Point32Health

Harvard Pilgrim Health Care | TUFTS Health Plan

Understanding the utilization management appeals process

A provider's guide to navigating pre-service clinical appeals

As valued partners in caring for Point32Health members, providers play a vital role in ensuring access to appropriate health services. Occasionally, you may disagree with a coverage denial made through our utilization management (UM) process. This flyer is designed to help you understand your options and guide you through the UM appeals process.

Our UM program reviews requests for coverage by evaluating medical necessity, consistency with clinical guidelines, and the appropriateness of care as outlined in each member's health plan benefits. If a request for coverage is denied, you have the right to initiate a UM appeal — also referred to as a clinical appeal or pre-service appeal — to have the denial reconsidered. This is a formal request for a second review of the decision.

Please note: The UM appeals process is distinct from the claims appeal process, which addresses provider reimbursement disputes for services that have already been rendered. For information on the payment dispute process, please refer to the Provider Claims Appeal flyer.

Initiating a UM appeal

If a coverage request has been denied in full or in part, members, their authorized representatives, or any treating or prescribing physician can request a UM appeal — either verbally or in writing.

To ensure your appeal is processed efficiently, please include all relevant medical records with your appeal request. For Tufts Health Together members, a Designated Representative Form is required. For other lines of business, appeals can be filed under the direction of the treating physician. If the appeal is being submitted by an associate on behalf of the physician (such as a nurse practitioner, physician assistant, or office staff), the request must indicate that the individual is working under the direction of the physician. For inpatient admission appeals, it is also acceptable to submit the request on facility letterhead. Appeals that do not include a valid Designated Representative Form or appropriate confirmation of the treating physician's involvement will be dismissed.

Submitting your appeal by product	Fax	Phone
Tufts Medicare Preferred	617-972-9516	Call Member Services
Tufts Health Plan Senior Care Options		
Tufts Health One Care		
Harvard Pilgrim Health Care Commercial	617-509-3085	Call Harvard Pilgrim Health Care or Tufts Health Plan Member Services
Tufts Health Plan Commercial	617-972-9509	
Tufts Health Direct	857-304-6321	
Tufts Health Together	857-304-6342	
Tufts Health RITogether	857-304-6406	

UM appeals process: step-by-step overview

Overview of clinical appeal process

UM denial issued → **Appeal** submitted → **Appeal analyst** conducts intake & outreaches to provider, if additional information is required → **Physician Reviewer** reviews appeal → **Determination** is made → **If denial is overturned,** services are now approved / **If denial is upheld in full or in part,** provider will be informed of further member appeal rights

Once Point32Health receives your appeal, an Appeals Analyst reviews the request and will reach out to your office or facility directly if additional medical records or information is needed. Your appeal will be reviewed by a Point32Health physician reviewer, and in some cases, it will also be reviewed by a physician consultant with a similar specialty as the requesting provider.

Standard appeals timelines

We strive to review all appeals as quickly as possible. Standard review times vary by product and are detailed in the member's handbook. Generally, you can expect a determination for medical UM appeals for **most products within 30 days.** However, Part B and D drugs reviews are conducted within 7 days.

If a delay could significantly affect the member's health or wellbeing, you may request an expedited appeal. **Appeals related to future inpatient admissions (including behavioral health facilities) are automatically expedited (i.e. appeals for services that have not been rendered yet/before head in bed). Inpatient concurrent reviews are automatically expedited.**

Expedited reviews

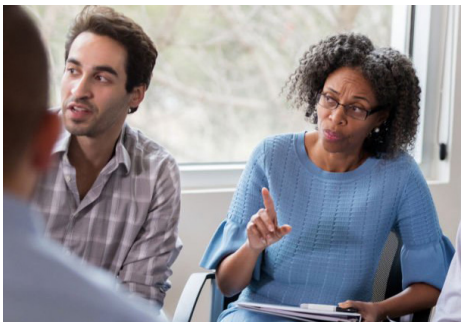
For expedited appeals, a decision will be made **within 72 hours,** unless an extension is needed.

Extensions

The plan may also issue an extension. Extension periods vary by product:

- Tufts Medicare Preferred*, Tufts Health Plan Senior Care Options*, Tufts Health One Care*, Tufts Health Together, Tufts Health RITogether: up to 14 calendar days
- Harvard Pilgrim Health Care Commercial, Tufts Health Plan Commercial, Tufts Health Direct: up to 30 calendar days

** Appeals related to Part B and Part D drug requests cannot be extended for these products.*



After a determination is made

When a determination is made, the member and the physician requestor will be notified verbally and/or in writing. If the denial is overturned, the services are now approved. If the denial is upheld in full or in part, you'll be informed of further member appeal rights.

For Commercial and Medicaid products, prior to filing a UM appeal, you can request a peer-to-peer discussion regarding a medical or behavioral health service. This conversation allows you to consult directly with one of our medical directors or clinical reviewers.

For more information, please refer to the Peer-to-Peer Form and applicable sections of our Provider Manuals.

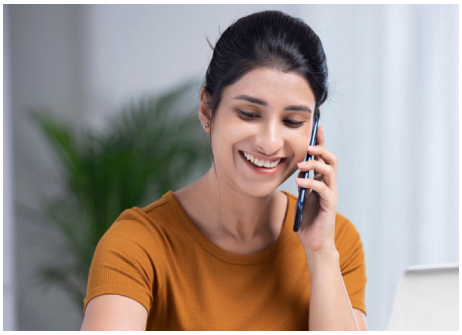
Further member appeal rights

In the event your UM appeal is denied, your determination letter will provide details on your options for further member appeal and include any necessary forms. This process varies based on the line of business and service type.

- **Appeals for Medicare and dual Medicare-Medicaid members:** In the event of an appeal denial for Medicare covered services, an automatic Level 2 Appeal will occur with MAXIMUS Federal Services, an Independent Review Entity. The appeal decision notification will occur verbally and/or in writing. Dual members also have the right to file an external appeal Fair Hearing request with the Office of Medicaid's Board of Hearings (BOH).
- **Appeals for other lines of business:** The provider may file a second level appeal on the member's behalf with one of the agencies as follows:
  - **Commercial and Tufts Health Direct:** State's designated Division of Insurance or for certain self-insured employer groups by an Independent Review Organization process coordinated by the Plan
  - **MA Together:** Office of Medicaid's Board of Hearings
  - **RI Together:** Office of the Health Insurance Commissioner (OHIC) and State Fair Hearing with OHHS. (RI Board of Hearing appeal)

Have questions about your appeal?

- **Your denial letter** will include detailed information on next steps.
- **If you have additional questions,** please contact the Provider Service Center, and note that you are calling about a UM, or a pre-service, appeal.



Appealing a discharge date for Medicare and duals members

Medicare members wishing to appeal a discharge date can do so through the Centers for Medicare and Medicaid Services (CMS) mandated appeals process via the Quality Improvement Organization (QIO).

The member may contact Acentra at 888-319-8452 for assistance.

More information is included in the hospital notice or can be found in the Tufts Health Plan Senior Products Provider Manual.