Carelon Behavioral Health Out-of-Network Provider Guide and FAQ

Carelon Behavioral Health (Carelon) values provider partnerships and recognizes that it is only through exceptional professionals like yourself that we can make high quality mental health care more accessible to a greater number of people. We thank you for your service and commitment in providing the best quality care to our member(s) for the recently authorized out-of-network service(s).

We want to support you as you support our members on their path to better health. Please see our **Out-of-Network Provider FAQ** on page 2, created to assist you and your office in providing care to Carelon members.

Carelon adheres to the following guidelines for non-participating providers:

- Carelon verifies the out-of-network provider is eligible and complies with the sanction/exclusion/preclusion/opt-out/State License/Accreditation prior to authorizing services to treat a Carelon member. Failure to provide all the information may result in denial of the Provider's OON authorization.
- Pursuant to Federal Regulations, Carelon will not reimburse providers who are not eligible or do not meet the licensure requirements applicable to the authorized Medicaid and/or Medicare service.
- Carelon does not require providers to sign a Single Case Agreement (SCA) in order to reimburse an eligible provider for authorized Medicaid and/or Medicare covered services at 100% of Medicaid and 100% of Medicare allowable rate.
- Provider(s) shall not seek or accept any payment from the member for authorized services except for the in-network cost-sharing amount – if any.

Who we are

Carelon Behavioral Health is a specialty behavioral health organization serving more than forty-seven million individuals across the U.S. Using our deep clinical expertise, we support employers, health plans, and government clients as they work to address the needs of specialized groups. As a national leader in the fields of mental and emotional well-being, recovery and resilience, employee assistance, and wellness, Carelon supports individuals, families, and communities on their journey to living the lives they deserve.

Join a best-in-class network of providers

We invite you to join our network of 115,000+ providers. To start your application please visit the Join our Network page of the Carelon Behavioral Health website at www.carelonbehavioralhealth.com/providers/join-our-network.

For questions or to learn more, call our National Provider Services Line at 1-800-397-1630, from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday.

Thank you for your consideration, we look forward to hearing from you soon.

The Carelon Out of Network Team

Enclosure: Out-of-Network Provider FAQ

OON (Out-of-Network) Provider Frequently Asked Questions (FAQ)

Carelon Behavioral Health (Carelon) would like to thank you for your service and commitment to provide the best quality care to our member(s) for the authorized out-of-network service(s).

Before you provide services to our member(s), it is important that you read and understand the applicable Out-of-Network Provider Services Terms and Conditions included herewith.

Below, you can find answers to our most frequent questions regarding the OON process; and how to join us in our mission to help people live their lives to the fullest.

Q1: Does Carelon require an authorization for all OON services?

A1: No, Medicare Plan Directed Services, Outpatient Emergency Services and PPO Accounts with OON benefits, do not require an authorization.

Q2: How can I request an authorization for an Out-Of-Network Service?

A2: The provider or member may request authorization for an OON service by calling the phone number listed on the member's identification Card or listed in the member's benefits. The Clinical Care Manager will review the request and if the request meets criteria and an in-network provider is not available, the Care Manager will approve the OON authorization based on the member's benefit plan.

Q3: What is the Authorization Pre-Screening Process?

A3: Carelon's policy is to verify the out-of-network provider is eligible and complies with the sanction/exclusion/preclusion/opt-out/State License/Accreditation prior to authorizing services to treat a Carelon Member. Failure to provide all the information may result in denial of the Provider's OON authorization. The pre-screening process may occur by calling the phone number listed on the member's identification card or listed in the member's benefits. We can use "medical necessity" generally to include if an OON provider is the only provider suitable to handle the member care. If there is an in-network provider available that is able to treat the condition the member is presenting with then it would not be considered as meeting medical necessity for OON services

Q4: What happens after the OON service has been authorized? My services required an authorization, but do I also need to sign a Single Case Agreement?

A4: No, not all services requiring an authorization require that you sign a single case agreement. For Medicaid and Medicare authorized OON services that are authorized, we will send you a letter setting forth our terms and conditions. Your provision of services to the member for whom services have been authorized constitutes your acceptance of such terms and conditions.

