Carelon Behavioral Health
Policy and Procedure

Title:		Policy and Procedure number:
SCA (Single Case Agreement) and OON (Out of Network) Reimbursement Policy		NM 301.12
Responsible department:	**Owner:**	**Approver:**
Network Management	Koryn Allan	Nicole Nole, RVP Provider Solutions
Original effective date:	**Date of policy retirement:**	**Last approval date:**
04/10/10	N/A	08/24/26
Applicability		
☒ Commercial (incl. exchange) ☒ Medicare ☒ Medicaid (incl. grants)	Policy applies to: This Carelon Behavioral Health Policy and Procedure covers the operations of all entities within the Carelon Behavioral Health corporate structure, including but not limited to Carelon Behavioral Health, Inc., Carelon Behavioral Health of California, Inc., Carelon Behavioral Health IPA Strategies, LLC, and Carelon Behavioral Care, Inc.	
Regulatory information		
Resources and references		
Federal or state regulations and/or accreditation requirements:	42 CFR 422.105 and 422.111 Deficit Reduction Act (DRA) of 2005, Section 6085 Emergency Medical Treatment and Labor Act (EMTALA) Section 1867 of the Social Security Act	

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I. Purpose

To ensure consistency, efficiency, and compliance in the processing of out-of-network (OON) claims for behavioral health services delegated to Carelon Behavioral Health, including standardized reimbursement practices and consistent administration of Single Case Agreements (SCAs). This policy also establishes the

process for managing SCAs for providers delivering authorized OON services to Carelon Behavioral Health members.

II. Exceptions

N/A

III. Background and scope

This policy outlines the workflow followed after out-of-network (OON) services have been clinically approved as medically necessary and appropriate under the member's benefit plan. It applies to cases in which a Single Case Agreement (SCA) is required to authorize reimbursement for OON services for a defined period of time.

Functional Area(s) Involved in Review:
Network Operations
Network Reimbursement
Network Strategy
Clinical Care Management
Legal
Compliance

Departments Affected:
Clinical Care Management Departments
Network Operations
Network Reimbursement
Network Strategy

Who is responsible for implementing the policy/procedure? SCA Team

Who monitors compliance with the policy/procedure?
SCA Team

IV. Acronyms and definitions

Single Case Agreement (SCA): An agreement between Carelon Behavioral Health and an out-of-network provider to provide a covered service (s) to a specific member(s)

Medical Professional: An MD or DO Board Certified in Emergency Medicine

Behavioral Health Professional: An appropriately trained and licensed or certified individual psychiatrist, psychologist, psychiatric social worker or other licensed mental health or substance use provider.

Behavioral Out of Network Authorization: Refers to a situation where a member needs prior approval from their health plan/Carelon Behavioral Health to receive behavioral health services from an Out of Network Provider.

Out of Network (OON) Provider: A provider which has not contracted with the health plan/Carelon Behavioral Health for the covered services.

Out of Network Benefits:

A. Preferred Provider Organizations (PPOs) must furnish all services in-network and out-of-network but may charge higher cost sharing for plan-covered services obtained out-of-network. A PPO must cover all plan benefits furnished to its

   enrollees anywhere in the United States.

B. Health Maintenance Organizations (HMOs) may offer a Point of Service (POS) option. For Medicare Advantage plans, this may be a mandatory or optional supplemental benefit pursuant to 42 CFR 422.105 and 422.111.

Plan Directed Care: Care the member believes they were instructed to obtain or were authorized to receive, and such instruction and/or authorization was provided by a health plan/Carelon Behavioral Health representative. A representative of Carelon Behavioral Health/the health plan includes contracted providers.

Urgent Services: The treatment of 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:

1. 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;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part

Unsecured SCA: Single Case Agreement not signed by the Provider.

