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**Health Plan  
Overview**

The Centers for Medicare and Medicaid Services and the state of New York are contracted with WellCare Health Plans, Inc. to provide comprehensive, cost-effective managed care health services to enrolled members. WellCare is contracted with Harmony Behavioral Health, Inc. to provide behavioral health services for their enrolled members.

In accordance with each contractual agreement, the health Plans offer the behavioral health services described below.

**Healthy Choice**

**Healthy Choice** serves both adults and children who are eligible to participate in New York's Medicaid Program. Medicaid is a state and federal partnership which provides health coverage for selected categories of individuals and families with low incomes. Eligible enrollees can choose to join Medicaid or a program such as Healthy Choice. With an enrollment in Healthy Choice, members receive more benefits, more choice, more convenience and more coverage than with traditional Medicaid.

**Co-payments / Co-insurance / Deductibles**

- There are no co-payments, co-insurance or deductibles

**Covered behavioral health services include:**

- Unlimited inpatient mental health services, chemical dependency rehabilitation and treatment, medically-necessary managed detoxification and medically-supervised withdrawal treatment;
- Unlimited outpatient visits for the treatment of mental health diagnoses;
- Outpatient services include but are not limited to:
  - Assessment
  - Stabilization
  - Treatment and discharge planning

- Verbal therapies including education
  - Symptom management
  - Case management services
  - Crisis intervention
  - Outreach services
  - Clozapine monitoring and collateral services as certified by OMH
- Outpatient services may be provided in-home, office or the community;
  - All inpatient and intensive outpatient services require prior authorization, except in an emergency, and are subject to medical necessity, benefit coverage, limitations and exclusions;
  - Services may be provided by Psychiatrists (M.D. or D.O.), Advanced Registered Nurse Practitioners (ARNP), Psychologists (Psy.D. or Ph.D.), Licensed Clinical Social Workers (LCSW) or other providers licensed under OMH.
  - Excluded behavioral health services include:
    - Partial hospitalization program services
    - Outpatient substance abuse treatment programs and other services, including methadone maintenance treatment programs;
    - Intensive Psychiatric Rehabilitation Treatment Programs (IPRT);
    - Day treatment and continuing day treatment for children and adults;
    - Home and community-based services waiver for Seriously Emotionally Disturbed (SED) children;
    - Intensive Case Management (ICM);

- Services provided through OMH designated clinics for children with SED.

**Child Health Plus**

The Child Health Plus contract is issued pursuant to a special New York State Department of Health program designed to provide health insurance coverage to children of families who do not receive health insurance benefits from their employers and who cannot afford private coverage premiums. This coverage applies to children, under the age of 19, of families who do not receive other health insurance benefits, who are not eligible for Medicaid, who are permanent New York residents and reside in our service areas.

**Co-payments / Co-insurance / Deductibles**

- No co-payments
- Benefits vary by county and are subject to change

**Covered behavioral health services include:**

- 30 inpatient mental health and substance abuse days per contract year;
- Two partial-hospitalization days may be substituted for one inpatient day;
- 60 outpatient mental health and substance abuse visits per contract year; 20 of these 60 visits may be used for family members, if a child is diagnosed with a substance abuse disorder;
- All inpatient, partial hospitalization and intensive outpatient services require prior authorization, except in an emergency, and are subject to medical necessity, benefit coverage, limitations and exclusions;
- Services may be provided by Psychiatrists (M.D. or D.O.), Advanced Registered Nurse Practitioners (ARNP), Psychologists (Psy.D.

or Ph.D.), Licensed Clinical Social Workers (LCSW) or other providers licensed under OMH.

- Note: Long-term substance abuse treatment is excluded.

**Family Health Plus**

WellCare has a contract with the New York State Department of Health to provide coverage for Family Health Plus. Family Health Plus offers health coverage to adults who do not have private insurance, but have incomes too high to qualify for Medicaid.

