Clinical Decisions

Unless otherwise specified, 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

Appropriateness of Care

Harvard Pilgrim's Utilization Management (UM) programs are designed to ensure that decisions related to the authorization of health services are made in a fair, impartial, and consistent manner, and based solely on the medical necessity and clinical appropriateness of care and availability of benefits. Harvard Pilgrim does not reward individuals who conduct utilization review for issuing denials of coverage for appropriate, medically necessary services, or offer utilization decision-makers any financial incentives intended to reward the inappropriate restriction of care.

Medical Review Criteria

Harvard Pilgrim's UM and care management staff use evidence-based proprietary and non-proprietary Medical Necessity Guidelines (MNGs) and review criteria to evaluate the medical necessity and clinical appropriateness of selected services. The member's Benefit Handbook and Schedule of Benefits are also consulted to facilitate coverage decisions.

When prior authorization is required, Harvard Pilgrim's evidence-based proprietary and non-proprietary MNGs and review Criteria are used to review requests for most elective (non-urgent) services. Harvard Pilgrim uses an evidence-based process to review new developments and new applications for medical health technologies (i.e., procedures, pharmaceuticals, and devices). The process utilizes a structured framework to evaluate technologies and their intended use(s), complemented by analyses of available published peer reviewed literature, potential market, regulatory, legal, ethical, and actuarial impacts.

Clinical Experts (including Harvard Pilgrim clinicians and/or actively practicing experts in the field of interest) are consulted for feedback/recommendations based on available evidence. Relevant feedback is also obtained from Harvard Pilgrim's Payment Policy, Benefits Administration, Provider Contracting, Legal, and various internal stakeholder areas to capture and assess the potential impact of implementation.

Final recommendations are reviewed/approved by Harvard Pilgrim's Clinical Medical Policy Committee. To ensure providers understand the basis upon which Harvard Pilgrim coverage decisions are made, MNGs and review criteria are published on Harvard Pilgrim's public site at www.harvardpilgrim.org.)

These MNGs and review criteria are developed with input from actively practicing specialty physicians and reviewed at least annually (every 12-14 months) by Harvard Pilgrim's UM and Clinical Medical Policy Committee.

Harvard Pilgrim also utilizes evidence-based proprietary (InterQual Decision support criteria) and non-proprietary criteria to evaluate the medical necessity and clinical appropriateness of inpatient services provided at acute care hospitals, acute rehabilitation and long-term acute care (LTAC) hospitals, and skilled nursing facilities (see Harvard Pilgrim's *Prior Authorization Policy*).

Written notification of denial decisions explains which criteria set was used to make the denial decision. Members and providers impacted by a denial decision may request a copy of any criteria used to make the UM determination by calling Harvard Pilgrim's main number 888-888-4742.

Definition

Harvard Pilgrim defines "Medically Necessary" health care in the member's benefit plan, which is based upon the definition set forth in the applicable state regulations as follows:

Massachusetts

Medically Necessary or Medical Necessity — Those health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

- The service is the most appropriate supply or level of service for the member's condition, considering the potential benefit and harm to the individual
- The service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes
- For services and interventions that are not widely used, the use of the service for the member's condition is based on scientific evidence

Maine

Medically Necessary or Medical Necessity — Health care services or products provided to a member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Demonstrated through scientific evidence to be effective in improving health outcomes
- Representative of best practices in the medical profession
- Not primarily for the convenience of the enrollee or Physician of the other health care practitioner

New Hampshire

Medically Necessary or Medical Necessity — Those medical services which are provided to a member for the purpose of preventing, stabilizing, diagnosing or treating an illness, injury or disease or the symptoms thereof, in a manner that is:

- Consistent with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, location of service and duration
- Demonstrated through scientific evidence to be effective in improving health outcomes
- Representative of best practices in the medical profession, and not primarily for the convenience of the enrollee or physician or other health care provider

Medical Necessity Determination

The attending provider, in consultation with the member or his/her designee, is responsible for all clinical decisions regarding treatment provided to the member. Harvard Pilgrim and its designated UM partners makes utilization decisions (based on medical necessity and clinical appropriateness of care, and availability of benefits) that determine Harvard Pilgrim's coverage for certain items (e.g., continuous glucose monitors, medical drugs that cannot be self-administered) and services (e.g., infertility services, outpatient diagnostic imaging, lumbar spine surgeries, interventional pain management for back pain). Refer to the *Authorization Policy* for details of Harvard Pilgrim's authorization requirements.

Determinations of medical necessity are based on Harvard Pilgrim's definition of medically necessary health care. Any decision — including prospective, concurrent, or retrospective decisions — to deny coverage based on medical necessity is reviewed by a Harvard Pilgrim Medical Director, Clinical Reviews or designee.

Before making a denial based on medical necessity, Medical Director, Clinical Reviews or their designees may attempt to contact the PCP or attending physician (as appropriate) to discuss the individual situation. If the Medical Director, Clinical Reviews is unable to contact the PCP/attending provider they or their designee informs the treating practitioner's staff about how they can contact the Harvard Pilgrim Medical Director, Clinical Reviews to discuss the case (if desired). The Harvard Pilgrim Medical Director, Clinical Reviews is the final decision-maker for any denial based on medical necessity.

All utilization review decisions to deny coverage are made by qualified, licensed physicians, or when appropriate and when allowable by law, by licensed health care professionals with expertise in the specialty for which services are being requested. Note: Doctoral-level psychologists can render denial of coverage decisions for Behavioral Health/Substance Use Disorder services unless the requesting provider is a licensed physician; in which case, a licensed physician must render the denial of coverage decision.

Denial and termination of benefits decisions are communicated verbally and in writing to the attending physician, and in writing to the member and the facility (as appropriate), within standard time frames that accommodate the clinical urgency of the specific situation. Decision time frames are consistent with applicable state regulations and meet or exceed the National Committee for Quality Assurance (NCQA) standards for health plan accreditation.

Review Process

Prior Authorization Decisions

Urgent Care

Harvard Pilgrim does not require prior authorization for most urgent care services. In rare situations where prior authorization is required, requests are reviewed and decided within 24 hours upon receipt of the clinical information.

Acute hospital emergency admissions require notification to Harvard Pilgrim within two business days and may be subject to review for appropriateness of level of care (observation vs acute inpatient levels of care). Refer to the *Emergent Department/Urgent Admission Notification policy*.

If additional information is required to make a decision, providers are verbally notified at the time of the initial review and allowed up to 48 hours to submit requested information. If additional information is received, Harvard Pilgrim makes a decision within 24 hours of receipt of the information or next working day; if requested information is not received, Harvard Pilgrim makes an authorization or denial decision based on available information. (Providers are notified of the decision within 24 hours.)

Non-Urgent Care

Elective procedures/services require notification to Harvard Pilgrim at least one week prior to the date of procedure/service and may be subject to review for the appropriateness of the level of care (observation vs. acute inpatient levels of care may be subject to concurrent review to determine need for continued stay). Please refer to the Elective Admission Notification policy.

Some elective procedures/services require prior authorization. When prior authorization is required, pre-service requests for non-urgent care are reviewed, and an authorization or denial decision is made, within two working days of receipt of all necessary information. For state of Maine members only, a request by a provider for prior authorization of a non-emergency service must be answered by Harvard Pilgrim within 72 hours or two business days, whichever is less.

If additional information is required, the requesting provider is notified (in writing) within two business days of submission, and the provider is allowed up to 45 days to submit requested information. If additional information is received, a decision is made within two working days of receipt of necessary information; if requested information is not received, Harvard Pilgrim makes an authorization or denial decision based on available information. For rating state of Maine members only if additional information is received, a request by a provider for prior authorization of a non-emergency service must be answered by Harvard Pilgrim within 72 hours or two business days, whichever is less.

Decisions regarding non-urgent care are communicated to the provider within one working day of the decision.

Written or electronic confirmation of the decision is sent to the member and provider within one working day of verbal notification. Both providers and members have access to the Harvard Pilgrim Health Care portal where they can review the status of their request.

If the member is a minor or incapacitated to receive and/or understand the notification, the notification is sent to the appropriate contact person (e.g., parent, legal guardian, or next of kin) and is delivered by a provider or designee.

Concurrent Review

Harvard Pilgrim uses concurrent review to evaluate the medical necessity and clinical appropriateness of inpatient services (i.e., in selected acute hospitals, skilled/sub-acute nursing facilities, acute rehabilitation hospitals), and on-going home health care services.

Nurse Care Managers/Utilization Management Clinical Reviewers work collaboratively with providers to ensure the appropriate utilization of services and minimize disruption of care.

Denial decisions are communicated to the servicing provider within one working day of the decision and written or electronic confirmation is sent to the member and provider within 24 hours of verbal notification or the next working day.

