2012 Illinois Medicaid Provider Manual
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Section 1: Overview

About Harmony
Harmony Health Plan of Illinois, Inc., (Harmony) is a licensed Illinois Managed Care Organization (MCO). Harmony is a part of the WellCare group of companies. WellCare provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans, health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. As of June 30, 2012, WellCare served approximately 2.6 million members. Our experience and commitment to government-sponsored health care programs enables us to serve our members and providers as well as manage our operations effectively and efficiently.

Mission and Vision
WellCare's vision is to be the leader in government-sponsored health care programs in partnership with the members, providers, governments, and communities we serve. WellCare will:

- Enhance our members' health and quality of life;
- Partner with providers and governments to provide quality, cost-effective health care solutions; and
- Create a rewarding and enriching environment for our associates.

Our Values are:
- Partnership - Members are the reason we are in business; providers are our partners in serving our members; and regulators are the stewards of the public's resources and trust. We will deliver excellent service to our partners.
- Integrity - Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.
- Accountability - All associates must be responsible for the commitments we make and the results we deliver.
- Teamwork - With our fellow associates, we can expect - and are expected to demonstrate - a collaborative approach in the way we work.

Purpose of this Provider Manual
This Provider Manual is intended for Harmony’s contracted (participating) Medicaid providers delivering health care service(s) to Harmony members enrolled in a Harmony Medicaid Managed Care plan. This Provider Manual serves as a guide to the policies and procedures governing the administration of Harmony’s Medicaid plans and is an extension of and supplements the Provider Participation Agreement (Agreement) between Harmony and health care providers, who include, without limitation: physicians, physician groups, independent physician associations (IPAs), hospitals and ancillary providers (collectively, Providers). This Provider Manual replaces and supersedes any previous versions dated prior to December 1, 2012 and is available on Harmony’s website at https://www.harmonyhpi.com/provider/ProviderManual. A paper copy, at no charge, may be obtained upon request by contacting your Provider Relations representative.

In accordance with the Policies and Procedures clause of the Agreement, Harmony Medicaid providers must abide by all applicable provisions contained in this Provider Manual.
Manual. Revisions to this Provider Manual reflect changes made to Harmony’s policies and procedures. Revisions shall become binding thirty (30) days after notice is provided by mail or electronic means, or such other period of time as necessary for Harmony to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by Harmony in the form of Provider Bulletins and will be incorporated into subsequent versions of this Provider Manual. Provider Bulletins that are State-specific may override the policies and procedures in this Provider Manual.

**Harmony’s Health Plans**
Harmony has contracted with the Illinois Department of Healthcare and Family Services (HFS) to provide Medicaid managed care services. Harmony is the largest Medicaid health maintenance organization (HMO) plan in Illinois.

**Enrollment**
Membership enrollment in Harmony is voluntary as members may select other MCOs. Harmony accepts all eligible individuals without restrictions and abides by all federal and state laws and regulations that prohibit discrimination based on race, color, religion, sex, national origin, ancestry, age or physical or mental disability. Harmony will not tolerate discrimination against eligible or prospective members based on health status or need for health services.

The State is responsible for determining eligibility for the HFS medical program.

**Covered Services**
The following services are provided as medically necessary to eligible Harmony members:

- Hospital inpatient services;
- Home health care services;
- Physical therapy;
- Speech and language therapy;
- Laboratory and x-ray services;
- Transportation;
- Emergency services;
- Transplant services (non-experimental);
- Family planning services;
- Abortions and sterilizations, if approved by HFS under extreme circumstances;
- Contraceptive devices;
- Durable and non-durable medical equipment and supplies;
- Whole blood and blood products;
- Physician services;
- Hospital outpatient services;
- Mental health and substance abuse services;
- Preventive services;
- Alcohol and substance abuse treatment services;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
- Maternity care services;
- Well-child care services;
- Health education;
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- Skilled nursing care (first ninety (90) days);
- Immunizations (children and adults);
- Hospice;
- Chiropractic services;
- Podiatric services;
- Orthotic/prosthetic devices, including prosthetic devices or reconstructive surgery incident to mastectomy;
- Nurse midwife services;
- Medical procedures performed by a dentist;
- Ophthalmologist (eye specialist);
- Limited dental services for adults; and
- Over the counter items.

**NOT Covered**
- Elective cosmetic surgery; and
- Custodial care services.

**Covered by HFS (not by Harmony)**
- Optical/Vision (children only);
- Dental services (children only); and
- Pharmacy (children and adults).

**Provider Services**
Harmony’s Provider Services department is comprised of two teams, Provider Relations and Provider Solutions. The Provider Relations team is responsible for provider education, recruitment, contracting, new provider orientation, monitoring of quality and regulatory standards such as Healthcare Effectiveness Data and Information Set (HEDIS®), and investigation of member complaints. The Provider Solutions team includes Provider Operations, collecting credentialing and re-credentialing documents, and coordinating contract loads, demographic changes, and terminations. It is also comprised of a Claims Resolution team which does claims research to facilitate resolution of claims issues.

Harmony offers an array of provider services that includes initial orientation and education, either one-on one or in a group setting, for all providers. These sessions are hosted by our Provider Relations representatives.

Provider Relations representatives are available to assist in many requests for providers. Contact your local market office for assistance, or call the Provider Service number located on your **Quick Reference Guide** to request a Provider Relations representative contact you.

Providers may contact the appropriate departments at Harmony by referring to the **Quick Reference Guide** on Harmony’s website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources). Provider Relations representatives are available to assist in many requests for participating Harmony providers. Contact your local market office for assistance.
Website Resources
Harmony’s website, http://www.harmonyhpi.com/, offers a variety of tools to assist providers and their staff.

Available resources include:
- Provider Manuals;
- Quick Reference Guide;
- Clinical Practice Guidelines;
- Clinical Coverage Guidelines;
- Forms and documents;
- Provider search tool (directories);
- Authorization look-up tool;
- Training materials and job aids;
- Newsletters;
- Member rights and responsibilities; and
- Privacy statement and notice of privacy practices.

Secure Provider Portal - Benefits of Registering
Our secure online Provider Portal offers immediate access to an assortment of useful tools.

Providers can create individual sub-accounts for staff member’s use, if needed.

All providers who create a login and password using their Harmony Provider Identification (Provider ID) number have access to the following features:
- **Claims submission status and inquiry**: Submit a new claim, check the status of an existing claim, and customize and download reports.
- **Member eligibility and co-payment information**: Verify member eligibility and obtain specific co-payment information.
- **Authorization requests**: Submit authorization requests, attach clinical documentation and check authorization status. You can also print and/or save copies of authorization forms.
- **Training**: Take required training courses and complete attestations online.
- **Reports**: Access reports such as active members, authorization status, claims status, eligibility status, HEDIS® care gaps lists, and more.
- **Provider news**: View the latest important announcements and updates.
- **Personal inbox**: Receive notices and key reports regarding your claims, eligibility inquiries and authorization requests.

How to Register

After registering for Harmony’s website, providers should retain login and password information for future reference.

For more information about Harmony’s web capabilities, please contact Provider Services or your Provider Relations representative.
Additional Resources
The *Harmony Medicaid Resource Guide* contains information about our secure online Provider Portal, member eligibility, authorizations, filing paper and electronic claims, appeals, and more. For more specific instructions on how to complete day-to-day administrative tasks, please see the *Harmony Medicaid How-To Guide*. Both documents can be found on our website at [http://www.harmonyhpi.com/provider/forms](http://www.harmonyhpi.com/provider/forms).

Another valuable resource is the *Quick Reference Guide*, which contains important addresses, phone/fax numbers and authorization requirements. You can find the *Quick Reference Guide* at [http://www.harmonyhpi.com/provider/resources](http://www.harmonyhpi.com/provider/resources).
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

This section is an overview of guidelines for which all Harmony Medicaid Managed Care providers are accountable. Please refer to the Provider Participation Agreement (Agreement) or contact your Provider Relations representative for clarification of any of the following. Harmony Medicaid providers, must in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;
- Agree to cooperate with Harmony in its efforts to monitor compliance with its Medicaid contract(s) and/or State of Illinois rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations;
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to Harmony members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii)];
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Practice Nurses (APN) should provide direct member care within the scope or practice established by the rules and regulations of the State of Illinois and Harmony guidelines;
- Assume full responsibility to the extent of the law when supervising P.A.s and A.P.N.s whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician or extender title (examples: M.D., D.O., A.P.N., P.A.) to members and to other health care professionals;
- Honor a member’s request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any member in need of health care services;
- Maintain the confidentiality of member information and records;
- Respond promptly to Harmony’s request(s) for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all of Harmony's policies governing content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance;
- Ensure that:
  - all employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement between the provider and Harmony;
  - to the extent the provider maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and
• the contracted provider maintains written agreements with all employed and downstream contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement;

• Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;

• Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Harmony, the member, or the requesting party at no charge, unless otherwise agreed;

• Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen;

• Not discriminate in any manner between Harmony Medicaid members and non-Harmony Medicaid members;

• Ensure that the hours of operation offered to Harmony members are no less than those offered to commercial members;

• Not deny, limit or condition the furnishing of treatment to any Harmony member on the basis of any factor that is related to health status, including, but not limited to the following:
  o medical condition, including mental as well as physical illness;
  o claims experience;
  o receipt of health care;
  o medical history;
  o genetic information;
  o evidence of insurability, including conditions arising out of acts of domestic violence; or
  o disability;

• Freely communicate with and advise members regarding the diagnosis of the member’s condition and advocate on the member’s behalf for the member’s health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;

• Identify members who are in need of services related to children’s health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to Harmony-sponsored or community-based programs; and

• Must document the referral to Harmony-sponsored or community-based programs in the member’s medical record and provide the appropriate follow-up to ensure the member accessed the services.

Excluded Services
Excluded services are defined as those services that members may obtain under the HFS plan, and for which Harmony is not financially responsible. These services may be paid for by HFS on a fee-for-service basis or other basis. In the event the service(s) is(are) excluded, providers must submit reimbursement for services directly to HFS.
Providers are required to determine eligibility and whether services are covered prior to rendering services. Harmony is not financially responsible for non-covered benefits or for services rendered to ineligible recipients.

**Responsibilities of All Providers**
The following is a summary of the responsibilities of all providers who render services to Harmony members. These are intended to supplement the terms of the Agreement, not replace them. In the event of a conflict between this Provider Manual and the Agreement, the Agreement shall govern.

**Provider Identifiers**
All providers are required to have a Medicaid provider number and a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 5: Claims.

**Living Will and Advance Directive**
Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Providers must comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care hospices, and health maintenance organizations (HMOs) specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d) and State of Illinois requirements.

Each Harmony member (age eighteen (18) years or older and of sound mind), should receive information regarding living will and advance directives. This allows them to designate another person to make a decision should they become mentally or physically unable to do so. Harmony provides information on advance directives to members in the Member Handbook.

Information regarding living will and advance directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members’ medical records.

A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

**Provider Billing and Address Changes**
Prior notice to your Provider Relations representative or Provider Services is required for any of the following changes:
- 1099 mailing address;
- Tax Identification Number (Tax ID or TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address;
- Telephone or fax number;
- Panel changes; and/or
- Directory listing.

**Provider Termination**
In addition to the provider termination information included in the Agreement, you must adhere to the following terms:
• Any provider must give at least ninety (90) days prior written notice (one hundred eighty (180) days for a hospital) to Harmony before terminating your relationship with Harmony “without cause,” unless otherwise agreed to in writing. This ensures that adequate notice may be given to Harmony members regarding your participation status with Harmony. Please refer to your Agreement for the details regarding the specific required days for providing termination notice, as you may be required by contract to give more notice than listed above;
• Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month; and
• Providers must continue to provide services to their members. Some members may be eligible for continued care with their provider for an additional ninety (90) days under the Transition of Care provision.

Please refer to Section 6: Credentialing of this Provider Manual for specific guidelines regarding rights to appeal termination (if any).

Note: Harmony must make a good faith effort to give written notice of termination of a provider, within fifteen (15) days following such termination, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

Out-of-Area Member Transfers
Providers should assist Harmony in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by the Harmony provider and the out-of-network attending physician/provider.

Members with Complex and Serious Medical Conditions
Harmony is required to have procedures in place to identify members with complex and serious medical conditions in order to ensure that any required course of treatment or regular care monitoring is provided to the member. Appropriate health care professionals shall make such assessments. Such procedures must be delineated in the Harmony’s Quality Assurance Plan, and ongoing monitoring shall occur in compliance with the contract with the State of Illinois.

The following is a summary of responsibilities specific to providers who render services to Harmony members who have been identified with complex and serious medical conditions:
• Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
• Coordinate treatment plans with members, family and/or specialists caring for members;
• Plans of care should adhere to any applicable sponsoring government agency quality assurance and utilization review standards;
• Allow members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the members’ conditions or needs, including direct access to a specialist as appropriate.
• Coordinate with Harmony, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or
entity formally designated as primarily responsible for coordinating the health care services furnished;

- Coordinate services to prevent duplication of services and share results on identification and assessment of the member’s needs; and
- Ensure the member’s privacy is protected as appropriate during the coordination process.

For more information on Utilization Management for Individuals with Special Health Care Needs (ISHCN), refer to Section 4: Utilization Management, Case Management and Disease Management.

**Access Standards**

All providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the member’s needs.

Harmony shall monitor providers against these standards to ensure members can obtain needed health care services within the acceptable appointments timeframes, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions set forth by Harmony.

Primary Care Providers (PCPs) may not schedule more than six (6) appointments per hour.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs (Adult) Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>PCPs (Adult) Sick Visits</td>
<td>Within 3 weeks</td>
</tr>
<tr>
<td>PCPs (Adult) Routine</td>
<td>Within 5 weeks</td>
</tr>
<tr>
<td>Pediatric Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Pediatric Sick Visits</td>
<td>Within 3 weeks</td>
</tr>
<tr>
<td>Pediatric Routine</td>
<td>Within 5 weeks</td>
</tr>
<tr>
<td>Pediatric Routine &lt;6 months old</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>OBGYN 1&lt;sup&gt;st&lt;/sup&gt; Trimester</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>OBGYN 2&lt;sup&gt;nd&lt;/sup&gt; Trimester</td>
<td>Within 1 week</td>
</tr>
<tr>
<td>OBGYN 3&lt;sup&gt;rd&lt;/sup&gt; Trimester</td>
<td>Within 3 days</td>
</tr>
</tbody>
</table>

In-office wait times for PCPs, pediatricians, and obstetrician/gynecologists (OB/GYNs) cannot exceed one (1) hour.

PCPs must provide or arrange for coverage of services twenty-four (24) hours per day, seven (7) days per week. To ensure accessibility and availability, PCPs must provide one of the following:

- A twenty-four (24) hour answering service that connects the member to someone who can render a clinical decision or reach the PCP; or
- An answering system with the option to page the physician for a return call.

See Section 10: Behavioral Health for mental health and substance use access standards.
Responsibilities of Primary Care Providers

The following is a summary of responsibilities specific to PCPs who render services to Harmony members. These are intended to supplement the terms of the Agreement, not replace them.

- Coordinate, monitor and supervise the delivery of primary care services to each member;
- No more than six (6) scheduled appointments shall be made for each PCP per hour;
- See members for an initial office visit and assessment within the first ninety (90) days of enrollment in Harmony;
- Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each member, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under the age of twenty-one (21);
- Provide information about community resources such as the Women, Infant and Children (WIC) program to eligible women, infants and children for nutritional assistance;
- Provide access to Harmony or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
- Submit an encounter for each visit including when the member receives a HEDIS® service. For more information on encounters, refer to Section 5: Claims;
- Ensure members utilize network providers. If unable to locate a participating Harmony provider for services required, contact Provider Services for assistance. Refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources; and
- Comply with and participate in corrective action and performance improvement plans.

Primary Care Offices

PCPs provide comprehensive primary care services to Harmony members. Primary care offices participating in Harmony’s provider network have access to the following services:

- Support from the Provider Services, Health Services and Marketing and Sales departments; as well as the tools and resources available on Harmony’s website at https://www.harmonyhpi.com/provider; and
- Information on Harmony network providers for the purposes of referral management and discharge planning.

Early and Periodic Screening, Diagnostic and Treatment

Any provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are responsible for:

- Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible members in accordance with 89 Ill. Adm. Code 140.485. All members under twenty-one (21) years of age should receive screening examinations including appropriate childhood
immunizations at intervals as specified by the EPSDT Program as set forth in §1902(a)(43) and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485 and the periodicity schedule provided by the American Academy of Pediatrics (AAP);

- Referring the member to an out-of-network provider for treatment if the service is not available within Harmony’s network. Out-of-network services may require a prior authorization from Harmony or the member’s IPA;
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Providing vaccinations in conjunction with EPSDT/Well Child visits. Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) program for Medicaid covered children eighteen (18) years old and younger;
- Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits;
- Monitoring, tracking and following up with members:
  - Who have not had a health assessment screening; and
  - Who miss appointments to assist them in obtaining an appointment;
- Ensuring members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with members to ensure they receive the necessary medical services; and
- Assisting members with transition to other appropriate care for children who age-out of EPSDT services.

Provider compliance with member monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the Harmony Quality Improvement Department and corrective action plans will be required for providers who are below eighty percent (80%) compliance with all elements of the review.

For additional details regarding EPSDT, see Section 3: Quality Improvement. For more information on the AAP periodicity schedule, refer to their website at http://www2.aap.org/immunization/IZSchedule.html.

Closing of Physician Panel
When requesting closure of your panel to new and/or transferring Harmony members, PCPs must:

- Submit the request in writing at least ninety (90) days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
- Maintain the panel to all Harmony members who were assigned to the PCP before the closing of the panel; and
- Submit written notice of the re-opening of the panel, including a specific effective date.

