CareSource

# ADMINISTRATIVE POLICY STATEMENT
# Marketplace

| Policy Name & Number | Date Effective |
|---|---|
| Claims Editing and Review-MP-AD-1178 | 09/01/2026 |
| **Policy Type** | |
| **ADMINISTRATIVE** | |

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable.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.

| This policy applies to the following Marketplace(s): | | | |
|---|---|---|---|
| ☒ **Georgia** | ☒ **Indiana** | ☒ **Ohio** | ☒ **West Virginia** |

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A. Subject
**Claims Editing and Review**

B. Background
All health care providers are expected to utilize the same standard coding sets and rules to codify the services provided during encounters with members. This codification is used to bill insurance carriers for reimbursement, known as a 'claim'. In the codification process, there are rules that must be followed to appropriately codify the encounter into a claim, which is then sent to the insurance carrier for reimbursement.

All claims submitted to CareSource for reimbursement consideration are subject to claims editing. This ensures that appropriate coding sets are used and rules are applied in billing by the provider. This also ensures that appropriate reimbursement is made to the provider for services rendered. This policy outlines the source of edits and rules CareSource utilizes for claims editing and review.

C. Definitions
NA

D. Policy
I. To ensure appropriate and timely reimbursement for services rendered to enrollees, CareSource utilizes automated claims editing to enforce appropriate coding and billing practices by providers when submitting claims.
   A. Appropriate coding and billing of claims allows for the accurate adjudication and reimbursement for services rendered to a CareSource enrollee.
   B. All claims submitted to CareSource are subject to this editing.

II. CareSource models edits and rules from the following sources:
   A. Industry standard coding rules, manuals, guidelines, directives, and relevant state and federal regulations for claims editing
   B. Resources used to source these coding and billing standards include, but are not limited to, the following list:
      1. The Accredited Standards Committee (ASC) X12 - claim submission rules and edits applied to inbound electronic claims (www.x12.org)
      2. Workgroups for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) – claim submission rules and edits applied to inbound electronic claims related to HIPAA compliant file exchanges
      3. *Current Procedural Terminology (CPT) Manual* from the American Medical Association (AMA)
      4. Healthcare Common Procedure Coding System (HCPCS) – Level II coding guidelines
      5. *Uniform Billing (UB) Editor - Manual* from the American Hospital Association (AHA) Coding directives
      6. *International Classification of Diseases, Tenth Edition Clinical Modifications* (ICD-10-CM) manual
      7. Centers for Medicare and Medicaid Services (CMS) rules and notifications

a. CMS billing rules and instructions (www.cms.gov)
b. Medicare *National Correct Coding Initiative (NCCI) Instructions/Manual*
c. Medicaid *NCCI Instructions/Manual*
d. Medicare Physician Fee Schedule instructions

8. Food and Drug Administration (FDA) guidelines (www.fda.gov)
9. Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov)
10. US Preventive Services Task Force (www.uspreventiveservicestaskforce.org)
11. State Agencies (as appropriate for enrollee's coverage)
    a. Georgia Office of Insurance and Safety (oci.georgia.gov)
    b. Indiana Department of Insurance (in.gov/idoi)
    c. Ohio Department of Insurance (insurance.ohio.gov)
    d. West Virginia Offices of the Insurance Commissioner (wvinsurance.gov)
12. State and national recognized medical association and specialty experts including, but not limited to:
    a. American College of Radiology
    b. American Academy of Pediatrics
    c. American College of Obstetricians and Gynecologists
13. CareSource's website (www.CareSource.com)
    a. policies
    b. provider manuals
    c. provider notifications

III. CareSource strives to keep our editing current with all changes as the changes occur; as such, edits may be added, modified, or removed based on changes, clarifications, and new directives received from these resources and any other resources that may become applicable.

IV. CareSource sends providers the outcomes of the edits through the standard Explanation of Payment (EOP) process. Provider EOPs indicate the outcomes by the use of industry standard Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) coding system. The provider can obtain additional information by reviewing CareSource's Provider Portal and/or the *CareSource Provider Manual* (www.CareSource.com).

V. Providers may file a dispute and provide additional information to support the provider's position for reconsideration of reimbursement. Instructions to file a dispute related to a denial or rejection of a claim can be found on CareSource's website. Please refer to the *Provider Manual*, under "Claim Dispute Process."

## E. Conditions of Coverage

NA

## F. Related Policies/Rules

NA

G. Review/Revision History

| | DATE | ACTION |
|---|---|---|
| **Date Issued** | 04/27/2022 | New policy |
| **Date Revised** | 05/10/2023<br><br>09/25/2024<br><br>11/05/2025<br>06/17/2026 | Annual review. Updated II. B. 11. Approved at Committee.<br>Annual review. Updated II. B. 11 and 12. Approved at Committee.<br>Annual review. Approved at Committee.<br>Periodic review. Approved at Committee. |
| **Date Effective** | 09/01/2026 | |
| **Date Archived** | | |

H. References

NA