Denials and Adverse Determinations

Administrative Denials

An "administrative denial" occurs when authorization or payment for a particular health care benefit or service is denied because Harvard Pilgrim determines:

- The service is not covered under the member's policy at the time the service is requested or provided
- A covered service is provided without primary care physician (PCP) approval or Harvard Pilgrim receives notification or provides authorization (in both instances, when required)
- A limited benefit has been exhausted

Member Liability

Members may not be held liable for the cost of services provided without required notification when an in-network provider is responsible for notifying Harvard Pilgrim. (Refer to "Failure to Notify" in the *Notification Policy*.)

Explanation codes (EX codes) on the Explanation of Payment (EOP) indicate when a member may be held financially responsible.

Clinical Denials

Prior authorization is required for selected elective (non-urgent) services. A clinical denial occurs when a Harvard Pilgrim Medical Director, Clinical Reviews or designee denies authorization (and payment), or ends coverage, for a particular health care service because service specific medical necessity criteria were not met.

Member Liability

Members may be held liable for the cost of services that are denied prospectively. Explanation codes (EX codes) on the Explanation of Payment (EOP) indicate when a member may be held financially responsible.

Members may not be held liable for the cost of services provided without required authorization when an in-network provider is responsible for obtaining prior approval. (Refer to "Failure to Notify" in the *Notification Policy*.)

Termination of Benefits

Termination of benefits occurs when a Harvard Pilgrim Medical Director, Clinical Reviews or designee determines:

- The care or service being provided is no longer medically necessary; or
- A member who requires ongoing care has exhausted a limited benefit described in the member handbook or Explanation of Coverage (EOC).

Member Liability

The member may be held liable for the cost of services provided after Harvard Pilgrim has notified the member of a benefit termination.

Review of Appropriateness of Denial

Any decision to deny coverage based on medical necessity is reviewed by a Harvard Pilgrim Medical Director, Clinical Reviews or appropriate designated clinician. Harvard Pilgrim's Medical Director, Clinical Reviews or their designees attempt to contact the primary care physician or requesting provider's office or attending physician to discuss the situation before making a clinical denial decision. Medical Director, Clinical Reviews are the final decision-makers on all denials based on medical necessity.

Denial decisions are communicated to the member's attending physician/provider and facility (as appropriate) within standard time frames that accommodate the clinical urgency of the specific situation.

- Termination of benefits decisions are communicated to the member (or authorized representative), PCP/attending provider, and facility on or before the last day covered by Harvard Pilgrim.

Harvard Pilgrim Medical Director, Clinical Reviews are available to discuss clinical denial decisions with the treating physician. To discuss a denial decision, call Harvard Pilgrim's Utilization Management department at 800-888-4742.

Reconsideration Review

When a service that requires prior authorization is denied on the basis of medical necessity, the requesting provider may request a reconsideration review on behalf of the member. Reconsideration is an informal process related to services that are yet to be provided. Reconsideration is not an appeal, nor is it a prerequisite for initiating an appeal.

- Reconsideration requests must be submitted within 20 calendar days of written notification of a denial decision. Inpatient/Concurrent reconsideration requests must be submitted by the requesting provider while the member is still in the facility or within 2 days of the decision if the member had been discharged.
- Reconsideration review typically occurs within one working day of receipt of the request.
- When possible, the Medical Director, Clinical Reviews responsible for the initial decision conducts the reconsideration review.
- If the Medical Director, Clinical Reviews responsible for the initial decision is not available, a clinical reviewer designated by the original physician decision-maker may review the request.
- If requested by the member or provider, reconsideration review will be conducted by a same or similar specialty physician.

If the adverse determination is not reversed after reconsideration, the member or the provider working on behalf of the member may still request an appeal as outlined in the original denial notification.

Notification

Notification of any denial (adverse determination) based on medical necessity includes:

- The specific rationale for the decision
- A description of the member's presenting symptoms or condition, diagnosis, and treatment interventions and the specific reasons why these fail to meet the relevant review criteria
- Alternative treatment option(s) offered if any
- A description of appeal rights
- Information on how to initiate an appeal

Notification Time Frames

Attending providers (e.g., physician and facility) are notified verbally or electronically and in writing of denial/decisions; members are notified in writing.

All denial notices are communicated to providers and members, within standard timeframes that accommodate the clinical urgency of the specific situation, and are consistent with relevant NCQA standards and state regulations.

Pre-Service Decisions

Urgent Care: Urgent pre-service requests are reviewed within one working day of receipt of the request. A decision is made within one day (24 hours) of receipt of the request and verbally communicated to providers within 24 hours of the decision. Written or electronic confirmation of a non-certification decision is sent to the member and providers within 24 hours of the decision.

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. A decision is made within 24 hours of receipt of necessary information, and communicated to providers within 24 hours of the decision.

Non-Urgent Care: Decisions regarding non-urgent pre-service requests are made within two working days of receipt of the request, and verbally communicated to providers within 24 hours of the decision. Written or electronic confirmation of a non-certification decision is sent to the member and provider(s) within one working day of the decision.

If additional information is required to make a decision, providers (and the member) are notified in writing within 24 hours of the initial review. Providers may be allowed up to 45 days to submit requested information. A decision is made within two working days of receipt of necessary information, and communicated to providers within one working day of the decision. Written or electronic confirmation of a denial/non-certification decision is sent to the member and providers within one working day of verbal notification.

If the member is a minor or not competent to receive and/or understand the notification, the notification is sent to the appropriate contact person (i.e., parent, legal guardian, or next of kin).

Concurrent Review

Decisions regarding skilled or sub-acute nursing facility or acute rehabilitation or acute hospital admissions, home health services or ongoing ambulatory services are made within 24 hours of the request and communicated to the servicing provider within one working day of the decision. Written or electronic confirmation of denial decisions is sent to the member and provider within 24 hours of verbal notification.

If additional information is required to make a decision, providers and members (as appropriate) are allowed up to 24 hours to submit requested information. A decision is made within 24 hours of receipt of necessary information and communicated to providers within 24 hours of the decision.

Post-Service Decisions

Post-service requests (when appropriate) are reviewed within five working days 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 25 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.

Appeals

Refer to *Appeals Overview* and *Contract Rate, Payment Policy, or Clinical Appeals* for information regarding the appeal of an adverse determination.

PUBLICATION HISTORY

01/01/12	removed First Seniority Freedom information from the appeals section
03/15/12	minor edits for clarity
09/15/12	reviewed; no changes
01/15/13	reviewed; updated reconsideration review and notification sections
03/15/15	updated prior authorization information under Member Liability in the Clinical Denials section; minor edits for clarity
11/15/15	reviewed; added submission information to the reconsideration review section; administrative edits
06/15/17	reviewed; administrative edits
01/01/23	reviewed; administrative edits
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