Covering Physicians/Providers
In the event that participating providers are temporarily unavailable to provide care or referral services to Harmony members, providers should make arrangements with another Harmony-contracted Medicaid participating and credentialed provider to provide services on their behalf, unless there is an emergency.
For additional information, please refer to Section 6: Credentialing.

**Termination of a Member**

A Harmony provider may not seek or request to terminate his or her relationship with a member, or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required, or the cost of Covered Services required by the Harmony member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The provider should provide adequate documentation in the member's medical record to support her or his efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the Harmony member until such time that written notification is received from Harmony stating that the member has been transferred from the provider's practice, and such transfer has occurred.

In the event that a provider desires to terminate his or her relationship with a Harmony member, the provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The provider should complete a **PCP Request for Transfer of Member** form, attach supporting documentation, and fax the form to Harmony's Provider Services. The form is available on Harmony's website at [https://www.harmonyhpi.com/provider/Forms](https://www.harmonyhpi.com/provider/Forms).

**Domestic Violence and Substance Abuse Screening**

PCPs should identify indicators of domestic violence or substance abuse. Sample screening tools for domestic violence and substance abuse are located on Harmony's website at [http://www.wellcare.com/Provider/CCGs](http://www.wellcare.com/Provider/CCGs).

If a member needs assistance regarding domestic violence, the provider should refer the member to the police or emergency services, the local domestic abuse hotline, or other community based resources.

In addition, the provider or member can call the Case Management Intake line at Harmony. The member will immediately be referred to the Case Management Department and a case manager will contact the member. If the member needs assistance after hours, please refer the member to the Nurse Advice Line.

If a member needs assistance regarding substance abuse, the provider should direct the member to call the toll-free Provider Hotline number for Harmony. For more information, refer to the **Quick Reference Guide** on Harmony's website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources).

**Smoking Cessation**

PCPs should direct members who wish to quit smoking to call Harmony's Customer Service and ask to be directed to the Case Management department. A case manager
will educate the member on national and community resources that offer assistance, as well as smoking cessation options available to the member through Harmony.

**Adult Health Screening**

A health screening should be performed to assess the health status of all adult Harmony Medicaid members. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

**Hospital / Facility Responsibilities**

Coverage is provided for eligible members for preventive, diagnostic, therapeutic, rehabilitative or palliative services. Care must be rendered under the direction of a doctor or by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority. The provider must be qualified to participate under Title XIX (Medicaid) of the Social Security Act.

In compliance with Section 1902 (a) (57) of the Social Security Act, hospitals must:

- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives;
- Document in the patient's medical record whether or not an advance directive has been executed;
- Comply with all requirements of state law respecting advance directives;
- Provide (individually or with others) education for staff and the community on issues concerning advance directives; and
- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

Harmony defines an *inpatient* as a patient who has been admitted to a participating hospital on recommendation of a licensed doctor and is receiving room, board and professional services in the hospital on a continuous twenty-four (24) hour-a-day basis. Transfers between units within the hospital are not considered new admissions, unless it is a transfer from a medical unit to a psychiatric unit. Refer to the Section 4: Utilization Management, Case Management, and Disease Management for more information.

Harmony defines an *outpatient* as a patient who is receiving professional services at a participating hospital, but who is not provided room and board and professional services on a continuous twenty-four (24) hour-a-day basis. Observation services are also considered outpatient. Observation services usually do not exceed twenty-four (24) hours.

However, some patients may require forty-eight (48) hours of outpatient observation services. Refer to the Section 4: Utilization Management, Case Management, and Disease Management for more information.

Hospital-based clinics, which are operated as part of a hospital, are considered outpatient hospital-based facilities by Harmony. As such, these facilities must follow
authorization rules for hospital based services. Refer to the Section 4: Utilization Management, Case Management, and Disease Management for more information.

Level of care determinations will be based on InterQual™ Criteria and Medical Director review.

**Cultural Competency Program and Plan**

**Overview**
The purpose of the Cultural Competency program is to ensure that Harmony meets the unique diverse needs of all members, to ensure that the associates of Harmony value diversity within the organization, and to see that members in need of linguistic services have adequate communication support. In addition, Harmony is committed to having our providers fully recognize and care for the culturally diverse needs of the members they serve.

The objectives of the Cultural Competency program are to:

- Identify members who have potential cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the member’s race, ethnicity, and primary language spoken;
- Make resources available to address the unique language barriers and communication barriers that exist in the population;
- Help providers care for and recognize the culturally diverse needs of the population;
- Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served; and
- Decrease health care disparities in the minority populations we serve.

Culturally and linguistically appropriate services (CLAS) are health care services provided that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent health care and services requires health care providers and/or their staff to possess a set of attitudes, skills, behaviors, and policies which enable the organization and staff to work effectively in cross-cultural situations.

The components of Harmony’s Cultural Competency program include:

- **Data Analysis**
  - Analysis of claims and encounter data to identify the health care needs of the population; and
  - Collection of member data on race.

- **Diversity and Language Abilities of Health Plan Staff**
  - Non-Discriminating – Harmony may not discriminate with regard to race, religion or ethnic background when hiring associates;
  - Recruiting – Harmony recruits diverse talented associates in all levels of management; and
  - Multilingual – Harmony recruits bilingual associates for areas that have direct contact with members to meet the needs identified, and encourages providers to do the same.

- **Diversity of Provider Network**
Providers are inventoried for their language abilities. This information is made available in the Provider Directory so members can choose a provider that speaks their primary language; and

Providers are recruited to ensure a diverse selection of providers to care for the population served.

**Linguistic Services**

- Providers will identify members who have potential linguistic barriers for which alternative communication methods are needed and will contact Harmony to arrange appropriate assistance;
- Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department;
- Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by Harmony’s Customer Service Department; and
- Written materials are available for members in large print format, and certain non-English languages prevalent in Harmony’s service areas.

**Electronic Media**

- Telephone system adaptations - members have access to the TTY/TDD line for hearing impaired services. Harmony’s Customer Service department is responsible for any necessary follow-up calls to the member. The toll-free TTY/TDD number can be found on the member identification card.

Providers must adhere to the Cultural Competency program as set forth above.

For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on Harmony’s website at [https://www.harmonyhpi.com/provider](https://www.harmonyhpi.com/provider). A paper copy, at no charge, may be obtained upon request by Contacting Provider Services or your Provider Relations representative.

**Cultural Competency Survey**

Providers may access the Cultural Competency Survey on Harmony’s website at [https://www.harmonyhpi.com/Provider/training](https://www.harmonyhpi.com/Provider/training).

**Member Administrative Guidelines**

**Overview**

Harmony will make information available to members on the role of the PCP, how to obtain care, what members should do in an emergency or urgent medical situation as well as member’s rights and responsibilities. Harmony will convey this information through various methods including a Member Handbook.

**New Member Resources**

All newly enrolled members will receive a notice of enrollment and the following:

- Member Handbook;
- Over-the-counter Brochure;
- Thank You Brochure; and
• Preventive Care Booklet.

Upon request, members can also receive the following:
• Provider Directory; and/or
• Certificate of Coverage.

**Member Identification Cards**
Member identification cards are intended to identify Harmony members, the type of plan they have, and to facilitate their interactions with health care providers. Information found on the member identification card may include the member’s name, identification number, plan type, PCP’s name and telephone number, co-payment information, health plan contact information, and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

**Eligibility Verification**
A member’s eligibility status can change at any time. Therefore, all providers should consider requesting and copying a member’s identification card, along with additional proof of identification such as a photo ID, and filing them in the patient’s medical record.

Providers may do one of the following to verify eligibility:
• Access the secure, online Provider Portal of the Harmony website at [https://www.harmonyhpi.com/provider](https://www.harmonyhpi.com/provider);
• Access Harmony’s Interactive Voice Response (IVR) system; and/or
• Contact Provider Services.

You will need your Provider ID number to access member eligibility through the avenues listed above. Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your Agreement for additional details.

**Member Rights and Responsibilities**
Harmony members have specific Rights and Responsibilities. These are included in the Member Handbook. Harmony members have the Right:
• To be treated with respect and recognition of their dignity and their right to privacy;
• To be treated with courtesy by their PCP, all office staff members, and staff members of Harmony;
• To receive information about the organization, its services, its practitioners, and provider and member rights and responsibilities;
• To participate with providers in making decisions about their health care.
• To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
• To make recommendations regarding the organization’s member rights and responsibilities policy;
• To choose their own doctor(s) within the Harmony network;
• To be told about their treatment plan before treatment begins;
• To receive care consistent with sound nursing and medical practices;
• To refuse treatment to the extent of the law and to be told of the outcome;
• To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
• To voice concerns, complaints or appeals about the organization and the care it provides and to receive prompt answers;
• To request information relating to Harmony’s Physician Incentive Plan; and
• To request a description of the financial relationships between Harmony and any health care provider.

Members can also ask for the percentage of total premiums spent on health care related expenses and the percentage of total premiums spent on other expenses, including administrative expenses.

Members have the right to request the following information from Harmony’s providers:
• Copy of the total bill for services received from the health care provider;
• Educational background, experience, training, specialty and board certification;
• The names of the licensed facilities in Harmony’s network where the health care provider presently has privileges for the treatment, illness or procedure the member is inquiring about;
• Information about the health care provider’s participation in continuing education programs; and
• Compliance with licensure, certification or registration requirements.

Harmony members have the Responsibility:
• To treat the PCP and office staff with courtesy and respect;
• To supply information (to the extent possible) that Harmony and its providers need in order to provide care;
• To follow plans and instructions for care that they have agreed to with their providers;
• To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;
• To decide about having a medical treatment or procedure before it begins;
• To help the PCP obtain their medical records;
• To not seek care from a specialist, unless referred by the PCP;
• To not seek care in an emergency room for conditions that are not life-threatening without contacting the PCP;
• To keep all scheduled appointments and be on time; and
• To follow the rules and regulations of Harmony.

Assignment of Primary Care Physician
Members enrolled in a Harmony Medicaid plan must choose a PCP or they will be assigned to a PCP within Harmony’s network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member’s health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.
**Changing Primary Care Physicians**
Members may change their PCP selection at any time by calling Customer Service. The requested change will be effective the first day of the following month of the request if the request is received after the tenth (10th) day of the current month.

**Women's Health Care Providers**
PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health care provider (obstetrician, OB/GYN, gynecologist, family practitioner) for Covered Services related to this type of routine and preventive care. In some instances, a women's health care provider can be chosen to serve as a member's PCP if the provider's credentials are appropriate.

**Hearing-Impaired, Interpreter and Sign Language Services**
Hearing-impaired, interpreter and sign language services are available to Harmony members through Harmony's Customer Service. PCPs should coordinate these services for Harmony members and contact Customer Service if assistance is needed. Please refer to the *Quick Reference Guide* for the Provider Services telephone numbers which may be found on Harmony’s website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources).
Section 3: Quality Improvement

Overview
Harmony’s Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities are implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas that includes, but is not limited to:

- Quantitative and qualitative improvement in member outcomes;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural competency;
- Credentialing;
- Quality of care/service;
- Patient Safety;
- Confidentiality;
- Preventative health;
- Service utilization;
- Complaints/grievances;
- Appeals;
- Adverse Events;
- Network adequacy;
- Disease and Case Management;
- Behavioral Health Services;
- Member and provider satisfaction;
- Components of operational service; and
- Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and/or medical record audits. Harmony’s Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities (including monitoring and evaluating outcomes and overall effectiveness of the QI Program and initiating corrective actions plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

The goals of the QI Program are to:

- Develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate, and evaluates the result of actions taken to improve quality of care outcomes and service levels;
- Ensure availability and access to qualified and competent providers;
- Establish and maintain safeguards for member privacy, including confidentiality of member health information;
- Engage members in managing, maintaining or improving their current states of health through fostering the development of a primary care provider-patient relationship and participation in care programs;
• Provide a forum for members, providers, various health care associations and community agencies to provide suggestions regarding the implementation of the QI program, and
• Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.

Provider Participation in the Quality Improvement Program
Network providers are contractually required to cooperate with quality improvement activities. Providers are invited to volunteer for participation in the QI Program through committee representation, quality/performance improvement projects, EPSDT assessments, and feedback/input via satisfaction surveys, grievances, and calls to Provider Services. Harmony seeks input from and works with members, providers, and community resources and agencies to actively improve the quality of care provided to members. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report assessing the progress in meeting goals. Harmony evaluates the effectiveness of the QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities that address the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and identifies any modifications to the QI Program. This report is available as a written document.

Member Satisfaction
On an annual basis, Harmony conducts a member satisfaction survey of a representative sample of members. Satisfaction with services, quality, and access is evaluated. The results are compared to Harmony’s performance goals, and improvement action plans are developed to address any areas not meeting the standard.

Clinical Practice Guidelines
Harmony adopts validated evidence-based Clinical Practice Guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede Clinical Practice Guidelines, the Guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Quality Improvement Committee. Clinical Practice Guidelines, including preventative health guidelines, are on Harmony’s website at http://www.wellcare.com/Provider/CPGs.

Healthcare Effectiveness Data and Information Set
HEDIS® is a tool used by more than ninety percent (90%) of America’s health plans to measure performance on important dimensions of care and service.

HEDIS® is a mandatory process that occurs annually. It is an opportunity for Harmony and providers to demonstrate the quality and consistency of care that is available to members. Medical records and claims data are reviewed to ensure that the required
data are captured. Compliance with HEDIS® standards is reported on an annual basis with results available to providers upon request. Through compliance with HEDIS® standards, members benefit from the quality and effectiveness of care received and providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

**Medical Records**
Each provider is required to maintain a primary medical record for each member. Medical records should be comprehensive and reflect all aspects of care for each member. Medical records include, but are not limited to:

- medical charts;
- prescription files;
- provider specialist reports;
- consultant and other health care professionals’ findings;
- appointment records; and
- other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided.

Harmony conducts reviews of the medical records of providers to determine compliance with established documentation standards, professional practice guidelines, and preventive health guidelines. In accordance with Harmony’s contract with HFS and requirements from federal and state regulatory agencies, Harmony periodically assesses the medical records of our members to demonstrate our compliance with these requirements.

The medical record review is conducted to assess the quality of care delivered and documented. The medical record review tool consists of four (4) sections: general documentation, EPSDT, obstetrical, and adult preventive care. In the medical record review, two (2) sections are reviewed for compliance with the specific elements. If a provider does not attain a composite score of eighty percent (80%) or greater, a corrective action plan and a medical record re-evaluation is required. Information from the medical record review may be used in the re-credentialing process.

The following lists the general documentation requirements for medical records. Please see the specifically identified areas for detailed EPSDT, Obstetrical and Adult Preventive Care medical record requirements. All medical records, including all entries in the medical record, at a minimum must:

- be neat, complete, clear, and timely and include all recommendations and essential findings in accordance with accepted professional practice;
- be signed and dated and include the name and profession of the provider;
- be legible to readers and reviewing parties;
- be dated and recorded in a timely manner;
- include the member’s name (first and last name or identifier) on each page;
- include the following personal and biographical data in the record:
  - name;
  - member identification;
  - date of birth;
  - gender;
  - address;
• home/work telephone numbers;
• emergency contact name and telephone numbers - this may include next of kin or name of spouse;
• legal guardianship, if applicable;
• marital status; and
• if not English, the primary language spoken by the member and if applicable, any translation or communication needs must be addressed;

• prominently note allergies and adverse reactions to medication;
• include a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-protected health information release in the record;
• include a current medication list;
• include a current diagnoses/problem list;
• include a summary of surgical procedures, if applicable;
• include age appropriate lifestyle and risk counseling;
• include a screening for tobacco, alcohol or drug abuse with appropriate counseling and referrals, if needed;
• include a screening for domestic violence with appropriate counseling and referrals, if needed;
• include the provision of written information regarding advance directives to adults (eighteen (18) years and older);
• include an assessment of present health history and past medical history; include education and instructions, verbal, written or by telephone;
• include, if surgery is proposed, documentation of a discussion with the member of the medical necessity of the procedure, the risks, and alternative treatment options available;
• include evidence that results of ordered studies and tests are reviewed;
• include consultant notes and referral reports;
• include evidence of follow-up visits, if applicable; and
• include appropriate medically-indicated follow-up after hospital discharge and emergency department visits.

Clinical encounters/office visits must minimally include:
• chief complaint;
• history and physical examination for presenting complaint;
• treatment plan consistent with findings; and
• disposition, recommendations and/or instructions provided.

General medical record office practices include safeguarding of member confidentiality in accordance with the HIPAA, state and federal guidelines, and professional practice standards. Confidentiality of member information must be maintained at all times. For more information regarding medical records compliance, including confidentiality of member information and release of records, refer to Section 8: Compliance.

Medical record office practices should include timely provision of the transfer of a member’s records to the new PCP when a member changes his or her PCP.

Quality medical record reviews include quality of care reviews, quality studies, and other quality-focused initiatives, including HEDIS® reviews. Providers should have procedures in place to permit the timely access and submission of medical records to Harmony, or
its representatives, upon request without a fee to the extent permitted by state and federal law. Records remaining under the care, custody, and control of the physician or health care provider shall be maintained for a minimum of ten (10) years from the date of when the last professional service was provided.

**Early and Periodic Screening, Diagnosis and Treatment**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated comprehensive child health program for Medicaid recipients from birth through age twenty (20). It is designed to identify physical and mental defects and provide treatment (or referral when indicated) to correct or ameliorate defects and chronic conditions.

The preventive pediatric health care guidelines for children are located on our corporate website at [http://www.wellcare.com/Provider/CPGs](http://www.wellcare.com/Provider/CPGs).

The AAP recommends that a member should have EPSDT visits on or before the following:

- Initial visit, newborn, within the first week, one (1) month, two (2) months, four (4) months, six (6) months, nine (9) months, one (1) year, fifteen (15) months and eighteen (18) months.
- Then once a year for two (2) through twenty (20) year olds.
- A complete history and physical examination within the first ninety (90) days of joining Harmony.

