San Bernardino County
Department of Behavioral Health

Out of Network Access Procedure

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Purpose

To provide procedural guidance to Department of Behavioral Health (DBH) staff regarding the approval and payment for out of network services provided to clients receiving eligible of out of network Behavioral Health Services (BHS) for Medi-Cal clients of the San Bernardino County (County) Mental Health Plan (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS).

Out of Network Services Requests

Under specific circumstances DBH may approve eligible Medi-Cal clients of the County MHP or DMC-ODS to receive BHS from a provider, group of providers, or entity that does not have a network provider agreement or contract with DBH. Clients, their authorized representatives, or their current provider may submit a request for out of network service coverage by calling the DBH Access Unit at 888-743-1478 (TTY 711). Upon receipt of the request, the Access Unit shall send the client written acknowledgement of receipt of the request and begin to process the request within three (3) working days.

Department of Health Care Services Directive Standards

If DBH has not met network adequacy, and time and distance standards, California Department of Health Care Services (DHCS) may direct DBH to allow clients to receive services from out of network provider(s). In this event, DBH shall reimburse the out of network provider(s) in a timely manner. Clients shall be permitted to continue receiving services from out of network provider(s) until DBH's provider network is able to provide the services in accordance with the standards. The requirement to allow out of network providers may apply only to a subset of the services provided by DBH.

Alternative Access Standards

For any area of the county where time and distance standards are not being met, clients in that area may be approved by DBH to receive BHS from out of network provider(s). In this event, DBH shall reimburse the out of network provider(s) in a timely manner. Clients shall be permitted to continue receiving services from out of network provider(s) until DBH's provider network is able to provide the services in accordance with the standards. The requirement to allow out of network providers may apply only to a subset of the services provided by DBH.

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Continuity of Care Standards (MHP Specific)

Clients seeking to continue receiving MHP services with an out of network or terminated network provider shall be approved to continue receiving those services for up to twelve (12) months when DBH determines through its assessment that, in the absence of continued services, the client would suffer serious detriment to their health or be at risk of hospitalization or institutionalization and the following conditions are met:

1. DBH is able to determine that the client has an existing relationship with the provider (i.e., the client has received mental health services from an out of network provider at least once during the twelve (12) months prior to their initial enrollment in the DBH MHP;
2. The provider type is consistent with the State Plan and the provider meets the applicable professional standards under State law;
3. The provider agrees, in writing, to be subject to the same contractual terms and conditions that are imposed upon currently contracting network providers, including, but not limited to, credentialing, utilization review, and quality assurance;
4. The provider supplies DBH with all relevant treatment information, for the purposes of determining medical necessity, including documentation of a current assessment, a current treatment plan, and relevant progress notes, to the extent allowed under federal and state privacy laws and regulations;
5. The provider is willing to accept the higher of DBHs provider contract rates or Medi-Cal Fee For Service (FFS) rates, and
6. DBH has not identified, verified, and documented disqualifying quality of care issues to the extent that the provider would not be eligible to provide services to any other clients.

Indian Health Care Standards

Medi-Cal eligible clients are permitted to receive MHP services from an Indian Health Care Provider (IHCP) if desired.

Transition of Care Standards (DMC-ODS Specific)

Clients seeking to continue receiving DMC-ODS services with an out of network provider during a transition from State Plan Drug Medi-Cal (DMC) to DMC-ODS, or transition from one DMC-ODS county to another DMC-ODS county shall be approved to continue receiving those services as follows:

- DBH determines through its assessment that moving a client to a new provider would result in serious detriment to the health of the client, or would produce a risk of hospitalization or institutionalization;
- DBH is able to independently determine that the client was receiving treatment from the out of network provider prior to the client's date of transition to the County DMC-ODS plan;
- The out of network provider is willing to accept the higher of DBH's contract rates or DMC rates for the applicable DMC-ODS services;

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Transition of Care Standards (DMC-ODS Specific), continued

- The out of network provider meets DBH's applicable professional standards, and no quality of care issues can be documented to the extent that the provider would be ineligible to provide services to any DMC-ODS clients;
- The provider is verified as a current DMC certified provider, and
- The out of network provider supplies DBH with the following relevant treatment information, consistent with state and federal privacy laws and regulations:
  - Documentation of medical necessity and a qualifying diagnosis;
  - Copy of the current treatment plan, and
  - All relevant outcomes data.

DMC-ODS services with the existing provider shall continue for a period of no more than ninety (90) days unless medical necessity requires the services to continue for a longer period of time, not exceeding twelve (12) months.

