
Title 1	Northern Lakes Policies
Part 103	Managed Health Division
Subpart B	Contract Management
Policy No.	103.206
Subject	Out of Network Providers

Applicability

Policy applies to all MHD staff, NLCMH staff, and contract and network providers.

Policy

Northern Lakes CMH is responsible to provide direct access to behavioral health services for consumers and to promote consumer choice and effective freedom. At times, the current network of providers may not be able to meet the need of a consumer for required services. The MHD will have a process in place to provide access for that consumer in order for necessary treatment to be rendered in a timely and appropriate fashion by a provider who meets requirements.

Procedures

1. The MHD receives notice of a request for out-of-network authorization. Services require authorization under the same policies as those services provided by network "in-plan" providers.
2. The MHD must provide due diligence to assure the competency and appropriateness of the provider.
 - a. For organizational providers: At a minimum, the licenses, certifications, accreditation and liability insurance of an organizational provider will be requested immediately for review. These will be verified to make sure all are free from sanctions by any federal, state, or professional organization including Medicare and Medicaid.
 - b. For individual providers: At a minimum, license or registration and liability insurance will be requested immediately for review. These will be verified to make sure that all are free from sanction by any federal, state, or professional organization including Medicare and Medicaid. Also, a criminal background check on the individual will be facilitated.
3. It is the intent of the MHD to preauthorize services consistent with the Utilization Management Plan. In the event a provider unknowingly admits or serves a consumer without proper authorization, that admission or service must be reported to the MHD within 3 business days of discovery for retrospective review. This retrospective review must occur within 90 days. The provider information listed in #2 will be requested in addition to a claim and proper documentation to support the claim.

4. The Out-of-Network Provider must agree to accept the standard rate for services rendered. An agreement specific to the Member will be sent to the Provider, which indicates rates and billing requirements.
5. If a determination is made that the provider will be rendering services ongoing and that added capacity is needed in the network, an application packet will be sent to the Provider with follow-up for formal contracting, and acceptance to the provider network. Network Providers must meet all standards as established in Network Policies and Procedures for Network Development. These standards include but are not limited to: Credentialing and Privileging, Reporting, Training, Recipient Rights, Mental Health Code, and Person-Centered Planning.

Adoption Date: June 4, 2006

Review Dates: June 5, 2009

Revision Dates: