PerformCARE®	Policy and Procedure
Name of Policy:	Service Authorization Procedures and Standards for Out-Of-Network Providers
Policy Number:	PR-001
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Provider Relations Department
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	10/01/01
Last Revision Date:	10/01/18
Last Review Date:	11/07/19
Next Review Date:	11/01/20

Policy: PerformCare will make every effort to use network providers. In the event that a network provider cannot meet the clinical, geographic or other special needs of a member, an out-of-network provider may be accessed. All providers must be licensed and enrolled in the Pennsylvania Medical Assistance Program. PerformCare will make every effort to include in the network any frequently used OON Provider.

Purpose: To establish procedures for the use of out-of-network providers and to identify what constitutes an out-of-network provider.

Definitions: **Criteria for Member to Receive OON Services:** Criteria includes but is not limited to meeting one or more of the following:

1. Member has an emergency or need for services outside of the geographic area of the contracted network.
2. Member has a need for limited specialty practice not currently available in the network.
3. Member's health would be jeopardized by requiring the Member to relocate to a network Provider for services.
4. Member recently became enrolled in PerformCare and the Provider currently serving the Member is in the process of becoming credentialed and contracted with PerformCare.
5. Member has an existing care relationship with an out of network provider and will be transitioning to a new provider in the network, or PerformCare determines that continuity of care considerations merit the OON approval.

Network Provider: A Medicaid-enrolled behavioral healthcare provider who is credentialed and contracted with PerformCare.
Out-of-Network Provider: A licensed enrolled Medicaid behavioral healthcare provider, who is not credentialed, does not have a written provider agreement with PerformCare and therefore is not identified as a PerformCare network provider.
Out of Network Process: The out of network (OON) process ensures access to services that are necessary as a result of unique Member circumstances.

Acronyms: **RTF:** Residential Treatment Facility
CCM: Clinical Care Manager

Procedure:

1. Member Services and Clinical Care Managers
   - 1.1. Emergency service authorizations and special needs requests may be obtained from PerformCare 24-hours a day, seven days a week, by contacting PerformCare Member Services Department via dedicated toll free numbers for each contract. Members experiencing an emergency situation may secure care prior to receiving an authorization from PerformCare (see Policy *QI-002* for the definition of emergency care).
   - 1.2. Following stabilization, the feasibility of transporting the Member to a participating provider will be explored.
   - 1.3. PerformCare will process all claims as they relate to medical necessity criteria and reserve the right to deny claims that are not supported by appropriate clinical documentation or were not required to stabilize the emergency.
   - 1.4. PerformCare will accept claims from out-of-area emergency providers for up to the designated time period per contract beyond the discharge date, subject to retrospective review.
   - 1.5. Out-of-network services for Members that are other than an emergency situation are subject to prior authorization by PerformCare. Those services that cannot be provided by the network and are medically necessary for the treatment of the Member will be authorized in accordance with level of care criteria established by the Commonwealth in *Appendix T*.
   - 1.6. Emergency services - PerformCare may not deny payment for treatment obtained when a representative of PerformCare instructs the Member to seek emergency services.
   - 1.7. The entities specified in §42 CFR 438.114(b) (The MCO, PIHP, PAHP, PCCM) may not limit what

constitutes an emergency medical condition based on diagnoses or symptoms.

1.8. PerformCare may not deny payment for treatment obtained when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in §42 CFR 438.114(a) of the definition of emergency medical condition.

1.9. PerformCare may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's BH-MCO of the Member's screening and treatment within 10 calendar days of presentation for emergency services.

1.10. The attending emergency physician, or the provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in §42 CFR 438.114(b) as responsible for coverage and payment.

1.11. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

2. Whenever possible, PerformCare refers all Members to credentialed and contracted providers from the PerformCare network.