Please note that an EPSDT visit can be completed during a sick visit.

It is an HFS requirement that each provider enrolled in HFS as a Medical Assistance Provider agrees to provide supplies and services in full compliance with all applicable provisions of State and federal laws and regulations. The EPSDT program, in accordance with section 1905(r) of the Social Security Act, 42 USC 1396d(r), sets forth the basic requirements of EPSDT which must include all of the following services:

- **Comprehensive health and developmental history** including assessment of physical health, mental health (social, emotional, and behavioral issues), development and nutrition.
- **Comprehensive unclothed physical exam** including height, weight, head circumference (newborn to age twenty-four (24) months), and blood pressure (starting at age three (3)).
- **Developmental Milestones** and, when needed, developmental screening and assessment using a recognized standardized developmental screening tool.
- **Appropriate immunizations** or documentation of immunizations when received elsewhere.
- **Laboratory tests** to be performed at the provider’s discretion include tuberculosis screening, dyslipidemia screening, urinalysis, cervical cancer screening and sickle cell testing. Tests that are required or recommended are listed below:
  - **Lead test** (prior to age twelve (12) months and twenty-four (24) months) – **All children enrolled in HFS Medical Programs are expected to receive a blood lead test regardless of where they live.**
Hemoglobin and Hematocrit testing is recommended for nine (9) months to twelve (12) months, fifteen (15) months to eighteen (18) months (as medically necessary), and when a medical need is identified.

- **Health education** consists of anticipatory guidance and injury prevention.

- **Vision and Hearing Screening** includes the provider’s subjective assessment and periodic objective vision and hearing screening using HFS-approved instruments. If the objective screening is not performed by the provider, then a referral should be made for the objective screening(s).

- **Nutritional Assessment** can consist of health history, dietary evaluation, anthropometric measurements, biochemical measurements and clinical evaluations.

- **Risk Assessment** is essential in early identification of physical and mental problems in all ages. Areas that should be assessed include mental health, tobacco/substance abuse, and perinatal depression.

- **Oral Screening** is part of the physical examination. Children should be referred to dentist for routine and periodic examination at least annually.

- **Referral** to WIC, family case management, and other community agencies (as appropriate).

**Obstetrical Care**
Preconception and Perinatal Care Guidelines are specified in the *Clinical Practice Guidelines* for providers on Harmony’s website at [http://www.wellcare.com/Provider/CPGs](http://www.wellcare.com/Provider/CPGs).

**Adult Preventive Health**
Adult Preventative Health Guidelines are specified in the *Clinical Practice Guidelines* for providers on Harmony’s website at [http://www.wellcare.com/Provider/CPGs](http://www.wellcare.com/Provider/CPGs).

**Web Resources**
Harmony periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the Harmony website. Please check Harmony’s website frequently for the latest news and updated documents at [https://www.harmonyhpi.com/provider/quality](https://www.harmonyhpi.com/provider/quality).

**Patient Safety Plan**

**Overview**
Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of health care delivery by all inpatient and outpatient providers, Harmony supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues and grievances related to safety.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:
• Regular checkups for adults and children;
• Prenatal care for pregnant women;
• Well-baby care;
• Immunizations for children, adolescents, and adults; and
• Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, pap smears, and mammograms.

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from providers and the Quality Improvement Committee. Activities include distribution of information, encouragement to utilize screening tools, and ongoing monitoring and measuring of outcomes. While Harmony can and does implement activities to identify interventions, the support and activities of families, friends, providers, and the community have a significant impact on prevention.

Quality of Care Issues
Quality of care (QOC) issues may be identified by members, providers, regulatory agencies or any department within Harmony, including but not limited to, Customer Service, Grievance, Regulatory Affairs, Provider Relations, Risk Management, Health Services (Utilization Management (UM), Case Management (CM), Disease Management (DM), Quality Improvement (QI) or the Medical Director(s)). Quality of Care category types include:
• Procedural Issue;
• Medication Issue;
• Delay/Omission of Care;
• Death or Serious Disability;
• Post-operative Complications; and
• Patient Safety.

QI staff will:
• Investigate the QOC issue;
• Review the case against peer established criteria; and
• Document the nurse reviewer’s analysis.

If a Medical Director Review is required, she or he will review the QOC issue and make determination. The Medical Director determines and documents:
• Impact to Member/Severity:
  o 0 None - There is no impact of the quality, performance or functionality of a patient.
  o 1 Minor - A low-to-medium impact problem. One which allows the patient to continue to function. This may be a minor issue with limited loss or no loss of functionality or impact to the patient.
  o 2 Major - A problem where the patient’s system is functioning but is a severely reduced capacity. The situation is causing a significant impact to portions of the patient’s health. The system is exposed to a potential loss or interruption.
- 3 Critical - A catastrophic problem which may severely impact the patient.
  - Substantiated Labeling:
    - Substantiated (there is evidence of a deviation from the standard of care); or
    - Unsubstantiated (there is no evidence of a deviation from the standard of care).
  - Adverse Labeling:
    - No adverse event; or
    - Adverse event.
  - Action to be taken:
    - No further action;
    - Obtain additional information;
    - Request written feedback from provider;
    - Medical Director follow-up with provider;
    - Audit medical records;
    - Refer to Network Management;
    - Refer to specialist for peer review;
    - Refer to Credentialing/Peer Review Committee as appropriate; and/or
    - Track and trend.

If the Medical Director requests and reviews additional information, he or she will determine the additional action to be taken.
- No further action;
- Track and trend;
- Refer to Credentialing Committee for Peer Review; or
- Other (specify).

Record reviews identifying possible quality of care issues may be referred by the Medical Director to an internal or external peer reviewer when additional specialty expertise is needed to evaluate the appropriateness of care.

The Medical Director will refer a case to the Credentialing/Peer Review Committee when it meets the following criteria:
- Quality review suggests a pattern of inappropriate care; or
- The case requires further peer review opinion.

In the event the Credentialing/Peer Review Committee feels that there is evidence of deviation from standards of care, the QI Staff will coordinate the Peer Review Action, which may include:
- Close Case;
- Track and trend;
- Written Feedback;
- Medical Director follow-up with provider;
- Audit medical records;
- Refer to Network Management for provider education;
- Corrective Action Plan;
- Referral to like specialist peer review;
- Provider monitoring (not to exceed twelve (12) months);
- Provider sanctions;
• Recommend termination; and/or
• Additional information needed (specify in comments).

If the Peer Review Action requires reporting, the Credentialing Department will notify the provider of his or her action and appeal rights. Once the appeal timeframe has been exhausted, a report to the National Provider Data Base and/or other required agencies may be made.
Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)

Utilization Management

Overview
Harmony’s Utilization Management (UM) program is designed to meet the requirements of HFS and federal regulations while providing members access to high quality, cost-effective medically necessary care. For purposes of this section, terms and definitions may be contained within this section, within the Section 12: Definitions of this Provider Manual, or both.

The focus of the UM program is on:
- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member’s diagnosis and level of care required;
- Providing access to medically appropriate, cost effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers;
- Reducing overall expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities, and Harmony in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination of care and minimizing barriers in the delivery of behavioral and medical health care services.

Harmony’s UM program includes components of prior authorization, prospective, concurrent, and retrospective review activities. Each component is designed to evaluate health care and services based on the members’ coverage, the appropriateness of the services, and to determine the amount payment to providers of care.

Harmony does not reward its associates, any providers, physicians, other individuals, or entities performing UM activities for issuing denials of coverage, services, or care. Harmony does not provide financial incentives to encourage or promote under-utilization.

Medically Necessary Services
The determination of whether a covered benefit or service is medically necessary complies with the requirements established by the Code of Federal Regulations Title 42, Part 438.210, National Committee for Quality Assurance (NCQA®) accreditation standards, and HFS. Please see Section 12: Definitions for the definition of medical necessity or medically necessary.

Medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate
medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity, or a Covered Service.

In accordance with 42 CFR 440.230, each medically necessary service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

**Criteria for Utilization Management Decisions**
Harmony’s UM program uses nationally recognized review criteria based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of Illinois and professional knowledge and/or clinical expertise in the related health care specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:
- InterQual™;
- Harmony *Clinical Coverage Guidelines*;
- Medical necessity;
- State Medicaid Contract;
- State Provider Handbooks, as appropriate;
- Local and federal statutes and laws; and
- Medicaid and Medicare guidelines.

The nurse reviewer and/or Medical Director involved in the UM process apply medical necessity criteria in the context of the member’s individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address the individual member’s needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by contacting the UM department via Provider Services. The telephone number is listed on the *Quick Reference Guide* on Harmony’s website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources).

**Utilization Management Process**
The UM process is comprehensive and includes the following review processes:
- Notifications;
- Referrals;
- Prior Authorizations;
- Concurrent Review; and/or
- Retrospective Review.

Decision and notification timeframes are determined by NCQA® requirements, contractual requirements, and state law.
Harmony forms for the submission of notifications and authorization requests can be accessed on Harmony’s website at [https://www.harmonyhpi.com/provider/Forms](https://www.harmonyhpi.com/provider/Forms).

**After-Hours Utilization Management**
Harmony provides authorization of inpatient admissions twenty-four (24) hours per day, seven (7) days per week. Providers requesting after-hours authorization for inpatient admission should refer to the *Quick Reference Guide* on Harmony’s website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources) to contact an after-hours nurse. Discharge planning needs that may occur after normal business hours will be handled by Harmony’s after-hours nurse.

**Notification**
Notifications are communications to Harmony with information related to a service rendered to a member or a member’s admission to a facility. Notification is required for:

- **Prenatal services.** This enables Harmony to identify pregnant members for inclusion into the care coordination program. Obstetrical (OB) providers are required to notify Harmony of pregnancies via fax using the *OB Notification Form* as soon as possible after the initial visit. This process will expedite case management and claims reimbursement.
- **A member’s admission to a hospital.** This enables Harmony to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone by the following business day and include member demographics, facility name, admitting diagnosis, and clinical information that includes the severity of the illness, intensity of services, and illustrates medical necessity.

**Referrals**
For an initial referral, Harmony does not require authorization as a condition of payment. Certain diagnostic tests and procedures considered by Harmony to be routinely part of an office visit may be conducted as part of the initial visit without an authorization.

**Prior Authorization**
An authorization is the approval necessary for payment to be granted for Covered Services and is provided only after Harmony agrees the treatment is necessary and a covered benefit. Prior authorization is the process of obtaining authorization in advance of rendering a service. It may or may not require a medical record review. Prior authorization allows for efficient use of Covered Services and ensures that members receive the most appropriate level of care, at the most appropriate setting. Prior authorization is *required* for elective or non-urgent services designated by Harmony. Prior authorization may be obtained by the member’s PCP, treating specialist, or facility.

All prior authorization requests are reviewed for:

- **Benefit;**
- **Appropriate level of care;**
- **Utilization of a contracted provider; and**
- **Medical necessity utilizing the approved medical review criteria.**
Guidelines for prior authorization requirements by service type can be accessed on Harmony’s website at [https://www.harmonyhpi.com/provider/Forms](https://www.harmonyhpi.com/provider/Forms) or by calling Harmony.

Some prior authorization guidelines to note are:

- The prior authorization request should include the diagnosis to be treated and the **Physicians’ Current Procedural Terminology, Fourth Edition (CPT-4)** code describing the anticipated procedure. If the procedure performed and billed is different from that on the request but within the same family of services, a revised authorization is not required.

- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency, total number of visits requested, and the expected duration of care.

The attending provider or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission. Refer to the **Quick Reference Guide** on Harmony’s website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources) for a list of services requiring prior authorization.

**Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services and Transplants**

The attending provider or hospital staff is responsible for obtaining prior authorization from Harmony and for providing the prior authorization number to each Harmony provider associated with the case; i.e., assistant physician, hospital, etc. Failure to obtain prior authorization will result in denial of payment.

Requests for prior authorization should be submitted at least ten (10) business days prior to the planned admission or procedure. Once a procedure is approved, the approval is only valid for ninety (90) days from the date of issuance.

In cases when prior authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the member requires an additional or different procedure, the procedure will be considered an urgent procedure. The hospital's request for an update of the prior authorization will be considered timely if received within one (1) business day of the date of the procedure.

When prior authorization has been obtained for an outpatient procedure, and after the procedure has been performed it is determined that the member requires inpatient services, the admission should be considered an emergency. The hospital should notify Harmony of the admission within twenty-four (24) hours, and the request for a clinical update should be considered timely if received within one (1) business day of the beginning date of the episode of care.

Hospital requests for updates of authorization and retroactive authorizations of inpatient admissions following a procedure will be denied if it is determined that the procedure clearly required an inpatient level of care that should have been anticipated.
When it is determined that a member with outpatient observation status requires inpatient services, the request for authorization must be received within one (1) business day of the beginning of the episode of care.

**Procedures for Obtaining Prior Authorization for Dental Services**

Prior authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain prior authorization and to provide the prior authorization number to the hospital. The failure of the attending dentist to obtain the correct prior authorization number will result in denial of payment.

For prior authorization of dental services requiring hospitalization, contact Harmony's UM department at the telephone number listed on the *Quick Reference Guide* on Harmony's website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources).

**Procedures for Obtaining Prior Authorization for Transplants**

In order to receive prior authorization for a transplant, a written request with medical records must be received by Harmony for review. These records must include current medical history, pertinent laboratory findings, x-ray and scan reports, social history and test results that exclude viremia and other relevant information.

Transplant procedures and related services must be approved by Harmony prior to the transplant, regardless of the age of the member. Once a transplant procedure is approved, a prior authorization number will be assigned. The member must be eligible at the time services are provided, and these services cannot be approved retroactively.

For requests for approval of coverage of all transplant services, contact the Harmony’s UM department at the telephone number listed on the *Quick Reference Guide* on Harmony's website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources).

**Authorization Request Forms**

Harmony requests that providers use our standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to your request:

- **Inpatient Services Prior Authorization Form** is used to request authorization for planned elective/non-urgent inpatient, skilled nursing facility and rehabilitation admissions.
- **Outpatient Services Prior Authorization Form** is used to request authorization for services such as genetic testing, select outpatient hospital procedures, and transition of care.
- **Durable Medical Equipment (DME) and Orthotic-Prosthetic Authorization Form (Medicaid)** is used to request authorization for equipment and items such as motorized wheelchairs, insulin pumps and Dynasplint® systems.
- **Skilled Therapy Services Request Form** is used to request authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services.
- **Home Health Services Request Form** is used to request authorization for services such as skilled nursing, home health aide and skilled therapy services rendered in a home setting.

To ensure timely and appropriate claims payment, all forms must:

- Have all required fields completed;
• Be typed or printed in black ink for ease of review; and
• Contain a clinical summary or have supporting clinical information attached.

Incomplete forms are not processed and will be returned to the requesting provider. If prior authorization is not granted, all associated claims will not be paid.

All forms are located on Harmony’s website at https://www.harmonyhpi.com/provider/Forms. All forms should be submitted via fax to the number listed on the form.

**Prior Authorization for Inpatient Services**

Prior authorization is conducted prior to a member’s admission, stay, other service or course of treatment in a hospital or other facility. The attending provider is responsible for obtaining the prior authorization of the elective and/or non-urgent admission. An authorization is the approval necessary for payment to be granted for Covered Services and is provided only after Harmony agrees the treatment is necessary and a covered benefit.

Hospitals should use inpatient-qualifying criteria such as InterQual™ to determine the appropriateness of an inpatient admission and conduct concurrent review of the patient’s condition. The patient should remain hospitalized until the same criteria indicate hospitalization is no longer necessary. Harmony will notify providers at least thirty (30) days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions via posting to Harmony’s website or other means.

In determining if a member’s condition requires inpatient care, Harmony determines the medical necessity using inpatient-qualifying criteria such as those published by InterQual™. If the member is admitted, she or he must remain hospitalized until concurrent review performed by the hospital indicates discharge is necessary.

There is no limit on the number of days Medicaid allows for medically necessary inpatient hospital care. If a member is re-admitted to the hospital for the same or related problem within three (3) days of discharge, it is considered the same admission. All admissions are subject to medical justification and Harmony may request documentation to substantiate medical necessity and appropriateness of setting. Documentation must be provided upon request in pre-payment or post-payment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

For additional reimbursement for cost outliers or unusually expensive admissions, Harmony follows HFS guidelines when determining payment for each submitted case.

Hospital admission for diagnostic purposes is covered only when the services cannot be performed on an outpatient basis.

Certain services may only be reimbursed when performed on an outpatient basis unless medical necessity for an inpatient admission is documented and authorized. Diagnostic procedures such as chest x-rays are covered as part of the inpatient admitting process only when:

• The test is specifically ordered by a provider responsible for the patient’s care;
• The test is medically necessary for the diagnosis or treatment of the individual patient’s condition;
• The test does not unnecessarily duplicate the same test done on an outpatient basis before admission, or done in connection with a recent admission; or
• The test is billed with the admission.

If a hospital determines that an outpatient hospital setting would have met the medical needs of a member after the services were provided in an inpatient setting, the services may be billed to Harmony as outpatient if the claim is received within one hundred-eighty (180) days of the ending date of the service month. If the claim is received more than one hundred-eighty (180) days after the ending date, the services are not covered.

To substantiate the determination, a provider’s order must document the member’s status at the time of admission and any changes in the member’s status.

Reimbursement for psychiatric services is limited to short term acute care. The maximum length of stay considered for reimbursement by Harmony, or Harmony’s Delegated Behavioral Health Agent, is thirty (30) days. Psychiatric admissions which have a length of stay in excess of thirty (30) days will be denied reimbursement.

