

Overview

The Centers for Medicare and Medicaid Services (CMS) and the state of Ohio are contracted with WellCare Health Plans, Inc. to provide comprehensive, cost-effective managed care health services to enrolled members. WellCare is contracted to provide behavioral health services for their enrolled members. WellCare offers the behavioral health services described below.

Inpatient Care

Inpatient care for behavioral health conditions requires prior authorization and is evaluated for medically-necessary criteria using the InterQual[®] Behavioral Health Criteria. Only services provided at general hospitals are covered by the WellCare benefit. Members may seek inpatient services at free-standing facilities that are covered by the state.

Outpatient Care

The primary source of outpatient services is provided by the local Community Mental Health Center, which is contracted by the state to provide services under the member's benefits. WellCare is responsible for coordinating discharge planning to these providers and for providing additional outpatient options to members if they elect to not receive their services at their local agency.

**Communication
with Primary Care
Physicians**

Behavioral health care services are available to 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.

WellCare notifies the PCP in writing on the next business day after authorizing behavioral health care services. The letter serves as the PCP's notice that their member is receiving behavioral health care.

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. Further, the communication of medications is extremely important for patient safety to avoid potential drug-to-drug interactions.

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 WellCare’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.

WellCare’s Behavioral Health department strives to conduct timely utilization reviews in order to authorize benefit coverage for members’ care. Utilization management is an activity that touches all patients receiving care across the continuum of services: inpatient hospitalization, partial-hospital program, intensive outpatient program, outpatient psychiatric medical management, individual psychotherapy, group psychotherapy 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, Plan members have a choice of network providers within their geographical area.

Prior Authorization

All inpatient and outpatient behavioral health services require prior authorization, except in an emergency or if provided at a Community Mental Health Center.

No authorization is required for the state reimbursed providers under the auspices of the local Community Mental Health Board. The treating provider is responsible for obtaining authorization from WellCare's Behavioral Health department for all routine and urgent services for members. Authorization can be obtained by calling (800) 951-7719, or via the Web site at <http://ohio.wellcare.com>.

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 needs for continued care.

Emergency Services

Members experiencing an emergency behavioral health condition can receive medically-necessary care without prior authorization from WellCare.

Providers rendering emergency services must notify WellCare as soon as possible, after the services are rendered and may be required to forward medical

records to WellCare for utilization review.

**Medically
Necessary
Services**

All care received by WellCare members must be *medically necessary*. This means behavioral health care and services are medically necessary if they are needed to prevent, diagnose, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity or threaten some significant handicap.

Medically-necessary services are those recommended by the member's treating provider and determined by WellCare's Behavioral 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 WellCare's attention.

These standards are used by WellCare's Behavioral Health department to determine whether benefits are covered. If services are denied by the 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, or obtained by, WellCare's Behavioral Health department in order to render a decision on an appeal.

**Medical
Necessity Criteria**

WellCare follows criteria that serve as guidelines for determining the medical necessity and clinical appropriateness of all behavioral health services.

InterQual Behavioral Health Criteria, developed by McKesson Health Solutions, include specific sets of guidelines for adults, children, adolescents, geriatric and for dual diagnosis and substance abuse services.

When appropriate, WellCare also uses guidelines established by the American Psychiatric Association and American Academy of Child & Adolescent Psychiatry. In addition, WellCare adheres to all federal and state regulations and guidelines applicable to behavioral health services.

**Program
Oversight**

WellCare's Behavioral Health department'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.

The Behavioral Health department functions in concert with the Health Services programs of WellCare to ensure members receive the highest quality of behavioral health care.

Inpatient Services

Hospital and facility representatives must contact the WellCare Behavioral Health department by telephone or by accessing the 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 the Behavioral Health department 24 hours, seven days per week. In addition to authorizing inpatient and other forms of intensive programming, licensed 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 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 the Behavioral

Health department'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 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 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 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.

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 a 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.

**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;
- The failure of a provider to report continued stay

information;

- The failure of a provider to keep a scheduled doctor-to-doctor review;
- The Behavioral Health department has determined the member was ineligible to receive services on the date of service;
- The Behavioral Health department 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, providers, members and family members can contact WellCare's Behavioral Health department to request services. If a member contacts WellCare 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 bests 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 the local Community Mental Health

Centers, and then asked to select and call the provider of their choice to schedule an appointment.

- Generally, for initial services, authorizations are 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, referral and authorizations are made under the direction of the director of clinical services, the manager of outpatient services and the 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 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 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 outpatient case fails to meet the medical necessity guidelines, a 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.

WellCare's Behavioral Health department 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 an authorization denial is subsequently made by the behavioral health psychiatrist or medical director, a denial letter will be issued to the provider. All final 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;
- The provider failed to complete and/or submit an outpatient treatment plan for continued treatment;
- The provider failed to keep a scheduled peer-to-peer review;
- 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;
- 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**

WellCare's Behavioral Health department may reverse a pre-authorized treatment, service or procedure on retrospective review when:

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

**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 PCP 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;
- The diagnosis is unclear or treatment is ineffective.

Providers are required to coordinate all psychiatric referrals with WellCare's Behavioral Health department.

Coordination may be conducted by telephone, by submitting an updated outpatient treatment plan or by recommending a psychiatric referral. When a psychiatric referral is authorized, WellCare 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 PCP and a description of the authorized services by procedure code and the number of visits authorized.

**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 the Behavioral Health department 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.
- Please return the Treatment Plan Update form via fax to Behavioral Health at (877) 277-6890 or by mail to:

WellCare's Behavioral Health Department
Attn: Treatment Plan Update
P.O. Box 31401
Tampa, FL 33631-3401

The Treatment Plan Update form will be reviewed and, if determined medically necessary, will be authorized for 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.)

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 the Behavioral Health department at (877) 277-6890.

Electroconvulsive Therapy (ECT)

A peer-to-peer review will be conducted on electroconvulsive therapy (ECT) requests for members who meet DSM-IVR diagnostic criteria for clinical depression, are recommended by their treating provider, are 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 (877) 277-6890.

Referral for More Intensive Level of Service

When a member requires a referral for a more intensive level of care, providers are required to contact WellCare's Behavioral Health department 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.

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.

PCPs are listed on the Web site under the member's eligibility. The Behavioral Health department is available to assist providers in coordinating these services with the member's health services staff and the PCP.

Transitional Care when a Provider

If a provider leaves the WellCare network for reasons other than imminent harm to patient care, a

Leaves the Network

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 WellCare;
- The services are authorized;
- 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 the WellCare fee schedule as full rate of reimbursement less any applicable member co-payment;
- The non-participating provider agrees to adhere to WellCare's quality assurance requirements and agrees to provide medical information about care

being provided;

- The non-participating provider agrees to adhere to WellCare'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.

Provider Performance Appraisal

Quality of Care data is linked to the provider re-credentialing process. Information is supplied as requested to ensure evaluations are based on the most current data. WellCare is responsible for the collection, maintenance and distribution of information via Provider Performance Appraisal forms that will include the following:

| Area of Concern | Specialists | Source of Info/ Comments |
|--|--------------------|---|
| 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 |