# Prior Authorization Policy

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/.

## Overview

Harvard Pilgrim requires prior authorization (prospective review of medical necessity and clinical appropriateness) for selected medications, procedures, services and items. The prior authorization process is used to verify member eligibility, and facilitate the appropriate utilization of these elective, non-urgent services.

## Requirements

Servicing providers are responsible for obtaining prior authorization from Harvard Pilgrim (when required).

- When possible, authorization should be requested **at least one week prior to the date of service/admission to allow** Harvard Pilgrim time to determine eligibility, level of benefits and medical necessity.
- Failure to comply with Harvard Pilgrim's authorization requirements may result in an administrative denial of the claim payment for the service requiring prior authorization, as well as any related ancillary or supporting services. The provider is held liable for any denied claim, except in Maine.
    - For Maine providers, failure to comply with Harvard Pilgrim's prior authorization requirements will result in a retrospective medical necessity review of the services. Services not meeting medical necessity criteria will be denied payment with provider liability. In accordance with applicable Maine law, Harvard Pilgrim may impose a provider penalty on any medically necessary, non-emergent services where prior authorization was not obtained before services were rendered.
- Members cannot be held liable for claims denied because a contracted provider did not obtain prior authorization.

Referring providers are responsible for obtaining prior authorization from Harvard Pilgrim for all non-emergent referrals including members enrolled in Narrow Network and Tiered Copay Plans. Servicing providers should validate that the referring provider obtained all the appropriate prior authorizations.

For New Hampshire fully insured members, Harvard Pilgrim's Medical Directors (or Physician Reviewers) are available for a peer-to-peer to discuss any service with the servicing practitioners and providers before the prior authorization determination. To do this, the provider should complete the Peer-to-Peer Request Form. The peer-to-peer review shall be made available by Harvard Pilgrim within two business days of the receipt of the request.

## Decisions

Authorization and denial decisions are made in a timely manner that accommodates the clinical urgency of the situation. 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.

Refer to Denials/Adverse Determination for administrative and clinical denial details.

Harvard Pilgrim's Medical Directors (or Physician Reviewers) are available for a peer-to-peer to discuss any clinical utilization management denial with practitioners and providers affected by the denial decision. Written notification of denial decisions includes information explaining how to contact the Medical Directors, and the provider should complete the Peer-to-Peer Request Form.

For New Hampshire fully insured members, Harvard Pilgrim's Medical Directors (or Physician Reviewers) are available for a peer-to-peer review following a prior authorization denial, but it must take place before a formal grievance has been made. The provider should complete the Peer-to-Peer Request Form. The peer-to-peer review shall be made available by Harvard Pilgrim within two business days of the receipt of the request.

## Non-contracted Providers

Prior authorization from Harvard Pilgrim is required for all elective (non-urgent) HMO member referrals to providers who are non-participating regardless of where the provider is located or where the service is rendered; members enrolled in POS or PPO products may self-refer to non-contracted providers and assume responsibility for coinsurance, deductibles, and balance bills as described in their Benefit Handbook. Harvard Pilgrim authorizes elective referrals to non-participating providers only in limited situations where we determine that medically necessary services are not available within our contracted provider network or that referral to the non-participating provider is medically necessary to minimize disruption of ongoing care.

Under continuity of care, new enrollees receiving active treatment at the time their Harvard Pilgrim membership becomes effective, may be authorized to continue treatment with non-participating providers for a defined transitional period as needed to minimize potential disruption of care. A member receiving active treatment from a provider whose Harvard Pilgrim contract was terminated for reasons other than quality deficiencies may be authorized to continue treatment with the provider with in-network coverage for a specified period of time. Please complete the Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form to make a request.

When a referral to a non-contracted provider is authorized, the non-contracted provider must agree to:

- Treat the member for an appropriate period of time (to be determined by the Harvard Pilgrim Physician Reviewers in consultation with the member or non-contracted provider as appropriate).
- Share information relevant to the treatment plan with Harvard Pilgrim (in accordance with HIPAA requirements).
- Accept Harvard Pilgrim's reimbursement and not charge the member an amount beyond any required copayment.

## Procedures and Services That Require Prior Authorization

Harvard Pilgrim's prior authorization requirements are subject to change. For up-to-date information, refer to resources posted on the Prior authorization page of the provider website.

## Action Required

Please refer to the specific authorization policy and authorization request form for details on criteria and information required at the time of request.

The facility, PCP, or specialist may request authorization through one of the following channels.

### Electronic

Submit a transaction record with required information using the *HPHConnect* or NEHEN transaction service.

- Detailed *HPHConnect* instructions and links to user guides are available at www.point32health.org/provider/electronic- services/hphconnect/.
- For NEHEN instructions, refer to your NEHEN documentation.

Harvard Pilgrim Response:

The request pends for receipt of medical information and evaluation. Review is completed within two business days after receipt of medical information. The final status will be available online.

In Massachusetts, prior authorization requests for admission to a post-acute care facility or transition to a post-acute care agency—including skilled nursing, intermediate or long-term care, rehabilitation facility, or home health agency—will be approved or denied by the next business day following receipt of required medical information.

### Fax

Send required information to Harvard Pilgrim by fax.

- **Fax:** 800-232-0816

Harvard Pilgrim Response:

The request pends for receipt of medical information and evaluation. Review is completed within two business days after receipt of medical information. The decision will be communicated in writing within one business day.

