the same date	Modifier use will not impact reimbursement
32	Mandated Services	Requires documentation for review; “as to who requested the services performed.
47	Anesthesia by surgeons	Informational only
50	Bilateral procedure	150% of the fee/schedule/allowable, requires single line entry without modifiers LT or RT. For radiology services where the Medicare Physicians Fee Schedule indicator is a “3”, the services should be billed without Modifier 50.
51	Multiple procedures	Primary procedure is reimbursed at 100% of the fee schedule/allowable, subsequent procedures reimbursed at 50% of the fee schedule/allowable amount
52	Reduced services	Requires documentation for review
53	Discontinued procedure	Requires documentation for review
54	Surgical care only	Requires documentation for review
55	Postoperative Management Only	Modifier use will not impact reimbursement
56	Preoperative Management Only	Modifier use will not impact reimbursement
57	Decision for surgery	Modifier use will not impact reimbursement
58	Staged or Related Procedure or Service by the same Physician During the Postoperative Period	Modifier use will not impact reimbursement
59	Distinct Procedural Service	Documentation should validate usage of this modifier. Outcome may impact reimbursement.
62	Two Surgeons	50% of the fee schedule/allowable amount
63	Procedure Performed on Infants less than 4kg.	Modifier use will not impact reimbursement
66	Surgical team	Reimbursement will be made after individual consideration and review of operative report
74	Discontinued outpatient procedure after anesthesia administered	Modifier use will not impact reimbursement
76	Repeat procedure or Service by same physician	Modifier use will not impact reimbursement

HEALTH NEW ENGLAND PROVIDER MANUAL

77	Repeat procedure by another physician	Modifier use will not impact reimbursement
78	Unplanned Return to the Operating/Procedure Room by the same physician following Initial Procedure for a Related Procedure during the Postoperative Period	Modifier use will not impact reimbursement
79	Unrelated procedure or service during the postoperative period	Modifier use will not impact reimbursement
80	Assistant Surgeon	20% of fee schedule/allowed amount
81	Minimum Assistant Surgeon/Physician Assistant	13% of fee schedule/allowed amount
82	Assistant surgeon (when a qualified resident surgeon not available.	20% of fee schedule/allowed amount
90	Reference (outside) Laboratory	Modifier use will not impact reimbursement
91	Repeat clinical diagnostic laboratory test	Modifier use will not impact reimbursement
AS	Physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery	13% of fee schedule/allowed amount
TC	Technical component	For procedures subject to TC modifiers as defined by CMS-based on fee schedule/allowable amount

HNE's Policy on HCPCS codes being billed by Physicians and Facilities

HNE currently accepts applicable Medicare approved HCPCS codes for Medicare Advantage members or members that have HNE secondary to Medicare ONLY. HNE does not accept Medicare approved HCPCS codes for our regular Commercial or HNE Be Healthy (Medicaid) Membership, unless certain provisions have been made to the provider's specific HNE contract.

Claims X-Ten

HNE processes all claims using claim editing software, Claims X-ten from McKesson. ClaimsXTen, reviews claims in a payable status and applies recommended modifications based on common coding guidelines established by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). If a service is edited, HNE will provide an adjustment code with the Explanation of Payment.

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-9-CM codes, using appropriate 3, 4 or 5 digit codes (If there is more than one diagnosis, it is important to include all appropriate ICD-9-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

HEALTH NEW ENGLAND PROVIDER MANUAL

- 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 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.
- Completed 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 'sub-total' the first page).
- Do not use highlighter on any claim form field.
- Do not submit photo-copied 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

The following information must appear on all electronic claims:

- The correct HNE Provider 5 digit number in the PIN field
- The correct HNE Member 11 digit ID number
- The HNE Payer Number: 04286

For more detailed information, please go to:

http://hne.com/HNE_Providers/index.html

Place of Service Codes

Code	Narrative	Code	Narrative
11	Office	41	Ambulance - Land
12	Home	51	Inpatient Psych Facility
21	Inpatient Hospital	52	Psychiatric Facility/Partial Hospitalization
22	Outpatient Hospital	53	Community Mental Health Center
23	Emergency Room - Hospital	54	Intermediate Care Facility/Mentally Retarded
24	Ambulatory Surgical Center	61	Comprehensive Inpatient Rehab Facility (CIRF)
25	Birthing Center	65	End Stage Renal Disease Treatment Facility
31	Skilled Nursing Facility	71	Public Health Clinic

HEALTH NEW ENGLAND PROVIDER MANUAL

32	Nursing Facility	81	Independent Lab
34	Hospice	99	Other

The above table is a partial listing of the codeset referenced under HIPAA. The most recent version of this codeset can be found on-line at <http://cms.hhs.gov/states/posdata.pdf>.

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

Clean Claim Requirements

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

CMS-1500 (Physician Claims)

Patient's 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-9-up to 5th digit if applicable -Current, valid codes)
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 & 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-9-up to 5th digit if applicable) (Current, valid codes)
Provider's Name, HNE's Provider ID Number		Secondary/Other Diagnosis Code(s) (ICD-9-up to 5th digit if applicable) (Current, valid codes)
Provider's Address		Attending Physician
Provider's Telephone Number		ICD-9 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		

HNEDirect Provider On-line Services

HNE Providers can now view up-to-date information on-line including claim status, member eligibility, and member benefits. HNEDirect is an on-line system that allows providers to get immediate answers to managed care questions 24 hours a day, 7 days a week. Once registered with HNEDirect, a provider can:

- Check eligibility
- Obtain the patient's HNE co-payment amount to ensure collection of the correct co-payment 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 (413) 233-3313 or (800) 842-4464, ext. 5000.

HEDIS and the Provider Information Portal (PIP) through HNEDirect

The Health Plan Employer Data and Information Set (HEDIS) is the most widely used set of performance measures in the managed care industry. HEDIS is designed to ensure that purchasers and consumers have the information they need to compare the performance of managed care plans. HEDIS contains 61 measures across 8 domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information

HNE is committed to achieving and maintaining high standards in these areas. HNE has developed an on-line tool to assist PCPs in monitoring their patients' activity related to the achievement of HEDIS standards. This tool will assist PCPs in ensuring that their patients have received appropriate and timely services. The on-line HEDIS tracking tool can be accessed through HNEDirect through the Provider Information Portal (PIP).

In addition to HEDIS information, PCPs may access the following reports on-line to assist in the management of their fully funded HNE patients:

- PCP Panel - This report displays detailed PCP panel information; details include prescription(s) and claims details.
- ER Visits within 30 Days - This report displays member specific information; details include member(s) information, provider(s) details, and procedures performed.
- Quality Measures - This report displays detailed information on HEDIS measures.
- Drug – Generic vs. Brand - This report displays the detailed drug usage of the PCP's panel members, categorized as generic vs. brand; details include: alternatives to brand drugs listed.
- ER Visit Rate - This report displays detailed ER usage by the PCP's panel members.
- Radiology Rate - This report displays detailed radiology usage by the PCP's panel members; details include: all radiology procedures, including MR/CT/PET scans.
- Daily Admits - This report displays HNE's best estimate of the PCP's panel members in hospitals on a daily basis.

Sample Screen – PIP Main Menu:

Health New England	
Physician Specific Reports	
Fully Funded Membership Only For Period 01/01/2010 - 05/31/2010	

Select Report	Select Report Criteria	
<input checked="" type="radio"/> PCP Panel <input type="radio"/> Provider/Patient Referrals <input type="radio"/> ER Visits within 30 days <input type="radio"/> Quality Measures <input type="radio"/> Drug (Generic/Brand) <input type="radio"/> ER Visit Rate <input type="radio"/> Radiology Rate <input type="radio"/> Daily Admits	Welcome, HNE Admin.	
	Select Provider	<input type="text"/>
	Patient Search :	Enter Last Name : <input type="text"/>
		OR
		Enter Complete HNE ID : <input type="text"/>
	From Date (MM/DD/YYYY) :	<input type="text"/>
	To Date (MM/DD/YYYY) :	<input type="text"/>
	<input type="button" value="Show Report"/>	

Information in the reports is based on claims submitted. It is therefore necessary that all claims be submitted in a timely manner to accurately reflect patient care activity. These tracking tools will help providers to view and manage patient care information at the click of a mouse, as well as minimize the need for time-consuming chart audits needed to obtain HEDIS compliance information.

To sign up for HNEDirect and PIP, or for more information, providers should visit www.hne.com or call Provider Relations at (413) 233-3313 or (800) 842-4464 ext. 5000.

Explanation of Payment (EOP) and Negative Balances

These reports can be found on HNEDirect at <https://www.hnedirect.com/login/index.aspx>
 Paper EOP's and Negative Balance Reports will now be accessed through HNEDirect for In-Plan Providers.

Out-of-Plan Providers can access their EOP's at <http://www.healthnewengland.com/hnedirect/> You will need your Tax Identification Number, your NPI Number and the trace number on your check to access your report.

Negative Balance Amounts on Explanation of Payments

A negative balance occurs when HNE is required to retract money previously paid to a provider.

Any retraction of money will be taken from payments for the same product (e.g., HMO, HNE Advantage, HNE Select Exclusive Group, HNE Select Preferred Group, Medicare Advantage) from which the original payment was made.

Accordingly, where the amount retracted for a product is greater than the amount paid for that product in a particular check run, a negative balance will appear on the EOP. The negative balance will continue to appear on subsequent check runs that include the same product until the negative balance amount has been recouped.

Retractions are made for different reasons. Here are some examples:

- Duplicate payment on a procedure
- Incorrect payment on a procedure
- Payment to the wrong provider
- Retroactive termination of a member

The following is a list of the different types of Negative Balance Explanations of Payments that providers may receive on the summary page of the EOP:

- Adjustments not applied
- Negative Service Balance Used
- Unused Negative Balance

EOPs that identify any of the three types of Negative Balances listed above should be saved for future reference, since they identify the member, or an additional member (or members) for whom the retraction was made.

Adjustments Not Applied

“Adjustments Not Applied” refers to retractions for a specific product that have not been subtracted from the current check amount. Amounts have not been subtracted because there was not enough money in claims submitted for the particular product during the current check run. This amount will carry forward on future check runs until all of the negative balance has been recouped.

The following examples show what the last page of the EOP would look like if Adjustments have not been applied to the current check.

Both of the examples below show that a retraction has occurred and the amount generated from the retraction cannot be recouped on the current check. In the first example there are no claims being paid for any products. In the second example, there are claims being paid for a different product than that for which the retraction occurred.

HEALTH NEW ENGLAND PROVIDER MANUAL

EXAMPLE 1

NEGATIVE SERVICES BALANCE USED:	\$.00
PREPAYMENT BALANCE USED:	<u>\$.00</u>
TOTAL CURRENT BALANCES USED:	\$.00
CLAIMS PAID THIS RUN:	\$ -182.88
ADJUSTMENTS NOT APPLIED:	<u>\$ -182.88</u>
CLOSING BALANCE:	\$.00

OR

EXAMPLE 2

NEGATIVE SERVICES BALANCE USED:	\$.00
PREPAYMENT BALANCE USED:	<u>\$.00</u>
TOTAL CURRENT BALANCES USED:	\$.00
CLAIMS PAID THIS RUN:	\$ 97.55
ADJUSTMENTS NOT APPLIED:	<u>\$ -17.60</u>
CHECK AMOUNT:	\$ 115.15

Negative Service Balance Used

“Negative Services Balance Used” refers to retractions (Adjustments Not Applied) listed on a previous EOP that are being subtracted from the current check. The amount is now being subtracted because there is enough money in the product line to have the money subtracted.

The following example shows what the last page of the EOP would look like if a retraction occurred on a previous EOP, there are payments being made for the same product and the outstanding negative balance can be recouped.

A check is generated for the total amount of the claims paid, minus the negative balance amount that remained. There is no “Unused” amount, which indicates that the entire negative balance has been recouped.

EXAMPLE

NEGATIVE SERVICES BALANCE USED:	\$ -30.68
PREPAYMENT BALANCE USED:	<u>\$.00</u>
TOTAL CURRENT BALANCES USED:	\$ -30.68
CLAIMS PAID THIS RUN:	<u>\$ 1023.66</u>
CHECK AMOUNT:	\$ 992.98

Negative Service Balance Unused

“Unused” refers to a previous negative balance for that provider that has not been applied in the current check run. This information indicates that there is still a negative balance for that product line.

The following example shows what the last page of the EOP would look like if a retraction has occurred on a previous EOP, there are additional retractions that have occurred for the same product on the subsequent EOP and the amounts generated from the retraction, as well as the “Unused” balance cannot be recouped.

HEALTH NEW ENGLAND PROVIDER MANUAL

The amount listed as “Adjustments Not Applied” will be added to the “Unused” amount and recouped on subsequent EOPs when a payment is made for the product to which the retraction applied. No check is issued in the example.

EXAMPLE:

NEGATIVE SERVICES BALANCE USED:	\$.00	UNUSED:	\$ -1,645.29
PREPAYMENT BALANCE USED:	<u>\$.00</u>		
TOTAL CURRENT BALANCES USED:	\$.00		
CLAIMS PAID THIS RUN:	\$ -293.42		
ADJUSTMENTS NOT APPLIED:	<u>\$ -293.42</u>		
CLOSING BALANCE:	\$.00		

Requests for research of negative balance issues must be submitted within one year of the original payment retraction date.

All requests should be submitted to the attention of Provider Relations. Providers should include the following information:

- (1) Provider Name
- (2) Federal Tax ID #
- (3) EOP Run Date
- (4) Check Number
- (5) Check Date

Negative Balance Applied Report

The Negative Balance Applied Report is generated when HNE makes an adjustment to a claim that results in a negative balance, that is, when monies owed to HNE exceed the payments to the provider. Provider practices will receive this report until no outstanding balance remains. The Negative Balance Applied Report will arrive at about the same time as the EOP. The Negative Balance Applied Report provides the following information:

- Information regarding the retraction(s) that produced the original negative balance
- Information regarding the payment amounts previously applied to the outstanding negative balance
- The amounts on the current EOP being applied to the outstanding negative balance
- The negative balance remaining as of the current Paid Date or confirmation that the negative balance has been satisfied

If providers have any questions about this process, please contact Provider Relations at (413) 787-4000 or (800) 842-4464, ext. 5000.

About the Negative Balance Applied Report

A negative balance occurs when Health New England (HNE) retracts money previously paid to a provider. When the amount retracted for a product is greater than the amount paid in a particular check run, a negative balance will appear on the EOP. The negative balance will continue to appear on subsequent check runs until the negative balance amount has been recouped.

Any retraction of money will be taken from payments for the same product (e.g. HMO, HNE Select Exclusive, etc.) from which the original payment was made.

Organization of this Report

- *Negative Balance Applied:* This is a summary of the total amount retracted from the current check run to be applied against the open negative balance carried forward for this product. This amount appears on the current EOP.
- *Original Negative Balance:* This is the detailed listing of original retractions from a prior check run for which there were insufficient funds to fully satisfy the amount owed to HNE. This resulted in the original negative balance carried forward. The EX code and description regarding the reason for the retraction appeared on the original EOP.
- *Amounts Previously Applied:* This is a claim by claim listing of retractions subtotaled by check run/paid date. The last paid date listed is identical to the retracted accounts on the current EOP and equals the “Negative Balance Applied.” These retractions are made in order to satisfy the amount owed HNE because of insufficient funds available at the time the original negative balance was created.
- *Negative Balance Remaining:* This is the amount, if any, still owed which will be collected on a future check run.

