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**Clinical Services Program**

The purpose of Harmony Behavioral Health's Clinical Services Program is to ensure that members receive medically necessary care provided at the most appropriate level of service. The goal is to provide the right service, in the right location at the right time to ensure that our members receive the highest quality of care. Harmony Behavioral Health strives to conduct timely utilization reviews in order to authorize benefit coverage for the member's care. Utilization management is an activity that touches all patients receiving care across the continuum of services: inpatient hospitalization, partial hospital program, residential treatment center, intensive outpatient program, outpatient psychiatric medical management, individual psychotherapy, group psychotherapy, home and school-based services, case management and any other outpatient mental health service.

**Access to Care Standards**

Providers must adhere to the following access to care standards:

**Emergent**

Members requesting or referred for emergency care must be evaluated immediately and receive the appropriate level of care in a timely manner.

**Urgent**

Members requesting or referred for urgent care must be evaluated within one day and receive the appropriate level of care in a timely manner.

**Routine**

Members requesting or referred for routine care must be evaluated within seven calendar days and receive the appropriate level of care in a timely manner.

In general, health plan members have a choice of network providers within their geographical area. If a network provider is unavailable, Harmony Behavioral Health may authorize a non-network provider to evaluate and treat a health plan member.

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#### **Prior Authorization**

All inpatient and outpatient behavioral health services require prior authorization, except in an emergency. The treating provider is responsible for obtaining authorization from Harmony Behavioral Health for all routine and urgent services for members. Authorization is obtained by telephone or via the Harmony Behavioral Health Web site. An initial authorization for services allows the member to be registered in the clinical services system. Routine services, such as individual therapy, medication management, etc., do not require submission of documentation. Ongoing services require submission of documentation to support the medical and clinical need for continued care.

#### **Emergency Services**

Members experiencing an emergency behavioral health condition may receive medically necessary care without prior authorization from Harmony Behavioral Health. Providers rendering emergency services must notify Harmony Behavioral Health as soon as possible after the services are rendered, and may be required to forward medical records to Harmony Behavioral Health for utilization review.

#### **Medically Necessary Services**

Harmony Behavioral Health strives to ensure that members receive medically necessary services that are provided at the most appropriate level of care, frequency and duration. Medically necessary services are defined as:

- necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- consistent with the generally accepted professional medical standards and not experimental or investigational
- reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available

- furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

**Medical  
Necessity  
Criteria**

Harmony Behavioral Health follows a set of criteria that serves as guidelines for determining the medical necessity and clinical appropriateness of all behavioral health services. The criteria, developed by McKesson HBOC, are called the InterQual<sup>®</sup> Level of Care Behavioral Health Criteria including specific sets of guidelines for adults, children, adolescents, geriatrics, and for dual diagnosis and substance abuse services. When appropriate, Harmony Behavioral Health also uses guidelines established by the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry. In addition, Harmony Behavioral Health adheres to all federal and state regulations and guidelines applicable to behavioral health services.

**Program  
Oversight**

Harmony Behavioral Health's Medical Director is a board certified psychiatrist who has overall responsibility for the provision and quality of all clinical services provided to members. The Medical Director has overall responsibility for all licensed Behavioral Case Managers, Clinical Coordinators, and Intake Coordinators. Harmony Behavioral Health functions in concert with the health services programs of WellCare Health Plans, Inc. to ensure that members receive the highest quality of medically necessary behavioral health care.

**Inpatient  
Services**

Hospital and facility representatives must contact Harmony Behavioral Health by telephone or by accessing the Harmony Behavioral Health Web site to initiate the pre-certification and authorization of inpatient services at the time of admission or, when emergency care dictates, within 24 hours of admission. Authorization of acute care is conducted by Harmony Behavioral Health on a 24 hour, 7-days per week basis. In addition to authorizing inpatient and other forms of intensive programming, licensed Harmony Behavioral Health Behavioral Case Managers arrange emergency evaluations during 23-hour observation periods,

as well as inpatient and psychiatric consultations on medical units when indicated.

