Title:		Policy and Procedure number:	
Out of Network (OON) Reimbursement Policy and Single Case Agreement (SCA) Contract Negotiation Process		NM 306.8	
Responsible department:	**Author:**	**Approver:**	
Network Management	Rosy Murphy	Nicole Nole, Director Network Development	
Original effective date:	**Date of policy retirement:**	**Last revision date:**	**Last reviewed/ approval date:**
4/10/2010	N/A	9/22/2023	9/28/2023
Applicability			
☒ Commercial (incl. exchange) ☒ Medicare ☒ Medicaid (incl. grants)	Policy applies to: All		
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 and expediency in processing OON claims for all Behavioral Health Services delegated to Carelon Behavioral Health, including standardization of reimbursement and consistent handling of Single Case Agreements (SCAs). To establish the SCA process for providers who are providing OON services to Carelon Behavioral Health members.

II. Exceptions

N/A

III. Background and scope

Review of the workflow process after the Out of Network (OON) service(s) has been clinically approved based on medical necessity under the member's benefit plan and the use of the Single Case Agreement (SCA) for a designated length of time.

Functional Area(s) Involved in Review:
Network Operations
Network Reimbursement
Network Strategy
Legal

Departments Affected:
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

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

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

SCA(s) are not to be used when there are adequate Carelon Behavioral Health providers for geographic and clinical specialty needs including instances when Members have out of network benefits.

For any incident or trending event that occurs after the Out of Network, service has been authorized reference QM 4.46 Member Safety Program Policy.

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 provider, state, federal or CMS 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.

Sanction Screening - In instances where an SCA is not required, the Sanction Check will be done prior to claims payment.

VI. Procedure

SCA Process and OON Reimbursement Policy

A. SCA PROCESS:

1. **Clinical Case Manager (CCM)/Network Team:**

a. CCM/Network receives OON Request and confirms the member is actively enrolled, does not have in-network access and is requesting an OON provider.

b. CCM/Network ensures requested Provider is not In-Network, no application is in process to become In-Network or if it is an In-Network provider missing a service, line of business and/or location.

c. CCM/Network attempts to redirect to an in-network provider if a compatible known provider exists.

d. CCM/Network reviews if OON provider is eligible and complies with the sanction/exclusion/preclusion/opt-out screening prior to authorizing services to treat Carelon Behavioral Health Member and applicable to the line of business.

e. CCM confirms member care cannot be redirected to an in-network provider, then the out of network request is authorized as medically necessary following the approval process of an OON request; reference Policy CUR 110.10.
   1) For Flexcare Plans, CCM pends the authorization within Flexcare. The authorizations are pended until the single-case-agreement is completed.
   2) For Connect Plans, CCM pends the authorization within ServiceConnect. The authorizations are pended until the single-case-agreement is completed.

f. CCM creates a ServiceConnect inquiry including all required information such as: Valid Provider and Member Record, Reason Codes 1, 2 and 3, Parent Code, Authorization#, Intake Form and pends it to the National SCA Team queue VONOQSCA or M5NOQOON as applicable.

2. **SCA Team:**
   a. The SCA team ensures that the required information is present and accurate on the inquiry. If not, the inquiry is returned to the CCM requestor for clarification.
      1) If no SCA is required, then the SCA team will follow the OON (Out of Network) Reimbursement process.

      2) If the SCA is required, the SCA Team will draft the SCA in Contraxx using the standardized approved SCA template with the information provided by CCM Requestor within the inquiry and it will be sent electronically to the provider with two automated follow-ups within a 10-day calendar period. The SCA Team uploads a copy of the SCA template same day it is sent to the provider in ServiceConnect as an attachment.

   b. If the signed SCA **is not received** within 10 days:
      1) The SCA Team will load the OON rates with an Unsecured SCA if the

provider is unresponsive after all required outreaches or if the maximum allowed OON rate was offered and declined by the Provider.

c. If the signed SCA **is received** within 10 days or if an OON reimbursement applies:
   1) For ConnectPlans, the SCA Team loads the rates in ServiceConnect - Review Tab for "Practitioners and Facilities" only
      - The rates are loaded based on the Service and Dates of Service (DOS) authorized by Clinical

   2) For FlexcarePlans, the SCA team completes the PDRF (Provider Data Request Form) and submits the event to Provider Data through NetworkConnect for "Practitioners, Groups and Facilities".
      - The rates are listed in the PDRF with the grouper and no expiration date and extended to the end of the year for inpatient services if grouper is not available
      - Once the event is returned from Provider Data to the SCA Team as completed, the SCA team confirms that the request has been loaded to Flexcare as indicated on the data load request form and closes the event.

   3) The SCA Team uploads the countersigned SCA as an attachment in ServiceConnect and in NetworkConnect under the Provider's File Cabinet and the SCA Inquiry is returned to Clinical.

   4) The SCA Team returns the inquiry to the CCM requestor

3. **Clinical Case Manager (CCM) Team:**
   a. CCM updates the Member's authorization as needed (i.e., un-pends, or updates the authorization).

   b. CCM completes any necessary Provider/ Member outreach.

   c. CCM will check if there is a claim on file for the particular dates of admission. If the claim is billed and denied (due to OON reasons), CCM will re-route the inquiry to the assigned claims queue for reprocessing.

   d. From the time of notice that the single case agreement is completed, the clinician has 14 business days to complete the authorization and route to the claims team if there is a denied claim on file for the DOS and service level authorized.

   e. If there are no claims on file for the date of admission, CCM will close out the inquiry within 7 business days in ServiceConnect

4. **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 reprocess the claims.

