
Overview

Harmony Behavioral Health's primary goal is to ensure that the most medically and clinically appropriate service is provided to members in the right location for the right length of time. Harmony Behavioral Health strives to conduct timely clinical utilization reviews in order to authorize benefit coverage for member's care.

Utilization management activities touch 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 covered outpatient mental health service. Covered services vary depending on the health plan.

Focus on Recovery and Resiliency

Harmony Behavioral Health supports services that promote the philosophy that individuals should be encouraged to believe that they can recover from their mental illness. Through a service delivery system that is member and family-focused, individuals can have hope that they can recover and lead productive and fulfilling lives. Similarly, the highest quality of treatment services promote and foster a hopeful sense of resiliency in children, adolescents and adults that they possess the coping resources to face the stressors of life and rebound successfully.

Medicaid Outpatient Services

Harmony Behavioral Health shall authorize Medicaid outpatient services based on the provider furnishing sufficient evidence that the services requested:

- are necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain
- are individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs
- are consistent with generally accepted professional medical standards and are not experimental or investigational in nature

- reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available
- are furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider
- are supported in the patient's medical record that includes: a date of service, start and end times, the setting, specific problems, behavior or skill deficits addressed, the specific services / intervention utilized, updates regarding progress towards treatment plan goals, and a legible signature and credentials of the provider

The following activities are not covered under the community behavioral health services program: travel time (excluding targeted case management), services paid for by another funding source, and escorting a member to and from a service site. In addition, services will not be authorized that represent a duplication of another provider's service.

Outpatient Guidelines

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 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. In lieu of individual authorization letters, high volume providers may elect to receive a faxed listing of all the authorization numbers issued for a specific time frame.
- Generally, for initial services, Harmony Behavioral Health authorizes as follows: for a private practitioner, an initial evaluation and 6-10 outpatient psychotherapy sessions and, if indicated, psychiatric medication management visits at the time of the initial referral. For a community mental health center or other traditional Medicaid provider, 10-20 hourly equivalent units of service involving HCPCS procedure codes.
- 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 shall be offered within seven (7) calendar days (a routine appointment is defined as a scheduled service provided to a member whose clinical status is indicative of someone requiring routine behavioral health services.)
- 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 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 his/her 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

**Additional
Criteria for
Medicaid
Services**

Harmony Behavioral Health endorses a best practice of providing enhanced outpatient services for Medicaid enrollees who have more serious behavioral health problems. Such patients may have been identified as Seriously and Persistently Mentally Ill (SPMI) for adults or Severely Emotionally Disturbed (SED) for children or are members who are at risk of needing more intensive residential or inpatient services. Such individuals typically have a history of psychiatric inpatient admissions and are assessed to function at an impaired level based on a GAF/CGAS of approximately 50 or below.

**Enhanced
Medicaid
Services**

Enhanced services include Day Treatment, Psychosocial Rehabilitation Services, Therapeutic Behavioral Onsite Services (TBOS), Psychological Testing and Targeted Case Management. Therapeutic Behavioral Onsite Services (TBOS) and Psychosocial Rehabilitative Services.

These enhanced Medicaid services require a specific preauthorization prior to treatment being provided. Providers are required to submit the Enhanced Services Request form (see Forms section). This form requires supporting documentation from the clinical record or the Enhanced Services Request Supplement (see Forms section) indicating the need for these services.

The Enhanced Services Request form may be faxed to Harmony Behavioral Health at 866-517-5835 (preferred) OR mailed to:

Harmony Behavioral Health
Attn: Enhanced Service Request
P.O. Box 25858
Tampa, FL 33622-5858

The Enhanced Service Request will be reviewed and responded to within five business days of receipt. If additional, clarifying clinical information is requested, processing may be delayed. If the provider fails to forward requested documentation to support the Enhanced Service Request within a reasonable period, it may result in an administrative denial of services.

Enhanced services are authorized for a specified frequency and duration that is patient-specific and can range from one month to one year. Providers are expected to adhere to these guidelines unless there are clinically significant changes that require provision of more intensive services. Providing services in excess of authorized guidelines may result in denial of services.