Behavioral health clinicians and non-clinical utilization management coordinators (UMC) staff the behavioral health utilization management program. Using nationally recognized clinical criteria and Harvard Pilgrim's medical necessity standards, the behavioral health clinicians conduct concurrent clinical review for acute care, extended care, and BH/SUD intermediate levels of care. The concurrent review process is focused on evaluating whether the member is receiving medically necessary care, receiving treatment or services in the appropriate level of care, and receiving proper transfer and discharge planning if transitioning to another facility, treatment program, or being discharged to home.

To effectively perform telephonic or faxed reviews, Harvard Pilgrim needs to receive all required clinical information within the requested time frame to meet regulatory and accreditation requirements.

Behavioral health clinicians may refer a case to Medical Affairs, if upon evaluation the case does not appear to meet medical necessity standards. A Medical Affairs psychiatrist or other appropriately licensed BH clinicians will conduct an independent clinical review and make a determination.

Coverage denial decisions do not preclude the member from obtaining a service or supply, or the provider from recommending them to the member. Clinical decisions regarding the member's care are solely the responsibility of the member and the attending provider. However, the provider will be held financially liable for the noncovered service/supply unless the member specifically agrees in writing, in advance, to pay for the service/supply. The provider's agreement with the member must meet the terms of the provider health agreement through which the provider participates with Harvard Pilgrim.

Post-Service Decisions

Failure to comply with Harvard Pilgrim's prior authorization requirements may result in an administrative denial of the claim payment (the provider is held liable for any denied claim). In situations where post-service review may be needed (e.g., when a member is unable to provide current insurance information), post-service requests are reviewed within five working days of receipt to determine if additional clinical information is needed.

Decisions are made and communicated to providers within 30 calendar days of receipt of the request except in situations where additional information is required to make a decision.

When additional information is required, the provider and member are notified in writing; providers are allowed up to 45 days to submit requested information. A decision is rendered and communicated to the member and provider within 15 days of receipt of the additional information.

If retrospective review results in a denial where the member could be held financially responsible, the member (or appropriate contact person) is notified in writing.

Type of inquiry	Contact	Telephone
Harvard Pilgrim's UM processes	Provider Service Center	800-708-4414 and select the option for the Referral/Authorization Unit
Specific authorization or denial decisions, or the management of individual medical cases	Harvard Pilgrim's UM staff	• 888-888-4742: Ask for Utilization Management Department • Mon.–Fri., 8:30 a.m.–5:00 p.m. • Inquiries received outside normal business hours are recorded on voice mail and responded to within one business day of receipt
UM of behavioral health services	Harvard Pilgrim Provider Service Center	800-708-4414
UM of Sleep Diagnostics	Evolent (formerly National Imaging Associates, Inc./NIA)	• 800-642-7543 • 24 hrs/day, 365 days a year • Authorization status and approved transaction numbers are also available to servicing providers through *HPHConnect* and NEHEN, or status and transaction numbers can be accessed through Evolent's website at www.radmd.com • Detailed *HPHConnect* instructions are available at www.harvardpilgrim.org/providers
UM of Outpatient Advanced Imaging Services	Evolent	• 800-642-7543 • 24 hrs/day, 365 days a year • Authorization status and approved transaction numbers are also available to servicing providers through *HPHConnect* and NEHEN, or status and transaction numbers can be accessed through Evolent's website at www.radmd.com • Detailed *HPHConnect* instructions are available at www.harvardpilgrim.org/providers
UM of non-emergent Lumbar Spine Surgeries (Fusion, Decompression, Microdiscectomy) and Interventional Pain Services (Sacroiliac Joint Injection, Interlaminar and Transforaminal Epidurals, Facet Joint Blocks, Radiofrequency Neurolysis)	Evolent	• 800-642-7543 • 24 hrs/day, 365 days a year • Authorization status and approved transaction numbers are also available to servicing providers through *HPHConnect* and NEHEN, or status and transaction numbers can be accessed through Evolent's website at www.radmd.com • Detailed *HPHConnect* instructions are available at www.harvardpilgrim.org/providers
UM of genetic & molecular diagnostic testing	Carelon Medical Benefits Management (formerly AIM Specialty Health)	• 855-574-6476 • www.carelon.com • Detailed *HPHConnect* instructions are available at www.harvardpilgrim.org/providers
UM of select medical drugs	Harvard Pilgrim Pharmacy Utilization Management	• 800-708-4414 (phone) or 617-673-0988 (fax) • Detailed *HPHConnect* instructions are available at www.harvardpilgrim.org/providers
UM of newborns who are premature and have medically complex cases to promote health outcomes	Progeny	• www.progenyhealth.com • Detailed *HPHConnect* instructions are available at www.harvardpilgrim.org/providers • 610-832-2001

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