



ADMINISTRATIVE POLICY STATEMENT

Marketplace

Policy Name & Number	Date Effective
Itemized Billing-MP-AD-1199	10/01/2026
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 Policy Statements may be superseded by federal and state laws and regulations, as applicable.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

Itemized Billing

B. Background

Itemized bill review is the analysis of inpatient facility itemized billing statement against CareSource policies and industry standard guidelines, as well as state and/or federal billing guidelines. CareSource may request an itemized bill for an inpatient facility claim to verify that billed revenue codes represent charges for appropriately billed items, supplies and services. Routine items, supplies, and services are to be included in the primary inpatient room and board charge and are not separately reimbursable.

C. Definitions

- **Inpatient Hospital Claim** – Claims submitted for a member who has been formally admitted by a provider order for bed occupancy to receive inpatient hospital services with the expectation that the member will remain at least overnight.
- **Itemized Bill** – A comprehensive list of all services and goods provided during the inpatient hospital stay which lists the costs and descriptions associated with the service and/or good.

D. Policy

- I. CareSource follows the *CMS Provider Reimbursement Manual* guidelines, chapter 22, sections 2202.6 and 2203.
 - A. Routine services defined by CMS chapter and section above are services included by the provider in a daily service charge, sometimes referred to as the “room and board” charge.
 - B. Routine services are composed of two broad components: (1) general routine services, and (2) special care units (SCUs), including coronary care units (CCUs) and intensive care units (ICUs). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.
- II. For diagnostic-related group (DRG) high dollar claims exceeding \$25,000, an itemized bill is required for review.
- III. Inpatient facility claims require itemized billing and are reimbursed by percent of charge methodology when the payable exceeds \$50,000.
- IV. Outpatient claims are reimbursed by percent of charge methodology and total payable is greater than \$25,000 require an itemized bill for review.
- V. Reimbursed by HSS APC Price (HSS APC Grouper & Pricer) OR EAPG Payment (EAPG Grouper Pricer) and total payable is greater than \$25,000 and outlier amount is > \$0.00 require an itemized bill for review.

VI. The following supplies, items, and services are typically not separately billable and therefore are not reimbursable from the general room and board charge or primary service charge. This list contains examples only and is not an all-inclusive list:

- A. capital/medical equipment
- B. fluoroscope
- C. hydration flushes
- D. implants and supplies
- E. inpatient private duty nursing
- F. oximetry
- G. rental equipment
- H. routine supplies

VII. If upon review of the itemized bill, charges are determined to exceed state or federal reimbursement guidelines or a CareSource specific policy, then reimbursement will be reduced accordingly.

VIII. Provider exception requests to reimbursement reductions may be submitted via standard provider appeal process and should include supporting documentation (eg, medical records or operative notes to support requested payment exception).

E. State-Specific Information
N/A

F. Conditions of Coverage
N/A

G. Related Policies/Rules
N/A

H. Review/Revision History

DATE		ACTION
Date Issued	05/25/2022	New policy
Date Revised	10/11/2023	Annual Review; Approved at Committee
	04/09/2025	Revised 'inpatient' definition. added D.III-V.; approved at Committee.
	07/15/2026	Approved at Committee.
Date Effective	10/01/2026	
Date Archived		

I. References

1. Determination of cost of services. *The Provider Reimbursement Manual, I*. Centers for Medicare and Medicaid Services. Publication 15-1. Revised February 27, 2026. Accessed June 15, 2026. www.cms.gov
2. Outlier payments. Centers for Medicare and Medicaid Services. February 26, 2026. Accessed June 15, 2026. www.cms.gov
3. Payments for Outlier Cases, 42 C.F.R. §§ 412.80-.84 (2026).