**Co-payments / Co-insurance / Deductibles**

- No annual deductibles
- Co-insurance may apply to some services
- Co-payments vary by county
- Benefits vary by county and are subject to change

**Covered behavioral health services include:**

- 30 inpatient mental health and substance abuse days per contract year;
- Two partial-hospitalization days may be substituted for one inpatient day;
- 60 outpatient mental health and substance abuse visits per contract year;
- All inpatient, partial hospitalization and intensive outpatient services require prior authorization, except in an emergency, and are subject to medical necessity, benefit coverage, limitations and exclusions;
- Services may be provided by Psychiatrists (M.D. or D.O.), Advanced Registered Nurse

Practitioners (ARNP), Psychologists (Psy.D. or Ph.D.), Licensed Clinical Social Workers (LCSW) or other providers licensed under OMH.

**Communication with Primary Care Physicians**

Behavioral health care services are often available to health Plan members without a Primary Care Physician (PCP) referral. However, it is very important that providers communicate with the member's PCP, who is responsible for coordinating all of the member's health care services.

Providers may contact a member's PCP only after the member signs an "Authorization to Obtain/Release Information." If the member refuses to sign such a release, the provider should document the refusal in the medical record.

If the member signs an "Authorization to Obtain/Release Information," the provider should prepare a brief summary report advising the PCP of the assessment and treatment plan of the member, including a diagnostic impression and projected dates for treatment completion.

Whenever significant changes in the treatment plan or the member's clinical status occur, a follow-up report should be made. At the end of the member's episode of care, the provider should send the PCP a final report summarizing the diagnosis, treatment provided and outcome of the clinical intervention.

**Clinical Services Program**

The purpose of Harmony Behavioral Health's Clinical Services Program is to ensure that members receive medically necessary care 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 members' care. Utilization management is an activity that touches patients receiving more intensive services including inpatient hospitalization, partial-hospital

programming, residential treatment and intensive outpatient services.

**Services for Which Members Can Self-Refer****Mental Health and Chemical Dependence Services**

Members may self refer to one mental health assessment from a participating provider and one chemical dependence assessment from a detoxification or chemical dependence participating provider in any calendar year period without prior authorization or referral from their Primary Care Provider. In the case of children, such referrals may originate at the request of a school guidance counselor (with parental or guardian consent, or pursuant to procedures set forth in Section 33.21 of the Mental Hygiene Law), LDSS Official, Judicial Official, Probation Officer, parent or similar source.

**Access to Care Standards Emergent / Urgent / Routine**

Providers must adhere to the following access to care standards:

- Members requesting or referred for emergency care must be evaluated immediately and receive the appropriate level of care in a timely manner;
- Members requesting or referred for urgent care must be evaluated within one day and receive the appropriate level of care in a timely manner;
- 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;
- Following an emergency or hospital discharge, mental health or substance abuse follow-up visits with a participating provider (as included in the benefit package): within five days of request, or as clinically indicated;
- Non-urgent mental health or substance abuse visits with a participating provider (as included in

benefit package); within two weeks of request;  
and

- Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS: within ten days of request.

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

**Prior Authorization**

All inpatient, partial hospitalization and intensive outpatient 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 can be obtained by calling (800) 241-1103, or via the Harmony Behavioral Health Web site at [www.harmonybehavioralhealth.com](http://www.harmonybehavioralhealth.com). An initial authorization for services allows the member to be registered in the clinical services system.

Routine outpatient services, such as individual therapy, medication management, etc., do not require prior authorization submission of documentation.

**Emergency Services**

Members experiencing an emergency behavioral health condition can 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.

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**Medically Necessary Services**

All care received by Harmony Behavioral Health members must be “medically necessary.” This means behavioral health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity or threaten some significant handicap.

Medically necessary services are those recommended by the member’s treating provider and determined by Harmony Behavioral Health’s Medical Director to meet the following criteria:

- The services are appropriate and consistent with the diagnosis and treatment of the member’s medical condition;
- The services are required for the direct care and treatment of the condition;
- The services are not primarily for the convenience of the member, the member’s family or the provider;
- The services are provided in accordance with general standards of good medical practice as evidenced by: reports in peer-reviewed medical literature, reports and guidelines as published by nationally recognized health care organizations that include supporting scientific data and any other relevant information brought to Harmony Behavioral Health’s attention.

These standards are used by Harmony Behavioral Health to determine whether benefits are covered. If services are denied by Harmony Behavioral Health’s Clinical Management Department, the Initial Adverse Determination letter will include notice of the availability, upon request of the member or the member’s designee, the clinical review criteria relied upon to make such a determination. The notice will also specify what, if any, additional necessary information must be provided to,

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or obtained by, Harmony Behavioral Health in order to render a decision on an appeal.

**Medical Necessity  
Criteria**

Harmony Behavioral Health follows criteria that serve 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 Level of Care Behavioral Health Criteria including specific sets of guidelines for adults, children, adolescents, geriatric 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 & 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 Care Managers, Clinical Coordinators and Intake Coordinators. Harmony Behavioral Health functions in concert with the Health Services programs of WellCare Health Plans, Inc. to ensure 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 24 hours, seven days per week. In addition to authorizing inpatient and other forms of intensive programming, licensed Harmony Behavioral Health Behavioral Care Managers arrange emergency evaluations during 23-hour observation periods, as well

as inpatient and psychiatric consultations on medical units when indicated. Discharge planning should begin at the time of admission. It is the responsibility of the provider to ensure that members have a follow-up appointment scheduled at the time of discharge to occur within five business days of the discharge.

**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;
- Likely to attempt to harm him/herself or others, without care or treatment;
- 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 services. The

Care Managers determine if the data provided meets InterQual Behavioral Health Criteria and, if so, an authorization will be granted for continued inpatient stay. The facility is verbally notified of all authorization and non-authorization decisions on the same business day.

**MD – MD Review**

If the Care Manager determines that further clinical information is necessary, the Care Manager and the facility UR staff will assist in coordinating a MD–MD review between the Harmony Behavioral Health Medical Director or Physician Advisor (PA) and the attending physician. The Care Manager will arrange a MD–MD telephone review (within one business day) with the attending hospital physician or licensed psychiatrist. The facility utilization reviewer will be notified of the date and time of the scheduled telephone review.

If the Care Manager determines that the information provided meets InterQual criteria for discharge, the case is referred to the Medical Director or Physician Advisor, who is then responsible for determining whether to provide authorization or non-authorization for continued care.

**Inpatient Clinical Denials**

At completion of the MD–MD clinical review, the Harmony Behavioral Health MD/PA informs the attending physician of his/her decision, and 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/member appeal rights are attached to the non-authorization letter.

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**Reconsideration**

If a decision of non-authorization is issued and the scheduled MD–MD telephone review has not occurred, the facility or the attending physician may request an MD– MD 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 MD–MD reconsideration. The facility must file an expedited or standard appeal.

If the non-authorization decision is upheld following the subsequent MD–MD review, the facility can 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.

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**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 doctor-to-doctor 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 has 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 and , providers, members and as well as family members can contact Harmony Behavioral Health to request a referral for services. If a member contacts Harmony Behavioral Health directly, an Intake Coordinator under the supervision of a licensed Behavioral Care 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 their 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 - 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 three to six months and up to one year depending on the specific needs of the member.
- Routine appointments for members who present minimal risk must be offered within seven calendar days.
- In cases requiring urgent care, a licensed Behavioral Care 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 and, referral services 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.

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**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 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 biological, psychological and social impairment.
- Outcomes will be documented with the use of "best practice" outcome tools and measurements.

**Exclusions**

Outpatient therapy is not medically indicated and is not authorized by Harmony Behavioral Health. Outpatient services are indicated 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);

- 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;
- A treatment recommended has not been recognized as safe and/or effective.

**Outpatient Clinical Denials**

When an intensive 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 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 intensive outpatient 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 intensive outpatient services from Harmony Behavioral Health;

- The provider failed to complete and/or submit an outpatient treatment plan documentation to support 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 A treatment recommended has not been recognized as safe and/or effective,
- The frequency of services provided exceeds authorization guidelines.

**Reversals of Pre-Authorized Treatment**

Harmony Behavioral Health may reverse a pre-authorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Harmony Behavioral Health upon retrospective review is materially different from the information that was presented during the pre-authorization review;
- The relevant medical information presented to Harmony Behavioral Health upon retrospective review existed at the time of the pre-authorization but was withheld from/or not made available to Harmony Behavioral Health;
- Harmony Behavioral Health was not aware of the

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existence of the information at the time of the pre-authorization review;

- Had Harmony Behavioral Health been aware of the information, the treatment, service or procedure being requested would not have been authorized under the same criteria utilized during the pre-authorization review.

