ADMINISTRATIVE POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Itemized Billing-WI MP-AD-1458	10/01/2025-09/30/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy 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 Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

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.

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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 admitted by a provider's order to an inpatient hospital bed to receive inpatient services.
- **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. 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

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H. routine supplies

IV. 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.

V. 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. Conditions of Coverage
N/A

F. Related Policies/Rules
N/A

G. Review/Revision History

DATE		ACTION
Date Issued	08/14/2024	Approved at Committee
Date Revised	9/10/2025	Term “physician” changed to “provider,” approved at Committee.
Date Effective	10/01/2025	
Date Archived	09/30/2026	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Determination of cost of services. *The Provider Reimbursement Manual, I.* Centers for Medicare and Medicaid Services. Publication 15-1. Accessed June 14, 2024. www.cms.gov
2. Outlier payments. Centers for Medicare and Medicaid Services. December 1, 2021. Accessed June 14, 2024. www.cms.gov
3. Payments for Outlier Cases, 42 C.F.R. §§ 412.80-.84 (2023).

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