Carelon Behavioral Health
Policy and Procedure

Title:		Policy and Procedure number:	
SCA (Single Case Agreement) and OON (Out of Network) Reimbursement Policy		NM 306.10	
Responsible department:	**Author:**	**Approver:**	
Network Management	Rosy Murphy	Nicole Nole, Staff VP Network - National	
Original effective date:	**Date of policy retirement:**	**Last revision date:**	**Last reviewed/ approval date:**
04/10/10	N/A	03/25/25	03/25/25
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 Strategies, LLC, Carelon Behavioral Health of California, Inc. and Carelon Behavioral Health, Inc., 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 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 as deemed appropriate and medically necessary under the member's specific benefit plan and the use of the Single Case Agreement (SCA) applies for a designated length 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 these will default to the applicable Medicare or Medicaid allowable and Carelon Fee Schedules.

C. SCA(s) are not to be used for Emergency Inpatient Admission. After clinical authorization it will default to Carelon Fee Schedules consistent with plan benefit design, member in-network "Cost share "applies.

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 pan benefit design without an SCA.

E. SCA(s) are not to be used if there is a request from an in-network provider to render services to a specific member, for a specific length of time for a covered service(s) that are currently not contracted, or location, or age range, or an eligible plan, or provider not credentialed within the in-network group and so forth. The request is re-directed to our Provider Relations Team to assist the in-network provider on any update needed to be done on their file to treat our Carelon Member(s) and for the claims to be paid at the in-network level after the file is updated without 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 Behavioral Health will reimburse facilities for covered inpatient emergency services at 100% of Carelon Fee Schedules consistent with plan benefit design without a signed SCA. Out-of-Network Authorization is required, member in-network "Cost share "applies.

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

1. OON Provider or Member

a. 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.

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

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

b. CCM/Network Support ensures there are no in-network Providers available, the requested Provider is not in-network or is an in-network provider but needing an update, or there is a provider application in process to become in-network.

c. CCM/Network Support attempts to redirect to an in-network provider if a compatible known provider exists.
d. CCM reviews if OON provider is eligible and verifies the out-of-network (OON) provider is not excluded from participation in state and federal programs.
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.
    1) For FlexCare Plans, CCM pends the authorization within FlexCare. The authorizations are pended until the Single Case Agreement (SCA) process is completed.
    2) For Connect Plans, CCM pends the authorization within ServiceConnect. The authorizations have a hold code on the auth to prevent claims payment until the Single Case Agreement (SCA) process is completed.
    3) The provider may request a date extension for an existing authorization.

    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.
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/OON Request Form and pends it to the National SCA Team queue VONOQSCA.

3. 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. The inquiries are processed in the order they are received, the standard SCA Team timeline is 10 business days, unless it is an escalation.
    1) 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/authorization and it will be sent electronically to the provider with two automated follow-ups within a 10-day calendar period.
b. If the signed SCA **is not received** within a 10-day calendar period:
    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 a 10-day calendar period:
    1) For Connect Plans, the SCA Team loads the rates in ServiceConnect - Review Tab for "Practitioners and Facilities" only
        - The rates are loaded for the Service Codes and Dates of Service (DOS) authorized by Clinical
    2) For FlexCare Plans, the SCA team submits the event to Provider Configurations through NetworkConnect for "Practitioners, Groups and Facilities":
        - If the grouper is available, it is used with no expiration date; if the grouper is not available, for inpatient services the rate load is extended to the

end of the year
- Once the event is returned from Provider Configurations to the SCA Team as completed, the SCA team confirms that the request has been loaded to FlexCare as requested and closes the event.

d. The SCA Team uploads the countersigned SCA as an attachment in ServiceConnect.
e. 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 and Carelon Behavioral Health Fee Schedule 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 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.
b. **Medicare -** 100% of the Medicare allowable rate and Carelon Behavioral Health Fee Schedule based on POS (Place of Service). Carelon Behavioral Health will not reimburse providers who are not eligible per the 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 Medicare covered services.
c. **Commercial** - 100% of the Carelon Behavioral Health Fee Schedule consistent with the Plan Benefit Design and 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 exclusion screening. Carelon Behavioral Health's OON Provider Services Terms and Conditions will apply.

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 and Carelon Behavioral Health Fee Schedule 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 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.
b. **Medicare** - 100% of the Medicare allowable rate and Carelon Behavioral Health Fee Schedule based on POS (Place of Service). Carelon Behavioral Health will not reimburse providers who are not eligible per the 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 Medicare covered service.

3. **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 Carelon Behavioral Health Fee Schedule consistent with the Plan Benefit Design and parity-compliant reimbursement levels for covered Services based on POS (Place of Service). Carelon Behavioral Health will not reimburse providers that are not eligible per the exclusion screening. Carelon Behavioral Health's OON Provider Services Terms and Conditions will apply.
4. **Urgent/Non-Urgent with OON Benefit:** Carelon Behavioral Health will reimburse out of network behavioral health eligible providers, with or without prior approval according to plan requirement/benefit/procedure/direction and/or the appropriate line of business reimbursement requirement consistent with the Plan Benefit Design. No SCA will be required, and members will be responsible for plan specific OON "Cost Share" (herein defined as a member deductible, copayment, or coinsurance) as applicable.

Carelon Behavioral Health will set standard OON reimbursement levels and rate guidelines by line of business. In the event that the provider refuses to accept the standard reimbursement, the allowed rate will be loaded in the system in accordance with the plan benefit design to reimburse the authorized out-of-network (OON) Provider. If an exception is made due to the nature of complexity such as cultural needs, the corresponding plan account executive approval will be attached to the inquiry. In the event the OON Provider disagrees with a claim's payment decision, the provider has the right to dispute or request a reconsideration of such claim payment decision by submitting a written appeal or 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 reconsideration should be submitted to the address listed on the top of the page of the claim's remittance statement.

Reports regarding Single Case Agreements are monitored in each Region in order to determine recruitment opportunities.

SCA Inquiry Escalation Process

After Clinical authorization has been granted, the SCA inquiry can be escalated by any Carelon team member 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	
				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
SCA025	SCA Escalation - Clinical Timeline Requirement	2	2	• State Legislation Requirement	State Legislation Requirement, i.e., WA ITA (Involuntary Treatment Act), California SB 855, etc.
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

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

Carelon Behavioral Health
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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.