HNE's Vaccine Policy

State Supplied Vaccines in General:

- All State Supplied Vaccines (as defined by the Massachusetts Department of Public Health) are configured in our system for specific age ranges identified by the Massachusetts Department of Public Health.
- Any member receiving a vaccine on the State Supplied list, whose age is outside of the State specified age-range must have an invoice attached to the claim for processing. This will support the fact that the vaccine was purchased and not supplied free from the State.

IN ALL OTHER INSTANCES, STATE SUPPLIED VACCINES ARE NOT COVERED:

- HNE expects providers to get these from the State.
- HNE expects providers to give the state supplied vaccines on the approved schedule (CDC and AAP).
- The State supplied vaccine CPT codes are listed on the next page.

Other Vaccines:

HNE will cover non-State supplied vaccines for HNE members under the following conditions:

- The physician must bill for the vaccine using the appropriate J-code or CPT code (this allows vaccines to be considered a preventive service for High Deductible Health Plans).
- The physician may purchase the vaccine through any supplier (**as long as it is not State-supplied**).
- HNE will reimburse the physician using the HNE fee schedule, which is based on a percentage of AWP and is updated quarterly.

STATE SUPPLIED VACCINES		
CODE	VACCINE	AGE LIMIT
90632	Hepatitis A-adult dosage	18 years and under
90633	Hepatitis A-pediatric/adolescent dosage	1 year to 2 years old
90645	Hemophilus influenza B	2 years to 18 years old
90648	Hemophilus influenza B	0 days to 1 year old
90669	Pneumococcal conjugate	60 days to 5 years old
90698	Diphtheria, tetanus toxoids (DTap-Hib-IPV)	42 days to 4 years old
90700	Diphtheria, tetanus toxoids, DTap)	60 days to 6 years old
90702	Diphtheria and tetanus toxoids (DT)	60 days to 6 years old
90707	Measles, mumps and rubella virus	60 days to 18 years old
90710	Measles, mumps, rubella and varicella (MMRV)	1 year to 12 years old
90713	Poliovirus	60 days to 18 years old
90715	Tetanus, diphtheria toxoids (Tdap)	11 years to 12 years old Available for catch-up of all 13-18 year olds (Effective 8/1/09)
90716	Varicella virus	1 year old 4 years to 6 years old 11 years to 12 years old Available for catch-up of all 13-18 year olds (Effective 8/1/09)
90718	Tetanus and diphtheria toxoids (Td)	7 years to 18 years old
90723	Diphtheria, tetanus toxoids, acellular pertussis, Hepatitis B and poliovirus (DTap-Hepb-IPV)	42 days to 6 years old
90732	Pneumococcal polysaccharide	2 years to 18 years old
90734	Meningococcal conjugate	11 years to 12 years old Available for catch-up of all 13-18 year olds (Effective 8/1/09)
90740	Hepatitis B, dialysis or immunosuppressed (3 dose)	18 years and under
90743	Hepatitis B, adolescent	18 years and under
90744	Hepatitis B, pediatric/adolescent	18 years and under
90746	Hepatitis B, adult	18 years and under
90747	Hepatitis B, dialysis or immunosuppressed (4 dose)	18 years and under

Provider Appeal Guidelines and Review Sheet

Health New England Provider Appeal Guidelines

(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: HNE Claims Department, One Monarch Place, Springfield, MA 01144. Faxed On Time Corrected Claims will not be accepted)

Provider Appeal Guidelines:

- Providers have the right to file a Provider Appeal if they disagree with how HNE processed a claim.
- Provider Appeals must be submitted within one year from the date of service. An appeal submitted after the one year deadline will be denied.
- A Provider Appeal must be submitted on the HNE Provider Appeal form, which can be found under the Provider Forms on the following page and on HNE website, www.hne.com.
- The control number, the 12 digit number on the HNE Explanation of Payment (EOP), must be listed on the Provider Appeal form.

Please include with your appeal:

- The EOP and all supporting documentation, such as operative and office notes, authorizations, invoices, and other information which would be pertinent to the review process, rationale for appeal, and desired resolution.
- PLEASE NOTE: If you are disputing a denial of a Prior Authorization Request Form 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.

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 (relates to decisions made during the precertification process that impact how a claim has been processed), such as:

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

Durable Medical Equipment (DME)

At HNE the term “DME” is used to denote anything billed with an A, E, L, or K HCPCS code, with a few exceptions (e.g. certain drugs and pharmaceuticals). This includes standard durable medical equipment, high-tech or other specialized DME, medical and surgical supplies, ostomy supplies, oxygen and respiratory equipment and supplies, and orthotics and prosthetics.

Most DME is dispensed to HNE members by HNE’s contracted DME and orthotics & prosthetics vendors. However, certain DME products may be dispensed to members by physicians at the time of the visit, by hospitals and by other contracted HNE vendors or manufacturers who dispense specialized products. Standard items will be dispensed unless the physician’s order specifies a non-standard item.

Contracted DME Vendors

HNE has developed a comprehensive reference document which describes HNE’s coverage and reimbursement guidelines. This document is located on HNE Direct for HNE DME vendors. The list is called “AELK Master List” since it addresses billing and reimbursement details for HCPCS codes used to bill durable medical equipment (DME).

The information in the AELK Master List applies only to HNE’s contracted DME vendor network, specifically those vendors 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 ext. 5000 or (413) 233-3313.

Prior Approval Requirements for DME

HNE does require DME vendors to receive a prescription from a physician or ordering practitioner prior to dispensing an item to ensure that the item is medically necessary. The vendor does not need to submit the prescription to be reimbursed. HNE may request to see the physician’s prescription order.

The AELK Master List should be consulted to determine whether the item is covered or not. Very few DME items require approval by Health Services prior to dispensing. This information is available on the AELK Master List, as well.

Prior approval can be obtained by calling Health Services at (800) 842-4464 ext. 5027 or (413) 787-4000 ext. 5027 or by faxing the Prior Approval Request Form to (413) 233-2700.

HEALTH NEW ENGLAND PROVIDER MANUAL

Billing Guidelines and Procedures

DME Vendors Only – Modifiers

Every DME item billed with an A, E, L, or K HCPCS code must be billed with a modifier. The AELK Master List contains the acceptable modifier for each HCPCS code.

- “NU” is required for items which are purchased and are never rented
- “RR” is required for any item that is rented for the billed period
- “NR” is required for any item that has been rented previously for the designated number of rental periods and is being purchased in the current billed period

If a DME item is billed by a DME or orthotics and prosthetics vendor without a modifier, the claim will be denied.

DME Vendors Only – “SC” Modifier

HNE will reimburse higher than the standard rate for covered, non-standard, medically necessary items when the member presents a prescription for the non-standard item. The vendor should bill the HCPCS code corresponding to the standard item and attach an “SC” modifier. Rather than the standard reimbursement, HNE will reimburse the vendor a percent of the billed charge based upon the default percent of charge listed in the vendor’s contract. HNE reserves the right to audit the vendor’s prescriptions for any item which HNE has been requested to reimburse.

Physicians Only –Modifiers

There are no modifier requirements for physicians billing for DME.

Features of the AELK Master List

Field Name	Description
Introduction	This is a general overview of what is contained in the AELK Master List and how to read it.
HCPCS CODE	Every current A-, E-, L- and K-HCPCS code and those recently deleted are listed here. These codes correspond to standard DME, and specialty/high tech DME, large equipment, oxygen and respiratory supplies, medical and surgical supplies, ostomy supplies and orthotics and prosthetics. Codes deleted prior to 2000 do not appear on the list. Codes related to administrative, miscellaneous and investigational items, e.g. radiopharmaceuticals, do not appear on this list.
Description	HCPCS Manual short description (see HCPCS Manual for complete description)
EX Description	If reimbursement for an item is denied, this EX Code and the denial explanation will appear on the Explanation of Payment (EOP).
Prior Approval	This field indicates whether prior approval is required from Health Services before an item can be provided. HNE has reviewed the prior approval requirement for all codes.
Mod	Effective July 1, 2003, all covered items must be billed with a modifier. This column lists the modifier(s) that must be used for billing. Rental items must be billed with an "RR" modifier. If a rental item is converted to a sale after a period of time, the item should have an "NR" modifier (sale of a rental item after the rental period.) The rental payments will be deducted from the purchase rate of the item. Any item that may only be purchased, including supplies and disposables, should be billed with an "NU" modifier. Modifiers "KM" and "KN" are listed as well but are infrequently used. These modifiers have the Medicare definition but are used according to the HNE-designated methodology. If the incorrect modifier or no modifier is used, the item will be denied as billed incorrectly.
Rental Period	If a rental ("R") or rental to purchase ("RP"), this field designates units of time for the rental period that are to be billed, e.g., monthly, weekly, etc.
HNE Purchase Fee	This is the HNE fee schedule rate that will be reimbursed less any deductible, coinsurance, and copay until the benefit maximum is reached. If an item is a rental prior to purchase, the rental payments will be deducted from this rate. This is referred to as BASE on the grid.
HNE Rental Fee	This is the HNE fee schedule rate that will be reimbursed less any deductible, coinsurance, and copay until the maximum benefit is reached or until the item is purchased, if qualified for purchase. This is referred to as TECH on the grid.

Guidelines for Billing E1399

The following guidelines apply to DME vendors only:

When should a DME item be billed with HCPCS code E1399?

The HCPCS Manual describes E1399 as “Durable medical equipment, miscellaneous.” Therefore, this code should only be used to bill for DME for which no presently active HCPCS code accurately describes the DME item.

When will HNE provide reimbursement for a DME item billed with E1399?

HNE will provide reimbursement for a DME item billed with E1399 when the item is covered under the vendor’s contract, is covered by the member’s benefit, and is medically necessary or otherwise authorized by Health Services in advance.

What are the guidelines for processing DME items billed with E1399?

- The DME item will be denied as “billed incorrectly” if it is billed with E1399 when a more precise, descriptive HCPCS code exists.
- A DME item billed with E1399 for a total charge (including multiple units) of less than or equal to \$300 will be reimbursed at the provider’s contracted default discount rate.
- If a DME item with total charges (including multiple units) greater than \$300 for code E1399 is submitted on a claim, it must be accompanied by an invoice. The claim and invoice will be reviewed and a payment determination made.
- ***Special Instructions for DME Vendors Who Bill Electronically:*** *DME vendors who bill electronically must submit paper claims with an invoice for any DME items billed with E1399 for total amounts greater than \$300, otherwise the claim will be denied as billed incorrectly.*

How will the amount reimbursed be determined?

- If a DME item is appropriately billed with E1399, the conditions for reimbursement above are met, and the total billed charge is less than or equal to \$300, HNE will apply the provider’s contracted discount rate for E1399 to the billed charge.
- If a DME item is appropriately billed with E1399, the conditions for reimbursement above are met, and the total billed charge is greater than \$300, HNE will apply the provider’s contracted discount rate for E1399 to the billed charge.

Balance Billing

DME vendors’ contracts do not allow balance billing of members under any circumstance. DME vendors may bill members for any copay, deductible or coinsurance, as well as for non-covered items or amounts in excess of the member’s benefit.

DME dispensed by Physicians

HNE participating physicians may provide members with therapeutic and medically necessary DME during an office visit, especially in instances where the dispensing of such DME items is essential to providing timely and effective care to the member versus referring the member to a DME vendor (e.g. splint). HNE will reimburse physicians for such DME at its standard Physician Office Allowable DME Fee Schedule.

In instances where, in the physician's opinion, it is not medically necessary to dispense the DME from the physician's office, the physician's office should either contact an HNE participating DME vendor to have the item(s) delivered to the member's home or give the member a written order for the DME. The member can either visit a participating DME vendor or call to arrange for the items to be delivered to their home.

Certain DME, for example, gauze, is included in the physician's office visit fee and will not be paid separately, nor is it covered when provided by the DME vendor.

The AELK Master List guidelines were developed as a reference document specifically for contracted DME vendors. While in many cases the information may be applied to DME ordered by and dispensed by a physician, there may be instances where this cross-application is not correct. Any questions about coverage should be directed to Provider Relations at (800) 842-4464 ext. 5000 or (413) 233-3313.

HNE contracts with a DME vendor who is willing to provide a physician's office with certain DME which the physician may dispense as necessary. The DME vendor will bill HNE directly and replenish the physician office's stock. This methodology allows the physician to dispense medically necessary DME in a timely and effective manner while avoiding the additional work of billing for the DME.

DME Dispensed by Vendors or Manufacturers of Specialized DME:

Certain vendors or manufacturers of specialized DME are not subject to the guidelines in the AELK Master List. These vendors and manufacturers have contracts that specifically address coverage, prior approval, coding and billing guidelines, as well as reimbursement. Providers should refer to their individual contracts if they fall into this category.

Billing for DME by Vendors when HNE is the Secondary Payer:

Refer to Section IV.B, Coordination of Benefits Guidelines.

Medicare:

Refer to Section IV.C, Coordination of Benefits Guidelines for Medicare Recipients.

HNE Products and Benefits

HNE is a Health Maintenance Organization licensed in Massachusetts. HNE's service area includes: Franklin, Berkshire, Hampden and Hampshire counties and part of Worcester County in Massachusetts as well as Hartford, Litchfield and Tolland counties in Connecticut.

We provide insurance 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. We refer to these as "self-funded" plans. An easy way to identify a self-funded member is by the group number which can be found on the HNE ID card. Self-funded group numbers always start with an "S".

It is important to know that our fully-funded plans cover Massachusetts mandated benefits, however, self-funded plans can choose whether or not to cover these mandated benefits. Also, HNE's fully-funded plans include many standard benefits such as \$0 preventive care and \$0 allergy shots. These benefits 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 HNEDirect, please call (413) 233-3060 or (800) 791-7944.

HNE offers several types of products to both fully-insured and self-insured groups. Below is a brief description of our products. Benefit details are available through HNEDirect or by calling HNE Member Services.

HNE HMO (fully-funded) and Select Exclusive (self-funded)

These plans provide covered services within our contracted network. HNE has several types of HMOs in which member cost sharing may include co-payments, deductibles and coinsurance. Specific benefits can be found through HNE Direct or by calling HNE Member Services.

Nurse Practitioner-a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L.c.112, §80B.

Primary Care Provider-This plan requires 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 approval by HNE Health Services. The PCP can be either a physician or a nurse practitioner.

Specialty Care-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. Any referral to a non-participating provider requires prior approval by HNE Health Services.

HNE Advantage Plus (fully-funded)

The benefits and guidelines for the HNE Advantage Plus Plan are similar to the HMO Plan, however it is a point of service (POS) plan. Members may elect to receive care from non-participating providers and hospitals. This plan requires that each member select a PCP. 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 but some services may need prior approval by HNE Health Services. For those services, the level of coverage will be higher when an authorization is obtained.

Medically necessary services received from non-participating providers may be 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. Also, certain services may require prior approval by HNE Health Services. Failure to obtain prior approval may result in a reduction of benefits which is a penalty of a specified dollar amount described in the member enrollment materials.

HNE Select Preferred (self-funded)

The structure of the Preferred Option is also essentially a point of service (POS) plan, in which the member may elect 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, 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 paperwork required to obtain prior approval when being admitted by a non-participating provider.

PPO Plans

HNE currently offers 3 types of PPO Plans. These plans are available to both fully-funded and self-funded groups. Below are the general plan descriptions. Benefit details are available through HNE Direct or by calling HNE Member Services.

HNE PPO:

Like the POS service plan, members may be seen by participating providers as well as non-participating providers. Members are not required to choose a PCP. When receiving care within the network, members will be subject to coinsurance and deductibles. If the non-participating provider's charges are greater than HNE's maximum allowable fee the member may be billed for the balance. Authorizations are still required for some services. Failure to obtain authorizations may result in a reduction of benefits which is a penalty of a specified dollar amount described in the member enrollment materials.

Premier PPO or PHCS PPO:

Under this plan, members can obtain medically necessary treatment from HNE participating providers, PHCS (Private Health Care Systems) participating providers and non-participating providers. The member's co-payment is slightly higher when using PHCS 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 member may be billed for the balance. Authorizations are still required for some services and failure to obtain authorization may result in a reduction of benefits. The member is not required to select a PCP.

HNE PPO National:

Under this plan, members can obtain medically necessary treatment from HNE participating providers, PHCS (Private Health Care Systems) participating providers and non-participating providers. Members' co-payments are the same when using HNE and PHCS 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 member may be billed for the balance. Authorizations are still required for some services and failure to obtain authorizations may result in a reduction of benefits. The member is not required to select a PCP.

HNE Exclusive Provider Organization (EPO) Plan (self-funded)

With an EPO Plan, In-Plan services are provided by a limited network of contracted providers.

Members enrolled in this plan are directed to work with their providers to ensure that services are received at approved facilities. Services that EPO members receive outside of the approved network are treated as out-of-plan services. HNE does not cover these services without prior approval.

HNE issues ID cards to members enrolled in this plan that identify them as EPO members.

CPI Physician Review-GIC/CPI product

Provider process for tier designation review-GIC Plan

If you want to receive additional information about how HNE arrived at your tier designation, or if you believe that your tier designation was not correctly determined, you may have your tier designation reviewed by the Plan by following the steps outlined below:

1. Email or mail your review request to either Dr. Thomas Ebert (tebert@hne.com) or Lyn Lourenco (llourenco@hne.com) or send to Health New England, 1 Monarch Place, Suite 1500, Springfield, MA 01144-1500 and request that HNE undertake a review of your tier designation. **The Plan will conduct a review only if you request it within 15 days of receiving your tier designation.** If you do not request a review within the 15 day period, you will need to wait until the next annual cycle.
2. The Plan's review will focus solely on matters related to your quality and efficiency scores. Therefore, be sure to specify the reasons why you are asking the Plan to review your tier designation. Please provide all of your reasons for believing that your tier designation is in error and include a copy of any information you have to support those reasons.

Within 20 days of the Plan's receipt of your written review request and the complete package of supporting documentation, the Plan will review the information or will investigate the factors that contributed to your tier designation and will notify you in writing of the outcome of the review. The Plan's decision will contain the following:

- Your physician link identification code
- The clinical specialty or field in which you are being scored
- The date of your request

HEALTH NEW ENGLAND PROVIDER MANUAL

- The nature of your review request concerns (i.e., clinical quality, cost efficiency or tier designation)

The Plan's written response will also list the Plan's key findings and rationale for its conclusions. If the findings could affect your score(s), the Plan will recalculate them. If the recalculated scores affect your tier designation, the Plan will adjust your tier designation accordingly. The Plan's decision is not subject to further review.

Emergency Services

What is an Emergency medical condition?

An Emergency Medical Condition is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

In the HNE Service Area

The member always has coverage for care that they believe is an emergency. HNE encourages the member, if the situation allows, to call their PCP first. If a member calls their PCP, the PCP may direct the member to an ER, urgent care facility or ask the member to visit a doctor's office. HNE requires PCPs to provide on-call coverage 24 hours a day, seven days a week. The PCP (or the covering physician) should call the member back as soon as possible if the member reached an answering service.

The below hospitals are currently contracted with HNE to provide emergency services:

Athol Memorial Hospital, 2033 Main Street, Athol, MA
Baystate Medical Center, 759 Chestnut Street, Springfield, MA
Berkshire Medical Center, 725 North Street, Pittsfield, MA
*Brattleboro Memorial Hospital
Cooley Dickinson Hospital, 30 Locust Street, Northampton, MA
Fairview Hospital, 29 Lewis Avenue, Great Barrington, MA
Franklin Medical Center, 164 High Street, Greenfield, MA
*Hartford Hospital, 80 Seymour Street, Hartford, CT
Holyoke Hospital, 575 Beech Street, Holyoke, MA
*Johnson Memorial Hospital
Mary Lane Hospital, 85 South Street, Ware, MA
Mercy Medical Center, 233 Carew Street, Springfield, MA
Noble Hospital, 115 West Silver Street, Westfield, MA
North Adams Regional Hospital, Hospital Avenue, North Adams, MA
St. Vincent Hospital, 123 Summer Street, Worcester, MA
UMass Memorial Medical Center

- Hahneman Campus, 281 Lincoln Street, Worcester, MA
- Memorial Campus, 119 Belmont Street, Worcester, MA
- University Campus, 55 Lake Avenue, North, Worcester, MA

Wing Memorial Hospital, 40 Wright Street, Palmer, MA

The below urgent care facilities are currently contracted with HNE to provide urgent care services:

510 Medical Walk In, 510 North Street, Pittsfield, MA
Accessible Medical Arts, 630 S. Main Street, Lanesboro, MA 01237
Ambulatory Employee Industrial Occupational and Urgent Healthcare, 170 University Drive, Amherst, MA
Baystate Medical Practice Rapid Care, 95 Sargent Street, Belchertown, MA 01007
Concentra Urgent Care, 140 Carando Drive, Springfield, MA 01104
Family Care Medical Center, 1515 Allen Street, Springfield, MA 01118
Hampden County Physician Associates, Medical Care Center, 98 Shaker Road, East Longmeadow, MA
Northgate Medical, 1985 Main Street, Springfield, MA 01103
Occupational Medicine Services, 15 Stoddard Avenue, Pittsfield, MA 01201
On Call Urgent Care Center, 51 Locust Street, Northampton, MA 01060
ReadyMed by Fallon Clinic, 222-224 Boston Turnpike, Route 9, Shrewsbury, MA 01545

**Participating only for Self-Funded members*

Unless otherwise indicated in this Provider Manual, all emergency follow-up care must be coordinated by the member's PCP. All HNE members have been instructed to contact their PCP to coordinate all follow-up care. Please note: this does not apply to PPO members.

Out of the HNE Service Area

The member always has coverage for care that he/she believes is an emergency. However, only initial treatment will be covered outside of the HNE Service Area. Follow-up care once the member is medically able to return to the service area must be provided or coordinated by the PCP. Please note: this does not apply to PPO members.

Emergency Inpatient Admissions

Emergency or urgent inpatient admissions must be reported to HNE within 24 hours (one business day) by the hospital or the admitting physician. Call HNE at (413) 787-4000, ext. 5027 or (800) 842-4464, ext. 5027.

Emergency admissions should be referred to participating hospitals unless it would be medically appropriate to treat the patient elsewhere.

- If an HNE member is admitted to an out-of-area hospital as a result of an emergency, HNE will cover the cost of services in that hospital only until the member's medical condition allows for return to the service area and the care of the PCP. Please note: this does not apply to PPO members.
- If the member is admitted to a hospital on an inpatient basis as the result of a medical Emergency, the ER copayment will be waived. The member must pay a copayment for each ER visit if the visit does not result in an admission.

Infertility Service

Infertility services are mandated benefits in the Commonwealth of Massachusetts and in Connecticut. This means that fully-funded plans must cover these services. Self-funded plans may choose not to cover them.

HNE covers many traditional infertility treatments, where medically indicated, including evaluation, artificial insemination (AI) and Intra-Uterine Insemination (IUI) services. Prior approval is required for AI services and IUI services. In addition to these traditional infertility treatments, HNE may also cover non-experimental, Assisted Reproductive Technology (ART) infertility procedures with prior approval. These include but may not be limited to In Vitro Fertilization and Embryo-Placement (IVF-EP); Gamete Intra-Fallopian Transfer (GIFT); sperm, egg, and/or inseminated egg procurement, processing, and banking; Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility; and Zygote Intra-Fallopian Transfer (ZIFT). Prior approval by HNE is required for all ART procedures.

Eligibility

HNE covers Infertility services for Massachusetts and Connecticut residents only. This is defined in the terms of HNE's Infertility Protocol. HNE covers Infertility services for a Connecticut resident only until her 40th birthday, as Connecticut law requires. Self-funded employer groups may limit or exclude infertility treatment. Providers should contact HNE when a member's infertility coverage is in question.

Prior Approval

To obtain prior approval, fax the Infertility Treatment Authorization Request Form to Health Services at (413) 233-2700. A copy of the most current HNE protocol for coverage of infertility services and Infertility Treatment Authorization Request Forms may be obtained by calling Health Services at (413) 787-4000 ext. 5027 or (800) 842-4464 ext. 5027.

Obstetrical and Gynecological Services

Members may have a pregnancy test performed by the PCP or a participating OB/GYN. If the member is pregnant, she may receive all of her pregnancy care, delivery, and one post-natal office visit from a participating obstetrician. The obstetrician must submit either the American College of Obstetricians and Gynecologists (ACOG) Antepartum Record Form or the Obstetrical Pre-registration Form following the member's first prenatal visit, to Health Services

HEALTH NEW ENGLAND PROVIDER MANUAL

for prior approval, including the patient's hospital admission and delivery. Each contains a section for Obstetrical High Risk/Pre-term Labor Assessment which is completed and submitted following the first prenatal visit and again following subsequent visit(s) if a risk factor is identified.

The obstetrician is responsible for all obstetrical services and referrals related to the member's pregnancy. The obstetrician may also provide routine medical services unrelated to the member's pregnancy.

Any elective surgical procedures to be performed during the hospital admission and following delivery (i.e., planned tubal ligation) can also be communicated to HNE by submitting the ACOG form either at the initial or subsequent visits. These services do not require submission of a separate Prior Approval Request Form or In-Plan Specialty Referral. Mail the ACOG Antepartum Record or Pre-registration form to Health Services or fax the form to (413) 233-2700.

A copy of the Clinical Guideline for Uncomplicated Obstetric Care and forms may be obtained by calling one of the HNE Network Operation Representatives at (413) 787-4000 ext. 5000 or (800) 842-4464 ext. 5000.

The obstetrician should also make certain that the pregnant member selects a participating Pediatrician to provide services to the newborn.

Each HNE female member is covered for one routine gynecological exam each calendar year. No referral is required. The annual gynecological exam may include a PAP smear, pelvic exam and mammographic exam. The exam may be performed by the member's PCP or any HNE participating gynecologist. No matter who performs the exam, the exam is paid to the provider by HNE on a fee-for-service basis.

Annual Vision Exam

Each HNE member is covered for one vision exam each calendar year. No referral is required. The exam may be performed by any HNE participating optometrist or ophthalmologist.

Chiropractic Benefit

The HNE chiropractic benefit is managed by OptumHealth. OptumHealth is a health and wellness company with over 15 years of experience 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 visit the OptumHealth Care Solutions website (click on "Provider Locator" in the list of links on the bottom of the home page). OptumHealth contact information is as follows:

Mailing Address:
OptumHealth Care Solutions
Kingston, NY 12402

Phone Number:
(888) 676-7768

Web Address:
optumhealth.com/P.O. Box 5600

Fax Number:
(845) 382-1341

DME (Includes durable medical equipment, specialty medical equipment, medical and surgical supplies, orthotics and prosthetics, oxygen and respiratory supplies)

The AELK Master List is located on HNEdirect.com.

Laboratory

The ordering physician must provide the member with a written order if the test is not provided on site. The ordering physician must always direct the member or member's specimen to an HNE participating laboratory provider to ensure coverage.

Blood specimens may be drawn in the physician's office. If testing is not performed in the office, only phlebotomy services may be billed.

The following section shows the HNE Physician Office Allowable Lab List which specifies testing that may be performed in Physicians' offices, provided that applicable laboratory certification requirements are met.

HNE Physician Office Allowable Lab Tests

HNE participating physicians may perform certain laboratory tests in their office for HNE members and may bill and be reimbursed by HNE on a fee-for-service basis. A list of the HNE physician office allowable lab tests is shown in the chart on the following 2 pages. The provider office laboratory (when applicable) must meet all local, state, and federal requirements relating to physician office laboratory standards and licensing.

HEALTH NEW ENGLAND LAB ALLOWABLE LIST

CPT #	Procedure Description	CPT #	Procedure Description
36400	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture-femoral or jugular vein	84075	Phosphatase, alkaline
36405	Venipuncture, under age 3 years-scalp vein	84100	Phosphorus inorganic (phosphate)
36406	Venipuncture, under age 3 years-other vein	84132	Potassium-serum, plasma or whole blood
36410	Venipuncture, age 3 or older, necessitating physician's skill, for diagnostic or therapeutic purposes	84144	Progesterone
36415	Collection of venous blood by venipuncture	84146	Prolactin
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)	84152	Prostate Specific Antigen (PSA)-complexed (direct measurement)
36600	Arterial puncture, withdrawal of blood for diagnosis	84153	Prostate Specific Antigen (PSA)-total
38220	Bone marrow-aspiration only	84154	Prostate Specific Antigen (PSA) - Free
80047	Basic metabolic panel (calcium, ionized)	84155	Protein, total, except by refractometry-serum, plasma or whole blood
80048	Basic metabolic panel (calcium, total)	84165	Protein-electrophoretic fractionation and quantitation, serum
80050	General health panel	84203	Protoporphyrin, RBC-screen
80051	Electrolyte panel	84295	Sodium-serum, plasma or whole blood
80053	Comprehensive metabolic panel	84436	Thyroxine-total
80061	Lipid panel	84439	Thyroxine-free
80069	Renal function panel	84443	Thyroid stimulating hormone (TSH)
80076	Hepatic function panel	84450	Transferase (ast) (sgot)
80100	Drug screen, qualitative-multiple drug classes chromatographic method, each procedure, each	84460	Alanine amino (alt) (sgpt)
80101	Drug screen, qualitative-single drug class method (eg, immunoassay, enzyme assay), each drug class	84460	Assay of triglyceridesAlanine amino (alt) (sgpt)
80104	Drug screen, qualitative-multiple drug classes other than chromatographic method, each procedure	84478	Triglycerides
80162	Digoxin	84479	Thyroid hormone (T3or T4) uptake or thyroid hormone binding ratio (THBR)
80185	Phenytoin-total	84520	Urea nitrogen-quantitative
81000	Urinalysis, nonauto w/scope	84525	Urea nitrogen – semiquantitative (eg, reagent strip test)
81001	Urinalysis, automated, with microscopy	84550	Uric acid-blood
81002	Urinalysis , non automated, without	84702	Gonadotropin, chorionic (HCG)