Deficit Reduction Act (DRA) of 2005, Section 6085: Effective January 1, 2007, DRA states: any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a state where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

Emergency Medical Treatment and Labor Act (EMTALA): Enacted by Congress in 1986, the Emergency Medical Treatment & Labor Act (EMTALA) was to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare- participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request

is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Medicare Advantage Program: Medicare Advantage Organizations (MAO), or Carelon Behavioral Health as delegated, are financially responsible for emergency services and urgently needed services: Regardless of whether services are obtained within or outside the plan's authorized service area and/or network (if applicable); regardless of whether there is prior authorization for the services; if the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis; and whenever a plan provider-a provider with whom the MAO [or Carelon Behavioral Health] has a written contract to furnish plan covered services to its enrollees-or other plan representative instructs an enrollee to seek emergency services within or outside the plan. Regardless of the plan type being offered, Medicare Advantage organizations must arrange for medically necessary care outside of the network, but at in-network cost-sharing, in order to provide all Medicare Part A and Part B benefits. That is, if an enrollee requires a medically necessary covered service that is not provided by the providers in the network, the plan must arrange for that service to be provided by a qualified non-contracted provider.

V. Policy

Single Case Agreements (SCAs) are used for all Members regardless of whether they have out-of-network benefits or not, when Carelon Behavioral Health does not have an established network or cannot meet a member's clinical/services needs with existing contracted providers.

A. SCA(s) are not to be used when there are adequate Carelon Behavioral Health providers for geographic, cultural competency concerns, clinical special needs, including instances when members have out of network benefits.

B. SCA(s) are not to be used for Medicare, Medicaid Members. After clinical authorization Carelon will reimburse Provider for authorized Medicaid and/or Medicare covered services at 100% of applicable Medicaid and/or Medicare allowable rates, or at the reimbursement rate otherwise required by applicable law, regulation, state-approved payment methodology, or Carelon Behavioral Health Fee Schedules, as applicable. Provider shall accept such payment hereunder as payment in full for services rendered to the Member. Carelon will not require a Single Case Agreement (SCA) to reimburse the Provider.

C. SCA(s) are not to be used for Emergency Inpatient Admission. After clinical authorization (if applicable) Carelon will reimburse Provider for inpatient emergency admissions, with or without out-of-network benefits, at 100% of the Carelon Fee Schedule, consistent with the applicable plan benefit design. An out-of-network authorization may be required, and the member's in-network cost share will apply in accordance with regulatory requirements (e.g., the No Surprises Act).

D. SCA(s) are not to be used for Claims Exceptions, or if Carelon is the Secondary Payer, or COS (Continuation of Services) for members in active treatment that have been clinically approved after provider termination, or COC (Continuity of Care) due to the member being new to the Health Plan and/or where the Transition of Care to an in-network provider is available. These OON authorizations will be processed for the authorized length of time consistent with the plan benefit design without an SCA. SCAs should not be used when an in-network provider requests authorization to render covered services to a specific member for a defined period due to limitations related to their current contract, such as non-contracted services, service location, age range, eligible plan participation, provider credentialing status within the in-network group, or similar circumstances. In these situations, the request should be redirected to the Provider Relations Team, which will assist the in-network provider with any necessary updates to their provider file. Once the required updates are completed, the provider may treat Carelon members and claims can be processed and reimbursed at the in-network level without the need for an SCA.

For any incident or trending event that occurs after the Out of Network service has been authorized, reference QM 4 Member Safety Program Policy. This policy requires in-network providers, and those providers authorized to provide out-of-network services, to cooperate with quality improvement and/or monitoring activities.

Carelon Behavioral Health will allow reimbursement as follows:

Urgent without an Out of Network (OON) Benefit - Carelon Behavioral Health allows reimbursement for urgent services provided by OON Behavioral Health professionals and facilities unless state or federal regulations or client contracts and/or requirements indicate otherwise.

Non-Urgent without an OON Benefit - Carelon Behavioral Health allows reimbursement for non-urgent professional/outpatient services and inpatient facility services (upon stabilization of the member) in the event there is no access/availability of in network providers, if there was plan-directed care, or in the case of continuity of care, with prior clinical approval, for plans with no OON benefits.

Urgent/Non-Urgent with an OON Benefit - Carelon Behavioral Health also allows for reimbursement, according to the plan's benefit package/Evidence of Coverage, of OON behavioral health services without prior approval for plan designs with an OON benefit.

Outpatient Emergency Services with or without an OON Benefit – Carelon Behavioral Health will reimburse medical professionals and facilities for covered services administered in an emergency room (ER) setting following the Claims Emergency Service Policy 44. Out-of-Network Authorization and SCA are not required.