**Inpatient  
Medical  
Necessity  
Criteria**

Acute inpatient care is indicated when in the course of a clinical or medical evaluation the provider determines that a member is:

- experiencing an acute crisis which is at a level of severity that meets the requirements for involuntary examination
- without care or treatment, the person is likely to attempt to harm himself /herself or others
- the person is unable to care for himself/herself

Such self-neglect or self/others-harm is determined to pose a real and eminent threat of substantial danger to the member. This likelihood is supported by evidence of recent behavior or past history in causing, attempting or threatening such harm. As a result, the member cannot be treated effectively in an outpatient, alternative ambulatory setting and/or cannot benefit adequately from the care, help and support of willing family members and friends.

**Concurrent  
Review  
Process**

When a contracted facility has obtained authorization for an admission, a concurrent stay review is required on a regular basis. The facility is responsible for contacting Harmony Behavioral Health's licensed Care Managers with updated clinical information on the scheduled day of review. Care Managers collect only that information necessary to certify the requested service(s). Care Managers do not routinely request copies of medical records and, when requested, only require the section of the medical record relevant to determine the need for ongoing medically necessary service. The Care Managers determine if the data provided meet InterQual Behavioral Health Criteria and, if so, an authorization will be granted for continued inpatient stay. The facility is notified of all authorization and non-authorization decisions on the same business day.

**Inpatient  
Clinical  
Denials**

At completion of the peer to peer clinical review, the Harmony Behavioral Health physician and/or the physician's assistant informs the attending physician of his/her decision, then informs the Care Manager of the decision. The Care Manager will verbally inform the facility of the decision on the same business day. If additional days are not approved, a non-authorization letter is sent to the facility. The letter includes the decision, a statement of clinical rationale, and specific clinical review criteria upon which the clinical review was based (InterQual Behavioral Health Criteria /ASAM criteria). Facility and member appeal rights are attached to the non-authorization letter.

**Reconsideration**

If a decision of non-authorization is issued and the scheduled peer to peer telephonic review has not occurred, the facility or the attending physician may request a peer to peer reconsideration within one business day of the non-authorization decision. The Care Manager will attempt to schedule the review on the next business day with the physician who issued the original non-authorization decision or with an alternate PA. Administrative non-authorization decisions are not subject to peer to peer reconsideration. The facility must file an expedited or standard appeal.

If the non-authorization decision is upheld following the subsequent peer to peer review, the facility may request either an expedited or standard appeal by phone or in writing.

**Expedited  
Appeal**

In concert with the reconsideration process, providers have the right to request an expedited appeal and receive a decision within 72 hours of the request. Expedited appeals are considered most typically for inpatient treatment when the member's health or ability to function could be seriously harmed by waiting on a standard appeal response.

**Inpatient  
Administrative  
Denials**

An administrative denial of inpatient services may be made under certain circumstances, including:

- the failure of a provider to obtain an authorization for

admission or continued inpatient care from Harmony Behavioral Health

- the failure of a provider to report continued stay information to Harmony Behavioral Health
- the failure of a provider to keep a scheduled peer to peer review with Harmony Behavioral Health
- Harmony Behavioral Health has determined the member was ineligible to receive services on the date of service
- Harmony Behavioral Health has determined the member has exhausted his/her covered benefits
- the provider rendered a non-covered service

A provider does have the right to appeal such decisions.