Exclusions

These services are authorized to promote the member's recovery and overall quality of life as well as to reduce the frequency of crises, need for acute services and otherwise allow the member to reach a baseline level of satisfactory functioning. These services are considered medically and clinically necessary when the member's treatment plan,

clinical progress notes or other documentation reflect:

- that enhanced services need to be provided and these services have been approved by a psychiatrist or other licensed professional
- a current update of the member's clinical status with a recently updated treatment plan
- **specific** and **measurable** goals related to symptom reduction, behavior change, cognitive functioning, self-care, work or school performance, and/or social functioning
- **specific** criteria and **measurable** indicators to identify when services will be reduced, when enhanced services will be completed, and when the member's episode of treatment is concluded
- an alternative treatment approach if the specific enhanced services are not effective
- The specific progress to date achieved by the member:
 - 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
 - treatment of a medical disorder that will not improve over time
 - educational attainment, personal growth, and/or self-improvement
 - the convenience and comfort of the member and/or his/her family
 - avoiding incarceration
 - failure to involve family in treatment

Claims Processing

Harmony Behavioral Health provider claims for authorized behavioral health services are received, processed and adjudicated by WellCare in Tampa, Florida.

Timely Claim Submission

Claims should be submitted as soon as possible after the date of service, but always within the timely filing period as required by the health plan according to applicable Federal (Medicare) and/or State (Medicaid and State Children's Health Insurance Programs) requirements. Providers are currently required to submit claims within 180 days of the date of service. Failure to submit claims within the timely filing limits may cause delay in processing or denial.

In the event the member's health plan is the secondary payer, providers must submit their claim to WellCare within ninety (90) days of payment from the primary payer.

Coordination of Benefits

Coordination of benefits is the procedure used to process health care payments when a person is covered by one or more insurers which provides health care benefits to them.

Prior to submitting a claim to WellCare, behavioral health providers must identify whether the health plan member also has coverage by any other payer having primary responsibility for claim payment. If the health plan member has coverage from another payer, the behavioral health provider must first submit the claim to the payer having primary responsibility.

Dual Eligible (Medicare and Medicaid) Members

When a health plan member is covered under a Medicaid health plan and also is covered under a Medicare health plan, they are considered as having "dual eligibility." In these cases, the behavioral health provider is required to coordinate the health plan member's care with the Medicare carrier and Harmony Behavioral Health to determine benefit coverage and financial responsibility for the claim.

Providers must first submit claims for behavioral health services rendered to dual eligible health plan members to the Medicare carrier and receive an Explanation of Medicare Benefits (EOMB) before submitting a claim to WellCare for further adjudication.

Some behavioral health providers may not be authorized to provide behavioral health services to health plan members covered by Medicare or having dual eligibility. In such cases, when a behavioral health provider submits a claim to the Medicare health plan, an EOMB is returned, denying the claim. WellCare may consider adjudicating these claims as “Medicaid Only” on a case by case basis, provided the behavioral health provider:

- verified the member’s dual eligibility on or before the date of service.
- coordinated the member’s care with the Medicare carrier and Harmony Behavioral Health.
- obtains prior authorization for services from Harmony Behavioral Health.

When such authorization is granted, the behavioral health provider may submit a “Medicaid Only” claim to WellCare, following these guidelines:

- complete a CMS-1500 claim for Medicaid-only payment
- attach the EOMB from the Medicare carrier or, in the absence of an EOMB, attach a letter requesting that the claim be considered for “Medicaid Only” payment because Medicare will not cover the service
- send the claim and supporting documents to the appropriate claims mailing address for the region

Claims Submission

Providers have an affirmative duty to supervise the provision of, and be responsible for, the goods and services claimed to have been provided, to supervise and be responsible for the preparation and submission of the claim, and to present a claim that is true and accurate. Attention should be given to ensure that claims reflect goods and services that were:

- actually furnished to the member by the behavioral health provider
- not excessive, covered and medically necessary

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- of a quality comparable to those furnished to the general public by the behavioral health provider's peers
 - not billed in whole or in part to the member or the member's responsible party, except for co-payments authorized by the health plan
 - provided in accordance with applicable provisions of all applicable rules, regulations, handbooks, and policies and in accordance with federal, state and local law
 - documented in medical records at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered

Accepted Claim Formats

Claims may be submitted to the WellCare in one of the following formats:

- Electronic Claims Submission (EDI)
- CMS 1500 Form
- UB-92 (CMS 1450) Form

HCPCS Coding

Effective October 16, 2003, behavioral health providers are required to use HIPAA compliant diagnostic codes (ICD-9) and procedure codes (HCPCS and CPT), regardless of the type of claim submission. This is a federal requirement. New procedure codes and fees are effective January 1 of each year and the 90-day grace period for the billing of discontinued procedure codes has expired. Behavioral health providers may find a listing of new and discontinued CPT procedure codes in the most recently published CPT manual or may search up-to-date CPT procedure codes online at:

https://catalog.ama-ssn.org/Catalog/cpt/cpt_search.jsp

All previous HCPCS Level III Code Sets, also known as local codes and/or home grown codes, have been discontinued. Behavioral health providers should only use HIPAA compliant codes sets for claims and encounter submissions. Behavioral health provider claims submitted with discontinued procedures codes may be suspended or denied.

