KENTUCKY ONLY: MEDICAID POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
10/31/2014	02/11/2017	02/11/2016

Policy Name	Policy Number
Out-of-Network Providers Policy for Medically Necessary Services	PY-0031

Policy Type		
☐ Medical	☐ Administrative	☒ Payment

Medicaid Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) apply to Medicaid health benefit plans administered by CSMG and its affiliates and are derived from literature based on and supported by applicable federal or state coverage mandates, clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medicaid Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan benefit document (i.e., Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medicaid Policy Statement and the plan benefit document, then the plan benefit document will be the controlling document used to make the determination. In the absence of any applicable controlling federal or state coverage mandate, benefits are ultimately determined by the applicable plan benefit document.

A. SUBJECT

Out-of-Network Providers Policy for Medically Necessary Services

B. BACKGROUND

CareSource will reimburse out-of-network providers for preauthorized, medically necessary services in accordance with the guidelines in this policy.

C. DEFINITIONS

N/A

D. POLICY

I. Preauthorized, medically necessary services rendered to CareSource members by out-of-network providers will be reimbursed at 65% of the Kentucky Medicaid fee schedule unless otherwise noted.
   A. The following items will be reimbursed at 90% of the Kentucky Medicaid fee schedule:
      1. Emergency care (non-participating professional and facility services provided to members in an Emergency Room setting)
      2. Services provided for family planning
      3. Services for children in foster care
   B. Single case agreements for providers and/or otherwise negotiated services will be reimbursed at the mutually agreed upon rate.

CONDITIONS OF COVERAGE
HCPCS
CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued:	10/31/2014
Date Reviewed:	10/31/2014, 02/14/2016
Date Revised:	02/14/2016 – addition of negotiated single case agreement for providers would override current policy.

G. REFERENCES

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.