HEALTH NEW ENGLAND PROVIDER MANUAL

CPT #	Procedure Description	CPT #	Procedure Description
	microscopy		quantitative
81003	Urinalysis , automated without microscopy	84703	Gonadotropin, chorionic (HCG) Qualitative
81005	Urinalysis-qualitative or semiquantitative, except immunoassays	84704	Gonadotropin, chorionic (HCG) free beta chain
81007	Urinalysis-bacteria screen	85002	Bleeding time
81025	Urine pregnancy test, by visual color comparison methods	85004	Blood count-automated differential
82040	Albumin-serum, plasma or whole blood	85007	Blood count-blood smear, microscope examination with manual differential wbc count
82044	Albumin-urine, microalbumin, semiquantitative (eg, reagent strip assay)	85009	Blood count-manual differential wbc count, buffy coat
82150	Amylase	85013	Blood count-spun microhematocrit
82247	Bilirubin, total	85014	Blood count-hematocrit (HCT)
82248	Bilirubin, direct	85018	Blood count-hematocrit (HGB)
82270	Blood, occult, by peroxidase activity (eg. guaiac), qualitative-feces, consecutive collected specimens with single determination for colorectal neoplasm screening	85025	Blood count-complete (CBC), automated (HGB, HCT, RBC, WBC, and platelet count) and automated differential WBC count
82272	Blood, occult, by peroxidase activity (eg. guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	85027	Blood count-complete (CBC), automated (HGB, HCT, RBC, WBC and platelet count)
82310	Calcium-total	85044	Blood count-reticulocyte, manual
82374	Carbon dioxide (bicarbonate)	85060	Blood smear, peripheral, interpretation by physician with written report
82378	Carcinoembryonic antigen (CEA)	85097	Bone marrow, smear interpretation
82435	Chloride-blood	85610	Prothrombin time
82465	Cholesterol, serum or whole blood, total	85651	Sedimentation rate, erythrocyte-non automated
82550	Creatine kinase (CK, (CPK)-total	85652	Sedimentation rate, erythrocyte-automated
82565	Creatinine-blood	85730	Thromboplastin time, partial (PTT)-plasma or whole blood
82607	Cyanocobalamin (vitamin B-12)	86140	C-reactive protein
82670	Assay of estradiol	86308	Heterophile antibodies-screening
82728	Ferritin	86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
82746	Folic acid-serum	86318	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)
82800	Gases , blood, PH only	86320	Immunoelutrophoresis-serum
82803	Gases, blood, any combination of PH, PCO2, PO2, CO2, HCO3 (including calculated O2 saturation)	86403	Particle agglutination-screen, each antibody

HEALTH NEW ENGLAND PROVIDER MANUAL

CPT #	Procedure Description	CPT #	Procedure Description
82805	Gases, blood, any combination of PH, PCO ₂ , PO ₂ , CO ₂ , HCO ₃ (including calculated O ₂ saturation) with O ₂ saturation, by direct measurement, except pulse oximetry	86430	Rheumatoid factor-qualitative
82810	Gases, blood, O ₂ saturation only, by direct measurement, except pulse oximetry	86480	Tuberculosis test, cell mediated immunity antigen response measurement-gamma interferon
82947	Glucose-quantitative, blood (except reagent strip)	86481	Tuberculosis test, cell mediated immunity antigen response measurement-enumeration of gamma interferon-producing T-cells in cell suspension
82948	Glucose-blood, reagent strip	86592	Syphilis test, non-treponemal antibody-qualitative (eg, VDRL, RPR, ART)
82950	Glucose-post glucose dose (includes glucose)	86677	Antibody-helicobacter pylori
82951	Glucose-tolerance test (GIT), 3 specimens (includes glucose)	87070	Culture, bacterial-any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
82952	Glucose-tolerance test, each additional beyond three specimens (list separately in addition to code for primary procedure)	87081	Culture, presumptive, pathogenic organisms, screening only
82962	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use	87086	Culture, bacterial-quantitative colony count, urine
82977	Glutamyltransferase, Gamma (GGT)	87088	Culture, bacterial-with isolation and presumptive identification of each isolate, urine
83001	Gonadotropin-follicle stimulating hormone (FSH)	87210	Smear, primary source with interpretation-wet mount for infectious agents (eg, saline, india ink, KOH preps)
83002	Gonadotropin-luteinizing hormone (LH)	87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)
83013	Helicobacter pylori-breath test analysis for urease activity, non-radioactive isotope (eg C-13)	87430	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method-streptococcus, Group A
83014	Helicobacter pylori-drug administration	87905	Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid)
83036	Hemoglobin-glycosylated (A1C)	87804	Infectious agent antigen detection by immunoassay with direct optical observation-influenza
83037	Hemoglobin-glycosylated (A1C) by device cleared by FDA for home use	87880	Infectious agent detection by immunoassay with direct optical observation-streptococcus, Group A

HEALTH NEW ENGLAND PROVIDER MANUAL

CPT #	Procedure Description	CPT #	Procedure Description
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen-quantitative or semiquantitative, single step method (eg reagent strip)	88738	Hemoglobin (HGB), quantitative, transcutaneous
83519	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen-quantitative, by radioimmunoassay (eg RIA)	89060	Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen-quantitative, not otherwise specified	89300	Semen analysis-presence and/or motility of sperm including hühner test (post coital)
83540	Iron	89310	Semen analysis-motility and count (not including hühner test)
83550	Iron binding capacity	89320	Semen analysis-volume, count, motility and differential
83615	Lactate dehydrogenase (LD), (LDH)	89321	Semen analysis-sperm presence and motility of sperm, if performed
83690	Lipase	89322	Semen analysis-volume, count, motility, and differential using strict morphological criteria (eg, kruger)
83718	Lipoprotein, direct measurement-high density cholesterol (HDL cholesterol)	89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology as indicated)
83721	Lipoprotein, direct measurement-direct measurement, LDL cholesterol	99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
83735	Magnesium		
83912	Molecular diagnostics-interpretation and report		

Miscellaneous Services including Pain Management, Biofeedback, Neuropsychological Testing, and Outpatient Electroconvulsive Therapy (ECT)

Various types of providers including hospitals, mental health clinicians and anesthesiologists may provide pain management services. Copayments are applicable for pain management services including an outpatient hospital copayment, if services are performed in the hospital.

Biofeedback is a covered benefit. Biofeedback can be used to treat medical conditions as well as mental health conditions. Biofeedback for mental health is treated like therapy and prior approval from Behavioral Health Services is required. Biofeedback to treat ADHD and ADD is not a covered benefit.

Neurobiofeedback is not a covered benefit. Neurobiofeedback is a non-invasive technique that is used to teach patients how to stimulate and suppress brainwaves of specific frequencies.

Neuropsychological testing is covered. The physician office visit copayment applies. **Prior approval from Behavioral Health Services (BHS) is required for fully funded members.**

Neuropsychological testing is not approved as a first assessment approach for Attention-Deficit/Hyperactivity Disorder.

Provider Collection Policy

HNE recommends that the provider submit the bill 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 bill to HNE, we expect providers and members 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 not applicable for Medicare Advantage Members. This form should only be used in one of the four circumstances described on the form:

**Member Assumption of Financial Responsibility for Medical Services
Statement of Understanding**

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)

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 drug utilization. Our clinical pharmacist oversees the pharmacy and therapeutics program and works with HNE's pharmacy benefits manager.

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

Prescription Benefit:

Most HNE members are covered for prescription drugs obtained at HNE participating pharmacies. If members have prescription drug coverage, this is noted at the bottom of the HNE ID card (*for example, RX\$10/20/35*). The retail prescription drug benefit is normally limited up to a 30-day supply.

Attention Deficit Disorder Medications that are classified as a controlled substance (CII and CIII) can be filled for up to a 60 day supply at an In-Plan Pharmacy (this is subject to the store's internal policy). One co-payment applies for each 30 day supply. This applies to the state of Massachusetts pharmacies only. All other states are subject to their own state laws and internal store policies.

HNE Pharmacy Network:

Members can get medications at participating pharmacies through our national pharmacy networks. That means whether they are home, on vacation, or away for business or other reasons, members can fill prescriptions at any of the more than 50,000 pharmacies that participate in our national network. Participating pharmacies include CVS, Costco, Stop & Shop, Rite-Aid, and Target. HNE's pharmacy benefits manager maintains the network by negotiating contracts and ongoing analysis to monitor quality of care and service.

Over the Counter Medications:

HNE covers a number of over the counter (OTC) medications such as allergy and PPI medications. HNE covers these medications as a cost saving measure to our members. These medications usually are covered at a Tier 1 copayment or less. Please refer to our formulary listings at www.hne.com for coverage.

Compounded Medications:

Copayments for compounds will vary based on ingredients. However, not all compounds are covered. For questions regarding coverage, please call HNE Member Services at (413)-787-4004 or (800)-310-2835.

Maintenance Medications at Retail:

HNE's Access 90 program allows our members to receive up to a 90 day supply of maintenance medications at participating retail pharmacies. A copayment 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 call HNE Member Services at (413) 787-4004 or (800) 310-2835.

Maintenance Medications at Mail Order:

Members with the mail order benefit may obtain up to a 90 day supply of maintenance medications through the mail. We recommend that our members obtain 2 prescriptions for new maintenance medications; one to be used for a preliminary 30 day supply to be filled by your local participating pharmacy and one to be used for up to a 90 day supply (plus refills) for up to one year to be filled by the mail order pharmacy.

When to use the WellDyneRX mail service prescription drug benefit (*if the member has the mail order benefit):

- After verification that the medication is a maintenance medication as defined by HNE
- After the member has filled as least 2 refills at retail and has not had an adverse reaction
- To take advantage of lower copayments for generic and formulary maintenance medications
- To plan ahead when members are going on vacation

How to use the WellDyneRX mail service prescription drug benefit:

- We recommend that our members obtain 2 prescriptions for new maintenance medications; one to be used for a preliminary 30 day supply to be filled by a local participating pharmacy and one to be used for up to a 90 day supply (plus refills) for up to one year to be filled by the mail order pharmacy.
- Complete the mail order profile and submit following the directions on the form or visit hne.com
- For faster service our members can order refills on line at www.hne.com as indicated on the invoice received from the mail order company. This only applies to prescriptions with refills and does not apply to any initial orders.

Specialty Medications:

Members being treated with specialty medications are required to use the specialty pharmacy to fill oral oncology and self-injectable medications with the exception of insulin products. HNE's specialty vendor supplies all forms of injectable medications for HNE members with a prescription benefit. Members without the benefit are covered only for medical injectables (i.e., administered by a medical professional) and are not covered for self-injectables. Order forms for specialty medications are available on line at www.hne.com or can be faxed to you by calling HNE Member Services at (413) 787-4004 or (800) 310-2835.

HNE's specialty vendor will provide injectable drugs to HNE members in the following settings:

- Private physician offices
- Hospital clinics
- Members' homes

This service is provided to both members and providers. You can call (800) 775-5138 to request drug order forms.

HNE Formulary

The formulary is more than a list of what drugs are covered. It is a tool for evaluating the appropriateness of a given agent or class of agents and determining the appropriate use of pharmaceuticals. The HNE formulary is an open formulary with restrictions.

The Pharmacy and Therapeutics Committee of our Pharmacy Benefit Manager (PBM) supports HNE's Pharmacy and Therapeutics Committee in evaluating drugs and recommending therapeutically effective and safe medications for treating most common medical conditions. The PBM and HNE committees each meet at least four times per year to consider changes to the formulary. New drug reviews are assigned to one of the PBM's clinical pharmacists. They gather appropriate clinical literature, contacts specialists as needed and obtain unbiased information in peer review journals. The PBM's review also includes relevant information from other sources, such as government agencies, clinical associations, and recognized commissions. Also considered are a number of factors, including status of FDA approved, quality dimensions, and whether the drug represents breakthrough therapy. In addition, all drug classes are reviewed annually.

Important Criteria:

- Drugs reviewed for addition must be FDA approved.
- Drugs under consideration will be compared to existing therapies and will be evaluated based on quality dimensions.
- If the drug under consideration is not similar to existing agents and is the only drug in its class, the evaluation will be made against existing therapies, including non-drug therapies.

HNE does not cover new brand name drugs, or existing drugs with new treatment purposes. There is at least a six month period after they are approved by the FDA. This is called the Clinical Review Period (CRP). You may ask

HEALTH NEW ENGLAND PROVIDER MANUAL

HNE to make an exception. If we approve coverage of the drug during the CRP, the member copayment will be \$50.00 or 50% of the cost of the medication, whichever is greater.

As part of the formulary evaluation process, HNE also uses an algorithm based on safety, efficacy and cost. All formulary recommendations are discussed at the HNE Clinical Care Assessment Committee, which acts as our Pharmacy and Therapeutics Committee, providing a forum for additional local practicing physician involvement. Recommendations are then forwarded to the HNE Medical Policy Committee, which renders the final decision. The Pharmacy and Therapeutics Committee reviews drug categories throughout the year, evaluating requests for addition when the requested drug's category is scheduled to be reviewed. Recently approved drugs that fill a treatment void may be reviewed out of cycle.

The formulary is reviewed annually and as necessary throughout the year. Providers can receive a formulary listing on request. Drugs added or deleted from the formulary during the year are communicated through periodic mailings to providers and members, and are posted on www.hne.com.

Generic Drugs

Generic substitution is mandated in Massachusetts and HNE supports and encourages the use of U.S. Food and Drug Administration (FDA), "AB" rated generic pharmaceuticals for HNE membership.

Approved FDA "AB" rated generic drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective and usually cost less. In most cases, Massachusetts law requires and HNE encourages the dispensing of generic drugs whenever possible. The HNE member pays the lowest copayment for generic drugs.

When you prescribe a brand name medication and an approved FDA "AB" rated generic is available you will need to complete and submit a Prior Authorization Form, To assist in expediting your medication request make sure you complete all questions on the form. Provide your assessment of medical necessity for the Brand product only. Include any documentation such as office notes, call log(s), action steps taken should the member have experienced an adverse reaction, serious side effect, and/or lack of efficacy to the generic product. HNE encourages you to go to the FDA web site and complete a Medwatch Adverse Event Reporting Form if the member had a serious adverse event. Your request will be reviewed and a determination will be based on the information you provide.

The highest member copayment applies for the brand drug.

Newly Approved Drugs

HNE does not cover new brand name drugs, or existing drugs with new treatment purposes. There is at least a six month period after they are approved by the FDA. This is called the Clinical Review Period (CRP). You may ask HNE to make an exception. If we approve coverage of the drug during the CRP, the member copayment will be \$50.00 or 50% of the cost of the medication, whichever is greater.

After review, the drugs will be covered under either the middle copayment level (Tier 2) for formulary additions or our highest copayment level (Tier 3) for drugs not added to the formulary. This does not apply to newly approved generic drugs. Generic drugs are covered under the lowest copayment level (Tier 1).

Excluded Drugs

For the most current list of excluded drugs, please call HNE Member Services at (413) 787-4004 or (800) 310-2835.

Review Process

If a physician requests an FDA approved medication for a non-FDA approved disease state/condition, the criteria for its use will be based upon at least 3 peer-reviewed journal articles, national guidelines and current standard of care. If the use of the medication does not fall into any of these categories, HNE's Pharmacy Services Department will generally deny the request.

You can obtain a copy of the Clinical Review Period Benefit Exception form at www.hne.com and click on the tab labeled "Provider" then "Pharmacy", and "Forms".

Medical /Pharmacy Benefit Drugs Requiring Prior Approval:

HNE continually monitors and evaluates new drug information, drug utilization and formulary compliance to meet our goal of providing high-quality pharmaceutical care. As part of this process, HNE limits quantities and use of certain drugs and requires prior approval for others.

In order to obtain a supply of medication request forms or a list of any medical or pharmacy drugs that require approval, visit www.hne.com or call HNE Member Services at (413) 787-4004 or (800) 310-2835. Complete the appropriate drug prior authorization form and fax it to the number on the form.

Our Pharmacy Benefit Manager (PBM) offers our providers the option to call in for prior approval by calling 1-866-209-1057. The PBM will contact the provider if necessary and will notify you of all decisions. They also provide an opportunity for case discussion and reconsideration of adverse determinations.

Drugs with Quantity Limits:

For the most current list of medications with quantity limits or quantity-based copayments, please visit www.hne.com or Member Services at the number noted above. Completed forms should be faxed to the number on the form. Only FDA maintenance indicator drugs are allowed through mailorder.