Intermediate care (i.e., step-down units) is reimbursable at the semi-private room rate.

Prior authorization requirements by service type may be found on the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources or on the searchable Authorization Look-up Tool at https://www.harmonyhpi.com/provider.

Review and Functions for Authorized Hospitals
Hospitals must meet the federal and state requirements for control of utilization of inpatient services including:
• Authorization and re-authorization of the need for acute care;
• Treatment pursuant to a plan of care; and
• Operation of utilization review plans.

At the time a Harmony member is admitted into a hospital for inpatient services, the admitting provider must certify that the inpatient services are medically necessary. The authorization must be made at the time of admission, or in the case of pending eligibility, before Medicaid payment is authorized. This requirement can be met by a comprehensive note in the medical record at the time of admission.

The attending provider, or Authorized Representative, must re-certify that inpatient services continue to be medically necessary and appropriate to the acute care setting. This requirement can be met by a comprehensive progress note in the medical record at least every two (2) days.

Harmony requires that a written plan of care be completed for each member prior to authorization for payment before admission to a hospital for elective admissions, within twenty-four (24) hours for emergency admissions or for pending Medicaid-eligible members. The plan should be multi-disciplinary and should include at least the attending provider and the nursing staff. The plan must include:
• Diagnoses, symptoms or complaints indicating the need for admission;
• A description of the functional level of the individual;
• Medication or treatment orders;
• Diet and activity level;
• Plans for hospital course; and
• Plans for discharge.

**Concurrent Review**
Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending provider, hospital utilization manager, Case Management staff, or hospital clinical staff involved in the member's care.

Concurrent review is initiated as soon as Harmony is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:
• Ensure that services are provided in a timely and efficient manner;
• Ensure that established standards of quality care are met;
• Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate;
• Complete timely and effective discharge planning; and
• Identify cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Harmony Medical Director.

To ensure the review is completed timely, providers must submit notification and clinical information on the next business day after the admission, as well as upon request of the Harmony review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

**Retrospective Review**
A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews:
• Retrospective Review initiated by Harmony:
  o Harmony requires periodic documentation including, but not limited to, the medical record (uniform billing form and/or itemized bill) to complete an audit of the provider-submitted coding, treatment, clinical outcome, and diagnosis relative to a submitted claim. On request, medical records should be submitted to Harmony to support accurate coding and claims submission.
• Retrospective Review initiated by providers:
  o Harmony will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage
determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the member’s needs at the time of service. Harmony will also identify quality issues, utilization issues, and the rationale behind failure to follow Harmony’s prior authorization/pre-certification guidelines.

Harmony will give a written notification to the requesting provider and member within thirty (30) calendar days of receipt of a request for a UM determination. If Harmony is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fourteen (14) calendar days of the post-service request.

The member or provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Utilization Management Department via Provider Services. Refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources.

**Service Authorization Decisions**

<table>
<thead>
<tr>
<th>Type of Authorization</th>
<th>Initial Decision Timeframe</th>
<th>Extension Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Pre-service</td>
<td>14 calendar Days</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Expedited Pre-service</td>
<td>72 hours</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 hours</td>
<td>48 hours</td>
</tr>
<tr>
<td>Post service</td>
<td>30 calendar days</td>
<td>14 calendar days</td>
</tr>
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</table>

**Standard Service Authorization**

Harmony will provide a service authorization decision as expeditiously as the member’s health condition requires and within the state-established timeframe which will not exceed fourteen (14) calendar days. Harmony will fax an authorization response to the provider fax number(s) included on the authorization request form. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider requests an extension, or if Harmony justifies a need for additional information and the extension is in the member’s best interest.

**Expedited Pre-Service Authorization**

In the event the provider indicates, or Harmony determines, that following the standard timeframe could seriously jeopardize the member’s life or health, Harmony will make an expedited authorization determination and provide notice within seventy-two (72) hours of the request. An extension may be granted for an additional forty-eight (48) hours if the member or the provider requests an extension, or if Harmony justifies a need for additional information and the extension is in the member’s best interest. **Requests for expedited decisions for prior authorization should be requested by telephone**, not fax or Harmony’s secure, online Provider Portal. Please refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources to contact the UM Department via Provider Services.

Members and providers may file a verbal request for an expedited decision.
**Urgent Concurrent Authorization**

An authorization decision for services that are ongoing at the time of the request, and that are considered to be urgent in nature, will be made within twenty-four (24) hours of receipt of the request. An extension may be granted for an additional forty-eight (48) hours.

**Observation**

Observation stays require notification only; no clinical documentation is requested or required. If the member transfers from observation to inpatient status, a new notification must be issued and clinical documentation is required. A review for medical necessity will examine services provided from the initial date of admission.

Harmony defines *observation services* as those services furnished by a hospital, including use of a bed and periodic monitoring by a hospital's nursing or other staff. Observation services are covered when it is determined they are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient.

Such services are covered only when provided by the order of a provider or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed twenty-four (24) hours, however, some patients may require forty-eight (48) hours of outpatient observation services. Outpatient observation services spanning more than forty-eight (48) hours occur only in rare and exceptional cases.

When a member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the patient needs further care as an inpatient admission or the patient may improve and be released. Observation is a covered revenue code on an inpatient claim.

Harmony does not cover outpatient observation services in the following situations:

- Complex cases requiring inpatient care;
- Post-operative monitoring during the standard recovery period;
- Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards; or
- Observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

A member may only transfer from outpatient status to inpatient status if it is determined that inpatient services are medically necessary and meet InterQual™ criteria. In order for the services to be covered, certification must be obtained within one (1) business day of the beginning date of this episode of care. To receive authorization for an inpatient admission, Harmony must receive documentation indicating the admission is medically necessary and appropriate.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges beginning from the date of initial observation.
observation. Outpatient observation services should not be used for services for which an overnight stay is normally expected. Services such as complex surgery which clearly require inpatient care may not be billed as outpatient.

Harmony only covers services that are medically appropriate and necessary. Failure to obtain the required authorization will result in denial of reimbursement of all services provided and extends to all professional services, not just the hospital services.

**Discharge Planning**

Discharge planning begins upon admission and is designed to identify medical and/or psychosocial issues that will need post-hospital intervention early. The Concurrent Review Nurse works with the attending provider, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level of care. An Inpatient Review Nurse may refer an inpatient member with identified complex discharge needs to Short Term Care Management for in-facility outreach.

**Short Term Case Management**

The goal of the Short Term Case Management (SCM) is to ensure that complex, high-risk members are discharged with a safe and effective plan in place, to promote members’ health and well-being, and reduce avoidable readmissions. The SCM will refer members with long-term needs to Case Management or Disease Management.

The Short Term Case Manager’s role is to identify and outreach to members in the hospital and/or who have been recently discharged who are at high risk for readmission to the hospital. The program is a two-fold process. It may begin with a pre-discharge screening to identify members with complex discharge needs, and to assist with the development of a safe and effective discharge plan. Post-discharge, the process focus is to support recently discharged members to help them meet immediate needs and allow the member to remain at home and reduce avoidable readmissions.

The SCM’s work includes, but is not limited to:

- screening for member needs;
- education;
- care coordination;
- medication reconciliation; and
- referrals to community based services.

Timely follow up is critical to quickly identify and eliminate any care gaps or barriers to care.

**Harmony Proposed Actions**

A proposed action is an action taken by Harmony to deny a request for services. In the event of a proposed action, Harmony will notify the member and the requesting provider in writing of the proposed action. The notice will contain the following:

- The action Harmony has taken or intends to take;
- The reason(s) for the action;
- The member’s or the provider’s right to appeal;
- Procedures for exercising member’s rights to appeal or file a grievance;
- Circumstances under which expedited resolution is available and how to request it; and
- The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Please see Section 7: Appeals and Grievances for more information.

**Peer-to-Peer Reconsideration of Adverse Determination**
In the event of an adverse determination following a medical necessity review, Peer-to-Peer Reconsideration is offered to the treating provider on the Notice of Action communication. The treating provider is given a toll-free number to the Medical Director Hotline to request a discussion with the Harmony Medical Director who made the denial determination. Peer-to-Peer Reconsideration is offered within three (3) business days following the receipt of the written review determination notification by the provider.

The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process.

**Services Requiring No Authorization**
Harmony has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of members including:

- Many services performed in an office setting or ambulatory surgery center do not require authorization including colonoscopies, hysteroscopies and select surgical procedures. A searchable Authorization Look-up Tool is available at www.harmony.hpi.com/auth_lookup. Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and provider offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require prior authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
  - Reproductive laboratory tests;
  - Molecular laboratory tests; and
  - Cytogenetic laboratory tests; and
- Certain tests described as CLIA-waived may be conducted in the provider's office if the provider is authorized through the appropriate CLIA certificate. A copy of the certificate must be submitted to Harmony.

All services performed without prior authorization are subject to retrospective review by Harmony.

Providers should reference the Quick Reference Guide at https://www.harmonyhpi.com/provider/resources and contact Provider Resources when determining whether or not a prior authorization is required.

**Second Medical Opinion**
A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the health care team,
including the member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the member by a qualified health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

**Individuals with Special Health Care Needs**

Individuals with Special Health Care Needs (ISHCN) are adults and children/adolescents who face physical, mental or environmental challenges daily that place their health and ability to fully function in society at risk, such as:

- individuals with mental retardation or related conditions;
- individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders;
- individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and/or
- children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that may lead to placement in foster care.

Providers who render services to members who have been identified as having chronic or life threatening conditions should:

- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the member’s condition or needs:
  - To obtain a standing authorization, the provider should complete the *Outpatient Services Prior Authorization Request Form* and document the need for a standing authorization request under the pertinent clinical summary area of the form.
  - The authorization request should outline the plan of care including the frequency, total number of visits, and the expected duration of care;
  - Coordinate with Harmony to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; and
- Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care provider. Members will have access to a specialty care provider through standing authorization requests, if appropriate.

**Emergency/Urgent Care and Post-Stabilization Services**

Emergency services are not subject to prior authorization requirements and are available to members twenty-four (24) hours per day, seven (7) days per week. Urgent care services should be provided within one (1) day. See *Section 12: Definitions* for definitions of “emergency services and care.”

Harmony provides payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the Harmony network. These services are not subject to prior authorization requirements. Harmony will pay for all emergency services that are medically necessary until the member is stabilized. Harmony will also pay for any medical screening examination conducted to determine whether an
emergency medical condition exists. Harmony will consider the following criteria when processing claims for emergency health care services:

- The age of the patient;
- The time and day of the week the patient presented for services;
- The severity and nature of the presenting symptoms;
- The patient's initial and final diagnosis; and
- Any other criteria prescribed by the HFS, including criteria specific to patients less than eighteen (18) years of age.

The attending emergency room provider, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Harmony, who shall be responsible for coverage and payment.

Harmony will not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. The determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. Payment shall be at either the rate negotiated under the Agreement, or the rates established by the HFS Medicaid Fee Schedule.

Harmony may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but will not refuse to cover an emergency service based on the emergency room provider, hospital or fiscal agent's failure to notify the member's PCP, or Harmony representative, of the member’s screening and treatment within said timeframes.

The member cannot be billed for the screening and/or treatment needed to stabilize the patient.

Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at the applicable triage rate, or as otherwise specified in the hospital contract. The triage rate covers all ancillary services rendered as well as the fee for use of the emergency room. This triage rate may be subject to the hospital's contracted reimbursement rate; in other words, the triage rate may not be the reimbursement rate in all cases. The triage rate is for the medical screening examination and stabilization services provided in the emergency room without regard to prior authorization.

If the hospital believes the medical record supports the existence of a true emergency situation, but the initial presenting information on the claim is not be identified as a true emergency, the claim may be submitted by hard copy with documentation. Harmony will conduct a retrospective medical review applying the prudent layperson criteria, and additional criteria outlined previously, and applicable payment applied.

If a triage rate was received, and the presenting claim did not clearly provide information for determining the presence of an emergency, additional documentation may be submitted for a medical retrospective review. A single form can be submitted with one or multiple claims. Each claim submitted should contain new information which provides
complete insight on the member’s visit to the emergency room (ER). All claims will be reviewed and a follow-up letter of determination (upheld or overturned) will be sent for each claim. In the event a claim decision is overturned based on the additional documentation, Harmony will automatically reprocess the claim at the appropriate ER payment rate determined by the provider contract. In the event the ER triage decision is upheld through this informal ER reconsideration process, you can still submit the claim for review under the formal appeals process. Submit all retrospective ER review requests utilizing the **ER Medical Review Request form**.

If, after medical review, the determination is made that an emergency or potential emergency did in fact exist, the services will be reimbursed at the hospital's specific outpatient contracted rate. Accurate coding is critical to ensure proper reimbursement.

If a member is not accepted for treatment as a Harmony member, hospitals should offer the following alternatives to the member:

- Refer the member to a specific alternate health care setting where he/she can obtain care the same day or next day;
- Instruct the member as to the generally appropriate setting for treatment for such a condition in the future.

There is no limit imposed on the number of visits allowed per day per member in true medical emergencies. However, more than one (1) non-emergency visit by the same member to the same hospital in the same day is subject to review for medical necessity and possible denial depending on the individual situation.

Post-stabilization services are services related to an emergency medical condition that are provided after a member is stabilized in order to maintain, improve, or resolve the member’s condition. Post-stabilization services are covered without prior authorization up to the point Harmony is notified that the member’s condition has stabilized.

**Continuity of Care**
Harmony will allow members in active treatment to continue care with a terminated treating provider when such care is medically necessary, through completion of treatment of a condition for which the member was receiving care at the time of the termination, until the member selects another treating provider, or during the next open enrollment period. None of the above may exceed six (6) months after the termination of the provider's contract.

Harmony will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider until completion of postpartum care.

For continued care under this provision, Harmony and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

**Transition of Care**
During the first thirty (30) days of enrollment, authorization is not required for certain members with previously approved services by the state or another managed care plan. Harmony will continue to be responsible for the costs of continuation of such medically
necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside Harmony’s network until such time as Harmony can reasonably transfer the member to a service and/or network provider without impeding service delivery that might be harmful to the member’s health. However, notification to Harmony is necessary to properly document these services and determine any necessary follow-up care.

When relinquishing members, Harmony will cooperate with the receiving health plan regarding the course of on-going care with a specialist or other provider.

When Harmony becomes aware that a covered member will be dis-enrolled from Harmony and will transition to a Medicaid fee-for-service program or another managed care plan, a Harmony Review Nurse/Case Manager who is familiar with that member will provide a Transition of Care report to the receiving plan, or appropriate contact person for the designated fee-for-service program.

If a provider receives an adverse claim determination which they believe was a transition of care issue, the provider should fax the adverse claim determination to the Appeals department with documentation of HFS/MCO approval for reconsideration. Refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources for the Appeals department contact information.

Non-Covered Inpatient Services
Harmony does not cover the services and procedures listed below. In addition, any services related to, required in preparation for, or as a result of non-covered services are also not covered:

- Services and supplies which are inappropriate or not medically necessary as determined by Harmony or other authorized agent;
- Services or procedures performed which are not in compliance with the policies and procedures contained in this Provider Manual;
- Miscellaneous and non-specific charges;
- Non-acute levels of care;
- Utilization review;
- Differential service charges; i.e., "STAT" or priority, after-hours or "call-back" fees;
- Late charges are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;
- Services mandated to be performed only on an outpatient basis;
- Clinic services while the member is an inpatient;
- Inpatient leave of absence;
- Patient or family education or supplies;
- Nursing services, including services traditionally accepted as nursing care even though provided by other ancillary departments;
- Private duty nurses, sitters or companions;
- Service charges for individual areas within the hospital; i.e., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the
hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;

- Resuscitation, code, CPR (cardiopulmonary resuscitation), etc. are non-covered. However, supplies associated with this service will be reimbursed;
- Investigational items and experimental services, drugs or procedures;
- Any services or items furnished for which the hospital does not normally charge;
- Services provided by an institution for mental disease or special disorders;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided; i.e., cardiac monitor in ICU, light source or call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
- Hospital-based therapy services for treatment of chronic conditions;
- Private rooms are non-covered services. However, if the member has a condition that requires an isolation room or special care unit (ICU, CCU), those are reimbursable. All other accommodations are reimbursed at the semiprivate room rate. Upon admission, members should be notified that private rooms are non-covered services. Members who request a private room after being informed of Harmony's policy will be responsible for the difference between the hospital's semi-private and private room rates. If the member has a condition that requires an isolation room or special care unit or if the hospital only offers private rooms or only has private rooms available, the member cannot be billed for the difference between the semi-private room rate paid by Harmony and the private room rate;
- Services which are not medically necessary to the patient's well-being; i.e., television, telephone, combs, brushes, guest meals, cots, etc.;
- Non-consumable multiple supply items; i.e., bath basins, admission kits, disposable pillows, etc.;
- Take-home prescription drugs, medical supplies, durable medical equipment and artificial limbs and appliances are non-covered;
- Cosmetic surgery or mammoplasties for aesthetic purposes;
- Infertility procedures and related services;
- Abortions, sterilizations and hysterectomies under some circumstances. See the Limits to Abortions, Sterilizations and Hysterectomy Coverage section below for details;
- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;
- Preventive health care. Members under age twenty-one (21) may receive this care through the EPSDT screening process;
- The ICD-9-CM procedure codes listed below:
  - 08.9 Other operations on eyelids;
  - 08.91 Electrosurgical epilation of eyelid;
  - 08.92 Cryosurgical epilation of eyelid;
  - 08.93 Other epilation of eyelid;
  - 18.01 Piercing of ear lobe;
  - 18.5 Surgical correction of prominent ear;
  - 18.9 Other operations on external ear;
  - 20.95 Implantation of electromagnetic hearing aid;
  - 23.3 Restoration of tooth by inlay;
  - 63.82 Reconstruction of surgically divided vas deferens;
  - 63.84 Removal of ligature of vas deferens;
- 64.5  Operations for sex transformation, not elsewhere classified;
- 64.94  Fitting of external prosthesis of penis;
- 64.95  Insertion or replacement of non-inflatable penile prosthesis;
- 64.97  Insertion or replacement of inflatable penile prosthesis;
- 66.79  Other repair of fallopian tube;
- 83.92  Insertion or replacement of skeletal muscle stimulator;
- 85.5  Augmentation mammoplasty;
- 85.50  Augmentation mammoplasty, not otherwise specified;
- 85.51  Unilateral injection into breast for augmentation;
- 85.52  Bilateral injection into breast for augmentation;
- 85.53  Unilateral breast implant;
- 85.54  Bilateral breast implant;
- 85.99  Other;
- 86.64  Hair transplant;
- 86.82  Facial rhytidectomy; and
- 86.92  Electrolysis and other epilation of skin.

