CareSource | NETWORK Notification

Notice Date: January 24, 2022
To: CareSource Marketplace Providers
From: CareSource
Subject: No Surprises Act
Effective Date: January 1, 2022

Summary
Effective Jan. 1, 2022, CareSource will comply with new state and federal requirements in alignment with the No Surprises Act, including how we process claims from certain out-of-network providers. This applies to claims with date of service starting Jan. 1, 2022.

The No Surprises Act, part of the Consolidated Appropriations Act of 2021, establishes patient protections for members enrolled in Marketplace plans, including protection from out-of-network providers' surprise bills (balance billing) for emergency care and other specified items or services.

Impact
CareSource presumes emergency services (including post-stabilization) and services from out-of-network providers at in-network facilities are covered under the No Surprises Act. Post-stabilization services are defined as emergency services needed to evaluate or stabilize an emergency medical condition per citation 42 CFR 438.114. Claims will be processed according to the Consolidated Appropriations Act of 2021 based on criteria below as billed on the claim. Providers are prohibited from balance billing members, aside from patient responsibility for copay, deductible, and coinsurance.

Out-of-network providers are encouraged to submit a new contract request, which can be done online at Becoming a Participating Provider or by working with a contract manager.

Emergency services:

- Outpatient Facility claims for emergency services should be billed with Revenue Codes 0450-0459, 0762, or emergent ambulance revenue/procedure codes.
- Inpatient Facility claims for post-stabilization emergency services should be billed with an Admit Type = 1, 2, or 5.
- Professional claims for emergency services should be billed with Place of Service 23, 41, or 42; CPT codes 99217-99220 or 00234-99236, or Emergency Indicator ‘E’ or ‘I’ in box 24c on the 1500 form.

Non-emergency services:

- Boxes 32 and 32a are required to be completed with the appropriate facility information.

Importance
Claims paid in accordance with this Act will be notated in the claim detail section of your Electronic Remittance Advice or Explanation of Payment notice with Remark Code N830. Providers do not need to submit documentation of notice and consent requirements with their claims. Prior authorizations will still be required for services that require medical necessity review.

Requests for open negotiation within the first 30 days following receipt of CareSource's initial payment should be submitted through this process, along with all relevant supporting documentation. Requests for open negotiation within the first 30 days following receipt of CareSource's initial payment should be submitted through the normal dispute or appeals processes. If you wish to file a dispute or appeal, please visit **CareSource.com** > Providers > Provider Portal > Provider Disputes and Appeals for information.

Multi-EXC-P-1030045