**Electronic
Claim
Submission**

Submitting claims electronically is a cost-effective alternative to traditional paper claim submission, offering providers advantages such as faster claims processing and payments, no form inventory to manage, reduced storage requirements, and savings on postage and mailing costs.

**CMS 1500 /
UB-92
(CMS 1450)
Claim
Submission**

Providers may continue to submit paper claims on either a CMS 1500 for non-institutional (professional) claims or UB-92 (CMS 1450) for institutional claims. Providers should complete each claim form with the following information:

Non-Institutional (Professional) Claims - CMS 1500

- The Insured's identification number (Block 1a)
- The Insured's name (Block 4)
- The Insured's address (Block 7)
- The Patient's name (Block 2)
- The Patient's date of birth (Block 3)
- The Patient's address (Block 5)
- The Patient's relationship to the Insured (Block 6)
- Other insurance (Block 11d, and if "YES", complete Blocks 9a, 9b, 9c, and 9d)
- Provider ID (Block 19)
- Diagnosis code(s) (Block 21)
- Prior authorization number (Block 23)
- Date of service (Block 24a)
- Place of service, if applicable (Block 24b)
- Procedure or service codes (Block 24d)
- Charges (Block 24f)
- Days or units (Block 24g)
- Federal tax identification number (Block 25)
- Total charge (Block 28)
- Amount paid (Block 29)
- Balance due (Block 30)
- Signature of provider and date (Block 31)
- Name and address of facility where services were rendered, if other than home or office (Block 32)
- Billing name, address, telephone number, and provider ID number (Block 33)

Institutional (Hospital/Facility) Claims - UB-92 (CMS 1450)

- Provider name, address, and zip code (Block 1)
- Provider ID number (Block 2)
- Provider federal tax ID number (Block 5)
- Statement period (Block 6)
- Patient's name (Block 12)
- Patient's address (Block 13)
- Patient's date of birth (Block 14)
- Patient's sex (Block 15)
- Admission date (Block 17)
- Admission hour (Block 18)
- Revenue codes (Block 42)
- Description of services (Block 43)
- HCPCS rates (Block 44)
- Service dates (Block 45)
- Units (Block 46)
- Total charges (Block 47)
- Payer name and address (Block 50)
- Prior payments (Block 54)
- Estimated amount due (Block 55)
- Insured's name (Block 58)
- Insured's ID or Social Security number (Block 60)
- Treatment authorization code – Prior Authorization Number (Block 63)
- Principle diagnosis codes (Block 67)
- Other diagnosis codes (Blocks 68-75)
- Admission diagnosis codes (Block 76)
- Principle procedure (Block 80)
- Other procedures (Blocks 81a, 81b, 81c, 81d, 81e)
- Attending physician ID (Block 82)
- Other physician ID (Block 83)
- Signature of provider representative (Block 85)
- Date (Block 86)

A copy of the CMS 1500 and UB-92 (CMS 1450) claims forms are provided at the end of this section.

**Where to Send
Paper Claims**

Behavioral health providers submitting paper claims on either CMS 1500 or UB-92 (CMS 1450) should mail their documents to the address shown below:

WellCare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

**Encounter
Data**

Harmony Behavioral Health requires behavioral health providers receiving a monthly capitation payment to submit monthly encounter data for all member visits to the health plan. The health plan will record the encounter data received and report encounter data to government agencies as required by contract.

Encounter data may be submitted on CMS 1500, UB-92 (CMS 1450), EDI, or in another approved format, and should follow the same rules as submitting claims. Behavioral health providers mailing encounters should address their encounter submissions to the following address:

WellCare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

Behavioral health providers receiving a monthly capitation payment who fail to submit encounter data are subject to corrective action measures, monetary penalties under applicable state and federal law, and could be terminated from the behavioral health network.

**Provider ID
Number
Required**

Providers are required to use their assigned health plan Provider ID Number on all claim and encounter submissions, both electronic and paper.

