200.30.16 - Authorization of Out-of-Network Services

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1.0 Definitions

1.1 Assessed facility is a facility, which has met the requirements established by GOBHI under policies Assessment of Facilities (200.36.01) and Facility Contracting Requirements (200.37.08).

1.2 CCO benefit means allowable services that are not necessarily listed as an OHP benefit, yet are approved under contractual allowances.

1.3 Credentialed practitioner means a licensed practitioner who has successfully completed the relevant CCO's credentialing process.

1.4 Division of Medicaid Assistance Program (DMAP) Provider Identification Number (PIN) – means either the practitioner or facility has been authorized and provided a current PIN to bill under the Oregon Health Plan (OHP).

1.5 In-Network – means a credentialed practitioner and/or assessed facility that is under contract with GOBHI.

1.6 Medicaid Rate – means the per diem, unit, or hourly rate listed in the behavioral health fee schedule as published by the Oregon Health Authority (OHA).

1.7 Out-of-Network (OON) Provider – means a practitioner or facility that is not under contract with GOBHI.

1.8 Single case agreement – means a contract between GOBHI and an OON provider, which allows a specific GOBHI member to obtain an OHP covered benefit, which is medically necessary.

2.0 Policy

Greater Oregon Behavioral Health, Inc. (GOBHI) members will have access to all medically appropriate, behavioral health services that are covered under the Oregon Health Plan or

the relevant CCO's behavioral health benefit. Either GOBHI will coordinate timely and adequate access to the service at the member's or their designated representative's request, or the member can utilize an out-of-network provider of their own choice, as long as that provider meets the criteria outlined in this policy.

3.0 Procedures

3.1 When an in-network provider is unable to provide a medically appropriate behavioral health service, that is covered under the member's OHP or CCO benefit, then GOBHI may arrange with an OON provider to provide the service, or the member or their designated representative can select a provider.

3.2 All OON services require an authorization.

3.2.1 The OON provider must request authorization for medically appropriate services under the procedures defined by GOBHI in policy Service Delivery Authorization (200.30.13). GOBHI will evaluate the authorization request based on:

3.2.1.1 If there is an in-network provider qualified to deliver the same service(s)

3.2.1.2 If the delivered service(s) were medically appropriate and delivered by a qualified professional,

3.2.1.3 If the submitted documentation supports medical necessity of the service(s),

3.2.1.4 If the billing codes utilized are consistent with the behavioral health fee scheduled as published by the OHA.

3.3 The OON provider must provide services in a timely manner.

3.4 In order for an OON provider to be eligible for reimbursement for authorized, medically appropriate services, the OON provider must agree to the following requirements:

3.4.1 Accepts the established Medicaid rate for the delivered service(s), ***or***

3.4.2 Accepts payment equal to 30% of their usual and customary charge

3.5 When a member or their designated representative selects an OON provider, GOBHI has the right to evaluate the justification for utilization of the OON provider and determine if an in-network provider is qualified to deliver that medically appropriate service(s).

3.5.1 If members cannot receive services in their own community, OON referrals for these circumstances will be approved.

3.5.2 For all other OON requests, a simple explanation is required as to why the in-network provider cannot be utilized.

3.5.3 For out of state referrals, the same rules apply.

3.5.4 In the event of a retro authorization request, where GOBHI determines that an in-network provider is qualified, GOBHI will reimburse the OON, if all reimbursement requirements are met, for delivered services, then refer the member back to an in-network provider, who will work with the member to determine how to best meet the member's needs.

3.5.5 The member or their designated representative has the right to file a complaint pursuant to policy Complaints (200.22.01).

4.0 **Effectiveness Criteria:**