CareSource

REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Payment to Out of Network Providers-MP-PY-1359	IN, KY, WV: 02/01/2023 OH: 03/01/2023
Policy Type	
REIMBURSEMENT	

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.

This policy applies to the following Marketplace(s):			
☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Payment to Out of Network Providers

B. Background

Reimbursement policies are designed to assist providers 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 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 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** – Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
- **Emergency Medical Condition** – An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

D. Policy

Services provided by out-of-network providers are not covered under Marketplace Plans and require prior authorization 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. Durable Medical Equipment (DME) - 60% of the Medicare rate;
   B. Orthotics/Prosthetics - 60% of the Medicare rate;
   C. All 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. Labs not related to Covid testing - 60% of the Medicare rate;
   F. All other services will be reimbursed at 60% of the Medicare rate (see exclusion list below in section IV.).

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. Covid testing labs
B. Home health services
C. Hospice
D. Private Duty Nursing (PDN)
E. All services in a Federally Qualified Health Center (FQHC), Rural Health Clinics (RHC) and Indian Health Clinics

E. Conditions of Coverage
NA

F. Related Policies/Rules
Evidence of Coverage and Health Insurance Contract

G. Review/Revision History

	DATE	ACTION
Date Issued	12/14/2022	New policy
Date Revised		
Date Effective	IN, KY, WV: 02/01/2023 OH: 03/01/2023	
Date Archived		

H. References
1. American Medical Association. Managed Care. Out-of-Network Care Policy H-285.904 (2022). Retrieved 10/05/2022 from www.policysearch.ama-assn.org.
2. Fuchs, B., Hoadley, J. January 19, 2021. Summary of the No Surprises Act. January 1, 2021. Retrieved 10/05/2022 from www.commonwealthfund.org.
3. Glossary. (2022). Emergency medical condition. Retrieved 10/05/2022 from www.healthcare.gov.
4. Glossary. (2022). Emergency services. Retrieved 10/05/2022 from www.healthcare.gov.
5. No Surprises Act of the 2021 Consolidated Appropriations Act. Pub. L. No. 116-260, 134 Stat. 1182, Division BB, § 109. Retrieved 10/05/2022 from www.congress.gov.

I. State-Specific Information
A. Indiana
1. Effective: 02/01/2023
B. Kentucky

1. Effective: 02/01/2023

C. Ohio
   1. Effective: 03/01/2023

CI. West Virginia
   1. Effective: 02/01/2023

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