Provider Payment Disputes

Policy

The terms of this policy set forth the guidelines for reporting the provision of care rendered by Mass General Brigham Health Plan participating providers, including but not limited to, use of standard diagnosis and procedure codes in compliance with HIPAA (Health Information Portability and Accountability Act) medical transaction code set standards.

Reimbursement

Providers are reimbursed in accordance with the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan . Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. This is the General Coding and Billing PPG. All claims are subject to audit, and Mass General Brigham Health Plan may request medical records from the provider.

Requesting an Administrative Appeal

As described in the Billing Guidelines Section of the Provider Manual, providers can request a review and possible adjustment of a previously processed claim within 90 days of the Explanation of Payment (EOP) date on which the original claim was processed. If the provider is not satisfied with the outcome of the request, an appeal can be submitted to Mass General Brigham Health Plan's Appeals and Grievances Department.

An appeal is a request for reconsideration of a claim denial by to Mass General Brigham Health Plan. Appeal requests must be submitted in writing within one of the following timeframes:

- 90 days of receipt of the Mass General Brigham Health Plan Explanation of Payment (EOP)
- 90 days of receipt of the EOP from another insurance, when applicable
- 90 days of the date of the claim's adjustment letter

The appeal must include additional, relevant information and documentation to support the request. Requests received beyond the 90-day appeal requests filing limit will not be considered.

When submitting a provider appeal, please use the *Request for Claim Review Form*

Provider Audit Appeals/General Claims Audit Appeal Requests

For claims audited and adjusted post-payment, if the provider disagrees with the reason for the adjustments, a letter of appeal or a completed Mass General Brigham Health Plan Provider Audit Appeal Form may be submitted to Mass General Brigham Health Plan's Appeals Department within 90 days of the EOP.

The request must be accompanied by comprehensive documentation to support the dispute of relevant charges. To the extent that the provider fails to submit evidence of why the adjustment is being disputed, the provider will be notified of Mass General Brigham Health Plan ' inability to thoroughly review the request. The provider can resubmit the appeal within the 90 days EOP window. The appeal's receipt date will be consistent with the date Mass General Brigham Health Plan received the additional documentation.

Mass General Brigham Health Plan will review the appeal and, when appropriate, consult with Mass General Brigham Health Plan clinicians or subject matter experts in the areas under consideration. The

appeal request will be processed within 30 calendar days from Mass General Brigham Health Plan's receipt of all required documentation.

The appeal determination will be final. If the appeal request is approved, Mass General Brigham Health Plan will adjust the claims in question within 10 calendar days of the provider's notification of the final determination.

Claim Adjustments/Requests for Review

Request for a review and possible adjustment of a previously processed claim (not otherwise classified as an appeal) should be submitted to the Claim Adjustment Requests mailbox within 90 days of the EOP date on which the original claim was processed. All such requests should be submitted by completing a Request for Review Form and including any supporting documentation, with the exception of electronically submitted corrected claims. When submitting a provider appeal, please use the *Request for Claim Review Form*

Corrected Claims and Disputes of Duplicate Claim Denials

Mass General Brigham Health Plan accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC) and HIPAA EDI standards. Corrected claims must be submitted with the most recent version of the claim to be adjusted. must be received no later than 60 days from the date of the original adjudication. Any payment disputes received after that time will not be considered. Mass General Brigham Health Plan will not accept handwritten claims, or handwritten corrected claims.

Provider payment disputes that require additional documentation must be submitted on paper, using the Request for Review Form. *Request for Claim Review Form*

Appealing a Behavioral Health Service Denial

Optum is Mass General Brigham Health Plan ' Behavioral Health Partner and is delegated all Behavioral Health (BH) related matters, including grievances/complaints and appeals. All BH related grievances/complaints and appeals must be submitted to Optum directly
For more information, please refer to the Behavioral Health provider manual or contact Optum

Late Charges

Mass General Brigham Health Plan accepts corrected claims to report services rendered in addition to the services described on an original claim. Mass General Brigham Health Plan will not accept separate

claims containing only late charges. Mass General Brigham Health Plan will not accept Late Charge claims from institutional (facility) providers, including, but not limited to hospitals; ambulatory surgery centers; skilled nursing facilities (SNF); hospice; home infusion agencies; or home health agencies.

Filing Limit Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 90 days of the EOP date on which the claim originally denied. Disputes received beyond 90 days will not be considered.

If the initial claim submission is after the timely filing limit and the circumstances for the late submission are beyond the provider's control, the provider may submit a request for review by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit and any supporting documentation. Documented proof of timely submission must be submitted with any request for review and payment of a claim previously denied due to the filing limit. A completed Request for Review Form must also be sent with the request. *Request for Claim Review Form*

Related Mass General Brigham Health Plan Payment Guidelines

General Coding and Billing
Inpatient Hospital Admissions
Modifiers
Provider Manual/Section8_Billing Guidelines (Commercial)
Provider Manual/Section10_Appeals And Grievances (Commercial)
Provider Manual/Section3_Provider Management (Commercial)

References

American Medical Association (AMA) Current Procedural Terminology (CPT)
CMS/HIPAA Information Series
HCPCS Level II
ICD-10-CM

Publication History

Topic: Provider Payment Disputes	**Owner: Network Management**

December 24, 2020	*Original Documentation*
December 28, 2023	*Document rebrand*

January 1, 2024	*Annual review, no policy change*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Health Partners Insurance Company.