# 200.30.16 - Authorization of Out-of-Network Services

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## 1.0 Definitions

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

1.2 Credentialed Practitioner – a licensed practitioner who has successfully completed the relevant GOBHI's credentialing process.

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

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

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

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

1.7 Single Case Agreement – a contract between GOBHI and an OON provider that allows a specific GOBHI member to obtain a medically necessary OHP covered benefit.

## 2.0 Policy

Greater Oregon Behavioral Health, Inc. (GOBHI) requires all service authorization requests from non-participating providers to be pre-authorized to ensure that medically necessary services are rendered in the most appropriate setting in accordance with plan benefits. Emergency Care Services do not require pre-authorizations.

GOBHI is responsible for payment of covered services provided by non-participating providers that were not pre-authorized if the covered services were delivered in good faith without the pre-authorization.

## 3.0 Procedures

3.1 When an in-network provider is unable to provide a medically appropriate behavioral health service, which is covered under the member's OHP 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 The service authorization request is entered into the Utilization Management system. Authorizations will be conducted in the following manner:

3.2.1 Verification that the member has coverage in place for the dates by checking the Oregon DHS Medicaid portal;

3.2.2 Check the requested provider status with Office of Inspector General (OIG), System for Award Management (SAM), and respective licensing board.

3.2.3 Verification that the requested provider for referral is non-participating provider with GOBHI;

3.2.4 Check to determine if the non-participating provider is DMAP registered;

3.2.5 Determine the specialty of the provider (if applicable);

3.2.6 Determine if the requested service is a covered benefit under the member's OHP;

3.2.7 If participating providers are available to deliver covered service, requests of information from the referring provider will be made as to the reason for the request for referral to a non-participating provider (if applicable);

3.2.8 The referral or request for authorization to a non-participating provider will be sent to the UM Coordinator for review. The UM Coordinator will evaluate the authorization request based on availability of qualified in-network providers to deliver the service, submitted documentation, and the billing codes utilized are consistent with the behavioral health fee scheduled as published by Oregon Health Authority. If the UM Coordinator determines medical necessity is not established, then the request is sent to the UM Physician Reviewer for final determination. The UM Physician reviewer determines if there was no medical necessity established for the referral and/or participating providers are available to provide equivalent services. The UM coordinator completes the denial process. The UM coordinator notifies the referring provider of the denial, and provides a Notice of Adverse Benefit Determination. The UM Coordinator may refer this member to the Care Management Team to assist with coordinating care with participating providers.

3.2.9 If the determination is made there are no participating providers available to provider equivalent services and the care provided meets the guidelines outlined, the UM Coordinator completes the authorization process. The UM coordinator notifies the referring provider and member of the authorization and follow the GOBHI service authorization policy.

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, whichever is the lesser rate.

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 Access to OON services will apply mainly to specialty care services such as eating disorders, gender dysphoria, pain management for the lower back, and ECT.

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

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

## 4.0 Compliance Criteria:

N/A.