CareSource

REIMBURSEMENT POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Payment to Out of Network Providers-NV MP-PY-1802	11/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding, and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Payment to Out of Network Providers

B. Background
This policy defines the reimbursement rate for claims received from providers who are not contracted (out of network) providers with CareSource.

C. Definitions
- **Out of Network Provider** – Provider not contracted with CareSource**.**

D. Policy
Services provided by out-of-network providers are not covered under Marketplace Plans unless prior authorization is obtained or an exception applies. When CareSource is required to provide out-of-network coverage and the reimbursement methodology is not defined, CareSource's standard reimbursement methodology will be as follows:

I. Preauthorized, medically necessary services rendered to CareSource members by out-of-network providers will be reimbursed at:
   A. durable medical equipment (DME) - 60% of the Medicare rate
   B. orthotics/prosthetics - 60% of the Medicare rate;
   C. applied behavior analysis (ABA) services that require prior authorization - 60% of the CareSource established ABA fee schedule;
   D. skilled nursing facility (SNF) - 60% of the Medicare allowable rate
   E. laboratories - 60% of the Medicare rate;
   F. all other services - will be reimbursed at 60% of the Medicare rate

   NOTE: Approved authorization does not ensure payment.

II. In the event of emergency services, CareSource will adhere to the Federal No Surprises Act (January 1, 2022).
   A. No prior authorization is required for emergency services.
   B. Emergency health care services, not otherwise subject to the No Surprises Act, will be reimbursed based on state regulations.

III. In the event of any conflict between this policy and a provider's agreement with CareSource, the provider's agreement will be the governing document.

IV. Exclusions
   The following will be reimbursed at 100% of the Medicare rate:
   A. home health services
   B. hospice
   C. private duty nursing (PDN)
   D. all services in a Federally Qualified Health Center (FQHC), Rural Health Clinics (RHC) and Indian Health Clinics

E. Conditions of Coverage

Reimbursement policies are designed to assist providers when submitting claims to CareSource and are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement of claims may be subject to limitations and/or qualifications. Reimbursement will be established based on a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify a member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claim payment.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	08/12/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	11/01/2026	
Date Archived		

H. References

1. Fuchs B, Hoadley J. Summary of the No Surprises Act. Center on Health Insurance Reform, Georgetown University; 2021. Accessed August 3, 2026. www.commonwealthfund.org
2. Managed Care: Out-of-Network Care H-285.904. American Medical Association. Updated 2025. Accessed August 3, 2026. www.policysearch.ama-assn.org
3. Reports, Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 2859 (2020).