
Overview	The UM Program defines and describes Harmony's multidisciplinary, comprehensive approach and process to manage resource allocation.
Prior Authorization	<p>Harmony provides a consistent process to make a determination of medical necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior Authorization requirements are applicable for pre-service decisions.</p> <p>The appropriate fax and phone numbers for submitting requests are available in the state-specific Quick Reference Guides, Provider Manual, Harmony Web site www.Harmonyhpm.com, and Outpatient, Inpatient, and Ancillary Authorization Request Forms.</p> <p>The provider will submit requests for authorization using any of the methods below:</p> <ol style="list-style-type: none">1. The provider submits a properly completed Inpatient, Outpatient, or Ancillary Services Authorization Request Form and submits via fax <u>OR</u>2. The provider requests selected services, including Urgent requests, via telephone. <p>It is necessary to include the following information in the request for services:</p> <ul style="list-style-type: none">• Member name and identification number• The requesting provider's demographics• Diagnosis Code(s) and Place of Service• Services being requested and CPT Code(s)• The recommended provider's demographics to provide the service• A history and any pertinent medical information related to the request, including current plan of treatment, progress notes as to the necessity, effectiveness, and goals
Retrospective Review	A retrospective review is any review for care or services that have already been provided. 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 Utilization Management determination. If Harmony is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to fourteen (14) calendar days of the post-service request.

**Standard,
Expedited
and
Extension of
a Service
Authorization
Decisions**

**Standard Service Authorization or
Organization Determination**

Harmony is committed to a two-business-day turn-around time on requests for prior authorization or pre-certification authorization decisions. If a decision can not be made due to insufficient information submitted, Harmony will request the additional information. Authorization request responses will be sent by fax to the provider's fax number(s) that are included on the Authorization Request form. By contract, Harmony cannot exceed 14 calendar days from receipt of a complete request to determine whether a member's request for non-urgent services is a medically appropriate and covered service.

Expedited Service Authorization

Approval or denial of non-emergency services when determined as such by the emergency room staff shall be provided by Harmony within 30 minutes of the request. Approval or denial shall be provided within 24 hours of request for services determined to be expedited by the treating provider. Requests for expedited decisions for prior authorization should be requested by telephone, not fax.

**Plan Criteria
for UM
Decisions**

Harmony ensures that Utilization Management (UM) decisions rendered are fair and consistent. It is essential that medical review criteria are objective and based on sound medical evidence and that appropriate health care professionals are

involved in the development, adoption and updating of the Utilization Medical review criteria. Appropriate health care professionals are providers with current knowledge relevant to the criteria scripts under review. Criteria are based on current clinical principles and processes. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay.

The medical review criteria:

- Are a resource used to apply consistency in the UM decisions.
- Used in the UM decision shall be provided, upon request, to the provider or member.

The medical review criteria stated below are updated and approved at least annually by the Medical Director, Medical Advisory Committee and Quality Improvement Committee. Appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts being reviewed have an opportunity to give advice or comment on development or adoption of Utilization Management criteria and on instructions for applying the criteria.

Harmony is responsible for:

- Ensuring consistent application of review criteria for authorization decisions and
- Consulting with the requesting provider when appropriate.

One or more of the following criteria are utilized when services are requested that require utilization review:

Criteria Updated

InterQual Criteria™	Annually
Hayes, Inc. Online™ (Medical Technology)	Ongoing
Federal Statutes, Laws and Regulation	Ongoing
Harmony's Coverage and Referral Guidelines	Annually

When applying criteria to members with more complicated conditions, Harmony will consider the following factors when applying criteria to a given individual (member):

- Age
- Co-morbidities
- Complications

- Progress of treatment
- Psychological situation
- Home environment, when applicable

Harmony will also consider characteristics of the local delivery system available for specific members, such as:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in Harmony's service area to support the member after hospital discharge.
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care when needed.
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

When Harmony's standard utilization management guidelines and criteria do not apply due to individual patient (member) factors and the available resources of the local delivery system, the Health Services staff determines the most appropriate alternative service for that member. The Medical Director may also utilize his/her clinical judgment in completing the service authorization request.

All new medical technology or questionable experimental procedures will require review by the Medical Director prior to approval to establish guidelines where applicable.

Providers may request a copy of the criteria used for a specific determination of medical necessity by contacting the Health Services' Utilization Management department.

Harmony's utilization management program includes components of prior authorization, prospective, concurrent and retrospective review activities, each designed to provide for evaluation of health care and services based on Harmony members' coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to providers of care.

