



REIMBURSEMENT POLICY STATEMENT GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Payment to Out of Network Providers		PY-1171	12/01/2021-07/31/2023
Policy Type			
Medical	Administrative	Medicaid	REIMBURSEMENT

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) 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.

CSMG Co. 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.

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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 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.

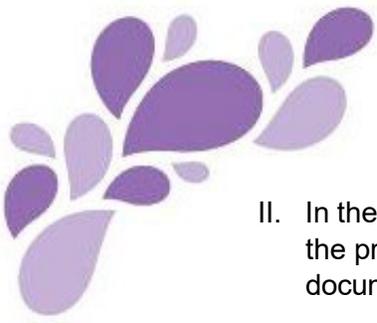
C. Definitions

- **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.
- **Out of Network** – Providers that are not part of CareSource's network or do not have a signed contract.

D. Policy

CareSource's standard reimbursement approach to out of network providers is as follows:

- I. Preauthorized, medically necessary services rendered to CareSource members by out-of-network providers will be reimbursed at
 - A. 90% of the Medicaid Fee schedule; and
 - B. 60% of the Medicaid Fee schedule for labs.
 - C. In the case where billed rate for any service provided is lower than the calculated allowed amount, CareSource will reimburse claim lines with the lesser of billed charges and the calculated allowed amount as shown in A or B above.



II. In the event of any conflict between this policy and any written agreement between the provider and CareSource, that written agreement will be the governing document.

III. Exclusions:

A. Emergency Health Care Services 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. Please refer to the individual fee schedules for appropriate codes.

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	09/15/2021	New policy
Date Revised		
Date Effective	12/01/2021	
Date Archived	07/31/2023	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

N/A

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