Inpatient Emergency Admission with or without an OON Benefit – Carelon will reimburse Provider for inpatient emergency admissions, with or without out-of-network benefits, at 100% of the Carelon Fee Schedule, consistent with the applicable plan benefit design. An out-of-network authorization may be required, and the member's in-network cost share will apply in accordance with regulatory requirements

(e.g., the No Surprises Act). Carelon will not require a Single Case Agreement (SCA) to reimburse the Provider.

Exclusion Screening - Carelon verifies the out-of-network (OON) provider is not excluded from participation in state and federal programs. Failure to provide all the information required to conduct exclusion screenings may result in denial of the provider's OON authorization and claims.

VI. Procedure

SCA End-To-End Process and OON Reimbursement Policy

A. SCA END-TO-END PROCESS

A. **Out-of-Network (OON) Provider or Member:**An out-of-network (OON) provider or member may request authorization for OON services by calling the phone number listed on the member's identification card or referenced in the member's benefit information.

2. Clinical Care Manager (CCM)/Network Support Team:

A. The CCM receives the out-of-network (OON) request and confirms that the member is actively enrolled, does not have adequate in-network access, and is requesting services from an OON provider for a medically necessary service.
B. The CCM/Network Support Team verifies that no appropriate in-network providers are available; the requested provider is not currently participating in the network; an in-network provider requires updates to their participation status; or A provider application is in process for the provider to become in-network.
C. The CCM/Network Support Team attempts to redirect the member to an in-network provider when a suitable and available provider can meet the member's needs.
D. The CCM reviews provider eligibility and verifies that the OON provider is not excluded from participation in any state or federal healthcare programs.
E. If the CCM confirms that the member's care cannot be redirected to an in-network provider, the OON request may be approved as medically necessary in accordance with the **OON authorization process outlined in Policy CUR 110**.
    1) **FlexCare Plans:** The CCM pends the authorization within FlexCare. The authorization remains pended until the Single Case Agreement (SCA) process is completed.
    2) **Connect Plans:** The CCM pends the authorization within ServiceConnect. A hold code is applied to the authorization to prevent claims payment until the Single Case Agreement (SCA) process is completed.
    3) **Authorization Extensions:** Providers may request an extension to an existing authorization. Once the extension request has been clinically reviewed and approved, the existing authorization is updated to reflect the new dates of service. No additional documentationis required, and the existing reimbursement rates will continue to apply to the extended authorization period.

The CCM creates a ServiceConnect inquiry and includes all required information, such as: Valid provider and member records; Reason Codes 1, 2, and 3; Parent Code; Authorization number; Intake/OON Request Form; and any other required supporting documentation. The inquiry is then pended to the National SCA Team queue (**VONOQSCA**) for processing

3. **SCA Team:**

A. The SCA Team reviews each inquiry to ensure all required information is complete and accurate. If information is missing or requires clarification, the inquiry is returned to the CCM requestor for correction. Inquiries are processed in the order received. The standard SCA Team turnaround time (TAT) is **2 business days for Regulatory SCAs** and **10 business days for Non-Regulatory SCAs**, unless the request has been identified as an escalation. Escalated requests are prioritized and processed in accordance with the applicable escalation turnaround time requirements.

1) The SCA Team drafts the Single Case Agreement (SCA) in Contraxx using the approved standard SCA template and the information provided by the CCM requestor within the inquiry and authorization. The SCA is then sent electronically to the provider and includes two automated follow-up notifications over a 10-calendar-day period.

B. If a signed SCA is **not received within 10 calendar days**:

1) The SCA Team loads the applicable out-of-network (OON) reimbursement rates using an Unsecured SCA when: The provider is unresponsive after all required outreach attempts have been completed; or, the provider declines the maximum allowable OON reimbursement rate offered.

C. If a signed SCA is **received within 10 calendar days**:

1. **Connect Plans:** The SCA Team loads the approved reimbursement rates in the ServiceConnect Review Tab for practitioners and facilities only. Rates are loaded only for the service codes and dates of service (DOS) authorized by the Clinical Team.