Harmony does not reward its associates or any practitioners, physicians or other individuals or entities performing utilization management activities for issuing denials of coverage, services or care and financial incentives, if any, do not encourage or promote under-utilization.

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 attending or ordering physician on the fax back communication. The attending or ordering physician is provided 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 business days following the receipt of the review determination notification by the provider. The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process.

**Second
Medical
Opinion**

Harmony will provide the member the right to a second surgical/medical opinion in any instance when the member disagrees with his/her provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second surgical/medical opinion, if requested, is to be completed by a provider chosen by the member who may select:

- A provider that is participating with Harmony; or
- A non-participating provider located in the same geographical service area of Harmony, if a participating provider not available.

A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion. If Harmony's network is unable to provide necessary services to a particular member, Harmony must adequately and timely cover these services out-of network for the member, for as long as Harmony is unable to provide them. Harmony will be financially responsible for a second surgical/medical opinion.

Member must inform their Primary Care Physician (PCP) of their desire for a second surgical /medical opinion.

If a participating provider is selected, the PCP will issue a script or a referral to the member for the visit.

If a non-participating provider is required, the PCP will contact Harmony for authorization.

Any tests that are deemed necessary as a result of the second surgical/medical opinion will be conducted by participating providers.

The PCP will review the second surgical/medical opinion and develop a treatment plan for the member. If the PCP disagrees with the second surgical/medical opinion request for services, the PCP must still submit the request for services to Harmony for an organization determination on the recommendation.

The member may file an appeal if Harmony denies the second surgical/medical opinion provider's request for services. The member may file a grievance if the member wishes to follow the recommendation of the second opinion provider and the PCP does not forward the request for services to Harmony.

Third Medical Opinion

If the member desires a third medical opinion or if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical opinion, a third medical opinion will be allowed.

Additionally, Missouri revised statutes require a second surgical opinion on specific elective surgical procedures. These must be provided prior to the surgery.

Members with Special Health Care Needs

Members with special needs are defined as adults and children/adolescents who face physical, mental or environmental challenges daily that place their health at risk and whose ability to fully function in society is limited. Examples include members with mental retardation or related conditions; members with serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders; members with disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; and

children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

The following is a summary of responsibilities specific to physicians who render services to Plan members who have been identified with special health care needs:

- Assess the member and develop a plan of care for those members determined to need a course of treatment or regular care;
- Coordinate treatment plan with member, family and/or specialist caring for member;
- Plan of care should adhere to community standards and DSS quality assurance and utilization review standards;
- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the member's condition or needs;
- Coordinate with Harmony, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member;
 - a) Members may request a specialist as PCP through Customer Service or their case manager. If the medical director agrees the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to that specialist by the Customer Service department.
- Coordinate services with community-based services and Medicaid Fee-for-Service programs to prevent duplication of services and assure continuity of care between all providers; and

- Ensure the member's privacy is protected as appropriate during the coordination process.

Emergency Care

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Emergency Services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

It is Harmony's policy that emergency services are covered:

- Regardless of whether services are obtained within or outside the network of providers available;
- Regardless of whether there is prior authorization for the services. In addition:
 - No materials furnished to members (including wallet card instructions) may contain instructions to seek prior authorization for emergency services, and members must be informed of their right to call 911.
 - No materials furnished to providers, including contracts, may contain instructions to providers to seek prior authorization before the member has been stabilized.
- In accordance with a prudent layperson's definition of "emergency medical condition" regardless of the final medical diagnosis;

- Harmony is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, Harmony is not responsible for any costs, such as a biopsy associated with treatment of skin lesions performed by the attending physician who is treating a fracture; and
- Whenever a plan provider or other Company representative instructs a member to seek emergency services within or outside Harmony
- Involuntary detentions (96-hour detentions or court-ordered detentions) or commitments shall not require prior authorization

Transition of Care

For members who voluntarily enrolled, or who were automatically reenrolled after regaining Medicaid eligibility, Harmony will honor any written documentation of prior authorization of ongoing covered services for a period of 60 calendar days after the effective date of enrollment or until the

Plan's PCP assigned to that member reviews the member's treatment plan, whichever comes first.

For mandatory assigned Medicaid members, Harmony will honor any written documentation of prior authorization of ongoing covered services for a period of one month after the effective date of enrollment or until the PCP assigned to that member reviews the member's treatment plan, whichever comes first.