## **Outpatient Services**

Outpatient behavioral health services can reasonably be expected to improve the member's condition or prevent further regression. Outpatient behavioral health services must be medically necessary and rendered or recommended by a physician, psychiatrist or other licensed professional and include a written treatment plan. Services are initiated through the following procedures:

- Primary care physicians, providers, members, and family members may contact Harmony Behavioral Health to request services. If a member contacts us directly, an intake coordinator, under the supervision of a licensed Behavioral Case Manager, will conduct an initial interview to gather basic demographic data. Following the interview, a referral will be made to a provider who best meets the member's needs in terms of behavioral health specialty and geographical location. All members will receive a choice of providers in their geographical area and may elect to change their provider if desired.
- In routine cases, the member will be given a choice of several participating providers, and then asked to

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select and call the participating provider of his/her choice to schedule an appointment. The provider will be sent an authorization letter on the next business day.

- Generally, for initial services, Harmony Behavioral Health authorizes as follows: for a private practitioner, an initial evaluation and 6 to 10 outpatient psychotherapy sessions and, if indicated, psychiatric medication management visits at the time of the initial referral.
- The typical authorization time frame can be from four to six months and up to one year, depending on the specific needs of the member.
- Routine appointments for members who present with minimal risk must be offered within seven calendar days.
- In cases requiring urgent care, a licensed Behavioral Case Manager will contact the provider to discuss the referral and arrange a timely appointment within 24 hours.
- In the event of an emergency, the member is instructed to go to the nearest emergency room or crisis stabilization unit for care and services.

All outpatient triage, referral and authorizations are made under the direction of the Director of Clinical Services, the Manager of Outpatient Services, and the Harmony Behavioral Health Medical Director.

#### **Outpatient Medical Necessity Criteria**

As the least intensive and restrictive level of care, psychotherapy, medication therapy and other outpatient services are most appropriate when the following guidelines are met:

- when the patient displays symptoms consistent with the presence of a diagnosable DSM-IV disorder (or its equivalent in ICD-9-CM) with an Axis V (Global Assessment of Functioning) rating in the mild

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impairment range or below, with a GAF score of 70 or less

- when outpatient treatment is likely to result in a demonstrable improvement in the member's symptoms, condition or illness relative to their diagnosis and without such treatment, it is likely that the member's symptoms subsequently will require a more intensive level of care
- when the treatment plan is appropriate for the member's illness or condition, represents a preferred practice of care, and is consistent with prevailing treatment standards given the member's illness or condition
- when the treatment plan is focused on the member's current, measurable symptoms and behaviors reflective of the member's biologic, psychological and social impairment

### Exclusions

Outpatient therapy is not medically indicated and is not authorized by Harmony Behavioral Health when the member's assessment indicates:

- the presence of long-standing, pervasive, maladaptive traits and/or behaviors that do not have or have not demonstrated the potential to be improved significantly within a reasonable period (approximately six months) of time
- the need for treatment of a medical disorder that will not improve over time
- the proposed services are focused on educational attainment, personal growth, and/or self-improvement
- services are proposed for the convenience and comfort of the member and/or his/her family
- services are proposed to avoid incarceration

Services are proposed that fail to involve the family in treatment.

**Outpatient  
Clinical  
Denials**

When an outpatient case fails to meet the medical necessity guidelines, a Harmony Behavioral Health clinical staff member will contact the provider to discuss the case and the specific reasons for recommending a change in the requested services or a denial of further services. Harmony Behavioral Health then will coordinate efforts with the provider to develop a plan for further treatment or closure of the episode of care with the member. If the requested services are not clearly supported by medical necessity criteria, the provider is requested to submit medical records and a peer-to-peer review is conducted. If a non-authorization is subsequently made by the Harmony Behavioral Health psychiatrist or Medical Director, a denial letter will be issued to the provider. All final Harmony Behavioral Health decisions are rendered by our board certified psychiatrists.