2. **FlexCare Plans:** The SCA Team submits the request to Provider Configuration through NetworkConnect for practitioners, groups, and facilities. When available, the provider grouper is used with no expiration date. If a grouper is not available rate loads are extended through the end of the calendar year. Once Provider Configuration completes the request and returns the event to the SCA Team, the SCA Team verifies that the rates were loaded correctly in FlexCare and closes the event.

D. The SCA Team uploads the fully executed (countersigned) SCA as an attachment in ServiceConnect and stores a copy in the NetworkConnect File Cabinet.

E. Upon completion of processing, the SCA Team returns the inquiry to the CCM requestor.

4. **Clinical Care Manager (CCM) Team:**

A. CCM updates the Member's authorization as needed (i.e., un-pends, removes hold code, or otherwise updates the authorization).

B. CCM completes any necessary Provider/ Member outreach.
C. CCM will close out the inquiry within 7 business days in ServiceConnect.

5. Claims Team:

A. Once Claims are received, the claims will be processed according to the rates and the authorization on file. The provider will receive the Remittance Advice.
B. Claims Processors review the queue and work inquiries daily to (re)process the claims.

B. OON REIMBURSEMENT POLICY

1. Urgent with no OON Benefit: Carelon Behavioral Health will reimburse OON Behavioral Health professionals and facilities for urgent services at 100% of the corresponding line of business allowable rate(s) and SCA requirement noted below:

A. **Medicaid -** 100% of the Medicaid allowable rate or at the reimbursement rate otherwise required by applicable law, regulation, state-approved payment methodology, or Carelon Behavioral Health Fee Schedules, as applicable. Medicaid reimbursement is based on the member's home state. Provider shall accept such payment hereunder as payment in full for services rendered to the Member. 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 exclusion screening. Carelon Behavioral Health's Out-of-Network (OON) Provider Services Terms and Conditions apply, and a countersigned Single Case Agreement (SCA) is not required for reimbursement of eligible Medicaid-covered services.

B. **Medicare -** 100% of the Medicare allowable rate or at the reimbursement rate otherwise required by applicable law, regulation, state-approved payment methodology, or Carelon Behavioral Health Fee Schedules, as applicable. Medicare reimbursement is based on the place of service (POS). Provider shall accept such payment hereunder as payment in full for services rendered to the Member. Carelon Behavioral Health will not reimburse providers who are not eligible per the exclusion screening. Carelon Behavioral Health's Out-of-Network (OON) Provider Services Terms and Conditions apply, and a countersigned Single Case Agreement (SCA) is not required for reimbursement of eligible Medicare-covered services.

C. **Commercial** - 100% of the Carelon Behavioral Health Fee Schedules consistent with Plan Benefit design, or at the reimbursement rate otherwise required by applicable law, regulation, or state-approved payment methodology, as applicable. Provider shall accept such payment hereunder as payment in full for services rendered to the Member. Carelon Behavioral Health will not reimburse providers that are not eligible per the exclusion screening. Carelon Behavioral Health's

Out-of-Network (OON) Provider Services Terms and Conditions apply. For commercial accounts without out-of-network benefits, Carelon Behavioral Health will request a countersigned Single Case Agreement (SCA) prior to reimbursing the provider.

2. **Non-Urgent Medicaid and Medicare Plans with no OON Benefit:** Carelon Behavioral Health will not require an SCA in order to reimburse providers for non-urgent covered services.

   A. **Medicaid -** 100% of the Medicaid allowable rate or at the reimbursement rate otherwise required by applicable law, regulation, state-approved payment methodology, or Carelon Behavioral Health Fee Schedules, as applicable. Medicaid reimbursement is based on the member's home state. Provider shall accept such payment hereunder as payment in full for services rendered to the Member. 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–exclusion screening. Carelon Behavioral Health's Out-of-Network (OON) Provider Services Terms and Conditions apply, and a countersigned Single Case Agreement (SCA) is not required for reimbursement of eligible Medicaid-covered services.

   B. **Medicare -**100% of the Medicare allowable rate or at the reimbursement rate otherwise required by applicable law, regulation, state-approved payment methodology, or Carelon Behavioral Health Fee Schedules, as applicable. Medicare reimbursement is based on the place of service (POS). Provider shall accept such payment hereunder as payment in full for services rendered to the Member. Carelon Behavioral Health will not reimburse providers who are not eligible per the exclusion screening. Carelon Behavioral Health's Out-of-Network (OON) Provider Services Terms and Conditions apply, and a countersigned Single Case Agreement (SCA) is not required for reimbursement of eligible Medicare-covered services.