**For Electronic
Claims
Submissions**

If submitting claims or encounters electronically, there is a required field in the file format for the assigned health plan Provider ID Number. Providers are encouraged to verify that their EDI software, billing company, or clearinghouse

has the correct health plan Provider ID Number and enter it in the correct data field. To obtain or inquire about your assigned health plan Provider ID Number, providers may call the WellCare EDI Department at 800-960-2530, ext. 4096.

**For Paper
Claims
Submissions**

Providers submitting paper claims and encounters should include their assigned health plan Provider ID Number on CMS 1500 and UB92 claim forms in the following data fields:

- CMS 1500 – Item 19 (Reserved for Local Use) or Item 33 (PIN #)
- UB-92 (CMS 1450) – Item 2 (Blank), Item 32 (Attending Physician ID) or Item 33 (Other Physician ID)

**Prohibition
Against Billing
Health Plan
Members**

Behavioral health providers are prohibited from billing health plan members for authorized behavioral health services, with the exception of any applicable co-payments, deductibles, co-insurance, or any other amounts listed as the health plan member's responsibility on the Explanation of Benefits /Provider Remittance Advice.

Examples of prohibited types of health plan member billings by behavioral health providers include, but are not limited to, the following:

- the difference between actual charges and the contracted reimbursement amount
- services denied due to timely filing requirements
- covered services for which a claim has been returned and denied for lack of information
- remaining or denied charges for those services where the provider fails to notify the Plan of a service that required prior authorization, payment for that service will be denied
- covered services that were not medically necessary, in the judgment of the Plan, unless prior to rendering the service, the provider obtains the member's informed

written consent and the member receives information, that they would be financially responsible for the specific service

Provider Assistance

Behavioral health providers in need of assistance regarding health plan member eligibility, claims status, benefit coverage and limitations or other issues may contact the member's health plan or Harmony Behavioral Health or use the health plan's interactive voice response (IVR) system. Health plan and Harmony Behavioral Health contact numbers may be found on the health plan member's identification card.

In addition, participating behavioral health network providers that are registered users of the Harmony Behavioral Health web portal may verify health plan member eligibility, access authorization and claims status reports, and use the many other features, functions and resources available.

Electronic Data Interchange (EDI)

Switching from paper claims to Electronic Data Interchange (EDI) claims and encounters submissions is easy if you understand how EDI works. The questions and responses below are designed to help you better understand electronic claims and encounters submissions.

Why should I send claims electronically?

Sending claims and encounters electronically saves time and money. There are no forms to order and store, no printing, no signatures required, and no more envelopes to stuff nor any postage costs. EDI also significantly reduces the turnaround time for claims adjudication, which means providers are paid faster. Providers also receive electronic confirmation that their claim or encounter has been received.

How do I submit claims electronically?

Submitting claims and encounters electronically is done through a clearinghouse. A clearinghouse is like an electronic post office, ensuring the data is properly formatted and HIPAA compliant. The clearinghouse sends provider claim and encounter data to the payer for processing. EDI requires using billing software or a billing agency that is able to pass the data through a clearinghouse.

How do I choose a clearinghouse?

There are many clearinghouses available to choose from depending on individual preferences. Most clearinghouses are capable of exchanging data with other clearinghouses, and WellCare has already established contracts with three of the leading clearinghouses (WebMD, Availity, ACS and SSI) to assist you with converting from paper claims and encounters to EDI submissions. If you already are submitting claims and encounters via EDI through another clearinghouse, it is likely that you'll be able to submit your claims and encounters to WellCare through your current clearinghouse. Always remember that sending claims electronically is much less costly and faster than submitting a paper claim. You should always choose the option that best suits your individual needs. If you need additional information, please contact your provider relations representative.

How much does it cost to use a clearinghouse?

WellCare has an agreement with ACS that includes FREE connectivity and software for submitting electronic claims and encounters for professional services (typically services billed on CMS 1500). WebMD, Availity and SSI offer various options to submit both institutional (UB-92), as well as professional (CMS 1500) claims and encounter data. Some clearinghouses may provide FREE standard service options or a variety of fee-based service options to choose from.

What data is required when I submit claims electronically?

The same information you submit on a paper claim is required on an electronic claim. The most important data elements are the provider identification (ID) and tax ID numbers, which are used to identify the provider, render appropriate payment and determine the mailing address. Each provider is assigned a unique WellCare provider identification number during the contracting, credentialing and configuration process. If you do not know your provider ID number, please contact a Harmony Behavioral Health Provider Relations representative.