2.1. When a credentialed provider cannot meet the clinical, geographic, or other special needs of the Member, an out-of-network agreement will be negotiated to meet a Member's needs. Out-of-Network providers can be identified through a variety of mechanisms:

2.1.1. The Member has an existing or preferred provider.

2.1.2. The referral source recommends a provider.

2.1.3. The Clinical Care Manager (CCM) or other PerformCare staff recommends a provider.

2.1.4. The oversight entity/County partner recommends a provider.

2.1.5. The CCM or other PerformCare staff utilize the Directory of Commonwealth Providers for the purpose of locating providers out of the PerformCare network.

3. The process to request an out-of-network agreement is outlined below.

3.1. The provider, a Member or his/her representative notifies the PerformCare CCM of a request for a service

or provider not currently in-network. (See #8 - #9 below regarding RTF placements).

3.2. The Clinical Care Manager will obtain Care Manager Supervisor approval for all OON requests and the CCM completes the PerformCare OON Request process for approval according to timeframes designated by the Clinical Care Management Department. Consultation with the Clinical Director and/or Medical Director will occur on case-by-case basis as needed. Critical information must be included on the request including CCM Name, Member name, Member Medical Assistance Number, Provider Name, Provider Address, Provider telephone number, provider contact person, type of service that will be authorized.

3.3. Upon approval, the request is transmitted to the Network Development Manager or delegate who will coordinate negotiation of an out-of-network provider agreement with the provider.

3.4. The Provider will be entered into the information system as an Out-of-Network Provider immediately upon receipt of critical information so that authorization can be generated by the CCM.

3.5. The out-of-network referral process will be expedited for emergency and urgent care. Emergency services, in or out-of-network, do not require prior authorization.

3.6. Contracting Staff will notify the Clinical Care Manager that the Provider is entered into the information system. The Clinical Care Manager or designated authorization staff then enters the authorization for inpatient, partial hospitalization and substance abuse residential services. The out of network agreement serves as the authorization for outpatient, crisis and targeted case management services.

4. When a Member experiences an emergency situation outside of the Territory or the Member is in the Territory, but the nearest emergency provider is not a network provider the Member may access any provider of emergency services regardless of network status.

4.1. When the emergency service provider contacts PerformCare and it is determined that the services were emergent and were necessary to treat a behavioral health condition, PA Medical Assistance program participation status will be researched. If not PA Medical Assistance-enrolled, out-of-state providers need to be enrolled in Medicaid in their home state. PerformCare does not

enter into OON agreements with non-Medicaid providers.

4.2. If the Provider is not enrolled in PA Medicaid, a Provider ID Number will be generated for the Provider to identify the OON Status. The number will consist of the nine (9) digit tax Identification Number plus "9999". If multiple agreements are generated with the same Provider, Provider Identification numbers will be assigned as Tax ID plus 9998, 9997 etc. The appropriate provider type and specialty combination will be assigned based on the Provider's license and credentials.

4.3. PerformCare gathers and evaluates information to include credentials such as license(s) and accreditation certificates as part of the contracting process. All Providers must be licensed in Pennsylvania or in their home state.

5. If a Member is placed in a treatment facility within the county by a juvenile or adult court or a county children and youth authority and PerformCare determines the placement is not medically necessary, PerformCare is not responsible for payment of that treatment. The Member does, however retain membership in the health plan.
6. When children or adolescents in substitute care are placed in treatment facilities the following applies:
   6.1. If the child is residing in a substitute care arrangement in a county outside the PerformCare service area, PerformCare will work with the appropriate county Children & Youth Agency that has custody to coordinate with the substitute caregiver(s) to assure the necessary and appropriate behavioral services are available to the child. As noted in *Appendix V*, behavioral healthcare for children in substitute care admitted to a mental health residential treatment facility varies, depending on the placement. Service payment determination has been adopted from *Appendix V* of the HealthChoices Program Standards and Requirements written by the Department of Human Services.

   6.2. If a child in substitute care is determined eligible for Medical Assistance outside a PerformCare covered county and is placed in substitute care in a PerformCare County, behavioral health services for the child will be covered under the fee-for-service system or BH-MCO of the home county unless the placement results in a permanent change of county residence.

   6.3. PerformCare is responsible to pay for out-of-network, medically necessary emergency treatment services for up

to ten (10) days for an enrolled child, if emergency placement is determined necessary by the county children and youth office or juvenile probation.

6.4. PerformCare is responsible for medically necessary services delivered to Members in treatment settings outside of the juvenile detention facility during the first thirty-five (35) days of detention.

6.5. Services delivered to Members within the juvenile detention center are not the responsibility of PerformCare.

7. When adopted children continue to receive support from the county children and youth agency through an adoption assistance agreement the following applies:
   7.1. Adopted children residing within a PerformCare covered county can be enrolled in PerformCare.
   7.2. Adopted children outside of a PerformCare covered county can be enrolled in the BH-MCO of the adoptive family's county of residence.
8. Use of an Out-Of-State PA Medical Assistance Enrolled Residential Treatment Facility (RTF) for Children/Adolescents (in network or out of network).
   8.1. Prior to placing a child in an out of state facility for RTF services the following activities will be completed to assure due diligence relative to providing the best possible treatment environment for the child.
      8.1.1. Contracting Staff will contact the licensing authority in the state to determine if there are any sanctions, admission bans, complaints or concerns lodged about the Provider that may influence the placement decision. Any issues or concerns will be shared with the parents and other team Members for consideration.
      8.1.2. Contracting Staff will contact the Medical Assistance program in the Provider's state to determine MA enrollment, if there are any sanctions, admission bans, complaints or concerns lodged about the Provider that may influence the placement decision. Any issues identified will be shared with the parents and other team Members for consideration.
      8.1.3. Contracting Staff will obtain all policies and procedures related to seclusion and restraint. Policy and Procedure will be reviewed to assure no aversive or restrictive measures are used.
      8.1.4. Contracting Staff will forward the RTF placement Packet to the Provider, which includes various

Bulletins on seclusion and restraint as well as verification that the Provider is subject to Pennsylvania rules and regulations relative to service delivery. The Provider will be required to sign and return the attestation prior to placement.

9. Use of an Out-Of-State Residential Treatment Facility (RTF) for Children/Adolescents not enrolled in the PA Medicaid program.
    9.1. Prior to placing a child in an out of state facility for RTF services the following activities will be completed to assure due diligence relative to providing the best possible treatment environment for the child.
        9.1.1. If the County/BH-MCO is considering placement of a child in an out-of-State RTF that is not enrolled in the Pennsylvania Medical Assistance Program, OMHSAS must review and approve the Provider before placement is made.
        9.1.2. Contracting Staff will contact the licensing authority in the state to determine if there are any sanctions, admission bans, complaints or concerns lodged about the Provider that may influence the placement decision. Issues identified will be shared with the parents and other team Members for consideration.
        9.1.3. Contracting Staff will contact the Medical Assistance program in the Provider's home state to determine if there are any sanctions, admission bans, complaints or concerns lodged about the Provider that may influence the placement decision. Issues identified will be shared with the parents and other team Members for consideration.
        9.1.4. Contracting Staff will obtain all policies and procedures related to seclusion and restraint. Policy and Procedure will be reviewed to assure no aversive or restrictive measures are used.
        9.1.5. Contracting Staff will forward the RTF placement Packet which includes various Bulletins on seclusion and restraint as well as verification that the Provider is subject to Pennsylvania rules and regulations relative to service delivery. The Provider will be required to sign and return the attestation prior to placement.
10. Balanced Budget Act of 1997
    10.1. PerformCare coordinates with the out-of-network providers and ensures that cost to the Member is no greater than it would be if the services were furnished within the network. Out of network providers are

compensated on the same fee schedule. Out of State Providers must be MA enrolled in their home state per *MA 1151.32*. PerformCare accepts the Medical Assistance rate assigned by the home state Medical Assistance program.

Related Policies: *QI-002 Procedures for Timeliness of Interventions*

Related Reports: *Out-Of-Network Agreement*
RTF Packet for Providers

Source Documents and References: *HealthChoices Appendix V (available on DHS website)*

Superseded Policies and/or Procedures: None

Attachments: None

Approved by:

Primary Stakeholder