3. **Non-Urgent Commercial Plans with No Out-of-Network (OON) Benefit:** Carelon Behavioral Health will reimburse eligible out-of-network providers for covered non-urgent services. Carelon Behavioral Health will reimburse OON eligible professionals and facilities for non-urgent services at 100% of the Carelon Behavioral Health Fee Schedules consistent with Plan Benefit design, or at the reimbursement rate otherwise required by applicable law, regulation, or state-approved payment methodology, as applicable. Provider shall accept such payment hereunder as payment in full for services rendered to the Member. Carelon Behavioral Health will not reimburse providers that are not eligible per the exclusion screening. Carelon Behavioral Health's Out-of-Network (OON) Provider Services Terms and Conditions apply. For commercial accounts without out-of-network benefits, Carelon Behavioral Health will request a countersigned Single Case Agreement (SCA) prior to reimbursing the provider.

4. **Urgent/Non-Urgent with OON Benefit:** Carelon Behavioral Health will reimburse eligible out-of-network providers, with or without prior authorization, in accordance with applicable plan requirements, benefit provisions, policies, procedures, and the reimbursement methodology established for the applicable line of business, consistent with the member's benefit plan design.

Carelon will not require a countersigned Single Case Agreement (SCA) to reimburse the Provider for Commercial Accounts with out-of-network benefits, as the reimbursement methodology and its calculation are already established within the plan benefit design. Provider shall accept such payment hereunder as payment in full for services rendered to the Member, except for Member "Cost Share" (herein defined as a Member deductible, copayment, or coinsurance) as applicable.

Out-of-Network (OON) Reimbursement Methodology, Rate Exceptions, and Provider Disputes

Carelon Behavioral Health establishes standard out-of-network (OON) reimbursement levels and rate guidelines by line of business, consistent with the member's benefit plan design and applicable state-specific payment methodologies. Notwithstanding any provision to the contrary, reimbursement for authorized services shall comply with all applicable federal and state laws, regulations, payment methodologies, and approved demonstration programs, including, but not limited to, All-Payer Model Agreements, Total Cost of Care Models, hospital rate-setting systems, Medicaid waivers, and other government-approved payment arrangements. Where required by applicable law or regulation, reimbursement shall be based on the methodology established by the applicable state, federal agency, regulatory authority, or approved payment model. The provider must accept such payment as payment in full for services rendered to the member, except for applicable member cost-sharing obligations, including deductibles, copayments, and coinsurance. Any reimbursement exception based on unique circumstances, such as cultural needs or other special considerations, must be supported by approval from the applicable Plan Account Executive, and the approval documentation must be attached to the inquiry. If a non-participating provider disagrees with a claim payment determination, they may submit a claim dispute, reconsideration request, or appeal in accordance with the applicable health plan's policies and procedures. Providers should follow the instructions, submission address, and filing deadlines listed on the claim remittance advice (RA) or Explanation of Payment (EOP), as outlined in the OON Provider Guide and FAQ.

Monitoring

Reports related to Single Case Agreements (SCAs) and out-of-network (OON) reimbursement are monitored and reviewed by each region to identify provider recruitment opportunities, evaluate network gaps, and support ongoing network development efforts.

SCA Inquiry Escalation Process

After clinical authorization has been approved, an SCA inquiry may be escalated by any Carelon team member based on the urgency of the request and the applicable priority level. Escalated requests are prioritized for review and processing, with turnaround times (TATs) ranging from 1 to 7 business days, depending on the escalation category and business need, as outlined below:

SCA INQUIRY ESCALATION PROCESS					
Action Reason Code	Action Reason Code Definition	Urgent Status	SCA Timeline (Business Days)	SCA ESCALATION REQUIREMENTS	
				Approval Document (Must be specific and attached to the SCA inquiry)	Narratives (SCA inquiries cannot be processed without clinical authorization)
SCA014	SCA State Complaint	1	1	• Director Level Approval	Used to log a complaint from a state regulatory body
SCA015	SCA Plan Complaint	2	2	• Director Level Approval	Used to log a complaint from a health plan
SCA025	SCA Escalation - Clinical Timeline Requirement	2	2	• Director Level Approval	Nature of the treatment where the Provider refuses to start the treatment without an SCA, and the member is at risk
SCA016	SCA Provider Complaint	3	5	• Director Level Approval	Used to log a Provider Complaint
SCA012	SCA Escalation	3	5	• Director Level Approval	Urgent Escalation requested by Carelon Team Members on behalf of the Provider/Member due to high risk or TAT Policy Requirement
SCA013	SCA Status Update	4	7	• Director Level Approval	Status Update for SCA inquiries not processed in the published SCA TAT

Clinical Criteria: Per Clinical Policy CUR 102 an out-of-network provider authorization request is reviewed by a Carelon Behavioral Health Clinical Care Manager using the following criteria (at least one needs to apply):

1. There are no network resources (i.e., facilities, practitioners and/or EAP affiliates) for required covered services within access standards of a member's residence.
2. Carelon Behavioral Health's network facilities are at capacity; Carelon Behavioral Health's network practitioners/EAP affiliates cannot accommodate new patients/clients.
3. Clinical/service needs (e.g., clinical specialty, language, cultural sensitivity, gender) cannot be met by available network resources.
4. Member preferences cannot be met by available network resources and are deemed relevant to treatment outcome.
5. The out-of-network authorization supports necessary continuity of care for a member with a history of treatment with an out-of-network provider per contractual obligations.
    a) Of note, if the member is new to the health plan, a single case agreement is not required and should be managed through standard continuity of care process.
6. Transportation available to a member or available support systems enables the member to only access an out-of-network resource.
7. The available network resources believe they cannot meet the member's service needs.
8. A network facility is not contracted for a specific required modality.
9. Emergency treatment/admission requires an out-of-network provider.
10. The facility/practitioner terminated network status during the member's course of treatment and either the disenrolled provider, if not disenrolled for a professional review action, or his/her patient in active treatment requested that the disenrolled provider continue treating the patient through the current period of active treatment or for up to 90 calendar days, whichever is shorter (see policy CUR 140 Continued Access when Network Providers Discontinue Participation in Carelon Behavioral Health's Network);
    a) Per Continuity of Services the provider is contractually required to treat the member for 90 days at the rates listed in their signed Carelon INN Agreement without an SCA.
11. New client transition as part of client implementation plan or new members joining health plans or employer groups with previous history with provider, transition benefits apply per contract may result in out of network authorization.
12. When the member is a full-time student and consequently outside of the geographic area of the network as allowed by benefit plan

13. Confidentiality issues are present whereby a member who is a provider or a member who is an employee (or an employee family member) of Carelon Behavioral Health or one of the plans Carelon Behavioral Health manages is in need of behavioral health treatment.
14. An administrative decision has been made by the client or Carelon Behavioral Health to approve an out-of-network provider.

In the absence of criteria specified in this document; Carelon Behavioral Health does not consider the following scenarios in and of themselves to constitute a valid reason for authorizing a request for out-of-network (OON) services:

1. A member has historically been paying "out of pocket" to see an OON provider and requests that Carelon Behavioral Health authorize care and pay for services related to the previously referenced OON provider.
2. A member has historically been seen by a specific provider who is part of an INN group or facility, and that specific provider leaves the INN group or facility and becomes OON. In turn, the member requests that Carelon Behavioral Health authorize care and pay for services related to the previously referenced provider who is now OON.

When there are adequate network providers to meet the member's needs and there are no compelling reasons for considering out of network authorization (see above V. Procedure A,114), Carelon Behavioral Health staff contacts the member, practitioner, or facility and informs them of the decision not to proceed with the out of network authorization.

Denial and appeal rights apply per contract requirements.

