CareSource

REIMBURSEMENT POLICY STATEMENT
Ohio Marketplace

Policy Name & Number	Date Effective
Payment to Out of Network Providers-OH MP-PY-1800	09/01/2026
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 Reimbursement policies may be superseded by federal and state laws and regulations, as applicable.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

Establishing clear policies for payment to out-of-network (OON) providers is essential to balance member access to care, cost containment, and regulatory compliance. While Marketplace plans generally do not cover services from OON providers without prior authorization, exceptions exist—particularly for emergency situations—ensuring members receive necessary care when in-network options are not available or appropriate. CareSource outlines a structured reimbursement methodology for OON services that are preauthorized and medically necessary, using standardized benchmarks like Medicare fee schedules to promote fairness and predictability in payments. This approach helps control healthcare costs while maintaining network adequacy and protecting members from unexpected financial burdens. Additionally, adherence to federal laws, such as the No Surprises Act, safeguards members' rights in emergency scenarios, reinforcing the CareSource's commitment to consumer protection within the commercial exchange environment.

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

C. Definitions

- **Out of Network Provider** – A provider not contracted with CareSource**.**

D. Policy

I. 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 approach to out-of-network (OON) providers is as follows:

A. Prior authorization is required for all services rendered by OON providers unless otherwise required by applicable law, regulation, contract, or Plan policy. Exceptions include emergency services and other services for which prior authorization cannot be required under federal or state requirements.

B. Requests for services provided by an OON provider will be reviewed on a case-by-case basis to determine medical necessity, network adequacy, and benefit eligibility. Failure to obtain required prior authorization may result in denial of coverage or reimbursement.

C. Preauthorized, medically necessary services rendered to CareSource members by out-of-network providers will be reimbursed at

1. 60% of the applicable Medicare fee schedule
2. If a service or procedure is not priced by Medicare, then the service or procedure will be reimbursed at 20% of billed charges.

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 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.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	12/14/2022	New policy. Approved at Committee.
Date Revised	07/29/2026	Periodic review. Policy number changed from PY-1359. Removed Covid testing language. Updated background, D. I,A,B,C for greater clarification and references. Approved at Committee.
Date Effective	09/01/2026	

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

Date Archived		

H. References

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