If a Single Case Agreement is required, Carelon will send the approved SCA to the OON provider for signature. Our team will make two outreaches over a 10-calendar day period to secure the signed agreement.

If a counter signed SCA is not required, Carelon will follow the 306 OON (Out-of-Network) Reimbursement and SCA Policy which can accessed by visiting our website at www.carelonbehavioralhealth.com/providers/join-our-network. We also share information on the OON Reimbursement policy below (*see **Q6***).

Q5: What does Carelon Behavioral Health define as a Single Case Agreement?

A5: Please refer to our 306 OON Reimbursement and SCA Policy which can be accessed by visiting our website at www.carelonbehavioralhealth.com/providers/join-our-network.

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Q6: What is Carelon's OON reimbursement policy for authorized services?
A6: Carelon will allow reimbursement as follows:

- **Medicaid** – 100% of the Medicaid allowable and in-network rate benefit level based on Member's Home State. Pursuant to Federal Regulations, except in limited circumstances as may be outlined pursuant to applicable law, Carelon Behavioral Health will not reimburse providers who are not currently enrolled by Medicaid or not eligible per the sanction/exclusion screening. Carelon Behavioral Health's OON Provider Services Terms and Conditions will apply, and Carelon Behavioral Health will not require a counter signed SCA to reimburse eligible providers for Medicaid covered services.

- **Medicare** - 100% of the Medicare allowable and in-network benefit level based on POS (Place of Service). Carelon Behavioral Health will not reimburse providers that have opted out of Medicare, are sanctioned, or are on the Preclusion list. Carelon Behavioral Health's OON Provider Services Terms and Conditions will apply, and Carelon Behavioral Health will not require a counter signed SCA to reimburse eligible providers for Medicare covered services.

- **Commercial** – 100% of the Carelon Behavioral Health Fee Schedules parity compliant reimbursement levels for covered Services based on POS (Place of Service). Carelon Behavioral Health will reimburse eligible providers for urgent services that meet the criteria for coverage. Carelon Behavioral Health will not reimburse providers that are not eligible per the sanction/exclusion screening. Carelon Behavioral Health's OON Provider Services Terms and Conditions will apply, and an SCA must be signed prior to providing services to a member within 10 days of receipt.

Q7: As an OON Provider, can I request a date extension to the service authorized?
A7: The provider may request a date extension for an OON service by calling to the phone number listed on the member's identification Card; or, listed in the member's benefits; or, by reaching out to the assigned Clinical Team member to request the extension. Once the extension has been clinically reviewed and approved by the clinical team, the existing authorization is updated to reflect the new date, no additional documentation is required, and existing reimbursement rates will apply to the new date.

Q8: In circumstances where a Single Case Agreement is required, how can I return the signed Single Case Agreement?
A8: If required, the provider will electronically sign the Single Case Agreement (SCA) sent to the e-mail address supplied on the authorization.

Q9: How can I obtain a copy of my countersigned Single Case Agreement?
A9: Please contact the phone number listed on the member's identification card or listed in the member's benefits to ensure you reach the appropriate team to handle your request.

Q10: Will my services be covered/reimbursed?
A10: Your services will be covered if the following criteria is met:

- The information we received when the out-of-network request was submitted and reviewed is complete and accurate
- We determine that the request meets the criteria for OON services and the services are authorized
- The member is eligible and enrolled in the health plan when the service is rendered
- The member did not reach a benefit limit that applies to the service at the time claim is processed
- The Out-of-Network Provider should check Member's eligibility prior to every visit. For the most up to date information, the provider can contact the phone number listed on the member's identification Card or listed in the member's benefits.

- Provider is responsible for collecting all applicable patient co-payments and co-insurance as set forth in the member's benefit package.