### Treatment Plan Update Form Submissions

- After the initial authorization time period, a Treatment Plan Update form (included in the **Forms** section of this manual) must be completed by the patient and provider 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 business days.
- Treatment plans will identify:
  1. Specific problems
  2. Specific goals
  3. Timelines for resolution
- Treatment plans should reflect progressive improvement or changes in the treatment plan to address lack of improvement
- Treatment plans should identify special discharge criteria at the beginning of the treatment and throughout the episode of illness period
- Progress should be noted using generally accepted tools/measures and will be submitted with the treatment plans as requested by Harmony Behavioral Health
- Please return the Treatment Plan Update via fax to Harmony Behavioral Health at (877) 277-6890

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 to 48 hours of the review. (Note: Failure to complete and return this form for review and approval may result in the denial of claims.)

**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 Care Managers are available to confer and assist with all member issues and make necessary referrals 24 hours, seven days per week.

**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.

**Out-of-Plan Authorizations**

Members will receive referral services from contracted providers whenever possible. These participating providers may request a referral to an out-of-network provider by contacting Harmony Behavioral Health, who may authorize approve treatment by a non-participating provider when no participating provider of that service is reasonably available.

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Harmony Behavioral Health will authorize approve referrals to non-participating providers in the following circumstances:

- The service is determined to be medically necessary;
- The member's care cannot be provided by a participating provider with the needed specialty and the geographic proximity to the member;
- Harmony Behavioral Health approves the plan of treatment in consultation with the member's Primary Care Physician and/or non-participating specialty provider;
- An out-of-plan referral is available if there is not a participating provider available within 30 minutes travel time, 30 miles travel distance from the member's home or two hours travel time in rural areas;
- Special requests for out-of-plan referrals (e.g., due to unique qualification of the provider or prior involvement of the provider in a complex treatment regimen) may be approved by Harmony Behavioral Health's Medical Director;
- Enrollees will not be responsible for additional cost outside of that for services rendered in-network as a result of services rendered by an out-of-network physician, provided that the services have received prior approval from Harmony Behavioral Health. The out-of-network referral must meet all of the criteria above.

Harmony Behavioral Health will consider any out-of-plan providers with appropriate location, credentials and qualifications for recruitment to become a participating provider.

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**Transitional Care  
for New Members**

A new enrollee whose behavioral health provider is not a member of the Harmony Behavioral Health network will be permitted to continue an ongoing course of treatment with the enrollee's current provider during a transitional

period. The transitional period extends up to 90 days from the member's effective date.

New members may continue their course of treatment with the non-participating provider if the following criteria are met:

- The enrollee elects to continue to receive care from a non-participating provider by notifying to Harmony Behavioral Health;
- The services are authorized by Harmony Behavioral Health;
- The enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition as defined below:
  - Chronic condition which is expected to require care for at least one year
  - Condition is optimally managed by close monitoring of clinical or laboratory parameters and adjustment of medication or other treatment
  - The primary condition may impact on the treatment of other medical conditions. Typical conditions would include severe asthma, brittle diabetes, unstable seizure disorders, medical management of selected transplants, AIDS, unstable angina and chronic pain syndrome
- The non-participating health care provider agrees to accept the Harmony Behavioral Health fee schedule as full rate of reimbursement less any applicable member co-payment;

- The non-participating provider agrees to adhere to Harmony Behavioral Health's quality assurance requirements and agrees to provide medical information about care being provided;
- The non-participating provider agrees to adhere to Harmony Behavioral Health's policies and procedures. including but not limited to procedures regarding referrals and obtaining pre-authorization.
- The non-participating provider must have a treatment plan approved by Harmony Behavioral Health.

**Transitional Care  
When a Provider  
Leaves the Network**

If a provider leaves Harmony Behavioral Health's network for reasons other than imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board impairing the provider's ability to practice, members may continue an ongoing course of treatment with that provider during a transitional period. The transitional period extends up to 90 days from the date the provider's contractual obligation terminates.