**Non-Covered Emergency Room Outpatient Services**

Not all emergency room and outpatient services are covered benefits for Harmony members. Those listed below as well as any services related to these services are non-covered:

- Services or procedures performed which are not in compliance with the policies and procedures contained in this Provider Manual;
- Routine physical examinations;
- Investigational items and experimental services, drugs or procedures;
- Services provided free of charge to the public by the hospital, county health departments, state laboratory or other state agencies; i.e., immunizations, metabolic screens for members under one (1) year of age, etc.;
- Any services and supplies which Harmony or an authorized agent deems as inappropriate or not medically necessary;
- Any services or items furnished for which the hospital does not normally charge;
- Services non-covered or denied by Harmony because they were provided on an inpatient basis;
- Non-acute levels of care;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided, i.e., cardiac monitor in ICU, light source or call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
- Late charges are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;
- Take-home prescription drugs, medical supplies, appliances and durable medical equipment;
- Differential service charges; i.e., "STAT" or priority, after-hours or "call-back" fees;
- Resuscitation, code, CPR, etc. are non-covered. However, supplies associated with this service will be reimbursed;
- Service charges for individual areas within the hospital; i.e., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the
hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;

- Nursing services, including services traditionally accepted as nursing care even though provided by other ancillary departments;
- Abortions, sterilizations and hysterectomies under some circumstances. See the Limits to Abortions, Sterilizations and Hysterectomy Coverage section below for details;
- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;
- Infertility procedures and related services;
- Patient or family education or supplies; and
- Cosmetic surgery or mammoplasties for aesthetic purposes.

### Out-of-State Providers and Service Limitations

Out-of-state hospital providers not contracted with Harmony will be reimbursed for Covered Services provided to eligible Harmony members while out-of-state if the claim is received within one hundred eighty (180) days from the date of service, and if at least one (1) of the following conditions is met:

- The hospital provider preauthorized the service through Harmony; or
- The service was provided to the Harmony member as a result of an emergency or life-endangering situation occurring out of state. If the out-of-state provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical record.

While out-of-state providers are eligible for reimbursement, the Medicaid program does not reimburse providers located outside the continental United States.

Routine health care or elective surgery provided by out-of-state providers is not covered unless prior authorization is obtained from Harmony. In order to receive prior authorization, the referring in-state provider is required to request prior approval by documenting in writing the medical necessity of obtaining services out-of-state and providing the name and address of the out-of-state medical provider. Provider reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of Harmony and are contingent upon the patient's eligibility at the time services are provided.

Requests for prior approval or questions regarding out-of-state services must be directed to Harmony’s Provider Hotline. Refer to the Quick Reference Guide on Harmony’s website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources).

If services are pre-authorized, a copy of the authorization letter from Harmony must be attached to out-of-state claims submitted for reimbursement.

Services rendered due to an emergency or life-endangering situation do not have to be pre-authorized. Any emergency service rendered by a non-participating provider and identified by Harmony as emergent is reimbursable at current Medicaid rates for these services.
Dialysis
Services for dialysis require prior authorization and must be rendered at a contracted facility.

Rehabilitation Services
Rehabilitation services as defined by federal regulation are not covered by Harmony. However, short-term rehabilitation services are covered by Harmony for members if services are received immediately following treatment for acute illness, injury or impairment. Short-term rehabilitation services include physical therapy, occupational therapy and speech therapy and are covered when the conditions listed below are met:

- The member’s provider must establish a written treatment plan that includes the services received as well as identifies the rehabilitation potential, sets realistic goals and measures progress. The plan must also include the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential.
- Authorizations must be obtained by the provider every five (5) business days to ensure the services rendered are necessary. When requesting an extended authorization, the provider must include the date of the initial acute illness, injury or impairment, the diagnosis, and an estimate of the duration of service.
- The services must be of such a level of complexity and sophistication or the member's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified therapist.
- The provider’s prognosis must include an expectation that the member's condition will improve significantly in a reasonable period of time, or the provider must provide evidence of an effective maintenance program in which the services are provided to treat a specific disease state.
- The plan for the member's treatment must include an amount, frequency and duration of services that are reasonable under accepted standards of practice.

Hospitalist Program
Hospitalists provide attending provider coverage in selected markets for members admitted to contracted facilities. Hospitalists provide the following services:

- Emergency room assessment of a member;
- Direct admissions to facilities where the PCP may not provide that service;
- Manages care as needed throughout the inpatient medical admission for members, excluding obstetrical and gynecological cases; and
- Refer members to the PCP upon discharge for follow-up care and communicating the treatment/discharge plan verbally within twenty-four (24) hours and in writing within seven days.

Limits to Abortions, Sterilizations and Hysterectomy Coverage
The following services have special requirements from the state of Illinois:

Abortion
Authorization is not required for the administration of an abortion. Abortions are covered for eligible Harmony members if the provider certifies that the pregnancy is a result of rape or incest or that the woman is in danger of death unless an abortion is performed. Termination of pregnancy shall not be provided to members eligible under the State Children’s Health Insurance Program (SCHIP) (215 ILCS 106).
An Abortion Payment Application (Form HFS 2390) certifying to the above situation must be properly executed and submitted to Harmony with the provider’s claim. This form may be completed and signed by the provider.

Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted.

**Sterilizations**

Prior authorization is not required for sterilization procedures. However, Harmony will deny any provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

Harmony will not and is prohibited from making payment for sterilizations performed on any person who:

- Is under twenty-one (21) years of age at the time she or he signs the consent;
- Is not mentally competent; and/or
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

The required Informed Consent for Voluntary Sterilization (Form HFS 2189) must be completed and submitted to Harmony.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is thirty (30) calendar days. The signed consent form expires one-hundred eighty (180) calendar days from the date of the member's signature.

In the case of premature delivery or emergency abdominal surgery performed within thirty (30) calendar days of signed consent, the provider must certify that the sterilization was performed less than thirty (30) calendar days but not less than seventy-two (72) hours after informed consent was obtained. Although these exceptions are provided, the conditions of the waiver will be subject to review. A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to Harmony. The provider must sign the consent form after the sterilization has been performed.

**Hysterectomy**

Prior authorization is required for inpatient hysterectomy procedures to validate medical necessity. Harmony reimburses providers for hysterectomy procedures only when the following requirements are met:

- The provider has ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member/individual and the attending provider must sign and date the Hysterectomy Form Patient Acknowledgement (Form HFS 1977);
• In the case of prior sterility or emergency hysterectomy, a member is not required to sign the consent form; and
• The provider submits the properly executed Hysterectomy Form Patient Acknowledgement (Form HFS 1977) with the claim prior to submission to Harmony.

Harmony will deny payment on any claim(s) submitted without the required documentation or with incomplete or inaccurate documentation. Harmony does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

All forms are located on Harmony’s website at https://www.harmonyhpi.com/provider/Forms.

Delegated Entities
Harmony delegates some utilization management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Harmony and the delegated entities.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that Harmony’s delegation requirements are met. These requirements include:
• A written description of the specific utilization management delegated activities;
• Semi-annual reporting requirements;
• Evaluation mechanisms; and
• Remedies available to Harmony if the delegated entity does not fulfill its obligations.

On an annual basis, or more frequently as needed, audits of the delegated entity are performed to ensure compliance with Harmony’s delegation requirements. For more information on Delegated Entities, refer to Section 9: Delegated Entities.

Case Management Program

Overview
Harmony offers comprehensive integrated Case Management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients.
Harmony trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for Harmony Case Management Programs.

Harmony’s multidisciplinary Case Management teams are led by specially trained Registered Nurses (RN) or Licensed Clinical Social Workers who perform a comprehensive assessment of the member’s clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. The Case Managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

Harmony’s Case Management teams also serve in a supportive capacity to the PCP and assist in actively linking the member to providers, medical and behavioral services, residential, social and other support services, as needed. A provider may request case management services for any Harmony member.

The Case Management process begins with member identification and follows the member until discharge from the Program. Members may be identified for Case Management by:

- Referral from a member's primary care provider or other specialist;
- Self-referral;
- Referral from a family member;
- Referral after a hospital discharge;
- After completing a Health Risk Assessment (HRA), and
- Data mining for members with high utilization.

Harmony’s philosophy is that the Case Management Program is an integral management tool in providing a continuum of care for Harmony members. Key elements of the Case Management process include:

- **Clinical Assessment and Evaluation** – a comprehensive assessment of the member is completed to determine where she or he is in the health continuum. This assessment gauges the member’s support systems and resources and seeks to align them with appropriate clinical needs.

- **Care Planning** – collaboration with the member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the provider’s plan of care. The member, or in the case of a minor, the parent or legal guardian, and the PCP receive a copy of the initial care plan and any subsequent Care Plans made due to changes in member status.

- **Service Facilitation and Coordination** – working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation, and follow-up.

- **Member Advocacy** – advocating on behalf of the member within the complex labyrinth of the health care system. Case Managers assist members with finding the services to optimize their health. Case Management emphasizes continuity of care for members through the coordination of care among providers, Community Mental Health Centers, and other providers.

Members commonly identified Case Management Program include:
• **Catastrophic Injuries** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns, and multiple traumas;
• **Multiple Chronic Conditions** – multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple intricate barriers to quality health care, i.e., acquired immunodeficiency syndrome (AIDS);
• **Transplantation** – organ failure, donor matching, post-transplant follow-up;
• **Complex Discharge Needs** – members discharged home from acute inpatient or skilled nursing facility (SNF) with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated non-healing wounds, advanced illness, etc.; and
• **Special Health Care Needs** – Children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental, and developmental disabilities.

**Disease Management Program**

**Overview**
Disease management is a population-based strategy that involves providing care across the continuum for members with certain disease states. Elements of the program include educating the member about the particular disease and self-management techniques, monitoring the member’s adherence to the treatment plan, and the consistent use of validated, industry-recognized evidence-based Clinical Practice Guidelines by the treatment team as well as the Disease Manager.

The Disease Management Program targets the following conditions:
• Asthma - adult and pediatric;
• Coronary artery disease (CAD);
• Congestive heart failure (CHF);
• COPD;
• Diabetes - adult and pediatric;
• HIV/AIDS;
• Hypertension;
• Depression; and
• Smoking Cessation.

Harmony’s Disease Management Program educates members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating the provider regarding the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of members, improve health outcomes and decrease medical costs. In addition, Harmony makes available to providers and members general information regarding health conditions on Harmony’s web site at [https://www.harmonyhpi.com/](https://www.harmonyhpi.com/).

**Candidates for Disease Management**
Harmony’s Disease Management member identification strategy leverages multiple channels for identifying those members who could most benefit from the DM Program services. Key member identification channels include data mining and monthly risk stratification through proprietary claims, utilization management, discharge, and
pharmacy data algorithms. Harmony also encourages referrals from providers, members, hospital discharge planners, and others in the health care community.

Interventions for members identified vary depending on their level of need and stratification level and are based on industry-recognized Clinical Practice Guidelines. Members identified at the highest stratification levels receive a comprehensive assessment by a Disease Management nurse, disease-specific educational materials, identification of a care plan and goals, and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific Clinical Practice Guidelines adopted by Harmony are on Harmony's website at http://www.wellcare.com/Provider/CPGs.

**Access to Case and Disease Management Programs**

If you would like to refer a Harmony member as a potential candidate to the Case Management Programs or the Disease Management Program, or would like more information about one of the programs, call the Harmony Case Management Referral Line or complete and fax the Care Management Referral Form which can be found on Harmony's website at https://www.harmonyhpi.com/provider/Forms. Members may self-refer by calling the Care Management toll free line or contacting the Nurse Advice Line after hours or on weekends (TTY/TTD available).

For more information on the Case Management Referral Line, refer to the Quick Reference Guide which on Harmony’s website at https://www.harmonyhpi.com/provider/resources.
Section 5: Claims

Overview
The focus of Harmony’s Claims department is to accurately process claims in a timely manner. Harmony has established toll-free telephone numbers for providers to access a representative in our Provider Services department. For more information, refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources.

Timely Claims Submission
Unless otherwise stated in the Agreement, the provider must submit claims (initial, corrected and voided) within six (6) months from the date of outpatient service or discharge date or three (3) months from the primary insurance payment date (whichever is later). For more information, please refer to the Illinois HFS website at http://www2.illinois.gov/hfs/MedicalProvider/Pages/default.aspx. Unless prohibited by federal law or the Centers for Medicare and Medicaid Services (CMS), Harmony may deny payment for any claims that fail to meet Harmony’s submission requirements for Clean Claims or that are received after the time limit in the Agreement for filing Clean Claims.

The following items can be accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Harmony;
- A provider’s electronic submission sheet with all the following identifiers, including patient name, provider name, date of service to match Explanation of Benefits (EOB)/claim(s) in question, prior submission bill dates; and Harmony product name or line of business; or
- Delivery notification receipt for paper claims.

The following items are not acceptable as evidence of timely submission:

- Strategic National Implementation Process (SNIP) Rejection Letter; and
- A copy of the Provider’s billing screen.

Tax Identification and National Provider Identifier Requirements
Harmony requires the payer-issued Tax ID / TIN and NPI on all claims submissions, with the exception of atypical providers. Atypical providers must pre-register with Harmony before submitting claims to avoid NPI rejections. Harmony may reject claims without the Tax ID and/or NPI. The provider’s NPI must be registered with the State and on the active Medicaid provider roster. The NPI for the correct category of service must be used to have the encounter accepted by the State. More information on NPI requirements, including HIPAA’s Administrative Simplification NPI Final Rule, is available on the CMS website at http://www.cms.gov/.

Taxonomy
Providers are encouraged to submit claims with the correct taxonomy code consistent with provider’s specialty and services being rendered in order to increase appropriate adjudication. Harmony may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.
Preauthorization number
If a preauthorization number was obtained, providers must include this number in the appropriate data field on the claim.

National Drug Codes
Harmony follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

Strategic National Implementation Process
All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines.

If a claim is rejected for lack of compliance with Harmony’s claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information, please see the Encounters Data section below.

Claims Submission Requirements
Harmony requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. Harmony utilizes the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), or later, for all coding. In addition, CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the provider must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

Harmony tracks billing codes and providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as a part of the retrospective review process. Should a provider continue to repeat the inappropriate coding practice, the provider will be subject to adverse action.

Providers using electronic submission shall submit all claims to Harmony or its designee, as applicable, using the HIPAA-compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider’s NPI, Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the member’s medical record prior to the initial submission of any claim. The provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses and/or non-covered services. For more information on paper submission of claims, refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources. For more information on Covered Services under Harmony’s plans, refer to Harmony’s website at https://www.harmonyhpi.com/.
Electronic Claims Submissions
Harmony accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Harmony must be in the ANSI ASC X12N format, version 5010A, or its successor. For more information on EDI implementation with Harmony, refer to the Harmony Companion Guides on Harmony’s website at https://www.harmonyhpi.com/provider/ClaimsUpdates.

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a Harmony contracted clearinghouse, to establish EDI with Harmony. For a list of Harmony contracted clearinghouse(s), for information on the unique Harmony Payer Identification (Payer ID) numbers used to identify Harmony on electronic claims submissions, or to contact Harmony’s EDI team, refer to the Provider Resource Guide and/or Provider How-To Guide on Harmony’s website at https://www.harmonyhpi.com/provider/forms.

HIPAA Electronic Transactions and Code Sets
HIPAA Electronic Transactions and Code Sets is a federal mandate that requires health care payers such as Harmony, as well as providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format.

For more information on EDI implementation with Harmony, refer to the Harmony Companion Guides on Harmony’s website at https://www.harmonyhpi.com/provider/ClaimsUpdates.

Paper Claims Submissions
For timelier processing of claims, providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties as specified in the Agreement. For assistance in creating an EDI process, contact Harmony’s EDI team by referring to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources.

If permitted under the Agreement and until the provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

- Paper claims must only be submitted on an original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for Clean Claims submission:
  - The information must be aligned within the data fields and must be:
    - On an original red-ink-on-white-paper claim form;
    - Typed. Do not print, hand-write, or stamp any extraneous data on the form;
    - In black ink;
    - Large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; and
    - In capital letters.
  - The typed information must not have:
- Broken characters;
- Script, italics or stylized font;
- Red ink;
- Mini font; or
- Dot matrix font.

**CMS Fact Sheet about UB-04:**

**CMS Fact Sheet about CMS-1500:**

**Claims Processing**

**Readmission**
Harmony may choose to review claims if data analysis deems it appropriate. Harmony may review hospital admissions on a specific member if it appears that two (2) or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider) Harmony will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by Harmony, may be subject to recoupment.

**48-Hour Rule**
Harmony follows HFS guidelines for outpatient services treated as inpatient services (excluding emergency and observation services followed by admission before midnight of the following day). All other ancillary charges should be shown on the inpatient claim. Please refer to http://www.hfs.illinois.gov section H-250.5 for additional information.

