REIMBURSEMENT POLICY STATEMENT
Ohio MyCare FIDE

Policy Name & Number	Date Effective
Payment to Out of Network Providers-MyCare OH FIDE-PY-1835	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 Reimbursement policies may be superseded by federal and state laws and regulations, as applicable.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

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 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** – Services needed to evaluate, treat, or stabilize 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
  - serious dysfunction of any bodily organ or part
- **Out of Network (OON) Provider** – A non-participating provider that is not contracted with CareSource.

D. Policy

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

II. Out-of-network providers have the option to negotiate a different rate than stated above.

III. Exclusions
   A. Emergency services will be reimbursed based on state regulations.
   B. Provider types with reimbursement methodology mandated by state/federal regulation/statute or rule or directive.
   C. Out of network Waiver providers will be reimbursed at the previous rate, during the transition of care period only.

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

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

Payment to Out of Network Providers-Ohio Medicaid

G. Review/Revision History

	DATE	ACTION
Date Issued	07/15/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	09/01/2026	
Date Archived		

H. References

1. Managed Care: Out-of-Network Care H-285.904. American Medical Association. Updated 2025. Accessed June 29, 2026. www.policysearch.ama-assn.org
2. Fuchs B, Hoadley J. Summary of the No Surprises Act. Center on Health Insurance Reform, Georgetown University; 2021. Accessed June 29, 2026. www.commonwealthfund.org
3. Reports, Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 2859 (2020). Accessed June 29, 2026. www.govinfo.gov

ODM Approved 07/21/2026