Health Net Pearl – Private Fee-for-Service Plan

DEEMED PROVIDER APPEAL PROCESS

This document gives deemed providers instructions for appealing an adverse decision, including when and how to submit a dispute. This information applies to Health Net's private fee-for-service plan (PFFS) Part C (medical) services only. Please note, these instructions do not apply to non-contracting providers.

Definitions

For the purposes of the PFFS deemed provider appeal process, the following definitions apply:

CLAIMS DISPUTE: A disagreement regarding decisions made during the claims adjudication process (for example, related to the provider contract, our claims payment policies, processing error, etc.), as well as decisions made as a predetermination of services not requiring prior authorization.

DEEMED PROVIDER: A provider is considered a deemed provider and must follow a PFFS plan's terms and conditions of payment if the following conditions are met:

a) In advance of furnishing services the provider knows that a patient is enrolled in a PFFS plan and

b) The provider either possesses or has access to the plan's terms and conditions of payment.

It is important to note that a provider is not required to furnish health care services to members of a PFFS plan. However, when a provider chooses to furnish services to a PFFS member and the deeming conditions have been met, the provider is automatically a deemed provider (for that member) and must follow the PFFS plan's terms and conditions of payment.

DISPUTE: A disagreement regarding a claim or utilization review decision.

PROVIDER APPEAL: A written request by a provider to change either an adverse reconsideration decision or adverse initial utilization review decision. Only after the reconsideration process has been complete may a provider request an appeal.

NON–CONTRACTING PROVIDER: A provider is a non-contracting provider if the provider furnishes services to a PFFS member but the deeming requirements are not met. For example, a provider cannot become deemed in circumstances where the provider does not know in advance of furnishing services that a patient is a member of a PFFS plan. This could occur in an emergency where a provider cannot communicate with the member before furnishing care or in certain situations where the provider does not inform the member of his or her enrollment in a PFFS plan. As a further example, a provider cannot become a deemed provider if the provider has not received or does not have reasonable access to a PFFS plan's terms and conditions of participation prior to furnishing services to a PFFS member.

PROVIDERS: Individuals or groups who are licensed or otherwise authorized by the state in which they provide health care services to perform such service and are eligible for payment under Medicare. Examples include physicians, podiatrists and independent nurse practitioners. This may also include institutional providers and suppliers of health care services. Examples include hospitals, skilled nursing facilities and behavioral health organizations, such as mental health or residential treatment facilities.

RECONSIDERATION: A written or verbal request for a formal review of a previous claim payment decision or a claim that requires reprocessing.

UTILIZATION REVIEW DISPUTE: Issues related to decisions made during the prior authorization, concurrent or retrospective review processes (services requiring prior authorization). For these types of issues, the provider appeal process only applies to appeals received subsequent to the services being rendered. The member appeal process applies to appeals related to pre-service or concurrent medical necessity decisions.

Provider Appeal Process

DISPUTE

A provider may submit a dispute in writing to the Health Net Pearl Claims Department at:

Health Net Pearl Claims
P.O. Box 1728
Augusta, GA 30903-1728

Providers have 60 days from receiving the initial decision to submit a dispute.

To facilitate the handling of an issue, providers should state the reasons they disagree with Health Net's decision and submit a copy of the denial letter or EOB statement and the original claim for reference.

A provider dispute that is submitted on behalf of the member is processed through the member appeal process, but only if the member has submitted written authorization allowing the provider to appeal on his or her behalf.

RECONSIDERATION – HEALTH NET PROCESS

If a provider would like to dispute a claim payment decision, he or she must contact the Health Net Pearl Claims Department at:

Health Net Pearl Claims
P.O. Box 1728
Augusta, GA 30903-1728

This is the first step in disputing a claim payment decision. Claims payment issues are generally resolved within 30 calendar days.

It may be necessary to forward claims payment reconsiderations involving clinical or coding reviews to a specialty unit within Health Net for investigation and resolution. Health Net issues a response within 30 calendar days, unless additional information is needed. If additional information is needed, Health Net sends the reconsideration decision within 30 calendar days of the receipt of the additional requested information.

If the decision is in the provider's favor, the claim is recalculated and reprocessed for any services affected by the decision. A remit is generated.

If the decision is not in the provider's favor, the Claims Department issues a letter to the provider with a short rationale as to why the claim was paid or denied correctly. The letter also includes instructions on how and when the provider may file a provider appeal if the provider wishes to pursue the issue further. The required Provider Dispute Resolution Request form is included in the mailing.

PROVIDER APPEAL

If a provider is not satisfied with the reconsideration decision (for claims disputes) or an initial utilization review decision, he or she may request a provider appeal in writing utilizing the Provider Dispute Resolution Request form. The provider is to submit all provider appeal request to Health Net Pearl Claims Department. Upon receipt, Health Net reviews the request to ensure that the issue has completed the reconsideration process and that all required documentation is included. The file is then forwarded to the Health Net Provider Appeals Unit.

If the Health Net Provider Appeals Unit receives a request for a provider appeal that has not completed the reconsideration process, it is returned to the Health Net Claims Department for processing.

ACKNOWLEDGEMENT OF PROVIDER APPEALS

Health Net acknowledges receipt of each provider appeal within 15 business days of receipt.

Providers are notified of Health Net's appeal decision in writing within 30 calendar days of receipt of the appeal, unless additional information is needed. If additional information is needed, the appeal decision is sent within 30 calendar days of the receipt of the additional requested information.

If the provider appeal decision is in the provider's favor, the Health Net Provider Appeals Unit requests that the claims be recalculated and reprocessed for any services affected by the decision.

If the provider appeal decision upholds the original position, a written response is sent. The notice includes the final determination. No further provider appeal is possible. The provider may not bill the member for any portion of the claim not specifically identified as member responsibility.

Provider disputes are reviewed, handled and resolved by Health Net without charge to provider.

The Health Net PFFS Terms and Conditions are available at:

https://www.healthnet.com/static/provider/unprotected/pdfs/national/2-PFF_Terms_and_Conditions.pdf