Q11: Do I need an SCA if Carelon is a Secondary Payer?
A11: Unless otherwise specified with respect to a particular Plan, Single Case Agreements and authorizations are done at the primary payer level only. Carelon waives authorization requirements when it is a secondary payer; no Single Case Agreement is needed. Providers may access the handbook for more information at:
www.carelonbehavioralhealth.com/providers/resources/provider-handbook

Q12: What is the Timely Filing Requirement for Submitting Claims for OON Provider Services that are Authorized?
A12: The timeframe can differ between client/plan/state. Unless otherwise identified in the plan handbook, providers must file or submit claims within ninety (90) calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payer. Providers are encouraged to carefully review the handbook as well as their state-specific handbook to verify claim submission guidelines, policies and procedures, medical necessity criteria, waiver form and more at
www.carelonbehavioralhealth.com/providers/forms-and-guides

Q13: As an OON provider, what is required on the claim I submit in order for Carelon to reimburse me for authorized services?
A13: The provider should submit a valid claim form that matches the authorized OON service to be reimbursed.

Q14: Where do I file a claim?
A14: Providers have two options to submit their claim for payment.
- Availity (our preferred method) availity.com
- Paper: Please reference the member's identification card, as the address may vary based on payment location

Q15: How do I register with Availity?
A15: To register with Availity:
1. Go to the Availity Portal at availity.com to complete the steps for your registration. Once you are registered, you will receive an email from Availity.
2. In the Notification Center section, you will see the following message:
   - Select **Start your Onboarding Journey: Learn about Availity's Tools and Features** to take an introductory class and learn about the functions and applications in Availity Portal.
3. To access the Availity Learning Center – Select Help and Training > Get Trained
4. To access online help, select Help & Training > Find Help
5. For further assistance, select Availity support in the Help and Training Menu to open a support ticket or browse articles in the support community

For EDI claims use Carelon's payer ID: BHOVO for submission through Availity.

Q16: Whom should I contact if I have a question about Availity?
A16: Contact Availity Client Services at 1-800-282-4548, 8 a.m. to 8 p.m. Eastern Time, Monday through Friday for additional support.

Q17: Does Availity offer any claims training for new users?
A17: Yes, Availity provides many tools and training resources for new users on topics such as eligibility, claims and compliance. You may access training sources at www.availity.com/training-and-education or by logging into the Availity portal at www.availity.com/Training-and-Education. After logging into the Availity portal, select Help & Training > Get Trained

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Q18: Who can I contact for any Claims related questions?
A18: For any claims related questions please contact the phone number listed on the member's identification Card or listed in the member's benefits to ensure you reach the appropriate team to handle your claim concern.

Q19: How can I dispute or appeal an OON claim payment?
A19: The non-participating provider has the right to dispute or request a reconsideration of the claim payment decision by submitting a written complaint to Carelon Behavioral Health, Appeals Department. The dispute or requests for reconsideration must be received within sixty (60) calendar days from the date of the claim remittance statement. All disputes or requests for reconsiderations should be submitted to the address listed on the top of the page of the claim's remittance statement.

Q20: What resources are available to me?
A20 Carelon wants to ensure that all providers have resources available to them. Below is a quick reference guide to the most frequently utilized resources:

- **Clinical Practice Guidelines:**
  Current Clinical Practice Guidelines, resources, measurement and more
  www.carelonbehavioralhealth.com/providers/resources/clinical-practice-guidelines
- **Medical Necessity Criteria:**
  Carelon Behavioral Health Medical Necessity Criteria
  www.carelonbehavioralhealth.com/providers/resources/medical-necessity-criteria
- **Provider Handbook:**
  Information on standard policies, procedures and guidelines including Clinical Practice Guidelines and Medical Necessity Criteria
  www.carelonbehavioralhealth.com/providers/resources/provider-handbook
- **Provider Forms, Guides and Resources:**
  Billing and Claims, clinical, and EAP forms
  www.carelonbehavioralhealth.com/providers/forms-and-guides
- **Availity Essentials Provider Resources:**
  Portal for claims submissions, eligibility, and benefits, and claim status
  www.carelonbehavioralhealth.com/providers/resources/provider-portals/availity-essentials

Join our Network

We strive to provide our members access to the country's best and most accessible behavioral health providers. We would love to include you.

To start your application please visit us at:
www.carelonbehavioralhealth.com/providers/join-our-network

Whether you have a question or are interested in learning more, please call our National Provider Services Line at 1-800-397-1630, from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday.