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**Document Scope:** (applies to Policy & Procedure only)

- The requirements herein apply only to the GCBH Central Office and its functions.
  - X - The requirements herein apply, verbatim, to GCBH and its network providers<sup>2</sup>.
  - The requirements herein apply both to GCBH and its network providers<sup>2</sup>. Additionally, network providers must have internal documents outlining their processes for implementing the requirements, insofar as they relate to actions for which network providers are responsible.
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**PURPOSE:** To define the requirements associated with the provision of out-of-network referrals to Medicaid enrollees, as required by 42 CFR §438.206(b)(4)&(5).

**DEFINITIONS**

- I. Covered Services – means a service identified as funded by the PIHP contract between the RSN and the State of Washington.
- II. Enrollee – means a Medicaid recipient who is currently enrolled with GCBH. For a child under the age of thirteen, or for a child thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of enrollee includes parents or legal guardians.
- III. Member Government – One of the eleven (11) county governments comprising the RSN.
- IV. Notice of Action – means a written notice issued by GCBH which communicates a decision not to authorize mental health services to an enrollee who meets medical necessity criteria, or to reduce, suspend or terminate previously authorized services.
- V. Notice of Determination – means a written notice issued by GCBH which includes the following:
  - A description of authorized services and time frames,
  - The right to a second opinion and how to access the second opinion if services beyond the intake or previously authorized benefit have not been determined by the network CMHA to be Medically Necessary and no services are authorized by the PIHP, and
  - Information about the availability of other services under EPSDT for Enrollees under 21 and their legal representative.
- VI. Requests for Services – for the purposes of this policy, includes both requests for a modality of treatment contractually identified as a benefit, and requests for a particular treatment approach that would fall within such a modality. Additionally, it includes requests initiated by an out-of-network agency on behalf of an Enrollee who lives within the RSN's geographic boundaries and has sought services outside those boundaries.
- VII. Service Delivery Network – means the collective of contracted Network Provider agencies located within the geographic boundaries of the RSN, and their subcontractors who provide covered services, comprising its service delivery system.

## POLICY

- A. When the GCBH service delivery network is unable to provide medically necessary covered services to an enrollee, or to provide them within timeframes established as access standards, out-of-network services are provided at no cost to the enrollee until they become available within the network. The GCBH Member Handbook informs enrollees of (1) the right to request services not available from a GCBH Network Provider, (2) the process for making that request, and (3) the right to appeal a decision denying such services.
- B. The GCBH Network Providers comprise a service delivery network; while a given Provider may not offer all covered services, GCBH strives to ensure that all covered services are continuously available within this network. Accordingly, all requests for services presumed by enrollees or Providers to be unavailable within the GCBH network are processed through the Care Coordinators at the GCBH Central Office. Such requests may be made by enrollees (or legal guardians) directly to the GCBH Care Coordinators or through a Network Provider, or may be initiated by a Network Provider subsequent to its identification of need for a covered service it cannot address.
- C. Before a referral for out-of-network outpatient services can be made, the following must occur: (1) An Intake done by a Network Provider, (2) a service authorization confirming Medicaid eligibility and medical necessity for a Level of Care, and (3) the development of a treatment plan identifying the goals necessitating a specific out-of-network service. These processes are completed, within contractual timeframes, for enrollees who request such services prior to an initial authorization for outpatient services. Assuming the prior completion of these processes, requests for out-of-network services are processed within fourteen (14) calendar days of receipt.
- D. The decision to refer an enrollee to an out-of-network resource is reached via a collaborative process involving, at a minimum, the Network Provider responsible for the enrollee's treatment plan, the GCBH Director, and the GCBH Medical Director and/or Care Coordinators. As warranted, requests are evaluated against the provisions of the American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct. If the requested service is not covered by the Level of Care previously authorized, the referral process also includes submission of a new, service-specific authorization request. Out-of-network care is provided only when it has been mutually determined, by all appropriate parties, that the requested service is essential to the enrollee's treatment plan and that there are no resources within the delivery network which will adequately address the enrollee's needs. The authorization decision is documented via a Notice of Determination or Notice of Action, issued by GCBH or its designee.
- E. The Network Provider responsible for the treatment plan of an enrollee requiring out-of-network services, or the Member Government with which the Network Provider is subcontracted, is responsible for covering any costs associated with such services. A Network Provider/Member Government may appeal the issue of financial liability to the GCBH Board, or a designated Board subcommittee, but the delivery of services determined medically necessary may not be delayed on the basis of such an appeal.
- F. The entity to which the out-of-network provider directs billings is responsible (1) for securing a written agreement, prior to service provision, which identifies the services to be provided and the reimbursement rate for those services, (2) for ensuring that billings provide all data elements needed for reporting of service delivery encounters, (3) for verifying, and retaining documentation evidencing, the credentials necessary for the

services to be provided, and (4) for verifying that the out-of-network provider is not debarred/excluded from receiving Federal funds in any of the fifty states.

## **PROCEDURE**

1. When an out-of-network service is authorized or reauthorized, a copy of the Notice of Determination is provided to the referring Network Provider, the out-of-network provider, and the appropriate (i.e., Child or Adult) GCBH Care Coordinator. When such a service is denied, a copy of the Notice of Action is provided to the Network Provider and the GCBH Care Coordinator.
2. The Network Provider responsible for the enrollee's treatment plan is also responsible for:
  - 2.1. Obtaining all necessary Releases of Information enabling communication of clinical information between providers and the GCBH Care Coordinators.
  - 2.2. Ensuring that out-of-network services are provided within the scope of the relevant Authorization for Services.
  - 2.3. Ensuring continuity of care, service coordination, and the receipt of adequate clinical documentation relating to care delivered by an out-of-network provider;
  - 2.4. Retaining all copies of all clinical documentation pertaining to the out-of-network care;
  - 2.5. Submitting encounter data for all services provided under the agreement.
  - 2.6. Assuring that the appropriate GCBH Care Coordinator is kept informed as to the status of the enrollee receiving out-of-network services, in regards to his/her continuing need for such services, and for providing any data necessary to the RSN for purposes of monitoring such care.
  - 2.7. Providing the GCBH Chief Financial Officer, or his/her designee, with information concerning the costs of out-of-network services they have funded, upon request, to enable the RSN to assess the financial impact of such services and to facilitate assessment of network sufficiency.
3. The GCBH Care Coordinators maintain data regarding all requests for out-of-network services, and periodically report to the Quality Management Oversight Committee regarding the frequency of such requests and any trends suggesting a potential need to make a particular service available within the GCBH Delivery Network. At a minimum, these data include the following elements:
  - 3.1. RUID and CID
  - 3.2. Enrollee name and date of birth
  - 3.3. Date of request for out-of-network services
  - 3.4. Service requested
  - 3.5. Nature of the authorization decision (i.e., approval or denial)
  - 3.6. Out-of-network provider name, credentials, and contact information.
  - 3.7. Dates of service initiation and termination.

## **APPROVAL**

/S/ Ken Roughton  
Ken Roughton, Ph.D, Director

08/05/2010