Mid-Valley Behavioral Care Network

OUT OF PANEL AGREEMENT FOR OUTPATIENT MENTAL HEALTH SERVICES

This Agreement is for outpatient mental health services for Willamette Valley Community Health (WVCH) Members provided by out-of-panel providers. This Agreement makes the mental health agency (Provider Agency) named below eligible for payment for outpatient mental health services provided to a specific WVCH Member when the services are authorized by Mid-Valley Behavioral Care Network (MVBCN). MVBCN is subcontracted by WVCH to manage and pay for its Members' mental health services.

This Agreement is between MVBCN and the Provider Agency named below:

Provider Agency: ____

Address: ____

City, State & Zip Code: ____

Phone: __________________________ Fax: __________________________

Tax ID: _________________________ DMAP #: ________________________

NPI #: _____________________ Taxonomy Code: ______________________

Credentialing & Liability Insurance

Provider Agency Representative Initials: ________. We (Provider Agency) hold a current Certificate of Approval for Mental Health Services and maintain professional liability insurance with limits not less than $1,000,000 per occurrence and $3,000,000 annual aggregate for services covered under this Agreement.

PLEASE ATTACH:

- ☐ Copy of applicable Certificate of Approval
  - If certified in multiple counties, submit Certificates for all
- ☐ Copy of professional liability insurance certificate with the above limits

Clinical Documentation

Provider Agency Representative Initials: ________. We (Provider Agency) agree to maintain clinical records consistent with OAR 410-141-3180, Record Keeping and Use of Health Information Technology, and with all applicable Oregon Health Authority (OHA) Administrative Rules (OAR) in Chapter 309.

Confidentiality Statement

Provider Agency Representative Initials: ________. We (Provider Agency) understand that we must maintain full confidentiality of private client information and protected health information in accordance with federal HIPAA standards (P.L. 104-191, 45 CFR Parts 160, 161,

and 164) and with applicable Oregon Revised Statutes (ORS) and Administrative Rules. We will not discuss or give out information about any Member served or his/her family without written authorization from the Member or family unless specifically allowed by law to do so. We understand that services provided through a Coordinated Care Organization (CCO) such as WVCH fall under ORS 414.679 and Senate Bill 1580 (2012) which require sharing of Member information for service and care delivery and coordination among CCO staff and the CCO provider network. HIPAA and Oregon Revised Statutes allow exchange of information necessary to authorize services and process claims without a Release of Information from the Member, parent/guardian, or the agency which holds custody.

Payment Schedule

Provider Agency Representative Initials: ________. We (Provider Agency) agree to be paid for services under this Agreement at the rates set by OHA for behavioral health services. These rates are commonly referred to as "DMAP rates". OHA's fee schedules are available at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx

Billing

Provider Agency Representative Initials: ________. We (Provider Agency) understand that paper claims for authorized services must be submitted using the red CMS 1500 (for 02/2012) claim form, as described in the document called "Authorization Process for WVCH Members Receiving Services Outside of Our Region".

Mandatory Abuse Reporting

Provider Agency Representative Initials: ________. We (Provider Agency) understand that under state law we are a mandatory reporter of abuse and must promptly report any suspected abuse or neglect to local child welfare or law enforcement personnel.

Critical Incident Reporting

Provider Agency Representative Initials: ________. We (Provider Agency) will notify MVBCN if any Member for whom we are authorized to provide services is involved in a Critical Incident while we are working with the Member. (See MVBCN Critical Incident definitions on page 4 of this Agreement)

Responding to Grievances

Provider Agency Representative Initials: ________. We (Provider Agency) agree to respond to grievances concerning mental health services from WVCH Members or their representatives as set forth in OAR 309-022-0190. Members or their representatives can also initiate a complaint by calling WVCH Member Services at 503-584-2150 or 866-362-4794

Criminal Background & Medicaid Exclusion

Provider Agency Representative Initials: ________. We (Provider Agency) certify that we follow the Department of Human Services guidelines for criminal history background checks for all service delivery staff. We certify that professional staff serving WVCH Members are not excluded from Medicaid participation. Verification of both of these checks for staff serving WVCH Members are available to MVBCN upon request.

Conditions of Agreement

By signing this document, We (Provider Agency) agree to assume all risks and responsibilities that are applicable. This Agreement may be modified or cancelled by either party at any time for any reason with or without prior notice. Any modification of this Agreement must include the date and signature of both parties in order for the revisions to be in force.

Provider Agency Representative: ____

Signature Date

____

Printed Name

MVBCN Representative: ____

Signature Date

____

Printed Name

Return this Agreement to:

MVBCN, Attn: Provider Credentialing

By mail:

550 Hawthorne Ave SE,
Suite 140
Salem, OR 97301

Or by fax:

503-585-4989

MVBCN Critical Incident Reporting

Outpatient Providers are required to report Critical Incidents involving WBCH members to the BCN using the Notification and Follow Up forms. Critical incidents are actions that result in serious injury or death or any other serious incident that is a risk to Member health and safety including:

- Member Suicide*
- Medication Error requiring Medical Intervention
- Attempted Member Suicide
- Member Death
- Allegation of Member Abuse or Neglect
- Danger to Health and Safety
- Alleged homicide of or by Member
- Police intervention

*Suicides of children and young adults (ages 0 to 24) are also reported to the county where the death occurred.

The Critical Incident Reporting Form and the Follow Up forms can be found in the Forms link on the MVBCN website (www.mvbcn.org). These must be completed for each incident. The Critical Incident Policy can be found in the policy section of the website

Contact the Quality Improvement Coordinator at 503-576-4538 with any questions