REIMBURSEMENT POLICY STATEMENT
OHIO MARKETPLACE

Policy Name		Policy Number	Effective Date
Payment to Out of Network Providers		PY-1175	11/15/2021-02/28/2023
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates 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.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Payment to Out of Network Providers

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon 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 their office staff are encouraged to use self-service channels to verify 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 claims payment.

This policy is intended to define the reimbursement rate for claims received from providers who are not contracted (out of network) providers with CareSource.

C. Definitions

- **Emergency Services** – Emergency health care services are used to treat an emergency medical condition.
- **Emergency Medical Condition** – A medical condition that manifests itself by signs and symptoms of sufficient severity or acuity, including severe pain, such that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:
  - Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- **Unanticipated out-of-network care** – Means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when either of the following conditions applies:
  - The covered person did not have the ability to request such services from an in-network provider.
  - The services provided were emergency services.

D. Policy

Services provided by out-of-network providers are not covered under the Marketplace Plans, however, exceptions exist. For those situations where CareSource is required to

provide out-of-network coverage, and the reimbursement methodology is not defined, CareSource's standard reimbursement will be as follows:

I. Preauthorized, medically necessary services rendered to CareSource members by out-of-network providers will be reimbursed at:
   A. 60% of the Medicare Fee schedule charges; and
   B. 60% of the Medicare Fee schedule for labs.
   C. If the code is not on the Medicare fee schedule, it will be reimbursed at 60% of the Medicaid fee schedule.
   D. If a service or procedure is covered by CareSource and not priced by Medicare or Medicaid, CareSource will use the Ohio Custom Fee Schedule for Ohio Marketplace payment determinations.

II. In the event of Emergency Services and unanticipated out of network care, CareSource will adhere to the Federal No Surprises Act, January 1, 2022, and Ohio's Revised Code (O.R.C.) §§3901.8.17 et seq.
   A. No prior authorization is required for Emergency Services.

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:
   A. Provider types whose reimbursement methodology is mandated by state/federalregulation/statute or rule or directive.

E. Conditions of Coverage

Where applicable, reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

Evidence of Coverage and Health Insurance Contract Ohio

G. Review/Revision History

	DATE	ACTION
Date Issued	05/27/2020	New policy
Date Revised	11/10/2021	Updated definitions. Added No Surpirse Act and ORC language. Added references. Approved at PGC
Date Effective	11/15/2021	
Date Archived	02/28/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. B. Fuchs, J. Hoadley. January 19, 2021. Summary of the No Surprises Act. January 1, 2021. Retrieved 11/01/2021 from www.commonwealthfund.org.
2. No Surprises Act of the 2021 Consolidated Appropriations Act. Pub. L. No. 116-260, 134 Stat. 1182, Division BB, § 109. Retrieved 11/01/2021 from www.congress.gov.
3. Out-of-network care reimbursement requirement, negotiations. Ohio Revised Code. Title 39 Insurance. Chapter 3902 Insurance Policies and Contracts. Retrieved 11/01/2021 from www.codes.ohio.gov.
4. Reimbursement for Unanticipated Out-of-Network Care. Ohio Revised Code. Title 39 Insurance. Chapter 3901 Health Insurance. Retrieved 11/01/2021 from www.codes.ohio.gov.

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