In Massachusetts, prior authorization requests for admission to a post-acute care facility or transition to a post-acute care agency—including skilled nursing, intermediate or long-term care, rehabilitation facility, or home health agency—will be approved or denied by the next business day following receipt of required medical information.

## Information Required

The following information is required for an authorization request:

- Member's name and Harvard Pilgrim identification number
- PCP's name and National Provider Identifier (NPI)
- Admitting provider's name and NPI
- Facility's name, location and NPI
- Diagnosis and clinical information
- Service requested (i.e., admission, procedure, etc.)
- Admission date (must be the actual date the member was admitted to inpatient status)

All requests for services must be submitted with a valid NPI for the requesting and servicing providers.

### Medical Information

To facilitate the authorization process, submit medical information to the designated Harvard Pilgrim reviewer as soon as possible.

## Authorization Changes

Harvard Pilgrim must be informed when any change to an authorized procedure occurs, such as a change in the date of service or a change in the authorized type of service (i.e., inpatient or surgical day care). Failure to notify us of changes may result in claims denial.

### Electronic

Edit the existing pending transaction record or submit a new transaction record, using the *HPHConnect* or NEHEN transaction service.

- Detailed *HPHConnect* instructions and links to user guides are available at www.point32health.org/provider/electronic- services/hphconnect/
- For NEHEN instructions refer to your NEHEN documentation.

### Telephone or Mail

Send changes to Harvard Pilgrim.

**Phone:** 800-708-4414
**Fax:** 800-232-0816
**Mail:** Harvard Pilgrim Health Care Referral and Authorization Unit 1 Wellness Way, Canton, MA 02021

## Honoring Prior Authorizations from Previous Insurers

Harvard Pilgrim Health Care honors existing prior authorizations from in-network providers for 90 days from the member's new plan start date when a patient switches to a Harvard Pilgrim Commercial plan from another insurer. This applies to benefit-equivalent medical and behavioral health services, as well as pharmacy drugs and items. (Please note that medical drugs are not in scope and will require a new prior authorization.) During this 90-day continuity of care period, no additional medical necessity review is required.

To continue medical and behavioral health services without interruption, providers must validate that the member had an active authorization on file with their previous insurer by submitting a copy of the authorization letter. Alternatively, providers can submit the following documentation:

- Previous provider information
- Dates of service
- CPT codes
- Number of units or visits authorized
- Authorization number from the previous plan

This information should be submitted by fax to 800-232-0816.

For pharmacy drugs, if an active authorization existed under the member's previous plan, providers are not required to submit proof of prior authorization. To request a 30-day prescription extension, call the Provider Service Center at 800-708-4414.

## Behavioral Health

For further details on prior authorization on behavioral health services, please refer to the Behavioral Health Care Authorization policy.

## Utilization Management with Vended Partners

Harvard Pilgrim Health Care has partnerships with approved vendors to conduct utilization management for certain services. For details on current programs — including services, requirements, criteria, and information on how to request prior authorization — please refer to the Vendor programs page on our provider website.

## Related Policies

Network Operations & Care Delivery Management

- Denials and Adverse Determination

Billing & Reimbursement

- Coordination of Benefits (COB) Claims

PUBLICATION HISTORY

| | |
|---|---|
| 01/01/12 | removed First Seniority Freedom information from header |
| 02/19/16 | reviewed; administrative edits for clarification |
| 11/05/21 | updated “Oncology Analytics” to “OncoHealth (formerly Oncology Analytics” |
| 01/01/22 | added “Non-contracted Provider Obligation” section |
| 01/01/23 | reviewed; administrative edits |
| 03/01/23 | updated “AIM Specialty Health” to “Carelon Medical Benefits Management” |
| 09/01/23 | updated for behavioral health insourcing effective on 11/01/23 |
| 01/17/24 | updated non-contracted providers section |
| 04/12/24 | updated Procedures and Services That Require Prior Authorization section; updated table in the Utilization Management with Vended Partners section; administrative edits. |
| 05/10/24 | updated/revised references to “National Imaging Associates, Inc./NIA” to “Evolent” |
| 10/01/24 | updated mailing address to 1 Wellness Way, Canton, MA 02021; administrative edits |
| 11/01/24 | removed telephone number from “Action Required” section; administrative edits |
| 01/01/25 | added and updated language on peer-to-peer reviews to align with NH RSA 420-J:6 |
| 02/01/25 | added link to the Peer-to-Peer Request Form |
| 04/04/25 | updated the “Action Required” section with information regarding prior authorization requests in Massachusetts for admission to a post-acute care facility or transition to a post-acute care agency; administrative edits |
| 07/01/25 | added bullet in “Requirements” section for Maine providers noting failure to comply with Harvard Pilgrim’s prior authorization requirements will result in a retrospective medical necessity review of the services |
| 01/01/26 | Added section on honoring prior authorizations from previous insurers during continuity of care period |
| 09/01/26 | Updated “Requirements” section to document scope of claim payment denial for services rendered without required prior authorization; revised “Utilization Management with Vended Partners” section and added link to “Vendor programs” page on Provider Website as source for details about current programs |
| 10/01/26 | Updated link and guidance in “Procedures and Services That Require Prior Authorization” section; other administrative updates |