Written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to the enrollment with Harmony:

1. Prior existing orders;
2. Provider appointments, e.g., dental appointments, surgeries, etc.; and

Harmony will not delay service authorization if written documentation is not available in a timely manner. Harmony is

not required to approve claims for which it has not received written documentation.

Harmony will establish, maintain, and monitor a panel of primary care providers from which the member may select a personal primary care provider. Harmony requires members to obtain a referral before receiving specialist services and has a mechanism for assigning primary care providers to members who do not select a primary care provider.

Harmony will also:

- Provide or arrange for necessary specialist care and in particular, give women members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. Harmony will arrange for specialty care outside of the Harmony's provider network when network providers are unavailable or inadequate to meet a member's medical needs.
- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Harmony utilizes the provision of translator services and interpreter services.
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management that allow for individual medical necessity determinations.
- Provide coverage for ambulance services, emergency and urgently needed services and post-stabilization care services.
- Have in effect procedures that:
 - Establish and implement a treatment plan that is appropriate.
 - Includes an adequate number of direct access visits to specialists.
 - Is time specific and updated periodically.
 - Ensures coordination among providers.

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- Considers the beneficiary's input.

**Special
Authorization
Requirements**

The following authorization requests have special requirements required by the State of Missouri.

Sterilizations

- The individual is at least 21 years old at the time consent is obtained;
- The member is mentally competent;
- The individual voluntarily gave informed consent in accordance with the provisions of this section, and a properly executed Sterilization Consent form is submitted to DSS. A copy of the Sterilization Consent form may be found in the **Forms** section of this manual.
- At least 30 calendar days, but not more than 180 calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.

An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form);

- Interpreters are provided when language barriers exist; and arrangements are made through our Customer Service department to effectively communicate the required information to an individual who is visually impaired, hearing impaired or otherwise handicapped; and
- The individual was not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

Hysterectomies

- The properly executed Hysterectomy Acknowledgement form is attached to the claim form submitted to Harmony. A copy of the Hysterectomy Acknowledgement form along with instructions on how to complete it can be found in the **Forms** section of this manual.
- The individual is informed, verbally and in writing, prior to the hysterectomy that she will 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 physician must sign and date the Exceptions to Hysterectomy Acknowledgement form except in the case of prior sterility or emergency hysterectomy. This informed consent must be obtained regardless of diagnosis or the member's/individual's age.

Regardless of whether the requirements listed above are met, a hysterectomy is not covered under the following circumstances:

- Performed solely for the purpose of rendering a member permanently incapable of reproducing;
- Performed for more than one purpose, but the primary purpose was to render the member permanently incapable of reproducing; or
- Performed for the purpose of cancer prophylaxis.

Abortions

Abortions are covered services if the provider certifies that the abortion is medically necessary to save the life of the mother or if pregnancy is the result of rape or incest. Harmony will cover treatment of medical complications occurring as a result of an elective abortion and treatments for

spontaneous, incomplete or threatened abortions and for ectopic pregnancies.

Abortions are not covered if used for family planning purposes.

An Abortion Certification form certifying the above situation must be properly executed and attached to the claim form when submitted to Harmony. A copy of the Abortion Certification form may be found in the **Forms** section of this manual.

The Sterilization Consent form, the Hysterectomy Acknowledgement form, the Exceptions to Hysterectomy Acknowledgement form and Abortion Certification form are the only forms accepted by Harmony in the reimbursement of these procedures and they can be found in the **Forms** section of this manual.

Claims for reimbursement of sterilizations, hysterectomies or abortions performed without the documentation required by federal regulation or with incomplete/inaccurate information will be denied.

After-Hours Utilization Management

Harmony shall provide sufficient medical and support staff resources, including a Medical Director, to process requests and provide information for the routine or urgent authorization/pre-certification of services, utilization management functions, provider questions, comments or inquiries, twenty-four (24) hours per day, seven (7) days per week.

Providers have the option of contacting the Health Services Department by phone twenty-four (24) hours a day, seven (7) days a week including holidays. For after hours, for any issues or requests requiring immediate clinical review or information, there is an on-call Nurse Manager and Medical Director available twenty-four (24) hours a day, seven (7) days a week. Physicians requesting after-hours authorization for inpatient admission should refer to their **Quick Reference Guide**.

**Delegated
Entities**

Harmony delegates some utilization management activities to external entities and provides oversight and accountability of those entities with DSS approval.

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 audits of the delegated entity are performed to ensure compliance with Harmony's delegation requirements.