Step Therapy Program

Step Therapy is an approach to medication management. Step Therapy is a program designed exclusively for certain conditions—diabetes, high blood pressure and high cholesterol. The HNE Step Therapy program is all about value. Most simply, that means getting a tried and true medication that’s proven safe and effective for your condition and getting it at the lowest possible cost. This program is designed to have prescription drugs be more affordable. We will work with you to be certain that our members are getting the appropriate drug for their condition. The use of samples does not satisfy the requirements of documented usage of a first or second line drug of medical necessity for a Step Therapy drug. If it is medically necessary for your patient to use a Step Therapy drug before trying a first and/or second line drug, please contact HNE to request a pharmacy review. If you have any questions about the program or need any pharmacy forms or our most current list, visit www.hne.com or contact HNE Member Services.

Note: Some of these Step Therapies have 3 steps. Members must try the first line drug before HNE will cover the second line drug. Members must try the second line drug before HNE will cover the Step Therapy drug.

Utilization Management, Case Management & Disease Management

The purpose of HNE's Utilization Management (UM)

The purpose of HNE's UM program is to confirm member eligibility, 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 discharge plans and to understand and/or resolve barriers to discharge. 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 behavioral health, medical care, or services. Prior authorization and pre-certification are defined as pre-service review. HNE requires pre-service review for the following:

- a. All admissions/procedures/services with an out-of-plan or out-of-network facility for HMO plans
- b. All admissions to a skilled nursing facility or inpatient rehabilitation facility for HMO plans
- c. Human organ transplants
- d. Selected elective outpatient/ambulatory procedures or services
- e. Selected durable medical equipment: (for specific plan requirements, refer to the individual member's benefit materials).
- f. Services which represent new or emerging technologies, unusually wide variation in use or are prone to abusive high utilization

Pre-service review also includes confirmation of member eligibility, coverage and assessment of medical necessity.

2. Concurrent Review

Review includes admission certification of urgent/emergent admissions and elective admissions that were not prior approved, the ongoing review of a member's inpatient stay, and the review for extension of previously approved ongoing courses of treatment over a period of time or number of treatments.

3. Post-Service Review

This includes review for care or services that have already been received (i.e., retrospective review).

There may be times when a service is not approved. A utilization management denial may be made only on the basis of whether it is medically necessary or appropriate or if it is not a covered service under the member's plan.

HNE knows that there is risk of under-utilization of necessary health services. It therefore states that:

- HNE's utilization management programs have been designed to ensure that medical decision-making is based on the appropriateness of care and services and the existence of coverage.
- HNE encourages all clinicians and administrative staff who are involved in utilization management review to work collaboratively to help members obtain access to appropriate health care resources.
- HNE does not provide compensation or other financial incentive or reward to its In-Plan providers or staff who conduct utilization management review that is based on the quantity or type of denial decisions rendered.

UM Review and Decision Process

All UM decisions are made in accordance with the terms of the member plan document. UM decisions shall be made 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. Written criteria govern all decision-making.

The HNE UM Decisions policy sets 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. At a minimum, this policy is updated on a bi-annual basis. 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. If providers would like a copy of HNE's most recent UM Decisions policy, providers may request a copy by calling Provider Relations at (413) 233-3313 or (800) 842-4464, extension 5000.

Physician Reviewers

The Chief Medical Officer and/or appropriate specialists and clinical practitioners are consulted for cases that do not meet medical criteria. Program staff may not make denial of service determinations for medical necessity. 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.

HNE staff responsible for making medical decisions are not influenced by fiscal considerations of the health plan. HNE does not reward practitioners or other individuals conducting reviews for issuing denials of coverage of service. Program decision-making is based only on clinical appropriateness of care and service, within the scope of defined benefits.

UM Decisions, Criteria and Definition of Medical Necessity

Consistent with generally accepted principles of professional medical practice and in consultation with the member, the physician treating a member makes all clinical decisions regarding medical treatment to be provided to the member, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the member and any third party.

In reviewing requests for prior approval, HNE may consider whether the service:

- Is a covered benefit or service
- Is medically necessary
- Is being provided in the appropriate setting
- Follows generally accepted medical practice
- Is available within the HNE network
- Meets HNE's clinical criteria for coverage

HNE utilizes commercially purchased criteria sets to assist with making level of care determinations. HNE's commercially purchased criteria sets are licensed criteria sets, which are the PROPRIETARY and CONFIDENTIAL property of the licensing company. HNE has a contractual obligation to protect the confidentiality of these licensed criteria. HNE makes available to the treating provider and the member, the specific portion of the criteria used where required by law or by applicable accreditation requirements.

HNE has also developed internal criteria that are used as a guideline when applying the standard of medical necessity for select procedures, treatments, and services. Providers who would like a copy of the HNE-developed clinical criteria that are used to make UM determinations should contact Health Services at (413) 787-4000 or (800) 842-4464, extension 5027.

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

- developed with input from practicing physicians 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. In addition, HNE will notify members and providers 60 days prior to the effective date of any material changes to HNE's criteria.

With respect to a member enrolled in a health benefit plan under which HNE only provides administrative services (i.e., for members enrolled in a Self-Funded plan), the payor may reserve the right to decide certain appeals of benefit denials. If so, HNE's role with respect to payment is limited to the benefit coverage recommendation of the payor.

HNE defines "medically necessary" as follows: health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

- The service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual
- Is known to be effective, based on scientific evidence, professional standards, and expert opinion in improving health outcomes

- The service is based on scientific evidence for services and interventions not in widespread use.

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 approval and would like to know its status or outcome, the provider should contact Health Services at (413) 787-4000 or (800) 842-4464, extension 5027, between 8:00 a.m. and 5:00 p.m., Monday through Friday.

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

- High Cost Radiology and Imaging - **MedSolutions at (888) 693-3211**
- Chiropractic Services - **OptumHealth at (888) 676-7768**
- Pharmacy Issues - **MedMetrics at (866) 209-1057**

Submitting additional information in the case of an adverse determination

When a requesting physician or PCP has received an adverse determination and has additional information that may influence the decision, the physician or his/her office staff should contact the HNE Nurse Case Manager within 10 business days after the denial notice has been issued so that HNE may review the request again based on this new information.

Reconsideration of Adverse Determinations

If a decision is based on medical necessity and appropriateness, the physician may request a reconsideration from a clinical peer reviewer. As required by Massachusetts State law, a provider who is treating a member has the right to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. This reconsideration process shall be initiated within one business day of the receipt of the request. It will be conducted between the provider and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available. If the adverse determination is not reversed by the reconsideration process, the member or the provider on behalf of the member, may pursue the grievance process established pursuant to Massachusetts General Laws chapter 176O. The reconsideration process allowed herein shall not be prerequisite to the formal internal grievance process or an expedited appeal required by Massachusetts General Laws chapter 176O.

Arranging a Telephone Conference for a Case Discussion or Reconsideration

To arrange a telephone conference time for a reconsideration, the requesting physician 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 physician and the HNE physician reviewer or clinical peer reviewer.

Case Management

HNE's Case Management Program is designed to offer physicians and members a Nurse Case Manager to facilitate care coordination. Case Managers are assigned members by specific provider regions or employer groups rather than by type of utilization management activity. This allows the Case Manager to follow each member through the entire continuum of care, regardless of whether the service the member is receiving is inpatient or outpatient. Each Case Manager is responsible for performing utilization review and coordinating follow-up care. By providing the member and provider with one direct contact at HNE for medical concerns, this design allows Case Managers to build trusting relationships with HNE members and providers.

In general, members who would benefit from coordination of care are those:

1. Experiencing high cost/catastrophic events
2. Experiencing sub-optimal ambulatory management
3. Who could be managed at a less intensive level of care
4. Receiving care outside of the network
5. Whose physician has sought case management assistance for high-risk members
6. Identified as a priority case

The case management process involves case identification, assessment, planning, coordination, monitoring and evaluation. HNE provides an After Hours On-Call Program. An HNE Case Manager is available to providers and members to assist in care coordination needs that are identified or planned to occur outside of HNE's usual business hours. The After Hours On-Call Program functions include:

1. Avoiding acute inpatient admissions when another level of care is appropriate

2. Assisting providers in transitioning members from one level of care to another appropriate level of care
3. Assisting in disposition planning for hospitalized members on weekends or holidays where delays may otherwise be experienced
4. Being available to members/families and providers during transitions in care to answer case management or HNE system specific questions

HNE provides ambulatory or hospital case management. Ambulatory case management includes the management of care for members with complex illnesses or who require complex coordinated care in the ambulatory setting (physician office, ECF, home care and outpatient care). Hospital case management includes the management of care for members with complex illnesses or who require complex coordinated care while admitted to an acute care facility.

Providers may refer a member to receive Case Management Services by calling the HNE Health Services Case Management queue at (413) 787-4000, ext. 5027 or (800) 842-4464, ext.5027.

High Risk Member Case Management

High-risk members are those who are likely to become hospitalized or require multiple health care services. This is a proactive approach to managing HNE's high-risk members, with the goal being to improve the member's functional status, reduce hospital admissions, and reduce medical costs. If providers have questions or would like to refer a member to this program, providers may contact Health Services by calling (413) 787-4000, ext. 5027 or (800) 842-4464, ext. 5027.

Disease Management

HNE is committed to helping our members with chronic health conditions live healthy lives. As part of this commitment, we offer Disease Management (DM) programs for members with diabetes, asthma, coronary artery disease, and high-risk pregnancy. Through our DM programs, HNE partners with physicians in support of the plan of care. The overall goal of this collaborative effort is to help members achieve and maintain control of their condition by improving self-management skills. Self-management skills impact clinical outcomes and are important in delaying and preventing exacerbations and complications of chronic disease. HNE DM programs provide members with education and support to help improve their ability to manage their health condition on a day-to-day basis.

Claims and encounter data are reviewed to identify members with chronic conditions and stratify them into low-, medium-, and high- risk categories based on the level of disease control. HNE provides DM interventions based on a member's stratification level. Interventions include: educational materials sent by mail, questionnaires, peak flow meters, health diaries, tracking tools, asthma action plans, live education workshops, virtual education classes on DVD and video, live grocery store tours, smoking cessation reimbursement, and telephonic assessment performed by a registered nurse.

If providers have questions or would like to refer a member to disease management, contact Health Services at 800-842-4464 or 413-787-4000 ext. 5027. If you go to www.hne.com and click on the "Health" tab, there is more information and helpful links regarding disease management.

Health Information Line (HIL)

The HIL provides health information and resources to HNE members 24-hours a day. HIL, also known as the Nurse Advice Line, 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 HIL vendor notifies HNE about member activity on a daily basis for quality and utilization purposes. The HIL is accessible through HNE's main telephone number (413) 787-4000 or (800) 842-4464 or directly at (866) 389-7613.

Behavioral Health (BH)

HNE follows the provisions of its UM Program and the UM Decisions Policy (See Section X.A) for review of behavioral health services. HNE covers mental health and substance abuse services that are medically necessary or according to the member's plan. 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

HEALTH NEW ENGLAND PROVIDER MANUAL

conducted by contacting Behavioral Health (BH) Department at (413) 787-4000 ext. 5028 or (800) 842-4464 ext. 5028. See Section X.B.6 for additional information about availability of licensed criteria sets.

Members will receive their first 15 outpatient behavioral health sessions without an approval.

For ongoing services, prior to visit 16, the therapist should fax a completed HNE Outpatient MH/SA Treatment Form to the BH Department at (413) 233-2800. In some instances, the BH Specialist may present the case to an HNE Physician Reviewer or other appropriate reviewer for a decision as needed. The HNE Physician Reviewer or other appropriate reviewer may consult with the treating provider for clarification. The provider will receive a phone call within two business days from the date of receipt of the request with the decision. A determination letter will be mailed to the provider on the next business day. If providers do not receive a determination letter within one week, they should contact the BH Department at (413) 787-4000 or (800) 842-4464, ext. 5028.

For ongoing therapy services up to 20 sessions year-to-date, fax page one of the HNE Outpatient MH/SA Treatment Form to the BH Department (413) 233-2800. A BH Specialist shall apply the previously noted BH criteria in determining whether to approve additional sessions.

For sessions beyond 20 year-to-date, fax both pages of the treatment form, documenting medical necessity. A BH Specialist shall apply the previously noted BH criteria in determining whether to approve additional sessions. This information may be reviewed by a consulting psychiatrist and a determination will be made to approve, deny, or modify the request.

Members who are denied coverage because of the absence of medical necessity will be notified in writing. They will have the option to appeal through HNE's Grievance Process, and will have the opportunity to continue their treatment at their own expense with either their HNE therapist or someone else of their choosing. Should the clinical condition change, a new determination of medical necessity can be arranged either by their HNE provider or by the Behavioral Health Manager.

HNE covers inpatient and partial hospitalization services. After hours direction of care is provided by hospital-based Crisis Teams. The BH Department conducts concurrent reviews of ongoing hospitalization services to ensure continued medical necessity.

Please note: for self-funded plans, certain benefit limits may apply. Effective January 1, 2010 there will be no benefit limits for fully-funded or self-funded plans. For specific benefit information, providers may contact Member Services or Behavioral Health Services.

Inpatient and Partial Hospitalization Services

HNE covers inpatient and partial hospitalization services with prior approval by a Crisis Team. The Behavioral Health Department conducts concurrent reviews of ongoing hospitalization services to ensure continued medical necessity.

What is not covered:

Services that are not covered under the mental health/substance abuse benefit include:

- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Services for problems of school performance
- Pastoral counseling
- Social work for non-mental health care
- Christian Science practitioner and sanitarium stays
- Services that a third party or court order requires, unless HNE determines that the service is Medically Necessary
- Hypnosis
- Telephone Therapy
- In-Home Therapy

Radiology Management Program

MedSolutions performs utilization management services for outpatient imaging services. Certain radiological services require prior approval. This prior approval policy **affects outpatient services only**; emergency room, observation and inpatient imaging procedures do not require prior approval. **Failure to obtain prior approval may result in denial of payment.** This policy is applicable to **all HNE Products.**

Procedures that Require Prior Approval:

- CT Scan
- MRI/MRA
- PET Scan
- Nuclear Cardiology (in office only)
- Virtual Colonoscopy

Prior Approval Process:

- The **ordering physician** is responsible for obtaining the prior approval from MedSolutions for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call. MedSolutions also has the ability to receive your requests online via a secure web application at www.medsolutionsonline.com.
- The **HNE facility providing radiological services** is responsible for ensuring that approval has been obtained prior to rendering service. Facility providers may confirm authorizations by visiting MedSolution's web site at www.medsolutionsonline.com. Providing services without prior approval may result in denial of payment.
- **Call center hours of operation are Monday through Friday, 8 am to 9pm EST.** Providers may obtain prior approval 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 Medsolutions within 48 hours of the next business day to obtain proper approval for the studies, which will still be subject to medical necessity review.)

Important Notes:

- If the ordering provider is not satisfied with MedSolutions decision, which may include the result of a case discussion with the original reviewer, the provider may request a Reconsideration of the pre-service denial. The reconsideration will be conducted by a clinical peer reviewer who was not involved in the initial decision. The provider may request a reconsideration by contacting MedSolutions at (888) 693-3211. The reconsideration will be conducted within one working day of the request. If the provider is still not satisfied with the outcome after a reconsideration, the provider may initiate a member appeal on behalf of the member by contacting HNE's Member Services Department at (413) 787-4004 or (800) 842-4464, extension 5025. The member must consent to the initiation of the member appeal.
- The provider may submit a provider appeal for post-service denials.