How do I check the status of an electronic claim?

Once your claim has been submitted through a clearinghouse, you should receive an electronic verification that your claim has been forwarded to WellCare (the payer) and whether the claim has been accepted or rejected. Once the claim is accepted and loaded into WellCare's claims

system, registered users may check the status of the claim online 24 hours per day, seven days per week at www.harmonybehavioralhealth.com. If you are unable to view the claim status online or if your claims are rejected, please use the following steps to determine the problem and how to resolve it.

For member errors check:

- Is the member's ID missing or incorrect?
- Is the member's date of birth missing or incorrect?
- Does the member's ID match the member name and date of birth?

For provider errors check:

- Is the provider's ID missing or incorrect?
- Is the provider's information in the correct field?
- Is the federal tax ID number missing or incorrect?
- Does the provider's ID match the tax ID?

If after checking these items you are still experiencing problems, please contact the WellCare EDI Department.

What would cause a claim to reject?

WellCare reviews many data elements during the claim adjudication process. Elements such as the member identification number, member's date of birth, provider number, tax identification number, date of service, authorization number and so on are checked against the system information file records. If data provided on the claim does not pass system checks and edits, the claim may be rejected. If you receive a rejection for a member error, please verify the member number and date of birth information. If your rejection is caused by a provider error, please verify the provider number and tax ID that was sent on the claim. This second scenario may require assistance from the WellCare EDI Department or your clearinghouse for resolution.

How do I begin to send claims electronically?

Once you have chosen a clearinghouse, you'll need to know the WellCare payer ID number. A listing of the WellCare clearinghouses, payer ID numbers and contact telephone numbers are shown below:

WebMD® (also known as Emdeon™, Envoy and NEIC)

- WellCare Payer ID: 14163
- Technical Support: 800-735-8254

Availity

- WellCare Payer ID: 14163
- Technical Support: 800-AVAILITY

ACS (also known as Consultec)

- WellCare Payer ID: 77004
- Technical Support: 800-987-6720

SSI

- WellCare Payer ID: 14163
- Technical Support: 800-880-3032

Other clearinghouses with connectivity to the clearinghouses listed above include:

- NDC
- Mysis
- McKesson
- FastTrack
- THIN
- MDP
- ENS/EDSS
- MedUnite
- Visionary

May I resubmit electronic claims after making corrections?

Yes. If you discover an error on your original claim, you may make corrections and resend your claim electronically.

Whom may I contact for general EDI questions or assistance?	Contact the WellCare EDI Department toll-free at 800-960-2530, ext. 4096.
Web-based Authorizations	Harmony Behavioral Health offers participating network behavioral health providers the opportunity to request authorization for medically necessary, covered behavioral health services through a Web-based application at www.harmonybehavioralhealth.com . This application allows the user to verify member eligibility, request authorization for behavioral health services, and print a copy of an approved authorization through the internet 24 hours per day, 7 days per week.
Registration	Participating behavioral health providers in the Harmony Behavioral Health network are encouraged to use our web-based application for requesting authorization of behavioral health services. Participating behavioral health providers may register online at www.harmonybehavioralhealth.com . Registration applications are typically reviewed and approved within 72 hours. For more information about the web-based application and registration process, please contact a Provider Connectivity Associate at 800-960-2530.
Applicability	The Web-based application will accept and process authorization requests for covered behavioral health services for eligible health plan members from participating Harmony Behavioral Health network providers.
Member Eligibility	The Web-based application verifies member eligibility before allowing the user to request an authorization for services. If the member is not eligible for services, the Web-based application will not allow the user to request an authorization for services. Please note however, that eligibility information may change at anytime and should be verified on the date of service, before providing behavioral health care services.

**Authorization
for Services**

The Web-based application allows the user to request authorization for services through a series of data entry screens. For many outpatient services, authorization is granted immediately and the user may print an authorization form as a screen print on a local printer. Some requested services, such as psychological testing, intensive outpatient services, partial hospitalization, school-based care, home care and most inpatient admissions, require a clinical review by Harmony Behavioral Health before an authorization is approved. The user will receive a message screen stating the requested service(s) requires a clinical review prior to determining whether or not authorization is approved. Behavioral health providers will be informed of the determination the next business day after the request is received by Harmony Behavioral Health. Behavioral health providers are reminded that authorization of services does not guarantee claim payment.

Data Security

The Web-based application is on the secured portion of the WellCare Web site and is HIPAA compliant. All data is protected from unauthorized disclosure.