**Outpatient  
Administrative  
Denials**

An administrative denial of outpatient services may be made under the following circumstances:

- the provider failed to obtain a prior authorization for outpatient services from Harmony Behavioral Health
- the provider failed to complete and/or submit an outpatient treatment plan for continued treatment to Harmony Behavioral Health
- the provider failed to keep a scheduled peer-to-peer review with Harmony Behavioral Health
- the member was ineligible to receive services on the date of service
- the member has exhausted his/her covered benefits
- the provider rendered a non-covered service
- the frequency of services provided exceeds authorization guidelines

**Outpatient  
Psychiatric  
Referrals**

A referral to a psychiatrist should be made in the following situations:

- when it is believed medication management would assist in obtaining the best outcome of the therapeutic process either alone or in combination with outpatient psychotherapy
- when a member is not improving during a course of outpatient psychotherapy due to continued symptoms of depression, anxiety or other complicating factors
- when the member's clinical status indicates there is the potential for danger to himself/herself, others, or property
- when increased psychiatric symptoms are interfering with the member's ability for self-care or to carry out normal activities of daily living
- when a medical opinion is necessary following an initial evaluation, or the member's primary care physician has requested a psychiatric consult due to the member's past psychiatric history and/or concurrent medical problems
- when a member requires ongoing post-hospitalization monitoring of medication management

Providers are required to coordinate all psychiatric referrals with Harmony Behavioral Health. Coordination may be conducted by telephone or by submitting an updated outpatient treatment plan, recommending a psychiatric referral. When a psychiatric referral is authorized, Harmony Behavioral Health will send the psychiatrist a letter authorizing services for the member. The letter will include the member's name and identification number, the name and address of the member's primary care physician and a description of the authorized services by procedure code and the number of visits authorized.

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**Treatment Plan Update Form Submissions** After the initial authorization time period, a Treatment Plan Update form (included in the Forms section) must be completed and returned to Harmony Behavioral Health in order to request further routine (i.e., psychotherapy or medication management cases) outpatient services necessary to complete the member's episode of care. Cases requiring peer to peer review will be processed within five (5) business days. Please return the Treatment Plan Update form via fax to Harmony Behavioral Health at 866-517-5835 OR by mail to:

Harmony Behavioral Health  
Attn: Treatment Plan Update  
P.O. Box 25858  
Tampa, FL 33622-5858

The Treatment Plan Update will be reviewed and, if determined medically necessary, Harmony Behavioral Health will authorize additional services by fax or mail within 24-48 hours of the review. (Note: Failure to complete and return this form for review and approval may result in the denial of claims for future dates of service.)

**Psychological Testing** Psychological testing requests require a completed Treatment Plan Update form as well as information describing the specific tests to be administered and the clinical need for each test. All requests will be reviewed for medical necessity. Psychiatric testing requests may be faxed to Harmony Behavioral Health at 866-517-5835.

**Electro Convulsive Therapy (ECT)** A peer-to-peer review will be conducted on ECT requests for members who meet DSM-IVR diagnostic criteria for clinical depression, are recommended by their treating provider, given a supportive second opinion by a second psychiatrist who is certified to perform ECT, and are cleared medically for the ECT procedure. Please fax ECT requests to 866-517-5835.

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#### **Referral for More Intensive Level of Service**

When a member requires a referral to a more intensive level of care, providers are required to contact Harmony Behavioral Health to coordinate care and receive prior authorization for these services. Licensed Behavioral Case Managers are available to confer and assist with all member issues and make necessary referrals on a 24-hour, 7-days per week basis.

#### **Labs, Diagnostic and Other Medical Services**

In the event that a member requires laboratory services, radiological services, other diagnostic services (e.g., EEG) or any other medical service, the provider must contact the member's primary care physician and arrange for such services through the member's health plan. Harmony Behavioral Health is available to assist providers in coordinating these services with the member's health plan and primary care physician.

#### **Out of Area Services**

If a member requires a referral to a provider located out of the member's geographical area for a covered behavioral health care service, the referring provider is required to coordinate the referral and obtain prior authorization from Harmony Behavioral Health.

#### **Community Agencies or Resources**

Whenever coordination or transitioning of care is necessary, or a member requires services not covered by the health plan, providers are requested to coordinate referrals of members with Harmony Behavioral Health.