Contract rate, payment policy, or clinical policy appeal

Information in this policy does not apply to members with the Choice or Choice Plus products offered through Passport Connect℠. For UnitedHealthcare's related policies/procedures, please go to www.uhcprovider.com/.

Description

An appeal may be submitted when a provider requests that a claim with an issue related to contract rate, payment policy, or clinical policy be reviewed. Examples:

- Provider believes that an incorrect contract terms/rates were applied to payment made resulting in either an under or overpayment.
- Provider believes that final claim payment was incorrect because of global reimbursement or (un)bundling of billed services (e.g., claim editing software).

Policy

Standard appeal filing limit

- Contract Rate, Payment Policy, or Clinical Policy appeals must be received no later than 180 days from the original explanation of payment (EOP) date.
  - Any appeal received after the applicable appeal filing limit will not be considered and cannot be appealed.
  - Members cannot be held liable for claims denied for exceeding the appeal filing limit.

Appeal requirements and required documentation

- All provider appeals must be submitted with a completed Request for Claim Review Form.
  - Claims submitted without a Request for Claim Review Form will be treated as a first submission, which may result in denial.
- Copy of the original supporting EOP
- Claim detail screen from electronic claim submission source (e.g., our secure provider portal, NEHEN)
- Supporting documentation (see below)

Supporting documentation

When submitting a written administrative or clinical appeal, it is necessary to include all supporting documentation specific to the denied claim. Appeal submissions must include the most appropriate supporting documentation. Examples of documentation include:

- Surgical/operative notes
- Office visit notes
- Pathology notes
- Medical record entries
- Medical invoices (e.g., DME or pharmaceuticals)
- Letter or explanation describing the issue (letters of explanation will not be considered without medical record documentation)

Medical record documentation and physician queries

Harvard Pilgrim will not accept retrospectively amended medical records or physician queries beyond 30 days from the service date.

Harvard Pilgrim considers medical record documentation and/or physician queries upon review as the official record to support services provided for the basis of coverage or reimbursement determination.

Clinical documentation or physician queries amended over 30 days from the service will not be accepted to defend reimbursement, increase reimbursement, or consideration of a previously denied claim.

Appeal response

If the appeal is received within the 180-day filing limit, Harvard Pilgrim will review the appeal. If your request for an appeal is beyond the 180-day filing limit from the date of Harvard Pilgrim's EOP original denial or payment date, it will not be considered.

After the appeal has been reviewed, Harvard Pilgrim will send a resolution letter.

- If the original decision is upheld, the letter outlines the reason(s) for upholding the original decision.
- If the denial is reversed, the letter explains that the claim will be adjusted in accordance with payment policy, member agreement, and hospital contract.

Second level appeal

A second level appeal may be submitted in instances where Harvard Pilgrim upholds the original claim denial or reimbursement and the provider has additional information to substantiate a second review.

Receipt date

Second level appeals must be received within 90 days of the date on the original appeal resolution letter you received from Harvard Pilgrim that explained the reason for upholding the original denial or reimbursement decision.

Required and supporting documentation

- A completed Request for Claim Review Form
- Copy of the original supporting EOP
- Claim detail screen from electronic claim submission source (e.g., our secure provider portal, NEHEN)
- Additional supporting documentation for the denied claim that specifically substantiates your reason for a second level appeal.

Second level appeal response

- If your request for a second appeal is beyond the 90-day filing limit from the date of Harvard Pilgrim's letter upholding the original denial, it will not be reconsidered.
- If the second appeal is received within the 90-day filing limit, Harvard Pilgrim will review the appeal.
- If the denial is upheld, the letter outlines the reason(s) for upholding the original decision.
- If the denial is reversed, the letter explains that the claim will be adjusted in accordance with payment policy, member agreement and hospital contract.

General billing tips

To submit appeals for Passport Connect (www.uhcprovider.com/), HPI (www.healthplansinc.com), or Student Resources (www.uhcsr.com), please visit the respective websites listed for details.

Claims appeals address

Mail all provider claim appeals to:

Harvard Pilgrim Health Care
P.O. Box 699183
Quincy, MA 02269-9183

Related policies and resources

- Appeals Overview
- Filing Limit Provider Appeals
- Request for Claim Review Form and Quick Reference Guide

PUBLICATION HISTORY

09/15/10	reviewed policy; organized information for clarity
09/15/16	reviewed policy; updated second level appeals filing limit submission time to 90 days; administrative edits for clarity
01/01/23	reviewed; no changes
08/15/24	updated web address for UnitedHealthcare and removed phone number
07/30/25	updated links
11/15/26	administrative updates; removed review response timeframe