REIMBURSEMENT POLICY STATEMENT
West Virginia Marketplace

Policy Name & Number	Date Effective
Payment to Out of Network Providers-WV MP-PY-1178	01/01/2022-01/31/2023

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.

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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 services"** Per W. Va. Code § 33-25A-8d - are those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;
- **"Prudent layperson"** - means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;
- **"Emergency medical condition for the prudent layperson"** - means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;
- **"Emergency medical condition"** - means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

D. Policy

Per our contract out of network providers are not covered within the Marketplace Plans but there are exceptions. For those situations where we are required to provide out of network

coverage, when the reimbursement approach is not defined, CareSource's standard reimbursement approach is as follows:

I. Preauthorized, medically necessary services rendered to CareSource members by out-of-network providers in the state of West Virginia will be reimbursed at 50% of the Medicare fee schedule. If the code is not on Medicare fee schedule, it will be reimbursed at 70% of the Medicaid fee schedule. If a service or procedure is not priced by Medicare or Medicaid, then it will be reimbursed to the provider at 20% of billed charges.

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.

II. Exclusions:
   A. Emergency Health Care Services and RAPHEL providers will be reimbursed based on state regulations.

E. Conditions of Coverage

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

F. Related Policies/Rules

Evidence of Coverage and Health Insurance Contract West Virginia

G. Review/Revision History

	DATE	ACTION
Date Issued	04/29/2020	New Policy
Date Revised	04/14/2021 12/15/2021	Reimbursement amount has changed. No Surprises Act language added. Updated references. Approved at PGC
Date Effective	01/01/2022	
Date Archived	01/31/2023	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. American Medical Association. Managed Care. Out-of-Network Care Policy H-285.904 (2021). Retrieved November 15, 2021 from www.policysearch.ama-assn.org.
2. B. Fuchs, J. Hoadley. January 19, 2021. Summary of the No Surprises Act. January 1, 2021. Retrieved November 15, 2021 from www.commonwealthfund.org.
3. No Surprises Act of the 2021 Consolidated Appropriations Act. Pub. L. No. 116-260, 134 Stat. 1182, Division BB, § 109. Retrieved November 15, 2021 from www.congress.gov.
4. West Virginia Code (2020). Chapter 33. Insurance. 33-25A-8d. Coverage of emergency services. Retrieved November 15, 2021 from www.wvlegislature.gov.

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