Clinical Transition Program

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

- new members 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 program requirements and transitional coverage available, providers should contact Health Services by calling (413) 787-4000 ext. 5027 or (800) 842-4464 ext. 5027.

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.

Both approval and denial of coverage are based on appropriateness, medical necessity, and the scope of HNE's contractual obligations to its members. HNE does not offer incentives to its staff or to physician reviewers to encourage coverage denials, nor is compensation tied to such denials.

Medical Technology Assessment Program

HNE has established the Medical Technology Assessment Program to ensure that members have equitable access to safe and effective care through the evaluation of developments in new technology and new applications of existing technology. This process involves review by HNE's internal Medical Technology Assessment Committee (MTAC) of all available scientific evidence and determinations from regulatory bodies. This information, coupled with input from local physicians through the HNE Clinical Care Assessment Committee (CCAC), form the basis for decision making regarding new medical technology.

Technology evaluation criteria, in general terms, include the following:

- Approval from appropriate regulatory bodies
- Scientific evidence must permit conclusions concerning the effect of the technology on health outcomes
- The technology must improve the net health outcomes
- The technology must be beneficial as an established alternative
- The improvement must be attainable outside investigational settings

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

PCP Data

HNE keeps 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. This data is summarized and 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.

It is the intent of HNE to monitor all data for the 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 protect 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. & 164.506(c)(4)].

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 included under payment and case management and care coordination activities are included within the limited health care operation. **Therefore, the disclosure of health information by physician 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 at HNE share those same concerns and as a company will proceed only in a manner that is consistent with applicable laws, as outlined above. Providers should contact the HNE Privacy Office at (800) 842-4464 or (413) 787-4000 ext. 3356, if they have additional questions or concerns.

HNE Clinical Guidelines and Standards

Clinical Guidelines and Standards

The HNE Clinical Care Assessment (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 Secretary at (413) 787-4000, ext. 3457 or (800) 842-4464, ext. 3457.

Unless new scientific evidence or revised national standards warrants review and update sooner, clinical guidelines are reviewed biennially. 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 ext. 3457 or (800) 842-4464 ext. 3457. In addition, clinical guidelines are available on the HNE web site (HNE.com) and the physician information portal (HNE Direct).

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 Product-Specific Standards
	Non-Medical Home	Medical Home	
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		

HIGH-VOLUME SPECIALTY PRACTITIONERS

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards	
Routine/Regular	Within seven business days of request		
Non-Urgent Symptomatic		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 PROVIDER

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards	
Routine/Regular	Within 10 business days of request	Within 14 business days of request	
Urgent and Life/Non-life Threatening Emergency Services	Requires immediate face-to-face medical care. The member or representative should call 911. Member referred to the nearest hospital-based psychiatric emergency service crisis team for immediate treatment	<u>Urgent</u> • Medicaid: Within 48 hrs of request <u>Non-life threatening</u> • Medicaid: Within 6 hrs of request	
After-Hours Care	24-hrs-a-day/7-days-a-week on-call system must be in place for member emergencies after hours.		
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.		
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		

Medical Record Standards and Reviews

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

MEDICAL RECORD DOCUMENTATION GUIDELINES / BENCHMARKS

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 is 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 chart	100%

Credentialing/Recredentialing

HNE is dedicated to providing its members with access to effective healthcare and, as such requires participating physicians to be board-certified or eligible to become board-certified within certain timeframes. Exceptions will be evaluated on a case by case basis. HNE's credentialing standards are more extensive than (though fully compliant with) NCQA requirements. HNE reviews the credentials of network providers every two years in accordance with state requirements.

Concerning their credentialing and recredentialing applications, practitioners have the right to:

- Review information submitted to support their applications
- Correct erroneous information
- Be informed of the status of their applications upon request
- Receive notification of these rights.

HNE participates with HealthCare Administrative Solutions, and as such accepts the Massachusetts Uniform Credentialing and Recredentialing On-line Application, CIMA/CAQH. HNE utilizes the services of Ingenix dba Aperture Credentialing, an NCQA –certified credentials verification organization for Primary Source Verification of the following elements of credentialing:

- Application Processing
- CVO Application and Attestation Content
- DEA Certification
- Education and Training
- License to Practice
- Malpractice Claims History
- Medical Board Sanctions
- Medicare/Medicaid Sanctions
- Ongoing Monitoring of Sanctions
- Work History

Quality Management Program – *(additional detail is available upon request)*

The HNE Quality Program is designed to be a coordinated, comprehensive and ongoing effort to assess the access to and effectiveness of all care and service provided. All efforts are focused 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 Management Program.

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

- Delegate oversight
- Utilization management (including behavioral health)
- Care coordination
- Access to services
- Patient safety
- Preventive health initiatives
- Case management
- Disease management
- Member and provider 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 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 data collection efforts
- 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 Program provides information and education in several ways, including the following:

- Availability of Quality 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.*

Serious Reportable Events and Never Events

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: (for purposes of this policy, the following definitions apply);

- **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's 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 28 Serious Reportable Events and Never Events in 1 of 6 categories: surgical, product or device, patient protection, care management, environment, and criminal. *A list of these 28 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 HNE Chief Medical Officer at fax number (413) 734-3356.
- 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.

* As of October 31, 2008, and subject to NQF updates.

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 copayment 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 under HNE’s Chief Medical Officer, Medical Directory 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 List of Serious Reportable Events and Never Events*
Surgical Events
Surgery performed on the wrong body part
Surgery performed on the wrong patient
Wrong surgical procedure performed on a patient
Unintended retention of a foreign object in a patient after surgery or other procedure
Intraoperative or immediately post-operative death in an ASA Class 1 patient
Product or Device Events
Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
Patient Protection Events
Infant discharged to the wrong person
Patient death or serious disability associated with patient elopement (disappearance)
Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
Care Management Events
Patient death or serious disability 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)
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates
Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
Patient death or serious disability due to spinal manipulative therapy
Artificial insemination with the wrong donor sperm or wrong egg
Environmental Events
Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility

* As of October 31, 2008, and subject to NQF updates.
Current April 2011

HEALTH NEW ENGLAND PROVIDER MANUAL

Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
Patient death or serious disability associated with a fall while being cared for in a healthcare facility
Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
Criminal Events
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
Abduction of a patient of any age
Sexual assault on a patient within or on the grounds of the healthcare facility
Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility

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 not for profit 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 is also 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 Web site: www.ncqa.org.

NCQA Accreditation

HNE's commercial HMO and POS products are currently accredited "Excellent" 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 a 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, which fall into 5 categories:

- Quality Management and Improvement
- Credentialing and Recredentialing
- Utilization Management
- Members' Rights and Responsibilities
- Member Connections

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

Provider Review and Corrective Action

Introduction and Purpose

The purpose of this policy is to create a framework to address provider actions which affect 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 which 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 which is also addressed by an HNE credentialing policy, the HNE Medical Director shall decide, in his or her discretion, whether to proceed under this policy, 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.

With respect to First and Second Level Utilization Management and Quality of Care Issues, the intent of this policy is to resolve the issues through discussion and cooperation between HNE and the provider. Where 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.

Provider Actions Warranting Further Review

The following are categories of actions for which a provider will be subject to review. The fact that an action may be listed under one category does not preclude HNE from treating such action as a more serious issue depending upon the nature, severity, frequency or effect of the action or any other relevant circumstances. If a provider has engaged in a prior action which was, or could have been, the subject of HNE review and corrective action, the occurrence of subsequent provider actions will be grounds for treating the issue in a more serious manner.

First Level Utilization Management and Quality of Care Issues

A First Level Utilization Management and Quality of Care Issue (“First Level UM/QC Issue”) involves a situation which requires provider improvement in areas pertaining to compliance with HNE administrative policies or the provision of satisfactory service to HNE members. Examples of First Level UM/QC Issues 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 First Level UM/QC Issue.

- Improve provider’s compliance with utilization management procedures developed by HNE (as set forth in the HNE Provider Manual, or otherwise communicated to the provider). Such procedures include, but are not limited to: prior approval requirements; pre-admission authorization requirements for non-emergency admissions; and discharge planning requirements
- Improve provider’s compliance with billing procedures, including but not limited to failure to submit bills in the proper format or failure to code services properly
- Address provider’s submission of bills for services not appropriately rendered by a provider in that specialty
- Improve provider’s cooperation in utilization management programs developed by HNE or required by regulatory agencies
- Improve provider’s maintenance of medical records to ensure compliance with standards adopted by HNE or required by law
- Address provider’s failure to submit needed data or forms, or provider’s compliance with HNE documentation requirements pertaining to utilization management
- Improve provider’s timeliness in responding to a request for information for credentialing or recredentialing

- Improve provider's cooperation with HNE in an NCQA or other accreditation process, or in any licensing process, or address failure to provide information necessary to such process
- Improve provider's verification of patients' status as an HNE member prior to rendering services
- Improve the quality of service provided to members such as, for example: ensure that appointments are scheduled in a timely manner; that members are seen promptly upon their arrival for appointments; that members' or providers' phone calls are returned in a timely manner; that members are informed of test results in a timely manner
- Improve provider's cooperation with HNE to resolve member grievances or appeals
- Improve provider's cooperation with an investigation of action under this policy
- Improve provider's maintenance of his or her facility in a safe and clean manner

Second Level Utilization Management and Quality of Care Issues

Provider actions that have a negative impact on HNE's utilization management or an adverse effect on HNE or its members shall be considered to be Second Level Utilization Management and Quality of Care Issues ("Second Level UM/QC Issues"). Examples of such Second Level UM/QC Issues 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 Second Level UM/QC Issue.

- Repeated (3 or more) First Level UM/QC Issues
- Failure to satisfy plan utilization protocols as demonstrated by patterns of over-utilization or under-utilization
- 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
- Violating provisions of the provider's contract with HNE or the HNE Provider Manual that pertain to confidentiality, billing or coordination of benefits
- Failure to maintain member medical information in a confidential manner or as required by law
- Inappropriate medical management of a patient, such as performing, ordering or referring for any medically unnecessary or inappropriate services or failing to provide or order necessary care or services
- Failure to meet any criteria for participation in the HNE provider network, as such criteria is listed in the HNE Agreement, unless the particular criterion is the basis of a Disciplinary Matter as defined below

Disciplinary Matters

Actions that affect a provider's ability to practice medicine, to 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 Medical Director, a provider has engaged in conduct which the HNE Medical Director believes to be a Disciplinary Matter, the provider may be immediately suspended from the HNE network, where appropriate, pending resolution of the matter.**

- Engaging in unlawful or unethical behavior related to provider's professional conduct or concerning HNE or its members
- Practicing medicine in violation of law or good and accepted medical practice
- Suspension or revocation of a provider's license to practice medicine in any jurisdiction in which 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 provider's narcotics license

HEALTH NEW ENGLAND PROVIDER MANUAL

- Adverse action against the provider taken or recorded by a professional society (e.g., initial or renewal membership denied, disciplinary action undertaken, or three or more complaints lodged against provider in the past two years)
- Suspension, revocation or voluntary surrender of Board Certification
- Denial, suspension, reduction, revocation, or non-renewal of hospital privileges at any hospital
- Indictment for or otherwise charged with a criminal offense
- Medicare or Medicaid sanctions imposed on a provider
- 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 which has the capacity to deceive or defraud
- Engaging in any conduct which warrants immediate termination of his/her contract with HNE as provided in that contract

Further Review and Corrective Action

If an issue concerning a provider action arises, the HNE Medical Director will review the matter. If additional information is required to determine whether the provider has engaged in conduct deemed to be a First Level UM/QC Issue, a Second Level UM/QC Issue, or a Disciplinary Issue, the HNE Medical Director (or his/her designee) shall gather such information from provider, HNE staff, and any others with relevant information. If, in the judgment of the HNE Medical Director, the matter warrants further review and/or corrective action, HNE may impose one or more of the following items of corrective action listed below.

First Level UM/QC Issues

Providers are expected to work with HNE to resolve First Level UM/QC Issues. The following actions are intended to be corrective in nature, rather than disciplinary, to bring about the required improvement. The HNE Medical Director (or his/her designee) will decide, in his or her discretion, which corrective action is appropriate to address the particular situation.

In some instances providers may be asked to take certain actions which they are already routinely performing, but such actions will be with greater frequency or detail, such as reporting certain information. In other instances providers may be asked to take actions in addition to those already required of participating providers. One or more of the following actions may be imposed.

Provider may be required to:

- Meet with the HNE Medical Director (or his/her designee) to discuss the matter. If necessary, the HNE Medical Director shall instruct the provider on the proper procedure.
- Attend training sponsored by HNE or others in order to educate provider. The provider shall be responsible for any expenses of such training.
- Follow specific utilization management or quality control criteria defined by HNE
- Submit periodic reports to HNE (e.g., reports analyzing patient service issues such as average waiting room time, average wait for appointment, etc.)
- Consult with an HNE staff person on a regular basis prior to the provision of certain services
- Cooperate with HNE in conducting patient satisfaction surveys
- Cooperate with HNE in auditing the provider's office practices

HNE may:

- Limit the number of HNE members in the provider's panel until the matter is resolved
- Require the provider to revise policies and procedures if existing ones contribute significantly to a utilization management or quality of care issue
- Contact the PHO and request that the PHO work with HNE and the provider to resolve the issue, and require the provider to comply with any actions imposed by the PHO
- Take any other appropriate action designed to remedy the situation

- Take any actions required or permitted by law

Second Level UM/QC Issues

The intent of this policy is to resolve Second Level UM/QC Issues through cooperation between HNE and the provider. Providers are expected to work with HNE to correct the problem. The corrective action is not intended to be disciplinary in nature.

Corrective action taken for a Second Level UM/QC Issue may consist of one or more of the items listed under the category of First Level UM/QC Issues.

In addition, where HNE has notified the provider of a performance standard, and the provider fails to meet that standard, HNE may adjust the provider's compensation to attain improvement of performance. Thus, where the Second Level UM/QC Issue concerns conduct pertaining to utilization (either over-utilization or under-utilization), or inappropriate medical management of a patient, HNE may impose one or more of the following items of corrective action to encourage provider to improve his/her performance:

- The provider may be reimbursed for services at a lower level than that stated in the HNE Fee Schedule for a specified period of time. Such corrective action may be taken prior to the date services are rendered or upon retrospective review after the services are rendered.
- Future fee increases may be withheld from the provider for a specified period of time.
- HNE may restrict reimbursement to the provider for ancillary services provided in the provider's office.
- The provider's fee increases may be conditioned upon the provider meeting HNE's utilization criteria.

In addition to the above items of corrective action, HNE may impose the following corrective actions for Second Level UM/QC Issues concerning conduct pertaining to utilization (either over-utilization or under-utilization), or inappropriate medical management of a patient, or for any other Second Level UM/QC Issue:

- The provider may be required to obtain approval from HNE prior to providing certain services to HNE members.
- In the event the matter involves the provider's failure to respond on a timely basis to a request for information for credentialing or recredentialing, the provider may be denied credentialing or recredentialing.
- HNE may take all actions required or permitted by law.
- HNE may take any other appropriate action designed to remedy the situation.

Disciplinary Matters:

Action taken to address a Disciplinary Matter may consist of any of the actions listed under; suspension or termination from the HNE network; making a report to the National Practitioner Data Bank or other appropriate entities; or any other action permitted or required by law.

Provider Appeals re: Disciplinary Matters

HNE shall notify a provider, in writing, of the corrective or disciplinary action imposed by HNE pursuant to this policy. Such notice may be provided via U.S. mail, fax, or electronic mail. 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 Medical Director's 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 Medical Director is appropriate given the nature, severity, frequency or effect of the action, or any other relevant circumstances.

HEALTH NEW ENGLAND PROVIDER MANUAL

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

- lost his/her license to practice medicine (or other discipline) in any jurisdiction
- been convicted of a crime

First Level Appeal

- Within fourteen days of receipt of a notice imposing corrective or disciplinary action, a provider shall submit a written statement to the HNE Medical Director 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 Medical Director shall respond to the provider's written statement within fourteen (14) days of receipt of provider's written statement.
- If the HNE Medical Director believes that the initial conclusion was correct, the Medical Director shall so notify the provider in writing.
- If the HNE Medical Director believes that the initial conclusion was not appropriate given the facts, circumstances and opinions raised in the provider's written statement, the Medical Director 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

- A provider who is not satisfied with the result of a First Level Appeal shall request, in writing, review of the matter by the Clinical Care Assessment Committee ("CCAC"). Such request shall be made within 14 days of receipt of notice of the decision under the First Level Appeal. The matter shall be brought to the CCAC at the next regularly scheduled meeting or as soon thereafter as is reasonably possible. Any provider on the CCAC who is in competition with the appealing provider shall be excused from serving on the CCAC, unless the two providers and HNE agree otherwise. In addition, the HNE Medical Director shall be recused from serving on the CCAC during Second Level Appeal proceedings.
- At the provider's option, his or her attorney may present the matter to the CCAC on the provider's behalf. If the provider chooses to have an attorney, the provider must give at least fourteen 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 CCAC 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 CCAC meeting.
- At the CCAC meeting, each party shall initially be given thirty (30) minutes to address the CCAC. HNE shall address the CCAC first, followed by the provider. Each party shall then be given ten (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 members of the CCAC.
- Within thirty (30) days of the CCAC meeting, the CCAC shall notify the provider, in writing, of its decision. The CCAC may affirm the decision of the HNE Medical Director, reverse the decision of the HNE Medical Director, or modify the decision of the HNE Medical Director 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 CCAC, and the arbitrator shall not have any authority to modify the decision of the CCAC, 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.

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, admitting privileges, or both are 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.

HNE Corporate Compliance Program (including Fraud, Waste, and Abuse Prevention Program)

Compliance Statement and Code of Conduct

It is Health New England's (HNE) policy to conduct its business in compliance with the laws and regulations of the United States and the Commonwealth of Massachusetts and to assure that HNE operates in a manner consistent with the letter and the spirit of the law.

HNE is committed to compliance with such laws and regulations and intends to assure that HNE's activities and operations, as carried out by the employees and other agents of HNE, are conducted in compliance with such laws and regulations. In recognition of this commitment, HNE has developed a Corporate Compliance Program that has been adopted and endorsed by the HNE Board of Directors.

Governing Principles

The HNE Compliance Program is based upon the following basic principles:

- Compliance with law is the policy of the company and is the best business practice.
- HNE should maintain policies and internal structures that encourage compliance.
- Compliance efforts should be designed to be as simple and effective as possible, and to avoid measures that will be confusing, ineffective or without substance.

Goals

The goals of the HNE Compliance Program are to:

- Provide a structure for compliance oversight and direction by management and the HNE Board of Directors
- Define, demonstrate, and communicate the organization-wide commitment to sustaining an ethical corporate culture
- Provide for the prevention and detection of illegal or unethical conduct by HNE employees and agents
- Provide a retaliation-free system for reporting and investigation of compliance violations or concerns
- Educate employees and agents of HNE on pertinent federal and state laws and regulations.

Scope

The scope of the HNE Compliance Program covers all employees, temporary employees, volunteers, and agents, including participating providers (first tier and downstream entities) and delegates (contractors and subcontractors, both first tier and downstream entities), including any related entities, of HNE and its subsidiaries, promoting compliance with applicable federal and state law and regulations while adhering to the highest ethical standards. The HNE Compliance Program also includes the HNE Privacy and Security Program, promoting the confidentiality, privacy and security of member protected health information, as well as the HNE Fraud, Waste, and Abuse Prevention Program.

Code of Conduct

Part of HNE's mission is to be a leading corporate citizen. This means that HNE, and all HNE associates and agents, should follow these three rules when conducting business on behalf of HNE:

- Act ethically and responsibly
- Obey the law
- If you learn that someone connected with HNE is breaking either of the first two rules, do your best to put things right, or to find someone who can

All employees and agents of HNE are advised as follows:

- No employee or agent of HNE has any authority to act contrary to the provisions of the Code, or to authorize, direct or condone violations by any other employee or agent of HNE.
- Any employee or agent of HNE who has knowledge of facts or incidents that he or she believes may violate the Code has an obligation to promptly report the matter.
- Any employee or agent who violates the Code, or who orders or who knowingly permits a subordinate to violate the Code, shall be subject to appropriate disciplinary action which may include discharge or termination of his/her relationship with HNE.

- HNE will make full, fair, timely, and understandable disclosures in the periodic reports required by law.

Reporting Concerns

Please tell us if you have a compliance concern. You can call our toll-free, anonymous compliance hotline, email, or send us a letter via fax or mail.

Compliance Hotline	(800) 453-3959 (available 24/7; reports can be made anonymously)
Email	compliance@hne.com (please use secure messaging at https://hne-mail.com)
Fax	(413) 233-2806
HNE mailing address	Health New England, Inc. Attn: Compliance Officer One Monarch Place Springfield, MA 01144-1500

When making a report, please provide as much detail as possible. Names, dates, and a description of the issues in question are helpful. For example, you may wish to describe why you think an activity is a cause for concern. If possible, please include your name and telephone number. That way, we can contact you if we have any questions during our investigation. If you wish to use email to report a concern, please use secure messaging to protect your confidentiality. For example, you may send and receive secure messages by logging in to the HNE Secure Mail Message Center. Go to <https://hne-mail.com>, create a login, and compose a message. You will be able to log in later to receive our response.

When making an anonymous report to the Compliance Hotline, you will be provided with a call identification number and a call back date. This will allow you to provide additional information (if needed) and receive status updates on the investigation.

Confidentiality and non-retaliation for good faith reporting:

Reasonable efforts will be made to protect the confidentiality of those who are reporting. However, confidentiality cannot be guaranteed, and will not be possible in some circumstances. Compliance issues will only be discussed with persons with an absolute “need to know.” HNE will not discriminate or retaliate against any employee or agent of HNE for reporting a compliance concern or for cooperating in any government or law enforcement authority’s investigation or prosecution.

Prompt response and corrective action:

All reports will be taken seriously and, if warranted, investigated by the HNE Compliance Officer. Reports of suspected fraud, waste, or abuse are investigated by the HNE Audit Manager. HNE takes appropriate actions to mitigate any harmful effects and works to identify opportunities for improvement and corrective actions designed to correct any underlying problems.

Enforcement of Standards through Well-Publicized Disciplinary Guidelines

HNE encourages its providers to report compliance concerns and resolve issues through discussion and cooperation between HNE and the provider even prior to requiring the implementation of formal remedies. The Provider Review and Corrective Action policy described in Section XI of the HNE Provider Manual apply 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.

Privacy and Security Program:

HNE has established a comprehensive Privacy and Security policy to protect HNE members from inappropriate use or disclosure of their protected health information (PHI). Under this policy, HNE has implemented appropriate administrative, physical, and technical safeguards to ensure the security of electronic PHI. For more information, review the HNE Notice of Privacy Practices, which is posted on hne.com. A copy of the notice is also available upon request.

Fraud, Waste, and Abuse Prevention Program:

Report Suspicious Activity

HNE has established a comprehensive Fraud, Waste, and Abuse Prevention policy prevent, detect, and correct fraud, waste, and abuse by employees, members, employers, brokers, providers, contractors, and subcontractors of HNE.

Under this program, HNE works to promote a sense of integrity and vigilance by means of comprehensive anti-fraud education for such individuals and entities. This program also provides procedures for prevention, detection, auditing, monitoring, investigation and follow-up. A written copy of the HNE Fraud, Waste, and Abuse Prevention Policy is available upon request.

Please notify HNE of potential fraud, waste, or abuse. You can call our toll-free, anonymous compliance hotline, email, or send us a letter via fax or mail. (See Section XIII.B of the HNE Provider Manual for details on reporting a concern to the HNE Compliance Program.)

You may also report fraud directly to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Hotline.

Contacting the HHS OIG Hotline

Phone: 1-800-HHS-TIPS (1-800-447-8477)

Fax: 1-800-223-8164

E-Mail: HHSTips@oig.hhs.gov

Web Site: <http://oig.hhs.gov/hotline.html>

TTY: 1-800-377-4950

Mail: Office of Inspector General

Department of Health and Human Services

Attn: HOTLINE

PO Box 23489

Washington, DC 20026

What are Fraud, Waste, and Abuse?

Fraud is the intentional use of false statements to cheat another person or company out of something of value. It includes any act that constitutes fraud under state and federal law.

Waste is any unnecessary cost that results from poor or inefficient practices.

Abuse is an activity that goes against sound business, monetary or medical practices. Abuse may include practices by providers, members, or customers that result in unnecessary costs to the health plan.

Suspicious Activity is any activity that you think is fraudulent, wasteful, or abusive. Below are some examples.

Examples of Suspicious Activity by Providers:

- Billing for services or supplies that were not provided. This includes billing for "no shows" (for example, billing members for services that were not actually furnished because the patients failed to keep their appointments).
- Misrepresenting the diagnosis for the patient to justify the services or equipment furnished
- Altering claim forms or medical records to obtain a higher payment amount
- Deliberately applying for duplicate payment (for example, billing HNE and the member for the same service or billing both HNE and another insurer in an attempt to get paid twice)
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment)
- Unbundling or billing for separate portions, rather than for the whole procedure (for example, the billing of a multi channel set of lab tests to appear as if the individual tests had been performed)
- Characterizing the service differently than the service actually rendered or misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services (for example, falsely indicating that a particular healthcare professional attended a procedure)
- Upcoding to maximize payments (for example, billing for 45-50 minutes of psychotherapy when the documentation states 20-30 minutes face to face psychotherapy)

- Using unlicensed staff and billing for their services as if provided by a licensed health care professional or physician
- Performing unnecessary procedures, tests, or even surgeries or prescribing additional and unnecessary treatments (over-utilization) or more expensive than indicated medications (drug diversion)
- Requiring a member to return for unneeded follow-up services
- Balance billing members for services
- Billing for non-covered services as covered services (for example, routine foot care billed as a more involved form of foot care to obtain payment)
- Participating in schemes that involve collusion between a provider and a member, or between a supplier and a provider that result in higher costs or charges
- Utilizing split billing schemes (for example, billing procedures over a period of days when all treatment occurred during one visit)
- Billing for “phantom” providers who are not really doctors, dentists, or health care professionals, who attempt to get money from a health plan by submitting claims on real members that they have not seen. These providers may or may not supply a W-9 and do not have licenses to perform the services.
- Billing for “phantom” patients who do not exist and did not receive services
- Billing for more hours than there are in a day

Examples of Suspicious Activity by Members:

- “Loaning” or using another person’s insurance card to obtain medical care and benefits
- Providing false information when applying for programs or services
- Filing requests for reimbursement for services or medications not received
- Adding an ineligible dependent to the plan or not taking a dependent off a policy when the dependent is no longer eligible for coverage
- Failing to disclose multiple coverage policies, or leveraging various coverage policies to “game” the system, resulting in improper coordination of benefits
- Using a false home address to obtain coverage when your primary address is out of the service area
- Forging or altering bills or receipts to obtain inappropriate reimbursement from the health plan
- Forging or altering a prescription or improperly obtaining prescriptions for controlled substances
- Obtaining prescription drugs from a provider, possibly for a condition from which the member does not suffer, and giving or selling this medication to someone else
- Doctor shopping: Member consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might also be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Examples of Suspicious Activity by Non-Members:

- Using a stolen member card for obtaining medical services, including medical supplies and prescriptions

Examples of Suspicious Activity by Brokers or Agents:

- Altering documents
- Accepting or offering kickbacks or bribery
- “Clean sheeting” or falsifying or misrepresenting member or group information to obtain better rates. This act makes the applicant for coverage appear to be a better risk for policy acceptance
- Failure to disclose information that may affect conditions of coverage.
- Sale of non-existent policies

Examples of Suspicious Activity by Employer Groups:

- Providing false employer or group membership information to secure healthcare coverage
- Falsifying information
- Misrepresenting who is actually eligible for coverage by representing them as an employee of the group
- Falsifying an employee hire date to modify the date of health care coverage
- Falsifying an employee termination date in order to eliminate premium payments

Examples of Suspicious Activity by a Health Plan:

- Fabricating claims

HEALTH NEW ENGLAND PROVIDER MANUAL

- Participating in schemes that involve collusion between a provider and an employee where the claim is assigned (for example, the provider deliberately over-bills for services, and the employee then generates adjustments with little or no awareness on the part of the member)
- Manipulating claims data on unassigned claims for one's own benefit (for example, through manipulation of member address or the claims history record, an employee could generate adjustment payments against many member records and cause payments to be mailed to an address known only to him/her)
- Failing to provide medically necessary items or services that the organization is required to provide (under law or under the contract) to a member, and that failure adversely affects (or is substantially likely to affect) the member.
- Marketing Schemes: When a health plan, or its subcontractor, violates the Medicare or Medicaid marketing guidelines, or other federal or state laws, rules, and regulations to improperly enroll members. Examples of such violations include, but are not limited to:
 - Offering members a cash payment as an inducement to enroll in a Medicare or Medicaid plan;
 - Unsolicited door-to-door marketing;
 - Use of unlicensed agents;
 - Enrollment of members without their knowledge or consent;
 - Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS;
 - Misrepresenting the product being marketed as an approved Medicare Plan when it actually is a Medigap policy or non-Medicare plan;
 - Requesting member financial information or check numbers (potential identity theft by marketing agents).
 - Requiring members to pay premiums up front.
 - False statements related to procuring a managed care contract, including but not limited to:
 - Falsification of health care provider credentials by the health plan or subcontractors
 - Falsification of financial solvency
 - Falsified or an inadequate provider network
 - Fraudulent subcontract
 - Fraudulent subcontractor
 - Bid-rigging (collusion between State employees and those submitting Request for Proposals and/or contracts) or self-dealing (award of Medicaid contracts based on friendship or family relationships with those in control of the selection process)
 - Illegal tying agreements (subcontractor requires the health plan to contract with other entities as a condition for the subcontractor to provide services)
 - Payments for excluded services, items, or drugs.
 - Inappropriate Enrollment/Disenrollment (for example, "Cherry-picking" or selecting the healthiest segment of the enrollment population or disenrolling undesirable members)
 - Misrepresenting or falsifying information furnished to members.
 - Not correcting inaccuracies in eligibility or coordination of benefits
 - Underutilization, for example:
 - Untimely first contact with clients
 - Untimely assignment of a primary care provider (PCP)
 - Delay in reassigning PCP upon an individual's request
 - Discouragement of treatment using geographic or time barriers (assigning PCP located far from the member's home or who offers limited office hours or has long waiting times)
 - Engagement in any Federally-prohibited discrimination activities
 - Failure to serve individuals with cultural or language barriers
 - Failure to provide educational services (for example, if the health plan contract requires health education or certain preventive services, such as smoking cessation education, a health plan can save expenses if it does not advertise or provide these services)
 - Failure to provide outreach and follow-up care or Federally-required referrals (for example, a health plan can save expenses by not advertising services, and therefore, members do not receive these services because they do not know they can be provided)
 - Failure to provide court-ordered treatment for health care that is medically necessary
 - Failure to provide members under a government contract comparable services such as those provided to commercial or fee-for-service members
 - Defining "appropriateness of care" and/or "experimental procedures" in a manner inconsistent with standards of care

- Delaying including approved pharmaceuticals on the formulary thereby avoiding the use of expensive new drugs
- Strict Utilization Review (UR) standards (For example, a health plan can hide its poor performance and lack of service delivery by adopting inappropriate utilization review guidelines.)
- Cumbersome appeal process for enrollees (For example, a health plan can save or delay expenses by inhibiting appeals or by creating burdensome appeal procedures for clients who are refused specific care.)
- Ineffective grievance process (For example, a health plan can appear to have fewer complaints than it actually does by adopting difficult-to-follow grievance procedures.)
- Inadequate prior authorization "hotline" (For example, a health plan requires a provider to obtain prior approval before performing a certain procedure, but fails to respond in a timely manner to such requests; once the procedure is performed, the claim may be denied because of lack of prior approval.)
- Unreasonable prior authorization requirements (For example, a health plan has a prior authorization process that makes it stringent or otherwise difficult to acquire approval for standard or routine care.)
- Cumbersome appeals process for providers (For example, a health plan can discourage providers from filing appeals by routinely delaying or "losing" appeals.)
- "Gag orders" or establish restrictions that prevent a PCP from freely advising the patient about his or her health status and limit discussion of alternative medical care or treatment for a condition or disease (prohibited by federal and state law)
- Incentives to PCPs and specialty providers to illegally limit services or referral
- Routine denial of claims (For example, routinely denying claims that unquestionably qualify as medically necessary services under the plan.)
- Embezzlement, Theft, and Related Fee-For-Service Fraud
- Embezzlement and theft -- Officers of the MCO or subcontracting providers steal or appropriate property entrusted to their care for their own use.
- Diversion of funds for medical service to unnecessary administrative costs
- "Bust outs" -- Premiums are paid to the MCO, but the MCO avoids paying vendors/providers by deliberately declaring bankruptcy.

Overview of Fraud and Abuse Prevention Laws:

The following is a summary of Federal and Massachusetts False Claims laws and whistleblower protections. Please note that this list is for informational purposes only and does not constitute legal advice. In addition, this list is intended to provide examples of laws that protect against fraud and abuse in the health care industry, but may or may not specifically apply to Health New England, Inc., or its subsidiary corporations.

The Federal False Claims Act

The False Claims Act (FCA), [31 U.S.C. §§ 3729-3733](#), is perhaps the most important legal tool available to the federal government to enforce fraud and abuse prohibitions. The FCA prohibits "knowingly" submitting (or causing or conspiring to submit) false or fraudulent claims for payment or approval to the federal government. "Knowingly" means when a person: (1) has actual knowledge of the false claim, (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud the government is required to be held liable under the FCA. Anyone who submits false claims is liable for civil monetary penalties of \$5,500 to \$11,000 per false claim plus damages up to three times the amount of the erroneous payment. Depending on the size and number of claims, this can amount to major financial liabilities for health care providers. Fraud may also result in criminal prosecution and conviction as well as exclusion from the federal government program or contract.

The FCA encompasses several different examples of falsifying claims including, but not limited to: falsifying medical records submitted, billing for services not rendered or goods not provided, duplicating billing to obtain double compensation, and billing, certifying, or prescribing services medically unnecessary.

Private or Qui Tam Actions under the Federal False Claims Act

The FCA includes "qui tam" provisions to encourage individuals who have direct knowledge of fraud to become "whistleblowers" by awarding them a percentage of the amount recovered. Under section [3730](#) of the FCA, a person, often referred to as a "qui tam relator," may bring a civil action for a violation of the FCA for the person and in the name of the United States Government. The person bringing the action must be an "original source" of the information. "Original source" means an individual who has direct and independent knowledge of the information on which the allegations are based. The government has 60 days to decide to join the action or allow the qui tam relator to proceed

HEALTH NEW ENGLAND PROVIDER MANUAL

individually. If the government joins, the relator is entitled to 15% to 25% of any proceeds of the action or settlement of the claim, depending upon the extent to which the person “substantially contributed” to the prosecution of the action. If the government does not proceed and the individual is successful, the person may receive 25% to 30% of the proceeds. The qui tam relator is also entitled to reasonable expenses and reasonable attorneys’ fees and costs.

Whistleblower Protections

The FCA contains important protections for whistleblowers in a health care organization. Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in relation to an action under the FCA are entitled to all relief necessary to make the employee whole. “Lawful acts” include investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the FCA. Relief to the employee shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees. (Refer to [31 U.S.C. § 3730 \(h\)](#).)

Federal Administrative Remedies for False Claims and Statements

The FCA also provides certain “administrative remedies” for false claims and statements. Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a false claim is subject to a civil penalty of not more than \$5,500 for each such claim in addition to any other remedy that may be prescribed by law. A “false claim” is defined by this section as any claim that the person knows or has reason to know: (a) is false, fictitious, or fraudulent; (b) includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent; (c) includes or is supported by any written statement that (i) omits a material fact; (ii) is false, fictitious, or fraudulent as a result of such omission; and (iii) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or (d) is for payment for the provision of property or services which the person has not provided as claimed. (Refer to [31 U.S.C. §§ 3801-3812](#).)

Federal Antikickback Statute under Medicare and Medicaid

The Federal Antikickback Statute, [42 U.S.C. § 1320-7b \(b\)](#), provides for criminal penalties for certain acts impacting federal health care programs. This includes any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (for example, Medicare and Medicaid). The statute provides that whoever knowingly and willfully solicits or receives or willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

The following types of remunerations are specifically prohibited:

In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program

In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program

To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program

To purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program

The statute provides certain exceptions to these requirements or “safe harbors” that allow certain types of remunerations that would otherwise be prohibited by definition. The statute also gives authority to the Secretary of Health and Human Services to establish regulations allowing for additional safe harbors. (Refer to [42 U.S.C. § 1320-7b \(b\) \(3\)](#).)

Federal Laws Prohibiting False Claims under Medicare and Medicaid

Other federal laws include stern civil and criminal penalties against individuals and entities falsifying claims that participate in federal health care programs, including Medicare and Medicaid (as Medicaid is federally funded, in part). Civil penalties apply to any person or entity, knowingly presenting or causing to present a claim that is for a medical or other item or service:

- That is part of a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided
- That the person knows or should know the claim is false or fraudulent

HEALTH NEW ENGLAND PROVIDER MANUAL

- That is presented for a physician's service by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service:
- Was not licensed as a physician
- Was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing)
- Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified
- Was furnished during a period in which the person was excluded from the program under which the claim was made
- Is for a pattern of medical or other items or services that a person knows or should know are not medically necessary

This law states that any such person or entity shall be subject to a civil money penalty of not more than \$10,000 for each item or service plus not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. (Refer to [42 U.S.C. §§ 1320a-7a.](#))

The law also states that any person or entity is guilty of a felony, who:

- Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program
- At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment
- Having knowledge of the occurrence of any event affecting (a) his initial or continued right to any such benefit or payment, or (b) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized
- Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person
- Presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician
- For a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan, if disposing of the assets results in the imposition of a period of ineligibility for such assistance

Any such person or entity convicted thereof shall be fined not more than \$25,000 or imprisoned for not more than five years or both. (Refer to [42 U.S.C. §§ 1320a-7b.](#))

The law also allows for the exclusion of individuals and entities from participation in any federal health care program if they are convicted of fraud under federal or state law (a) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—(i) in connection with the delivery of a health care item or service, or (ii) with respect to any act or omission in a health care program operated by or financed in whole or in part by any Federal, State, or local government agency; or (b) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency. (Refer to [42 U.S.C. § 1320-7.](#))

Other Federal Criminal Statutes and the Code of Federal Regulations

Examples of the U.S. Crimes and Criminal Procedure Statute, Title 18 U.S.C., violations include:

- Bribery (§ 201)
- False claims (§ 287)
- Conspiracy to commit fraud (§ 371)
- Theft of embezzlement in connection with health care (§ 669)
- False statements (§ 1001)
- False statements relating to health care (§ 1035)
- Mail fraud (§ 1341)

HEALTH NEW ENGLAND PROVIDER MANUAL

- Wire fraud (§ 1343)
- Health care fraud (§ 1347)
- Obstruction of a federal health care fraud investigation (§ 1518)
- Money laundering (§§ 1956-57)

Examples of Title 21 U.S.C. offenses include violations of the:

- Food Drug & Cosmetic Act (§ 331); and
- Controlled Substances Act (§§ 801-971).

The Code of Federal Regulations also provides specific rules and details for how to put the law into practice. Pertinent Centers for Medicare and Medicaid Services Department and Office of Inspector General, Health and Human Services regulations (42 C.F.R.) include but are not limited to:

- Introductions, Definitions (§ 400)
- Civil Money Penalties, Assessments, and Exclusions (§ 402)
- Special Programs and Projects (§ 403)
- Exclusions from Medicare and Limitations on Medicare Payment (§ 411)
- Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans (§ 417)
- Program Integrity: Medicare (§ 420)
- Intermediaries and Carriers (§ 421)
- Medicare +Choice or Medicare Advantage Program (§ 422)
- Conditions for Medicare Payment (§ 424)
- Program integrity--Medicare and State Health Care Programs (§ 1001)
- Program integrity--State-initiated exclusions from Medicaid (§ 1002) and
- Civil money penalties, assessments and exclusions (§ 1003)

The Massachusetts False Claims Act

The Massachusetts False Claims Act (MFCA), [M.G.L. c. 12, § 5A-50](#), was modeled after the Federal FCA. Any person who is defined as described below is liable under the MFCA to the commonwealth or political subdivision for a civil penalty of not less than \$5,000 and not more than \$10,000 per violation, plus three times the amount of damages, including consequential damages, that the commonwealth or political subdivision sustains because of the act of that person. Such “person” is defined as any natural person, corporation, partnership, association, trust or other business or legal entity, who:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval
- Knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment or approval of a claim by the commonwealth or any political subdivision thereof;
- Conspires to defraud the commonwealth or any political subdivision thereof through the allowance or payment of a fraudulent claim
- Has possession, custody, or control of property or money used, or to be used, by the commonwealth or any political subdivision thereof and knowingly delivers, or causes to be delivered to the commonwealth, less property than the amount for which the person receives a certificate or receipt with the intent to willfully conceal the property
- Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the commonwealth or any political subdivision thereof and with the intent of defrauding the commonwealth or any political subdivision thereof, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- Buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the commonwealth or any political subdivision thereof, knowing that said officer or employee may not lawfully sell or pledge the property;
- Enters into an agreement, contract or understanding with one or more officials of the commonwealth or any political subdivision thereof knowing the information contained therein is false
- Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or to transmit money or property to the commonwealth or political subdivision thereof
- Is a beneficiary of an inadvertent submission of a false claim to the commonwealth or political subdivision thereof, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the commonwealth or political subdivision within a reasonable time after discovery of the false claim .

A person violating the MFCA is also be liable for the expenses of the civil action brought to recover any such penalty or damages, including without limitation reasonable attorney's fees, reasonable expert's fees and the costs of investigation.

Private or Qui Tam Actions under the MFCA

Like the Federal FCA, the MFCA allows individuals, or relators, to bring civil action for violation of the MFCA, on behalf of the relator and the commonwealth or any political subdivision of the commonwealth. The action shall be brought in the name of the commonwealth or the political subdivision. The complaint shall be filed under seal for up to 120 days although the attorney general may ask the court for extensions of no more than 90 days for good cause shown. The Massachusetts attorney general must decide during this time frame and any approved extensions to join the action or allow the relator to proceed individually. If the government joins, the relator is entitled to 15% to 25% of any proceeds of the action or settlement of the claim, depending upon the extent to which the person "substantially contributed" to the prosecution of the action. If the government does not proceed and the individual is successful, the person may receive 25% to 30% of the proceeds. The relator shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, including reasonable attorney's fees and costs. All such expenses shall be awarded against the defendant. (Refer to [MGL c. 12 § 5c](#) and [5f](#).)

Whistleblower Protections under the MCA

Like the Federal FCA, the MFCA prohibits employers from interfering with employees who help to prevent fraud. Under this law, no employer shall make, adopt or enforce any rule, regulation, or policy preventing an employee from disclosing information to a government or law enforcement agency or from acting to further a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed under the MFCA. No employer may require as a condition of employment, during the term of employment, or at the termination of employment, that any employee agree to, accept or sign any agreement that limits or denies the employee's rights to bring an action or provide information to a government or law enforcement agency pursuant to the MFCA. No employer shall discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee in the terms or conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a government or law enforcement agency or in furthering a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed pursuant to the MFCA. An employer who violates these provisions shall be liable for such damages or equitable relief as a court shall deem appropriate, including: reinstatement with the same seniority status such employee would have had but for the employer's violation of the MFCA, two times the amount of back pay, interest on the back pay, and compensation for any special damage sustained as a result of the employer's violation of the MFCA. In addition, the defendant shall be required to pay litigation costs and reasonable attorney's fees. (Refer to [MGL c. 12 § 5j](#).)

Massachusetts Medicaid False Claims Act

The Massachusetts Medicaid False Claims Act prohibits false statements (refer to [MGL c. 118E § 39](#)) and fraudulent billing to the Medicaid program (refer to [MGL c. 118E § 40](#)) and includes Medicaid anti-kickback provisions (refer to [MGL c. 118E § 41](#)). The law also prohibits excessive charges by providers (refer to [MGL c. 118E § 42](#)) and inpatient admission or continued stay kickbacks (refer to [MGL c. 118E § 43](#)) under the Medicaid Program. The statute authorizes state prosecutors to bring criminal or civil action against any person violating the statutory provisions of the Massachusetts Medicaid Program. In addition to criminal penalties, the Act provides for civil penalties of treble damages and the cost of the government investigation and litigation.

Massachusetts False Health Care Claims Act and Antikickback Statute for All Payers

The False Health Care Claims Act ([MGL c. 175H](#)), applies more specifically to health care claims (rather than all false claims) but more generally claims to any health care payers (rather than to claims to the Commonwealth). This law prohibits the submission of fraudulent bills to private health insurers and other health care payers (refer to [MGL c. 175H § 2](#)). In addition, the statute prohibits the solicitation or receipt of kickbacks for purchasing, leasing, ordering or arranging for any good, facility, service, or item in connection with a private health care entity (refer to [MGL c. 175H § 3](#)). Violators are subject to criminal prosecution, and the health insurer or payer is entitled to bring a civil action to recover the full amount inappropriately paid, along with attorneys' fees and the costs of investigation.

Whistleblower and Whistleblower Protections:

Both the federal False Claims Act and the Massachusetts False Claims Act include provisions to encourage private citizens who know about fraud to file suit against those that committed the fraud. The government decides whether or

HEALTH NEW ENGLAND PROVIDER MANUAL

not to join in the suit. If a suit is successful, the “whistleblowers” are awarded a percentage of the amount recovered. These laws also include important protections for whistleblowers. The laws make it illegal to retaliate against those participating in a whistleblower action. If an employer retaliates in any way against an employee, the employee may bring an action against the employer. Settlement may include reinstatement, two times the amount of back pay plus interest, attorney’s fees, and damages.