VII. References and related documents

Addendums

Addendum A: Out-of-State Medicaid Reimbursement
Addendum B: California State Specific Requirement
Addendum C: Washington State HCA Specific Requirement
Addendum D: New York State Specific Requirement

Referenced Policies

CUR 102 Single Case Agreements
CUR 110 Authorizations to Out-of-Network Providers QM 4
Member Safety Program
Claims 44 Emergency Services Policy

Addendum A: Out-of-State Medicaid Reimbursement

Professional reimbursement	Facility reimbursement
Home State Medicaid rates	Home State Medicaid rates

A. When a Medicaid member is seen by a professional in a non-home state and a claim is submitted, the provider must accept the Medicaid fee schedule that applies to the member's home state. Billing an out of state Medicaid member for an amount between the Medicaid- allowed amount and charges for Medicaid services is specially prohibited by Federal Regulations 42 CFR 447.15.

B. If services are provided that are not covered by Medicaid to a Medicaid member, these services will not be covered. A Medicaid member can only be billed for a non-covered service if a written approval was obtained prior to services rendered.

C. When a Medicaid member is seen by a facility in a non-home state and a claim is submitted, the provider must accept the Medicaid reimbursement methodology & rates established by the home state for out-of-state services. Billing an out of state Medicaid member for an amount between the Medicaid-allowed amount and charges for Medicaid services is specially prohibited by Federal Regulations 42 CFR 447.15.

Addendum B: California State Specific Requirement

CALIFORNIA SPECIFIC: It is the policy of Carelon Behavioral Health of California, to meet and be governed by section 1367.03 (a) and rule 1300.67.2.2 (c). Carelon Behavioral Health of California shall arrange for the provision of covered services from providers outside the plan's network if unavailable within the network, if medically necessary for the member's condition.

A member's cost for medically necessary referrals to non-network providers shall not exceed applicable in-network co-payments, co-insurance, and deductibles under rule 1300.67.2.2 (c)(7)(C). If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards, set by law or regulation, a plan shall arrange coverage outside the plan's network in accordance with subsection (d) of section 1374.72 of the Knox Keene Act.

A required by section 1371.9 of the California Knox-Keene Act, if a member receives covered services from a contracted health facility at which, or as a result of which, the member receives services provided by an OON provider, the member shall pay no more than the same cost sharing that the member would pay for the same covered services received from a contracted provider. This amount per the Act shall be referred to as the "in-network cost-sharing amount."

A. A member shall not owe the OON provider more than the in-network cost-sharing amount. At the time of payment by Carelon Behavioral Health to the OON provider, Carelon Behavioral Health shall inform the member and the OON individual health professional of the in-network cost-sharing amount owed by the

member.

B. An OON provider shall not bill or collect any amount from the member for services except for the in-network cost-sharing amount. Any communication from the OON provider to the member prior to the receipt of information about the in-network cost- sharing amount pursuant to 1371.9 of the Act, shall include a notice in 12- point bold type stating that the communication is not a bill and informing the member that the member shall not pay until he or she is informed by Carelon Behavioral Health of any applicable cost sharing.

C. If an OON provider has received more than the in-network cost-sharing amount from the member for services, the OON provider shall refund any overpayment to the member within 30 calendar days after receiving payment from the member.

D. If the OON provider does not refund any overpayment to the member within 30 calendar days after being informed of the member's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the member.

E. An OON provider shall automatically include in his or her refund to the member all interest that has accrued pursuant to this section without requiring the member to submit a request.

Addendum C: Washington State HCA Specific Requirement

WASHINGTON SPECIFIC: (parent codes SWWA, NCWA, PCWA): As required by contract with the Washington State Health Care Authority (HCA), Carelon Behavioral Health must pay for court ordered involuntary mental health or substance use disorder treatment for uninsured and underinsured individuals' authorized stays at hospitals and freestanding Evaluation & Treatment centers regardless of whether the provider is in or out of network.

A. For OON Hospitals (Community Hospital or Psychiatric Hospital certified by WA Department of Health for E&T services), Carelon Behavioral Health will not require an SCA in order to reimburse authorized eligible providers according to the Inpatient Prospective Payment System (IPPS) rate posted on the Washington State Health Care Authority (HCA) website.

B. For OON freestanding Evaluation & Treatment Centers (licensed as Residential Treatment Facilities certified by WA Department of Health for E&T services), Carelon Behavioral Health will not require an SCA in order to reimburse authorized eligible providers according to the WA Carelon Behavioral Health Fee schedule.

C. For all other voluntary MH or SUD treatment for uninsured individuals' authorized stays at OON Facilities, Carelon Behavioral Health will not require an SCA in order to reimburse authorized eligible providers according to the WA Carelon Behavioral Health Fee schedule.

Addendum D: New York State Specific Requirement

NEW YORK SPECIFIC: It is the policy of Carelon Behavioral Health (Carelon) to comply with 11 NYCRR 38 and 10 NYCRR Subpart 98-5 by ensuring members have timely access to behavioral health services.

If no in-network (INN) provider is available within the required timeframe and the member submits an access complaint, Carelon will promptly respond, investigate, and attempt to locate an INN provider. If an appropriate INN provider is identified, Carelon will provide the member with the provider's contact information; Carelon is not required to schedule the appointment on the member's behalf.

If Carelon is unable to locate an INN provider that meets appointment wait time standards within three (3) business days of receipt of the access complaint, Carelon will ensure the member can obtain medically necessary services from an out-of-network (OON) provider at the in-network benefit level (see CUR 110 Clinical Policy).

The member shall not incur any greater cost-sharing than would apply for in-network services and shall count any cost-sharing paid for the OON provider towards the in-network out-of-pocket maximum.

The OON provider must:

- Be qualified to treat the member's behavioral health condition
- Meet applicable appointment wait time standards
- Be located within a reasonable distance of the member
- Charge rates that are not excessive or unreasonable.

Carelon will reimburse the OON provider for authorized services in accordance with the member's benefit plan design, using applicable reimbursement methodologies, including but not limited to Carelon Behavioral Health fee schedules, CMS, and Fair Health benchmarks, as applicable. Reimbursement may vary based on factors including, but not limited to, plan-specific benefit design, provider type, and service type.

A single case agreement (SCA) may be executed, when appropriate, in accordance with the member's benefit plan design, as outlined in Section VI.B (Procedure) of this policy.

11 NYCRR 38 applies to New York–regulated, fully insured commercial health plans, including individual, small group, and large group markets, QHP and non-QHP products, and applicable student health plans.

10 NYCRR Subpart 98-5 applies to New York regulated health maintenance organizations (HMO), including commercial HMO coverage, Medicaid managed care plans, Essential Plan coverage, and Child Health Plus.

VIII. Revision history

Version number:	Approval date:	Description of change(s):
7	09/12/23	SCA background and scope, Clinical authorization approval process for Flexcare and Connects plans and reference to Policy, use of Contraxx-Contract management system to draft SCAs, Groupers, Process for countersigned SCAs, Clinical Process and Timeline to close a returned SCA Inquiry, Claims Process after the SCA Inquiry has been closed by Clinical, SCA Escalation Process, Reference to Claims Policy # for Emergency Services
8	11/09/23	Medicaid Enrollment Regulations, Terms and Condition
9	03/28/24	Definition for Unsecured SCA, Extension of an Existing Authorization, Removal of the sunset PDRF (Provider Data Request Form), Addition of the New Approved OON Provider Services Terms and Conditions for all LOBs, not eligibility per the sanction/exclusion screening, New Carelon Behavioral Health rate guidelines in the event that the provider refuses to accept the standard reimbursement.
10	03/25/25	Name of policy updated from Out of Network (OON) Reimbursement Policy and Single Case Agreement (SCA) Process. "As deemed appropriate and medically necessary" added to Background and Scope. Clinical Care Mgmt added to Functional Area Involved in Review. Definition added for Behavioral Out of Network Authorization. Added section "SCA's are not to be used for…" "Outpatient Emergency Services", "Inpatient Emergency Admission" and "Exclusion Screening" added. "Sanction Screening" removed. Procedure reworded. Added Carelon Behavioral Health will not reimburse providers that are not eligible per the exclusion screening. Clinical Criteria for SCAs changed.
11	08/25/25	Changed OON Authorization IS required to MAY BE Required to comply with the No Suprises Act. Added Member Cost Share as the exception to provider accepting payment from Carelon as payment in full.
12	08/24/26	Added Addendum D "New York State Specific Requirement", Added language addressing All-Payer Models and other state-specific payment methodologies, Updated SCA turnaround times (TATs) for both Regulatory and Non-Regulatory SCAs. Policy owner changed due to Director change.