5. **SCA Inquiry Escalation Process**
   a. After Clinical authorization has been granted, the SCA inquiry can be escalated by any Carelon staff team members based on the urgency and priority level at any time:

SCA INQUIRY ESCALATION PROCESS					
Action Reason Code	Action Reason Code Definition	Urgent Status	SCA Timeline (Business Days)	SCA ESCALATION REQUIREMENTS	
				Carelon Approval (Must be specific and attached to the inquiry)	Narratives (SCA inquiries cannot be processed without clinical authorization)
SCA012	SCA Escalation	3	5	Prior to escalating, all Carelon Team members are required to obtain their Director Level Approval and attach their e-mail approval to the SCA Inquiry	SCA Escalation
SCA013	SCA Status Update	4	10		SCA Status Update
SCA014	SCA State Complaint	1	1		SCA State Complaint
SCA015	SCA Plan Complaint	2	2		SCA Plan Complaint
SCA016	SCA Provider Complaint	3	5		SCA Provider Complaint
SCA025	SCA Escalation - Clinical Timeline Requirement	2	2		SCA Escalation due to nature of the treatment where the Provider refuses to start the treatment without an SCA
SCA025	SCA Escalation - Clinical Timeline Requirement	2	2	Only copy of the State Legislation Requirement is needed	SCA Escalation due to State Legislation Requirement

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 rates noted below. Carelon Behavioral Health will not require an SCA in order to reimburse providers for urgent services.

   a. Medicaid - 100% of the Medicaid allowable and in-network rate benefit level based on Member's Home State. Pursuant to Federal Regulations, Carelon Behavioral Health will not reimburse providers who are not currently enrolled by Medicaid. Carelon Behavioral Health will not require an SCA in order to reimburse eligible providers for urgent Medicaid covered services.

   b. 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, sanctioned, or on the Preclusion list. Carelon Behavioral Health will not require an SCA in order to reimburse eligible providers for urgent Medicare covered services

   c. 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 reimburse Medical Professionals for covered services administered in an emergency room (ER) setting following the Emergency Service Policy 44.2.

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 and in-network rate benefit level based on Member's Home State. Pursuant to Federal Regulations, Carelon Behavioral Health will not reimburse providers who are not currently enrolled by Medicaid. Carelon Behavioral Health will not require an SCA in order to reimburse eligible providers for non-urgent Medicaid covered services.

   b. 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, sanctioned, or on the Preclusion list. Carelon Behavioral Health will not require an SCA in order to reimburse eligible providers for non-urgent Medicare covered services.

3. Urgent/Non-Urgent with OON Benefit: Carelon Behavioral Health will reimburse out of network behavioral health eligible providers, without prior approval, according to plan direction and/or the appropriate line of business reimbursement levels, e.g., Medicare enrolled providers. No SCA will be required, and members will be responsible for plan specific OON cost shares.

4. Non-Urgent Commercial Plans with no OON Benefit: Carelon Behavioral Health will reimburse providers for non-urgent services that meet the criteria for coverage listed below. Carelon Behavioral Health will reimburse OON eligible professionals and facilities for non-urgent services at 100% of the corresponding line of business rates noted above.

Clinical Criteria: A Non-Urgent service where a member does not have an OON benefit, reviewed by a clinical care manager using the following criteria:

A. 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.
B. Carelon Behavioral Health's network facilities are at capacity; Carelon Behavioral Health's network practitioners/ EAP affiliates cannot accommodate new patients/clients.
C. Clinical/service needs (e.g., clinical specialty, language, cultural sensitivity, gender) cannot be met by available network resources.
D. Member preferences cannot be met by available network resources and are deemed relevant to treatment outcome.

E. Continuity of care for a member with a history of treatment with an out- of-network provider.
F. Transportation available to a member or available support systems enables the member to only access an out-of-network resource.
G. The available network resources believe they cannot meet the member's service needs.
H. A network facility is not contracted for a specific required modality.
I. 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.
J. When the member is a full-time student and consequently outside of the geographic area of the network as allowed by benefit plan.
K. 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; an administrative decision has been made by the client or Carelon Behavioral Health to approve OON services/a SCA

In the absence of criteria specified above, Carelon Behavioral Health will not approve reimbursement for an OON Provider for the following scenarios:

A. 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.
B. 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.
C. When there are adequate network providers to meet the member's needs and there are no compelling reasons for considering OON authorization/a SCA (see above V. Procedure B,1-12), the clinical care manager contacts the member, practitioner, or facility and informs them of the decision not to proceed with the OON authorization/SCA. Denial and appeal rights apply per contract requirements.

Carelon Behavioral Health will set standard OON reimbursement levels and rate guidelines by line of business. Reports regarding Single Case Agreements are monitored in each Region in order to determine recruitment opportunities.

VII. References and related documents

Attachments

Exhibit A: Out-of-State Medicaid Reimbursement
Exhibit B: California State Specific Requirement
Exhibit C: Washington State HCA Specific Requirement

Referenced Policies

CUR 102 Single Case Agreements

VIII. Revision history

Version number:	Approval date:	Description of change(s):
306.8	9/12/2023	New Formatting, 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