Courtesy Dosing Standards (DMC-ODS Specific)

Opioid Treatment Programs/Narcotic Treatment Programs (OTP/NTP) Programs may provide replacement narcotic therapy to short term (less than 30 days) visiting patients approved to receive services on a temporary basis as permitted by California Code of Regulations (CCR), Title 9, Sections 10295 and 10210 (d).

- When a client is going to be traveling, and is not eligible for take home dosing, the home clinic shall identify an OTP/NTP clinic near the client's area of travel by:
  - First, checking the DBH OTP/NTP Contractors list for an OTP/NTP clinic near the client's area of travel, or
  - If there is no DBH contracted OTP/NTP clinic near the client's area of travel, locate a licensed OTP/NTP clinic in the State of California Narcotic Treatment Program Directory.
- When an OTP/NTP clinic near the client's area of travel has been identified:
  1. The home clinic contacts the receiving clinic to ensure they will accept the visiting client;
  2. The home clinic completes their clinic's courtesy dosing form, which is then signed by the client's doctor and faxed to the receiving clinic;
  3. The doctor at the receiving clinic reviews the courtesy dosing form and accepts responsibility for the client by signing and dating the form;
  4. The receiving clinic faxes the courtesy dosing form back to the home clinic, and
  5. The completed courtesy dosing form is retained by the home clinic in the client's medical record.
- The client will then be able to receive courtesy dosing services at the receiving clinic.

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Reimbursement for Out of Network Services

The reimbursement procedures for out of network services shall be as follows:

Out of Network Services	Reimbursement Procedure
• Department of Health Care Services Directive; • Alternative Access; • Continuity of Care, and • Transition of Care	Payment for out of network services will be processed by DBH Fiscal staff as follows: • DBH program staff provides written notification to Fiscal staff to process payment to an out of network provider; • Fiscal staff will contact the provider to obtain invoice and supporting documents; • Once received from provider, these documents will be sent to DBH Program staff for review and approval; • Fiscal staff will process payment upon receipt of approved documents from Program staff, and • When the out of network provider is not a Medi-Cal provider, it shall receive its published encounter rate, or in the absence of a published encounter rate, the reimbursement shall be at the rate for services provided under the State Plan's FFS payment.
Indian Health Care Providers	When the IHCP is not a Medi-Cal provider, it shall receive its published encounter rate, or in the absence of a published encounter rate, the reimbursement shall be at the rate for services provided under the State Plan's FFS payment.

Courtesy Dosing	• Claims for courtesy dosing services by DBH contracted OTP/NTP clinics are paid through the contract
	• Claims for courtesy dosing services by non-contracted OTP/NTP clinics are reimbursed as follows:
	  ○ The receiving clinic submits claims for courtesy dosing services to the client's home clinic, and
	  ○ The home clinic submits the claims to DHCS through the DBH Behavioral Health Management Information System.

DBH shall coordinate with out of network providers for payment purposes and ensure the cost to the client is no greater than it would be if the services were furnished within DBH's provider network.

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Retroactive Approval of Out of Network Services

The DBH Access Unit shall retroactively approve requests for out of network services and reimburse out of network providers for services that were provided if the request meets the requirements described above and the services that are the subject of the request meet the following requirements:

- Services occurred after the clients enrollment into the County MHP or DMC-ODS, and
- Dates of services are within thirty (30) calendar days of the first service for which the provider is requesting retroactive reimbursement.

Retroactive reimbursement requests shall be submitted in writing within thirty (30) calendar days of the first service to which the request applies.

Related Policy or Procedure

DBH Standard Practice Manual:

- Network Adequacy Monitoring Policy (QM6043)
- Network Adequacy Monitoring Procedure (QM6043-1)
- Out of Network Access Policy (QM6044)
- Service Availability Policy (QM6046)
- Timely Access Policy (QM6041)
- Timely Access Procedure (QM6041-1)

Reference(s)

- California Code of Regulations, Title 9, Section 10295 and 10210 (d) https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IFF195D40D45311DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)
- California Code of Regulations, Title 28, Section 1300.67.2.2 https://govt.westlaw.com/calregs/Document/IA926F8C0101711DFBF14F83A306F765F?contextData=(sc.Default)&transitionType=Default
- Code of Federal Regulations Title 42, Chapter IV Subchapter C, Part 438.14 and 438.68 https://www.ecfr.gov/cgi-bin/text- idx?tpl=/ecfrbrowse/Title42/42cfr 438_ main_02.tpl
- California Department of Health Care Services Mental Health and Substance Use Disorder Services Information Notice No. 18-011 https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-%20Network%20Adequacy/MHSUDS_IN_18-011_Network_Adequacy.pdf
- Revenue Agreement with the State of California for the Substance use Disorder Drug Medi-Cal Organized Delivery System (State Agreement No. 17-94066, Amendment 1)