REIMBURSEMENT POLICY STATEMENT
Georgia Marketplace

Policy Name & Number	Date Effective
Postpayment Review Non-Submission of Medical Records-GA MP-PY-1819	11/01/2026
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 Reimbursement policies may be superseded by federal and state laws and regulations, as applicable.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

Postpayment Review Non-Submission of Medical Records

B. Background

Reimbursement of claims will be established based upon a review of the actual services provided to a member. It is the responsibility of the provider to submit the most accurate and appropriate CPT, HCPCS, revenue codes, modifiers, and/or diagnosis codes for the product or service that is being provided.

Postpayment review of claims assists CareSource with ensuring accuracy in the payment process. Postpayment reviews may be completed as part of claim adjudication, payment integrity, quality improvement and quality of care, credentialing and recredentialing, utilization management, peer review, and other programs required for CareSource operations.

Providers must maintain medical records sufficient to establish medical necessity of services and demonstrate that conditions of payment for covered services have been met. Records must be furnished upon request to CareSource.

C. Definitions

- **Covered Services** – Health care services that are medically necessary, described as Covered Health Services and not otherwise excluded in the member's Evidence of Coverage, and provided to prevent, diagnose, or treat a sickness, injury, behavioral health disorder, substance use disorder, or their symptoms.
- **Medically Necessary Services** – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and meets accepted standards of practice.

D. Policy

I. Providers are required to maintain complete and accurate medical records that verify that services are medically necessary, substantiate the accurate coding of the claim, and validate that conditions of payment have been met.

II. CareSource will initiate contact with providers to request medical records as part of postpayment reviews. Providers are expected to return medical record requests within established timelines or based on the provider agreement. Providers who use third party health information management vendors remain responsible for providing medical records to CareSource.

III. Failure to provide complete medical records as requested will result in a recovery of payment for claims lacking medical records to establish medical necessity of services.

E. Conditions of Coverage

I. In the event of any conflict between this policy and a provider's agreement with CareSource, the provider's agreement will be the governing document.

II. Prior authorization is not a guarantee of payment or a final determination of medical necessity.

III. It is the responsibility of the provider to submit the most accurate and appropriate CPT or HCPCS codes along with the appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

IV. Providers must follow proper billing, industry standards, and state compliant codes on all claim submissions. Codes and the use of any modifiers must be fully supported in the medical record. CareSource may verify the use of any code through post-payment audit.

F. Related Policies/Rules

Behavioral Health Service Record Documentation Standards
Medical Necessity Determinations
Medical Record Documentation Standards for Practitioners
Overpayment Recovery

G. Review/Revision History

	DATE	ACTION
Date Issued	07/29/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	11/01/2026	
Date Archived		

H. References

1. *Georgia Marketplace Evidence of Coverage*. CareSource; 2026. Accessed July 20, 2026. www.caresource.com
2. *Georgia Marketplace Provider Manual*. CareSource. Accessed July 20, 2026. www.caresource.com