**Disclosure of Coding Edits**
Harmony uses claims editing software programs to assist in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations, an adjustment of the payment to the provider for the services, or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely claims payment dispute, along with appropriate medical records, to the address below. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service. Policy disputes can be mailed to:

Harmony Health Plan  
Payment Policy Disputes Department  
PO Box 31426  
Tampa, FL 33631-3426.
Prompt Payment
Refer to your Agreement

Coordination of Benefits
Harmony shall coordinate payment for Covered Services in accordance with the terms of a member's benefit plan, applicable state and federal laws, and CMS guidance. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to Harmony. Any balance due after receipt of payment from the primary payer should be submitted to Harmony for consideration and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the EOB. Harmony may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow Harmony policies and procedures regarding subrogation activity.

Encounters Data
Overview
This section is intended to provide delegated vendors, providers, and IPAs with the necessary information to allow them to submit encounter data to Harmony. If encounter data do not meet the standards described in the service level agreements for timeliness of submission, completeness, or accuracy, HFS has the ability to impose significant financial sanctions on Harmony. Harmony requires all delegated vendors and delegated providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

Timely and Complete Encounters Submission
Unless otherwise stated in the Agreement, vendors and providers should submit complete and accurate encounter files to Harmony as follows:

- Encounters submission will be weekly;
- Capitated entities will submit within ten (10) calendar days of service date; and
- Non-capitated entities will submit within ten (10) calendar days of the paid date.

The above apply to both corrected claims (error correction encounters) and cap-priced encounters.

Accurate Encounters Submission
All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once Harmony receives a delegated vendor's or provider's encounters, the encounters are loaded into Harmony's Encounters System and processed. The encounters are subjected to a series of SNIP edits to ensure that the encounter has all the required information and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI) SNIP edits, refer to their Transaction Compliance and Certification white paper at www.wedi.org/snip/public/articles/Testing_whitepaper082602.pdf. For more information on submitting encounters electronically, refer to the Harmony Companion Guides on Harmony's website at https://www.harmonyhpi.com/provider/ClaimsUpdates.
Vendors are required to comply with any additional encounters validations as defined by the State and/or CMS.

**Encounters Submission Methods**
Delegated vendors and providers may submit encounters using several methods:
- Electronically;
- through Harmony's contracted clearinghouse(s);
- via DDE; or
- using Harmony’s Secure File Transfer Protocol (SFTP) process.

**Submitting Encounters Using Harmony’s SFTP Process (Preferred Method)**
Harmony accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using Harmony’s SFTP process. Refer to Harmony’s ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with Harmony, refer to Harmony’s website at [https://www.harmonyhpi.com/provider/ClaimsUpdates](https://www.harmonyhpi.com/provider/ClaimsUpdates).

**Submitting Encounters Using Direct Data Entry**
Delegated vendors and providers may submit their encounter information directly to Harmony using Harmony’s DDE portal. The DDE tool can be found on the secure, online Provider Portal at [https://www.harmonyhpi.com/provider](https://www.harmonyhpi.com/provider). For more information on free DDE options, refer to the Harmony Medicaid Provider Resource Guide and/or Provider How-To Guide, on Harmony's website at [https://www.harmonyhpi.com/provider/forms](https://www.harmonyhpi.com/provider/forms).

**Encounters Data Types**
There are four (4) encounter types for which delegated vendors and providers are required to submit encounter records to Harmony. Encounter records should be submitted using the HIPAA-standard transactions for the appropriate service type. The four (4) encounter types are:
- Dental - 837D format;
- Professional - 837P format;
- Institutional - 837I format; and
- Pharmacy – NCPDP format.

Encounters submitted to Harmony from a delegated vendor or provider can be a new, voided or a replaced / overlaid encounter. The definitions of the types of encounters are as follows:
- New Encounter - an encounter that has never been submitted to Harmony previously.
- Voided Encounter - an encounter that Harmony deletes from the encounter file and is not submitted to the state.
- Replaced or Overlaid Encounter - an encounter that is updated or corrected within the Harmony system.
Balance Billing
Providers shall accept payment from Harmony for Covered Services provided to Harmony members in accordance with the reimbursement terms outlined in the Agreement. Payment made to providers constitutes payment in full by Harmony for covered benefits, with the exception of member expenses. For Covered Services, providers shall not balance bill members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of Harmony’s claims policies and/or procedures does not indicate that the service provided is a non-covered service, and members are to be held harmless for Covered Services.

Providers may not bill Harmony members for:

- The difference between actual charges and the contracted reimbursement amount;
- Services denied because of timely filing requirements;
- Services denied due to failure to follow Harmony procedures;
- Covered Services for which a claim has been returned and denied for lack of information;
- Remaining or denied charges for those services where a contracted provider fails to notify Harmony of a service that required prior authorization. Payment for that service will be denied;
- Services rendered that are the payment liability of medical groups contracted with Harmony; and
- Covered Services that were not medically necessary, in the judgment of Harmony, unless prior to rendering the service, the provider:
  - informs the member of the specific items or services that are not Covered Services and that they will not be paid for by Harmony; and
  - obtains the member’s informed written agreement to pay for those specific items or services. The provider shall contact Harmony for a coverage determination in any case where the provider is unsure if an item or service is a Covered Service.

Provider-Preventable Conditions
WellCare follows CMS guidelines regarding “Hospital Acquired Conditions,” “Never Events,” and other “Provider-Preventable Conditions (PPCs).” Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:
- a different procedure altogether;
- the correct procedure but on the wrong body part; or
- the correct procedure on the wrong patient.

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html and include such events as an air embolism, falls, and catheter-associated urinary tract infection.
Health care providers may not bill, attempt to collect from, or accept any payment from Harmony or the member for PPCs or hospitalizations and other services related to these non-covered procedures.

**Hold Harmless Dual Eligible Members**
Those dual eligible members whose Medicare Part A and B member expenses are identified and paid for at the amounts provided for by Medicaid shall not be billed for such Medicare Part A and B member expenses, regardless of whether the amount a provider receives is less than the allowed Medicare amount or provider charges are reduced due to limitations on additional reimbursement provided by Medicaid. Providers shall accept Harmony’s payment as payment in full.

**Claim Payment and Policy Disputes**
The claims appeal process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Harmony in writing within ninety (90) calendar days of the date of denial of the Explanation of Payment (EOP).

Documentation consists of a letter outlining the following:

- Date(s) of service;
- Member name;
- Member Harmony ID number and/or date of birth;
- Provider name;
- Provider Tax ID/TIN;
- Total billed charges;
- The provider’s statement explaining the reason for the dispute; and
- Supporting documentation when necessary (e.g. proof of timely filing, medical records).

To initiate the process, please mail to the address below, or fax to (877) 277-1808.

Harmony Health Plan  
Attn: Claim Payment Disputes  
PO Box 31370  
Tampa, FL 33631-3370

To dispute payment policy-related issues (denials beginning with IHXXX, MKXXX, or PDXXX), providers should send documentation within ninety (90) days of the date of the EOP to:

Harmony Health Plan  
Payment Policy Disputes Department  
PO BOX 31426  
Tampa, FL 33631-3426.

**Corrected or Voided Claims**
Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.
To submit a corrected or voided claim electronically:

- For institutional claims, the provider must include the original Harmony claim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (replacement for prior claim) or 8 (void/cancel of prior claim) in the standard 837-layout.
- For professional claims, the provider must have the frequency code marked appropriately as 7 (replacement for prior claim) or 8 (void/cancel of prior claim) in the standard 837-layout.

These codes are not intended for use for original claim submission or rejected claims.

**To submit a Corrected or Voided Claim via paper:**

- For institutional claims, the provider must include the original Harmony claim number and bill frequency code per industry standards.

Example:

Box 4 – Type of Bill: the third character represents the “Frequency Code”

```
<table>
<thead>
<tr>
<th>Field 4</th>
<th>Type of Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>Third character</td>
</tr>
<tr>
<td>117</td>
<td>Frequency Code</td>
</tr>
</tbody>
</table>
```

Box 64 – Place the Claim number of the Prior Claim in Box 64

```
298370064
```

- For Professional claims, the provider must include the original Harmony claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

```
22. MEDICAID RESUBMISSION CODE
7 OR 8
```

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

The correction or void process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a co-payment, coinsurance or deductible) – and noted “Payment lost/voided/missed.” This process will deduct the payment for this claim, or zero net amount if applicable.
2. The corrected or voided claim will be processed with the newly submitted information and noted “Adjusted per corrected bill.” This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.
The payment reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent for the newly submitted corrected claim.

**Reimbursement**
Harmony applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (physician office services versus other places of treatment).

**Surgical Payments**
Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/Complications** - A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a Harmony Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.

- **Admission Examination** - One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

- **Follow-up Surgery Charges** - Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on HFS policy.

**Multiple Procedures**
Payment for multiple procedures is based on:

- One-hundred percent (100%) of maximum allowable fee for primary surgical procedure;
- Fifty percent (50%) of maximum allowable fee for secondary surgical procedure; and
- Twenty-five percent (25%) of maximum allowable fee for all other surgical procedures.

The percentages apply when eligible multiple surgical procedures are performed under one (1) continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

**Assistant Surgeon**
Assistant surgeons are reimbursed at sixteen percent (16%) of the maximum allowable fee for the procedure code. Multiple surgical procedures for assistant surgeons are reimbursed as follows:

- Sixteen percent (16%) of one-hundred percent (100%) of the maximum allowable fee for primary surgical procedure (first claim line);
- Sixteen percent (16%) of fifty percent (50%) of the maximum allowable fee for the second surgical procedure; and
- Sixteen percent (16%) of twenty-five percent (25%) of the maximum allowable fee for all other surgical procedures.

Harmony uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes”, CMS is used as the secondary source.

**Co-Surgeon**
Each provider will be paid fifty percent (50%) of the maximum allowable fee for the procedure code. In these cases, each surgeon should report his or her distinct operative work, by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier ‘62’ added.

**Modifier**
Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code’s fee or cause a claim to pend for review. For more information, please refer to the HFS website at [http://www2.illinois.gov/hfs/Pages/default.aspx](http://www2.illinois.gov/hfs/Pages/default.aspx).

**Hospital-Based Physicians, Certified Registered Nurse Anesthetists, and Nurse Practitioners**
All inpatient and outpatient professional services must be billed on the physician’s claim form.

Hospital-based physicians, Certified Registered Nurse Anesthetists (CRNAs), specified nurse practitioners, and Physician Assistants (PAs) may designate the hospital as payee by agreement. The hospital must maintain each agreement authorizing such payments on file.

Services rendered to eligible members by hospital-based physicians, CRNAs, designated nurse practitioners and PAs will be covered both on an inpatient and outpatient basis as long as the services are medically necessary and within the contractual or financial agreement with the hospital. These services are subject to retrospective review by Harmony or its authorized agents.

**Overpayment Recovery**
Harmony strives for one-hundred percent (100%) payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.

Harmony will proactively identify inappropriate payments and contact providers to request reimbursement of the amount overpaid. In accordance with 215 ILCS 5/368d, no recoupment or offsets may be requested or withheld more than eighteen (18) months after the original payment is made, except in cases where a court, government administrative agency, or other tribunal has made a formal adjudication of fraud or the
provider has already been paid in full by any other payer, third party, or workers' compensation insurer.

In all cases, Harmony, or its designee, will provide a written notice to the provider providing pertinent information about the overpayment, including the amount, the reason for the recoupment, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the member. The notice will also provide the carrier address Harmony has on file but the provider may use the carrier address it has on file.

The standard request notification provides sixty (60) days for the provider to send in the refund or contact Harmony, or its designee, for further information or to dispute the overpayment. Failure of the provider to respond within the above timeframe will constitute acceptance of the terms in the letter and will result in offsets to future payments. The provider will receive an EOP indicating if the balance has been satisfied. If there are no future payments to offset, the provider must repay overpayments to Harmony within thirty (30) days of the provider’s receipt of notice of the overpayment. Any appeal of a recoupment or offset by a health care professional or health care provider must be made within sixty (60) days after receipt of the remittance advice.

If the overpaid balance has aged more than three (3) months and no refund has been received, the provider may be contacted by Harmony, or its designee, to arrange payment.

If providers independently identify an overpayment, they can send a corrected claim (refer to the Corrected or Voided Claims section above), contact Provider Services to arrange an off-set against future payments, or send a refund and explanation of the overpayment to:

Harmony Health Plans, Inc.
Recovery Department
PO Box 31584
Tampa, FL 33631-3584.

For more information on contacting Provider Services, refer to the Quick Reference Guide on the Harmony website at https://www.harmonyhpi.com/provider/resources.

Benefits During Disaster and Catastrophic Events
Refer to your Agreement.
Section 6: Credentialing

Overview
Credentialing is the process by which the appropriate Harmony peer review bodies evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include providers delivering health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities, and other ancillary facilities/health care delivery organizations.

This evaluation includes (as applicable to practitioner type):
- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide health care;
- Accreditation status, as applicable to non-individuals; and
- CLIA Certificate of Waiver.

Practitioners are required to be credentialed prior to being listed as participating network providers of care or services to Harmony members.

The Credentialing department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:
- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and Harmony policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals, and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to Harmony members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, state and accreditation requirements.
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the provider.
Credentialing may be done directly by Harmony or by an entity approved by Harmony for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet Harmony’s criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and Harmony requirements.

All providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms and files.

**Practitioner Rights**
Practitioner Rights are listed below and included in the application/re-application cover letter.

**Practitioner’s Right to Be Informed of Credentialing/Re-Credentialing Application Status**
Written requests for information may be e-mailed to credentialing@wellcare.com. Upon receipt of a written request, Harmony will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within fifteen (15) business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

**Practitioner’s Right to Review Information Submitted in Support of Credentialing/Re-Credentialing Application**
The practitioner may review documentation submitted by her or him in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, State licensing agencies and certification boards, subject to any Harmony restrictions. Harmony, or its designee, will review the corrected information and explanation at the time of considering the practitioner’s credentials for provider network participation or re-credentialing.

The provider may not review peer review information obtained by Harmony.

**Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe**
In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Harmony, the practitioner has the right to review the information that was submitted in support of his or her application, and has the right to correct the erroneous information. Harmony will provide written notification to the practitioner of the discrepant information.

Harmony’s written notification to the practitioner includes:
- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
• The timeframe for submitting the corrections;
• The addressee in Credentialing to whom corrections must be sent;
• Harmony’s documentation process for receiving the correction information from the provider; and
• Harmony’s review process.

Baseline Criteria
Baseline criteria for practitioners to qualify for provider network participation:

License to Practice – Practitioners must have a current, valid, unrestricted license to practice.

Illinois Medicaid Eligibility - All affiliated providers delivering Covered Services for Harmony must currently be enrolled and active as providers in the HFS Medical Program.

Drug Enforcement Administration Certificate – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for M.D., D.O., D.P.M., D.D.S., and D.M.D.).

Work History – Practitioners must provide a minimum of five (5) years of relevant work history as a health professional.

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for Harmony or must have verifiable educational/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a Harmony-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another Harmony-participating provider who has admitting privileges at a Harmony-participating hospital for the admission of members.

Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Harmony Plan. Providers are not eligible for participation if such provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the provider. Existing providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with Harmony policy and procedure.

New Providers – A provider is required to have a NPI to participate in Harmony’s network.

Liability Insurance
Harmony providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits as indicated below, unless otherwise agreed to by Harmony in writing:
• $1,000,000 per occurrence / $3,000,000 aggregate.

Providers must furnish copies of current professional liability insurance certificate to Harmony, concurrent with expiration.

**Site Inspection Evaluation**

Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety, and accessibility, performance standards and thresholds were established for:

- Office-site criteria:
  - Physical accessibility;
  - Physical appearance; and
  - Adequacy of waiting room and examination room space; and
- Medical / treatment record keeping criteria.

SIEs are conducted for:

- Unaccredited facilities;
- State-specific initial credentialing requirements;
- State-specific re-credentialing requirements; and
- When a complaint is received relative to office site criteria.

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of member complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

**Covering Physicians**

Primary care physicians in solo practice must have a covering physician who also participates with or is credentialed with Harmony.

**Allied Health Professionals**

Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Harmony.

Dependent AHPs include the following, and are required to provide collaborative practice information to Harmony:

- APN;
- Certified Nurse Midwife (CNM);
- PA; and
- Osteopathic Assistant (OA).

Independent AHPs include, but are not limited to the following:

- Licensed clinical social worker;
- Licensed mental health counselor;
- Licensed marriage and family therapist;
- Physical therapist;
- Occupational therapist;
- Audiologist; and
• Speech/language therapist/pathologist.

Ancillary Health Care Delivery Organizations
Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE if unaccredited. Harmony is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status, and liability insurance coverage prior to accepting the applicant as a Harmony provider.

Re-Credentialing
In accordance with regulatory, accreditation and Harmony policy and procedure, re-credentialing is required at least once every three (3) years.

Updated Documentation
In accordance with contractual requirements, providers should furnish copies of their current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to provider type) to Harmony, prior to or concurrent with expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report
On a regular and ongoing basis, Harmony or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most currently available information. This information is cross-checked against the network of providers. If providers are identified as being currently sanctioned, such providers are subject to immediate termination and notification of termination of contract, in accordance with Harmony policies and procedures.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a regular and ongoing basis, Harmony or its designee contacts state licensure agencies to obtain the most currently available information on sanctioned providers. This information is cross-checked against the network of Harmony providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with Harmony policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Harmony policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the provider should continue participation or whether termination should be initiated.

