REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Coding Guidelines-MP-PY-1714	02/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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. CareSource 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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

Table of Contents

A. Subject
Coding Guidelines

B. Background
Code assignment for claims is based upon the provider's (ie, physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis) documentation outlining the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. There must be a cause-and-effect relationship between the care provided and the condition.

ICD-10 guidelines are a set of rules regarding the classification of diagnoses and reasons for health care visits in all settings based on the statistical classification of disease published by the World Health Organization. These guidelines are approved by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS). Under the Health Insurance Portability and Accountability Act (HIPAA), adherence to these guidelines is mandatory.

In addition to general coding guidelines outlined by the ICD-10 manual, additional guidelines are provided within for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings.

The Current Procedural Terminology (CPT) is the official code set for compliance mandated by HIPPA for healthcare procedures and services. These codes are developed and maintained by the American Medical Association (AMA). These codes and their guidelines are designed to communicate as a statistical classification of clinically recognized and generally accepted services provided by healthcare professionals. The use of these codes and guidelines simplifies the reporting and processing of services for advanced analytics of these procedures.

CPT includes the use of modifiers to clarify the service that is being reported. Using modifiers increases reimbursement accuracy and coding consistency. In billing, medical necessity is demonstrated by the diagnosis code assigned (ie, ICD-10) and whether the documented elements are consistent with the problems addressed (ie, CPT).

The Medicare National Correct Coding Initiative (NCCI) aims to reduce improper payments. It includes edits for Procedure-to-Procedure (PTP), Medically Unlikely Edits (MUE), and Add-on Code (AOC). Claims denied by NCCI edits are based upon a determination of inappropriate coding and not on the basis of medical necessity. Clinical judgment is not needed to deny a claim based on correct coding.

C. Definitions
- **Claim** – A bill for services, a line item of services, or all services for one recipient within a bill.
- **Claim Adjustment** – A claim that has been incorrectly submitted or, as the result of an updated payment policy, payment amount can be changed.
- **Clean Claim** – A claim received by CareSource for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by CareSource.

D. Policy

I. Claims are to be submitted in accordance with NCCI and the coding standards set forth in the following guides:
   A. the healthcare common procedure coding system
   B. the current procedural terminology codebook
   C. the current dental terminology codebook
   D. the internal classification of diseases handbook

II. When adjudicating claims, CareSource utilizes code editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately, and efficiently. The software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure. The edits utilized include the following:
   A. Medicare and/or Medicaid NCCI Policy Manual
   B. ICD-10 guidelines
   C. CPT guidelines
   D. HCPCS guidelines
   E. CMS published materials, as applicable
   F. state and federal statutes and regulations
   G. other recognized industry standards, as applicable

III. Per ICD-10 guidelines, there must be a cause-and-effect relationship between the care provided and the condition. As such, the ICD-10 diagnosis and the CPT/HCPCS code demonstrate this through analytics in coding software. Claims may be denied due to an improper grouping of codes.

E. State-Specific Information
N/A

F. Conditions of Coverage
N/A

G. Related Policies/Rules
N/A

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

H. Review/Revision History

	DATE	ACTION
Date Issued	11/05/2025	Approved at Committee.
Date Revised		
Date Effective	02/01/2026	
Date Archived		

I. References

1. 2025 ICD-10-CM Official Guidelines for Coding and Reporting. AAPC; 2025.
2. CPT Codes. American Medical Association. Accessed September 18, 2025. www.ama-assn.org
3. Current Procedural Coding Expert. American Medical Association; 2024.
4. Medicaid NCCI Coding Policy Manual. Centers for Medicare and Medicaid Services; 2025.
5. Medicare National Correct Coding Initiative (NCCI) Edits. Centers for Medicare & Medicaid Services. Updated October 16, 2025. Accessed October 21, 2025. www.cms.gov