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 elective surgical procedures being done at an inpatient level of care and 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.

Peer-to-Peer/Reconsideration Review Process

A Harvard Pilgrim Medical Director, Clinical Reviews, or their designee, or practitioner is available by phone for providers to discuss denials (adverse determinations) based on medical necessity. Denial notices include contact information and instructions about how to arrange a peer-to-peer or reconsideration (where applicable). This process enables the servicing or requesting physician to communicate directly with the Plan physician or practitioner who rendered the decision, or a designee if the practitioner is not available. As part of the peer-to-peer or reconsideration process, further clinical justification or additional information may be provided.

Note: The peer-to-peer or reconsideration process is not a prerequisite for a formal standard or expedited appeal.

Initiating the Request

- **To submit a peer-to-peer request for a pharmacy or medical drug**, call 888-766-9818. Peer-to-peer requests for pharmacy services are not currently available via the online Peer-to-Peer Request Form.
- **To submit a peer-to-peer request for denials issued by one of our vendors**, contact the appropriate vendor:
  - **Evolent Health**: 800-642-7543
  - **Carelon**: 855-574-6476
  - **Progeny**: 888-832-2006
  - **OncoHealth**: 877-222-2021
  - **eviCore**: 888-511-0401
- **To submit a peer-to-peer or reconsideration request for medical or behavioral health denials**:
  - **Online:** For non-pharmacy requests, you may submit the Peer-to-Peer Request Form. The online form is available on the provider website.
  - **Call:** You may also call Harvard Pilgrim's Utilization Management department at 1-844-442-7324 to request a peer-to-peer review.

Once a peer-to-peer request is received, a Plan physician or practitioner will contact the requesting or servicing provider, or their office staff, to discuss the denial.

For New Hampshire fully insured members, peer-to-peer reviews are available before a decision or following a prior authorization denial but must occur before a formal grievance has been made to the Plan. Providers are asked to complete the Peer-to-Peer Request Form to initiate the peer-to-peer review, which will be completed within two business days of receipt of the request.

In accordance with applicable Massachusetts or Maine state requirements, if requested by the servicing provider, providers can seek formal reconsideration of an initial or concurrent adverse determination.

- **For Maine fully insured plans:** The reconsideration shall occur within one business day after the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse health care treatment decision, or between the provider rendering the service and a clinical peer of that provider, designated by the reviewer, if the reviewer who made the adverse decision cannot be available within one business day.
- **For MA fully insured plans:** The reconsideration shall occur within one business day after the receipt of the request and shall be conducted between the provider rendering the service and the review will be conducted by a board-certified, actively practicing, clinical peer reviewer in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review who was not involved in the initial decision.

Note: The processes described above do not apply to prior authorization requests denied by clinical vendors contracted by the plan to manage the prior authorization process for services on behalf of Harvard Pilgrim Health Care.

General Guidelines for Submitting a Peer-to-Peer/Reconsideration Request

- Submit requests **only** for denials based on medical necessity.
  Note: If a request is denied for administrative or benefit reasons—such as member ineligibility, service date issues, or non-covered benefits—a peer-to-peer review isn't available. You must go through the appeals process for benefit or administrative denials.
- When requesting a peer-to-peer review using the Peer-to-Peer Request Form, submit a separate form for each request. Forms containing information about multiple members are not accepted due to Health Insurance Portability and Accountability Act (HIPAA) concerns.
- If you or the member file an appeal, a peer-to-peer review cannot be completed. Instead, if you filed the appeal, you will be asked if you want to withdraw the appeal and complete the peer-to-peer request instead. If the member filed the appeal, their permission is required to withdraw the appeal.
- Refer to the instructions in the denial letter to request either a peer-to-peer review or appeal the denial.

Upon receipt, the peer-to-peer or reconsideration process shall occur within one business day.

- When possible, the Medical Director or Clinical Reviewer responsible for the initial decision conducts the peer-to-peer or reconsideration review.
  - If the original decision-maker is not available, a designated clinical reviewer may conduct the review.

If the peer-to-peer or reconsideration process does not reverse the denial determination, the provider or member may pursue the expedited or standard appeal process.

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
11/09/23	updated hyperlinks
04/01/25	removed the “Reconsideration Review” section and replaced it with the “Peer-to-Peer/Reconsideration Review Process” section; administrative edits.
08/12/25	updated links in the Appeals section