CareOregon

Provider Guide to Billing Out-of-Network

Network: CareOregon/Metro Behavioral Health

Updated: **07/09/2022**

The document is a resource for:
Out-of-network providers that would like to be reimbursed for services.

For questions, contact CareOregon Provider Customer Service at **503-416-4100**.

To support your clinic and members' access to care, CareOregon's out-of-network policy pays qualified providers for behavioral health services provided to CareOregon/Health Share members that meet CareOregon's authorization requirements.

Prior to Providing Services

See the Behavioral Health Utilization Management Procedure Handbook for guidance on how to begin providing services as an out-of-network provider:
link.careoregon.org/bh-um-handbook

1. **Review CareOregon's Guiding Clinical Principles:** Pages 1-8
   - Overview of CareOregon's clinical values and authorization categories.
   - Summary of the process for initial authorizations, assessments, prior authorizations, and requests for ongoing treatment.
2. **Submit Prior Authorization Documents for CareOregon's Clinical Review:** Page 9-18
   - Section "Guidelines for Medical Necessity Criteria" outlines documentation that CareOregon needs to approve each type of authorization request.

Please also review our *Noncontracted MH & SUD Fee Schedule* for additional details and requirements for specific services.

After Providing Services

See the CareOregon Provider Manual (pages 17-21):
link.careoregon.org/bh-provider-manual

1. **Claims Submission Process:** Pages 17-19
   - Review the claims submission & adjudication process for EDI and paper claims. Submit claims within 120 days of providing service to meet timely filing deadlines.
2. **Claims Reprocessing:** Page 19
   - As applicable, a resource for CareOregon's claims reprocessing procedures.
3. **Member Billing:** Page 19-20
   - References Oregon Regulations that prohibit (in most circumstances) billing members, including for missed appointments and bill balancing.