Provider Appeal through the Dispute Resolution Peer Review Process
Harmony may immediately terminate or it may suspend, pending investigation, the participation status of a provider who, in the opinion of the Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members. In such instances, the Medical Director investigates on an expedited basis.
Harmony Health Plans, Inc.  
Illinois Medicaid Provider Manual  
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Harmony has a Participating Provider Dispute Resolution Peer Review Panel process in the event Harmony chooses to alter the conditions of participation of a provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has two (2) levels. All disputes in connection with the actions listed below are referred to as a first level Peer Review Panel consisting of at least three (3) qualified individuals of whom at least one (1) is a participating provider and a clinical peer of the practitioner who filed the dispute.

The practitioner also has the right to consideration by a second level Peer Review Panel consisting of at least three (3) qualified individuals of which at least one (1) is a participating provider and a clinical peer of the practitioner that filed the dispute. The second level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by Harmony entitle the affected practitioner to the Provider Dispute Resolution Peer Review Panel Process:

- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service;
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service; or
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct; service or excessive claims and/or sanction history.

Notification of the adverse recommendation, together with reasons for the action, and the practitioner’s rights and process for obtaining the first and/or second level Dispute Resolution Peer Review Panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has a period of up to thirty (30) days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process.

Upon timely receipt of the request, the Medical Director or her or his designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing. Harmony then notifies the practitioner of the schedule for the Review Panel hearing.

The practitioner and Harmony are entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable or capricious.

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first level Panel hearing. In the event the findings are positive for the practitioner, the second level review shall be waived.
In the event the findings of the first level Panel hearing are adverse to the practitioner, the practitioner may access the second level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first level Peer Review Panel.

Within ten (10) calendar days of the request for a second level Peer Review Panel hearing, the Medical Director or his or her designee shall notify the practitioner of the date, time and access number for the second level Peer Review Panel hearing.

The second level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the second level Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the second level Panel hearing via certified or overnight recorded delivery mail. In the event the findings of the second level Peer Review Panel result in an adverse determination for the practitioner, the findings of the second level Peer Review Panel shall be final.

A practitioner who fails to request the Provider Dispute Resolution Peer Review Process within the time and in the manner specified waives any right to such review to which she or he might otherwise have been entitled. Harmony may proceed to implement the termination or suspend pending investigation, and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

**Delegated Entities**

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to Section 9: Delegated Entities section in this Provider Manual for further details.
Section 7: Appeals, Complaints and Grievances

Appeals Process

Provider Appeals Process
Overview
A provider may appeal a utilization or claim denial on his or her own behalf by mailing or faxing to Harmony a letter of appeal and/or a Provider Appeal Request Form with supporting documentation such as medical records. The Provider Appeal Request Form is available on Harmony’s website at https://www.harmonyhpi.com/provider/Forms.

Providers have ninety (90) calendar days from the original utilization management or claim denial to file a provider appeal. Cases appealed after that time will be denied for untimely filing. If the provider feels she or he has filed the appeal within the appropriate timeframe, the provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of Harmony or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, Harmony has fifteen (15) business days to review the case for medical necessity and conformity to Harmony guidelines and to render a decision to reverse or affirm.

Cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the provider to provide the requested documentation within sixty (60) calendar days of the denial to re-open the case. Records and documents received after that timeframe will not be reviewed and the case will remain closed. Medical records and patient information shall be supplied at the request of Harmony or regulatory agencies when required for appeals. The provider is prohibited from charging Harmony or the member for copies of medical records provided for this purpose.

For information regarding how to contact the Appeal Department, refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources.

Reversal of Denial of Provider Appeals
If it is determined during the review that the provider has complied with Harmony protocols and that the appealed services were medically necessary, the initial denial will be reversed. The provider will be notified of this decision in writing.

The provider may file a claim for payment related to the appeal, if one has not already been submitted. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. Harmony will ensure that claims are processed and comply with the federal and state requirements.

Affirmation of Denial of Provider Appeals
If it is determined that the provider did not comply with Harmony protocols and/or medical necessity was not established, the initial denial will be upheld. The provider will be notified of this decision in writing.
For denials based on medical necessity, the criteria used to make the decision will be provided in the notification letter. The provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

**Member Appeals Process**

**Overview**

A member appeal is a formal request from a member for a review of an action taken by Harmony. An appeal may also be brought on the member’s behalf by an Authorized Representative or a provider with the member’s consent. All appeals rights described in this *Section 7* that apply to members will also apply to the member’s Authorized Representative or a provider acting on behalf of the member with the member’s consent.

To appeal, the member may file an appeal request either orally via Harmony’s Customer Service or in writing within thirty (30) calendar days of the date of the adverse determination.

If an appeal is filed orally via Harmony’s Customer Service, the request must be followed up with a written, signed appeal to Harmony within ten (10) calendar days of the oral filing. For oral filings, the timeframes for resolution begin on the date the oral filing was received by Harmony.

Examples of actions that can be appealed include, but are not limited to, the following:

- Denial or limited authorization of a requested service, including the type or level of service pursuant to 42 CFR 438.400(b);
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for service;
- The failure to provide services in a timely manner; or
- For a resident of a rural area with only one managed care entity, the denial of a member’s request to exercise his or her right to obtain services outside the network.

If the member’s request for appeal is submitted after thirty (30) calendar days, then good cause must be shown in order for Harmony to accept the late request. Examples of good cause include, but are not limited to, the following:

- The member did not personally receive the adverse determination notice or received the notice late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member’s immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The member had incorrect or incomplete information concerning the appeal process.

Harmony will send a letter to the member within three (3) business days acknowledging receipt of the appeal request.

Harmony will not take or threaten to take any punitive action against any provider acting on behalf of or in support of a member requesting an appeal or an expedited appeal.
Types of Appeals
A member may file for a standard pre-service, retrospective, or an expedited appeal determination.

Standard pre-service appeals are requests for services that Harmony has determined are not Covered Services, are not medically necessary, or are otherwise outside of the member’s benefit plan.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the provider on his or her own behalf.

Only pre-service appeals are eligible may expedited.

Harmony ensures that the decision-makers assigned to appeals were not involved in previous levels of review or decision-making. When deciding an appeal of a denial based on lack of medical necessity, a grievance regarding a denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the appeal reviewers will be health care professionals with clinical expertise in treating the member’s condition/disease or will have sought advice from providers with expertise in the field of medicine related to the request.

Appointment of Representative
If a member wishes to use an Authorized Representative, she or he must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on Harmony’s website at https://www.harmonyhpi.com/provider/Forms. Members are provided reasonable assistance in completing forms and other procedural steps for an appeal including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY/TDD capability.

Appeal Decision Timeframes
Harmony must make a determination from the receipt of the request on a member appeal and notify the appropriate party within the following timeframes:

- Standard Pre-Service Request: **15 business days**
- Retrospective Request: **15 business days**
- Expedited Request: **24 hours**

The standard pre-service, retrospective, and expedited determination periods noted above may be extended by up to fourteen (14) calendar days if the member requests an extension or if Harmony requires additional information and documents how the extension is in the interest of the member. If an extension is not requested by the member, Harmony will provide the member with written notice of the reason for the delay.

**Standard Pre-Service and Retrospective Appeals Process**
A member may file a standard pre-service appeal request either orally or in writing within thirty (30) calendar days of the date of the adverse determination.
After filing a written appeal, a member may present his or her appeal in-person.

**Standard Pre-Service or Retrospective Appeal Decisions**
If Harmony reverses its original decision, Harmony will either issue an authorization for the pre-service request or send payment if the service has already been provided.

If Harmony affirms its initial action and/or denial (in whole or in part), it will:
- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in easily understandable language with reference to the benefit provision, guideline, protocol or other similar criteria on which the appeal decision was based, as well as inform the member:
  - Of the right to request an External Independent Review (EIR) within thirty (30) calendar days, how to do so and/or how to request a Fair Hearing with HFS;
  - Of the right to continue to receive benefits pending an EIR and/or request a Fair Hearing with HFS;
  - How to request the continuation of benefits; and
  - Information explaining that the member may be liable for the cost of any continued benefits if Harmony’s action is upheld in an EIR.

**Expedited Appeals Process**
To request an expedited appeal, a member or a provider (regardless of whether the provider is contracted with Harmony) must submit an oral or written request directly to Harmony. A request to expedite an appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member’s life, health, or ability to regain maximum function, including cases in which Harmony makes a less than fully favorable decision. In light of the short timeframe for deciding expedited appeals, a provider does not need to be an Authorized Representative to request an expedited appeal on behalf of the member.

Members who orally request an expedited appeal are not required to submit a written appeal request.

A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited appeal.

Harmony will resolve an expedited appeal and provide written notice to the parties involved as expeditiously as the member’s health condition requires, but no more than twenty-four (24) hours from the time Harmony receives the appeal. Harmony will make reasonable efforts to provide verbal notice to the member with the appeal determination.

**Denial of an Expedited Appeal Request**
Harmony will provide the member with prompt oral notification regarding the denial of an expedited appeal request and the member’s rights within twenty-four (24) hours. Harmony will subsequently mail a letter to the member within two (2) calendar days of the oral notification explaining:
- That Harmony will automatically transfer and process the request using the fifteen (15) business day timeframe for standard appeals beginning on the date Harmony received the original request; and
• The member’s right to resubmit a request for an expedited appeal and that if the member gets any provider’s support indicating that applying the standard timeframe for making a determination could seriously jeopardize the member’s life, health or ability to regain maximum function, the request will be expedited automatically.

External Independent Review Process
In the event that the appellant is not satisfied with Harmony’s appeal decision and wishes to file an EIR, the member or provider must submit the request in writing within thirty (30) calendar days of notification of the appeal decision. An acknowledgement letter will be mailed to the appellant within three (3) business days. The Appeals Coordinator will forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of Harmony’s decision, the criteria used, and the medical and clinical reasons for that decision.

The EIR organization will make a determination within twenty-four (24) hours for expedited reviews and fifteen (15) business days for standard requests. Upon receipt of the determination by Harmony, the Appeals Coordinator will implement the decision and update the file in the database. If the decision is reversed in whole or in part, the written decision letter will include information on the right to appeal through the Medicaid Fair Hearing process. The member and/or requesting provider will be advised in writing within two (2) calendar days from the date the decision was made.

Continuation of Benefits while the Appeal and Medicaid Fair Hearing are Pending
Harmony will continue the member’s benefits if:
• the member files the appeal timely;
• the appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
• the services were ordered by an authorized provider;
• the original period covered by the original authorization has not expired; and
• the member requests extension of the benefits.

As used in the paragraph above, “timely” means filing on or before the later of the following:
• Within ten (10) business days of Harmony mailing the Notice of Adverse Action; or
• Within ten (10) business days after the intended effective date of Harmony’s proposed action, whichever is later.

If, at the member’s request, Harmony continues or reinstates the member’s benefit while the appeal is pending, the benefits will be continued until one (1) of the following occurs:
• The member withdraws the appeal or request for the EIR review;
• Ten (10) business days pass after Harmony mails the Notice of Adverse Action; or
• The time period or service limits of a previously authorized service has expired.
If the final resolution of the appeal is adverse to the member (i.e., Harmony’s decision was upheld), Harmony may recover from the member the cost of any Covered Services furnished to the member while the appeal was pending.

Complaints and Grievances

Provider Complaints
Providers have the right to file a written complaint for disputes concerning payments for services, any administrative functions, and authorizations / referrals, no later than thirty (30) calendar days from the date the provider becomes aware of the issue generating the complaint.

Provider complaints can be mailed directly to Harmony’s Grievance Department at the following address:

WellCare Health Plans, Inc.
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33634-3384

Alternatively, providers can submit their complaints by contacting Provider Services at the number on the Quick Reference Guide.

Written resolution will be provided by Harmony to the provider within forty-five (45) calendar days from the date the complaint is received by Harmony.

A provider may not file a grievance on behalf of the member without written consent from the member as the member’s representative.

Harmony will make available to all providers written notice of the provider complaint procedures at the time the providers enter into contract with Harmony.

Member Grievances
A member may file a grievance. A grievance may also be filed on the member’s behalf by an Authorized Representative or a provider with the member’s written consent. All grievance rights described in this Section 7 that apply to members will also apply to the member’s Authorized Representative or a provider acting on behalf of the member with the member’s consent. Examples of issues that may result in a grievance include, but are not limited to:

- Provider Service including, but not limited to:
  - Rudeness by provider or office staff;
  - Failure to respect the member’s rights;
  - Quality of care/services provided;
  - Refusal to see member (other than in the case of patient discharge from office); and/or
  - Office conditions.

- Services provided by Harmony including, but not limited to:
  - Hold time on telephone;
  - Rudeness of staff;
A member may file a standard and/or expedited grievance within one (1) year of the incident or when the member was made aware of the incident.

Harmony will ensure that no punitive action is taken against a provider who, as an Authorized Representative, files a grievance on behalf of a member, or supports a grievance filed by a member. Documentation regarding the grievance will be made available to the member, if requested.

If the member wishes to use a representative, then she or he must complete an Appointment of Representative (AOR) statement. For more information, see the Appointment of Representative section above.

**Grievance Submission**

An oral grievance request can be filed, toll-free, by calling the Harmony Member Services Department at the number listed on the Quick Reference Guide on our website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources). An oral request may be followed up with a written request, but the timeframe for resolution begins the date the oral filing is received by Harmony.

Harmony will acknowledge the member’s standard grievance in writing within ten (10) business days of the date the grievance is received by Harmony. The acknowledgement letter will include:

- The name and telephone number of the Grievance Coordinator; and
- A request for any additional information, if needed to investigate the issue.

If Harmony determines, or a provider indicates, that a delay in processing a grievance would seriously jeopardize the member’s life, health, or ability to maintain or regain maximum function, the grievance will be expedited. A member may also request an expedited review of a grievance. Expedited grievances will be resolved within seventy-two (72) hours.

For more information on how to contact the Grievance Department or Member Services, refer to the Quick Reference Guide on Harmony’s website at [https://www.harmonyhpi.com/provider/resources](https://www.harmonyhpi.com/provider/resources).

**Grievance Resolution**

Upon resolution, a letter will be mailed to the member, the member’s representative, or provider within ninety (90) calendar days of the date the standard grievance was received by Harmony. The resolution letter will include:

- The results/findings of the resolution;
- All information considered in the investigation of the grievance;
- The date of the grievance resolution;
• Member rights to a Grievance Committee Review; and
• Member rights to a Medicaid Fair Hearing.

**Medicaid Fair Hearing for Members**
If a member is dissatisfied with the grievance decision reached by Harmony, the member may request a Medicaid Fair Hearing within ninety (90) calendar days of receiving the grievance resolution letter.
Section 8: Compliance

Harmony’s Compliance Program

Overview
Harmony’s corporate ethics and compliance program includes information on Harmony’s policies and procedures related to fraud, waste and abuse, and provides guidance and oversight to Harmony employees, contractors (including delegated entities) and business partners. All providers, including provider employees and sub-contractors and their employees, are required to comply with Harmony compliance program requirements. Harmony’s compliance-related training requirements include, but are not limited to, the following initiatives:

- Corporate Integrity Agreement (CIA) Training
  - Effective April 26, 2011, Harmony’s CIA with the OIG of the United States Department of Health and Human Services (DHHS) requires that Harmony maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at Harmony.

- HIPAA Privacy and Security Training
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to the HIPAA.
  - Training includes, but is not limited to discussion on:
    - Proper uses and disclosures of Protected Health Information (PHI);
    - Member rights; and
    - Physical and technical safeguards.

- Fraud, Waste and Abuse (FWA) Training
  - Must include, but is not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, etc.);
    - Obligations of the provider, including provider employees and provider sub-contractors and their employees, to have appropriate policies and procedures to address fraud, waste, and abuse;
    - Process for reporting suspected fraud, waste and abuse;
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
    - Types of fraud, waste and abuse that can occur.

- Cultural Competency Training
  - Programs that educate and identify the diverse cultural and linguistic needs of the members providers serve.

- Disaster Recovery and Business Continuity
  - A Business Continuity Plan that includes the documented process of continued operations of Harmony and its delegated functions in the event of a short-term or long-term interruption of services.

Details of the corporate ethics and compliance program and the Code of Conduct are on Harmony’s website at https://www.wellcare.com/AboutUs/default.
Provider Education and Outreach
Providers may:
  • Display State-approved health plan specific materials in-office;
  • Announce a new affiliation with a health plan; and
  • Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers, and print advertisement upon state approval.

Providers are prohibited from:
  • Orally, or in writing, comparing health plan benefits or provider networks among health plans, other than to confirm their participation in a health plan’s network;
  • Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity;
  • Furnishing health plans’ membership lists to the health plan, including Harmony, or any other entity; and
  • Assisting with health plan enrollment.

Code of Conduct and Business Ethics

Overview
Harmony has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Harmony’s Code of Conduct and Business Ethics policy can be found at https://www.wellcare.com/AboutUs/default.

The Code of Conduct and Business Ethics (the Code) is the foundation of iCare, Harmony's Corporate Ethics and Compliance Program. It describes Harmony's firm commitment to operate in accordance with the laws and regulations governing our business and accepted standards of business integrity. All providers should familiarize themselves with Harmony's Code of Conduct and Business Ethics. Providers and other contractors of Harmony are encouraged to report compliance concerns and any suspected or actual misconduct. Providers should report suspicions of fraud, waste and abuse and other compliance concerns by calling the Harmony FWA hotline at (866) 364-1350.

Fraud, Waste and Abuse
Harmony is committed to the preventing, detecting and reporting health care fraud, waste and abuse according to applicable federal and state statutory, regulatory and contractual requirements. Harmony has developed an aggressive, proactive FWA program designed to collect, analyze and evaluate data in order to identify suspected fraud, waste and abuse. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and Harmony vigorously investigate incidents of suspected FWA. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the ICD-9-CM, CPT-4, the HCPCS, and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.
In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines, and other penalties.

Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to fraud, waste and abuse (§ 423.504), providers and their employees must complete an annual FWA training program.