Members whose health care provider leaves the network may continue obtaining medical services from the terminated provider if the following criteria are met:

- The enrollee elects to continue to receive care from a non-participating health care provider by notifying Harmony Behavioral Health;
- The services are authorized by Harmony Behavioral Health;
- The enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition as defined below:
  - Chronic condition which is expected to require care for at least one year

- Condition is optimally managed by close monitoring of clinical or laboratory parameters and adjustment of medication or other treatment
- The primary condition may impact the treatment of other medical conditions. Typical conditions would include severe asthma, brittle diabetes, unstable seizure disorders, medical management of selected transplants, AIDS, unstable angina and chronic pain syndrome
- The non-participating health care provider agrees to accept Harmony Behavioral Health's fee schedule as full rate of reimbursement less any applicable member co-payment;
- The non-participating provider agrees to adhere to the Harmony Behavioral Health's quality assurance requirements and agrees to provide medical information about care being provided;
- The non-participating provider agrees to adhere to Harmony Behavioral Health's policies and procedures, including but not limited to procedures regarding referrals and obtaining pre-authorization. The non-participating provider must have a treatment plan approved by Harmony Behavioral Health.

**Provider  
Performance  
Appraisal  
Information and  
Quality of Care**

Quality of Care provider data is linked to the provider re-credentialing process. Information is supplied as requested to ensure evaluations are based on the most current data. Harmony Behavioral Health is responsible for the collection and maintains a provider database that includes the following information:

- Access availability,
- Over- and under-utilization,
- Risk management and sentinel events,
- Member satisfaction,
- Member complaints,
- Site reviews, and
- Medical record audits.

Maintenance and distribution of information via Provider Performance Appraisal forms will include the following:

<b>Area of Concern</b>	<b>Specialists</b>	<b>Source of Info/ Comments</b>
Accessibility Availability	As available	Complaints Provider Access and Availability Studies
Under- or Over- Utilization	As available	PCP Encounter rate Utilization data QI Health Improvement Data
Risk Mgmt, Ambulatory Sensitive Conditions Sentinel Events	X	Incident Reporting UM Data Any QI issues/level of concern after resolution
Member Satisfaction	N/A	Use Complaints rate as proxy
Site Reviews	As available	Medical Record/Site Review Database
Member Complaints	X	Complaint Database

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**Monitoring  
Over- and  
Under-Utilization**

Harmony Behavioral Health, in accordance with state and federal contracts and regulations, will facilitate the delivery of appropriate care and monitor the impact of its Utilization Management program to detect and correct potential under- and over-utilization of services.

The process shall determine over- and under-utilization of services whereby the Harmony Behavioral Health Medical Director institutes a Corrective Action Plan for both the provider and Harmony Behavioral Health.

The following tools will be utilized for monitoring:

- Inpatient Daily Census
- Monthly Inpatient Utilization Reports
- Provider Profiling
- Case Management

Harmony Behavioral Health monitors the Inpatient Daily Census report for all non-participating providers, hospital stays for outliers and Quality of Care issues. These include all readmissions, any complications and/or unexpected deaths. If necessary, the Harmony Behavioral Health Medical Director will communicate any issues with the provider and the PCP arising out of the review.

The Harmony Behavioral Health Medical Director will issue a monthly report on the Inpatient Utilization for all lines of business and have a Corrective Action Plan as needed for Harmony Behavioral Health. The report shall contain the following filters:

- Average length of stay by line of business
- Admissions per thousand by line of business
- Days per thousand by line of business

A comparison is made to established goals, established professional standards and the previous month's data.

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The Medical Director compares Harmony Behavioral Health's results to industry standards and develops a Corrective Action Plan as needed.

Over- and under- utilization data and reports are reported by the Harmony Behavioral Health Utilization Management Committee for review and recommendations. The recommendations and results are then communicated to the Quality Improvement Committee and then to the Board of Directors.

Each provider is given the opportunity to discuss the unique nature of the provider's professional patient population, which may have bearing on the provider's profile and to work cooperatively with Harmony Behavioral Health to improve performance.

Physician Profiling: The physician profiling reports will be monitored on a quarterly basis for a designated provider population. The report generated will contain the following:

- HEDIS® measurements
- Ancillary service utilization
- Inpatient services utilization
- Pharmacy utilization

Any issues arising out of these reports are discussed with the provider by Harmony Behavioral Health on an as-needed basis.