Providers, including provider employees and/or provider sub-contractors, must report to Harmony any suspected fraud, waste or abuse, misconduct or criminal acts by Harmony, any provider, including provider employees and/or provider sub-contractors, or by Harmony members. To report suspected FWA, please refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources or reports may be made anonymously through Harmony’s toll-free fraud hotline at (866) 364-1350. Details of the corporate ethics and compliance program, and how to contact the Harmony fraud hotline, may also be found on Harmony’s website at https://www.wellcare.com/AboutUs/default.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the member or his or her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA privacy and security rules and regulations, as may be amended. All provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members’ medical records and other PHI, and the practice is following those procedures and obtaining appropriate authorization from members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Each provider, with certain exceptions, must provide a notice of its privacy practices. The HIPAA Privacy Rule requires that the notice contain certain elements. The notice must describe the ways in which the provider, as a covered entity, may use and disclose protected health information. The notice must state the provider’s duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe individuals’ rights, including the right to complain to the DHHS and to the covered entity if they believe their privacy rights have been violated. The notice must include a point of contact for further information and for making complaints to the provider.

Some examples of confidential information include:
• Medical records;
• Communication between a member and a provider regarding the member's medical care and treatment;
• All personal and/or protected health information (PHI) as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
• Any communication with other clinical persons involved in the member's health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc);
• Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
• Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law.

Disclosure of Information
Periodically, members may inquire as to the operational and financial nature of their health plan. Harmony will provide that information to the member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, members may contact Harmony's Customer Service using the toll-free telephone number found on the member's ID card. Providers may contact Harmony's Provider Services by referring to the Quick Reference Guide on Harmony's website at https://www.harmonyhpi.com/provider/resources.
Section 9: Delegated Entities

Overview
Harmony’s compliance responsibilities extend to entities that, by written contract, perform functions or services on behalf of Harmony (commonly called a delegated entity). While certain activities may be delegated, Harmony is ultimately responsible and accountable to federal and state agencies for all services performed by its delegated entities. It is the responsibility of Harmony to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards, and Harmony policies and procedures.

Compliance
Harmony’s compliance responsibilities extend to delegated entities, including, without limitation:
- The Compliance Plan;
- HIPAA Privacy and Security;
- Fraud, Waste and Abuse Training;
- The Cultural Competency Plan; and
- Disaster Recovery and Business Continuity.

Refer to Section 8: Compliance for additional information on compliance requirements.

Harmony ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:
- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that Harmony has written agreements with each delegated entity that specify the responsibilities of the delegated entity and Harmony, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate Harmony associates have properly evaluated the entity’s ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity’s performance at least annually, including monitoring to ensure that quality of care and quality of service is not compromised by financial incentives;
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity’s performance is inadequate;
- Assure the delegated entity is in compliance with the requirement in 42 CFR 438;
- Assure that the contract with the delegated entity:
  - Identifies the population covered by the delegated entity;
  - Specifies the amount, duration and scope of services to be provided by the delegated entity;
  - Specifies the term and the procedures and criteria for termination;
  - Specifies that delegated entities use only participating Medicaid providers in accordance with the Illinois Contract;
  - Makes full disclosure of the method and amount of compensation or other consideration to be paid by Harmony;
  - Provides for monitoring by Harmony of the quality of services rendered to members, in accordance with the Illinois Contract;
o Provides for a State evaluation, through inspection or other means, of the quality, appropriateness and timeliness of services performed;

o Provides for inspections of any records pertinent to the Illinois Contract;

o Requires that records be maintained for a minimum of ten (10) years after completion of the Illinois Contract and after final payment is made under the Illinois Contract. If an audit, litigation or other action involving the records is started before the end of the ten (10) year period, the records must be retained until all issues arising out of the action are resolved;

o Contains no provision that provides incentives, monetary or otherwise, for the withholding from members medically necessary Covered Services, if the delegated entity agrees to provide Covered Services;

o Contains a prohibition on assignment, or on any further sub-delegation, without the prior written consent of Harmony;

o Specifies that the delegated entity agrees to submit encounter records in the format specified so that Harmony can meet specifications required by the Illinois Contract;

o Incorporates all the provisions of the Illinois Contract to the fullest extent applicable to the service or activity delegated pursuant to the delegated entity, including without limitation, the obligation to comply with all applicable federal and State law and regulations;

o Provides for Harmony to monitor the delegated entity’s performance on an ongoing basis, including specifying the frequency and method of reporting to Harmony, the process by which Harmony evaluates the delegated entity’s performance, and subjecting the delegated entity to formal review according to a periodic schedule consistent with industry standards, but no less than annually;

o Specifies that a delegated entity with NCQA®, URAC or other national accreditation shall provide Harmony with a copy of its current certificate of accreditation together with a copy of the survey report;

o Provides a process for the delegated entity to identify deficiencies or areas of improvement and any necessary corrective action;

o Specifies the remedies available to Harmony if the delegated entity does not fulfill its obligations, up to and including revocation of the delegated entity’s contract; and

o Contains provisions that require suspected fraud and abuse to be reported to Harmony.
Section 10: Behavioral Health

Overview
Harmony’s Medicaid plans include a behavioral health benefit. All provisions contained within the Provider Manual are applicable to medical and behavioral health providers unless otherwise noted in this section.

Harmony has designated Magellan Behavioral Health (Magellan) to manage Harmony’s behavioral health program. For complete information regarding benefits and exclusions, providers can contact Magellan by referencing the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources. You may also access Magellan’s medical necessity criteria and Clinical Practice Guidelines on Magellan’s provider website at www.MagellanHealth.com/provider or by calling 1-888-684-2026.

Members may refer themselves for behavioral health services and do not require a referral from their PCP. Some behavioral health services may require prior authorization, including those services provided by non-participating providers.

For complete information regarding benefits, exclusions and authorization requirements, or in the event you need to contact Harmony’s Customer Service for a referral to a behavioral health provider, refer to the Quick Reference Guide on Harmony’s website at https://www.harmonyhpi.com/provider/resources.

Continuity and Coordination of Care Between Medical and Behavioral Health Providers
PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if and when they are licensed to do so within the scope of their practice. Behavioral providers are required to use the DSM-IV multi-axial classification when assessing the member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the member’s medical record.

We strongly encourage open communication between PCPs and behavioral health providers. If a member’s medical or behavioral condition changes, Harmony expects that both PCPs and behavioral health providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between providers.

To maintain continuity of care, patient safety and member well-being, communication between behavioral health care providers and medical care providers is critical, especially for members with co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and positively impact member outcomes.

Responsibilities of Behavioral Health Providers
Harmony monitors providers against the standards stated below to ensure members can obtain needed health services within the acceptable appointment waiting times. The provisions below are applicable only to behavioral health providers and do not replace the provisions set forth in Section 2: Provider and Member Administrative Guidelines for
medical providers. Providers not in compliance with these standards will be required to implement corrective actions established by Harmony.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Provider – Emergent</td>
<td>Available 24 hours per day with a wait time not to exceed 1 hour</td>
</tr>
<tr>
<td>Behavioral Health Provider – Urgent</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>Behavioral Health Provider – Post-inpatient discharge</td>
<td>&lt; 7 days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Routine</td>
<td>&lt; 10 days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Non-life threatening emergency</td>
<td>&lt; 6 hours</td>
</tr>
</tbody>
</table>

All members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, prior to discharge, which includes the specific time, date, place, and name of the provider to be seen. The outpatient treatment must begin within seven (7) days of the date of discharge.

In the event that a member misses an appointment, the behavioral health provider must contact the member within twenty-four (24) hours to reschedule. In addition, behavioral health providers are to contact Magellan immediately if a member misses an appointment following an inpatient discharge. Magellan will conduct appropriate follow up with the member.

Behavioral health providers are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member’s condition requires. Members also have access to a toll-free behavioral crisis hotline that is staffed twenty-four (24) hours per day. The behavioral crisis phone number is printed on the member’s card and is available on our website.

For information about Harmony’s Case Management and Disease Management programs, including how to refer a member for these services, please see Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM).
Section 11: Pharmacy

Pharmacy Benefit
Retail, outpatient pharmacy services are a non-covered Plan benefit, but are covered by the state Medicaid fee-for-service program. Harmony provides pharmacy services for injectable drugs administered in a provider’s office and infusion products.

Injectable and Infusion Services
All injectable and infusion drug requests require submission of an Injectable/Infusion Drug Evaluation Review Request Form and are supplied by a specialty vendor. The form is available on Harmony’s website at https://www.harmonyhpi.com/provider/pharmacyservices.

Family planning services related to the injection of a contraceptive drug are covered.

Vaccines are covered by the Vaccines for Children (VFC) program. Harmony covers vaccines for members age twenty-one (21) and older.

Gardasil is covered by the VFC program through age twenty (20). Harmony will cover Gardasil for ages twenty-one (21) through twenty-six (26).

Synagis is covered by the State fee-for-service program.
Section 12: Definitions and Abbreviations

Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the participation agreement you have with Harmony.

“Action” means (i) denial or limitation of authorization of a requested service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) denial of payment for a service; (iv) failure to provide services in a timely manner; (v) failure to respond to an appeal in a timely manner; and (vi) if Harmony is the only MCO that is serving a rural area, the denial of a member’s request to obtain services outside of the contracting area.

“Advance Directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

“Advanced Practice Nurses (APN)” means a provider of medical and preventive services, who is licensed as an APN, holds a valid license in Illinois, and is legally authorized under state or rule to provide services. The APN must be enrolled with the Department and contracted with the MCO and includes Certified Nurse Midwives, Certified Family Nurse Practitioner and Certified Pediatric Nurse Practitioners.

“Appeal” means a request for review of a decision made by Harmony with respect to an Action.

“Authorization” means an approval request for payment of services. An authorization is provided only after Harmony agrees the treatment is medically necessary.

“Benefit Plan” means a schedule of health care services to be delivered or other health covered service contract or coverage document (a) issued by Harmony or (b) administered by Harmony pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

“Business Days” means traditional workdays, which are Monday through Friday. Federal and/or state holidays may be excluded.
“Capitation” means the reimbursement arrangement in which a fixed rate of payment per member per month is made to the Contractor for the performance of all of the Contractor’s duties and obligations pursuant to this Contract, except those services reimbursed through the Hospital Delivery Case Rate.

“Centers for Medicare and Medicaid Services (CMS)” means the agency within the United States Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the State Children’s Health Insurance Program under Title XXI of the Social Security Acts.

“Children with Special Health Care Needs (CSHCN)” means children who have serious medical or chronic conditions, or who are identified with special health care needs.

“Clean Claim” means a claim for Covered Services provided to a member that:

- is received timely by Harmony;
- has no defect, impropriety, or lack of substantiating documentation from the member’s medical record regarding the Covered Services;
- is not subject to coordination of benefits or subrogation issues;
- is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent (or their successors) that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional Harmony-specific requirements in the WellCare Companion Guide, including all then current guidelines regarding coding and inclusive code sets; and
- includes all relevant information necessary for Harmony to:
  - meet requirements of Laws and Program Requirements for reporting of Covered Services provided to members; and
  - determine payor liability, and ensure timely processing and payment by Harmony.

A Clean Claim does not include a claim from a Contracted Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

“CLIA” means the federal legislation commonly known as the Clinical Laboratories Improvement Amendments of 1988 as found at Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.

“Covered Services” means Medically Necessary items and services covered under a Benefit Plan.

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a
patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

“Emergency Services and Care” means those inpatient and outpatient health care services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, which are furnished by a provider qualified to furnish emergency services.

“Encounter” means an individual service or procedure provided to a member that would result in a claim if the service or procedure were to be reimbursed fee-for-service under the HFS Medical Program.

“Encounter Data” means encounter information, data and reports regarding Covered Services provided to a member that meets the requirements for Clean Claims.

“Enrollee” means any Potential Enrollee whose coverage under the Plan has begun and remains in effect.

“EPSDT” means the Early and Periodic, Screening, Diagnostic and Treatment services provided to children under Title XIX of the Social Security Act (42 U.S.C. § 1396, et seq.). The preventive component of this program is referred to as the "Healthy Kids" program.

“Fraud” means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

“Grievance” means an expression of dissatisfaction, including complaints, about any matter other than a matter that is properly the subject of an appeal.

“Ineligible Person” means a person which: (i) under either Section 1128 or Section 1128A of the Social Security Act, is or has been terminated, barred, suspended or otherwise excluded from participation in or has voluntarily withdrawn from participating in, as the result of a settlement agreement, any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act; (ii) has not been reinstated in the Medical Assistance Program or Federal health care programs after a period of exclusion, suspension, debarment, or ineligibility; or (iii) has been convicted of a criminal offense related to the provision of health care items or services in the last ten (10) years.
“Members/Individuals with Special Health Care Needs” means adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

“Medically Necessary” means that a service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with Harmony's guidelines, policies and/or procedures.

“Member” means an individual enrolled in a Benefit Plan issued by Harmony pursuant to an Illinois Contract.

“Member Expenses” means copayments, coinsurance, deductibles or other cost share amounts, if any, that a member is required to pay for Covered Services under a Benefit Plan.

“National Provider Identification Number (NPI)” means the national standard identifier for health care providers for use in the health care industry.

“Periodicity” means the frequency with which an individual may be screened or re-screened.

“Periodicity Schedule” means the schedule which defines age-appropriate services and timeframes for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program.

“Physician” means a person licensed to practice medicine in all its branches under the Medical Practice Act of 1987.

“Post-Stabilization Services” means medically necessary non-emergency services furnished to a member after the member is stabilized, in order to maintain such stabilization, following an emergency medical condition.

“Primary Care Provider” means a provider who is enrolled with the Department and contracted with Harmony, who within his or her scope of practice, and in accordance with State certification/license requirements, is responsible for providing all preventive and primary health care services to his or her assigned members under Harmony's plan.
“Prior Authorization” means the act of authorizing specific services before they are rendered.

“Provider” means a person who is approved by the Department to furnish medical, educational or rehabilitative services to members under the HFS Medical Program. Harmony is not a Provider.

“Referral” means a request by a PCP for a member to be evaluated and/or treated by a specialty physician.

“Routine Care” means the level of care that can be delayed without anticipated deterioration in the member’s condition.

“Service” means health care, treatment, a procedure, supply, item or equipment.

“Site” means any contracted provider (IPA, PHO, FQHC, individual physician, physician groups, etc.) through which Harmony arranges the provision of primary care to members.

“Stabilization or Stabilized” means, with respect to an emergency medical condition, and as determined by an attending emergency room physician or other treating provider within reasonable medical probability, that no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

“State” means the State of Illinois.

“Urgent Care” means services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict a member’s activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

“WellCare Companion Guide” means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to WellCare or its Affiliates, as amended from time to time. The WellCare Claims/Encounter Companion Guides are part of the Provider Manual.

“Women’s Health Care Provider” means a physician, specializing by certification or training in obstetrics, gynecology or family practice.
Abbreviations

AAP – American Academy of Pediatrics
ACIP - Advisory Committee on Immunization Practices
ACS – American College of Surgeons
AHP – Allied Health Professionals
AIDS - Acquired Immune Deficiency Syndrome
AMA – American Medical Association
AOR – Appointment of Representative
APN(s) – Advanced Practice Nurse(s)
ASAM - American Society for Addiction Medicine
CAD – coronary artery disease
CHF – congestive heart failure
CIA – Corporate Integrity Agreement
CLAS – Culturally and Linguistically Appropriate Services
CLIA - Clinical Laboratory Improvement Amendment
CM – case management
CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwife
COPD – chronic obstructive pulmonary disease
CPR – cardiopulmonary resuscitation
CRNA - Certified Registered Nurse Anesthetists
DDE – Direct Data Entry
DEA – Drug Enforcement Administration
DHHS – United States Department of Health and Human Services
DM – disease management
DME – Durable medical equipment
DOC – Delegation Oversight Committee
EDI – Electronic Data Interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
EPSDT – Early and Periodic Screening, Diagnosis, and Treatment
ER – emergency room
FDA – Food and Drug Administration
FQHC - Federally Qualified Health Center
FTE – full time equivalent
FWA – fraud, waste, and abuse
HCPCS - Healthcare Common Procedure Coding System
HEDIS® - Healthcare Effectiveness Data and Information Set
HFS – Illinois Department of Healthcare and Family Services
HIPAA - Health Insurance Portability and Accountability Act of 1996
HIV - Human Immunodeficiency Virus
HMO – health maintenance organization
HRA – health risk assessment
ICD-9-CM - International Classification of Diseases, Ninth Revision, Clinical Modification
IPA – independent physician association
ISHCN – Individuals with Special Health Care Needs
IVR - Interactive Voice Response
LTAC – long- term acute care
MCO – managed care organization
NCCI - National Correct Coding Initiative
NCQA® - National Committee for Quality Assurance
NDC – National Drug Codes
NIP – Network Improvement Program
NPI – National Provider Identifier
NPP – Notice of Privacy Practices
OA – Osteopathic Assistant
OB – obstetrical / obstetrician
OB/GYN – obstetrician / gynecologist
OIG – Office of Inspector General
OT – occupational therapy
PA – Physician Assistant
PCP – primary care provider / primary care physician
PHI – Protected Health Information (first reference is in compliance)
PPC – Provider-Preventable Conditions
Provider ID – provider identification number
PT – physical therapy
QI Program – Quality Improvement Program
QOC – quality of care
RN – registered nurse
SFTP - Secure File Transfer Protocol
SNF – skilled nursing facility
SNIP – Strategic National Implementation Process
SSN – Social Security Number
ST – speech therapy
TB – tuberculosis
TIN / Tax ID - Tax Identification Number
TOC – transition of care
UM – Utilization Management
VFC – Vaccines for Children
WEDI - Workgroup for Electronic Data Interchange
WIC – Women Infants and Children program