ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Pass-Through Billing-IN MCD-AD-0811	03/01/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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 documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement 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.

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.

Table of Contents

A. Subject

Pass-through Billing

B. Background

NA

C. Definitions

- **Pass-through billing** – Pass-through billing occurs when the ordering physician, professional provider, facility or ancillary provider requests and bills for a service, but the service is not performed by the ordering physician, professional provider, facility or ancillary provider. You may only bill for services that you or your staff perform.

D. Policy

I. CareSource does not permit pass-through billing.
   A. CareSource will only reimburse providers for services performed by the provider or by the staff that are under the direct supervision of the provider who bills for the services.
   B. Providers must bill CareSource only for those services which they or their direct employees perform. Providers will not bill, charge, seek payment for or submit any claims to CareSource, nor will they have any recourse against CareSource or any of its members for amounts related to the provision of pass-through billing.
   C. Laboratories that perform the services must bill Medicaid directly unless otherwise approved by the Centers for Medicare and Medicaid services.

E. Conditions of Coverage

F. Related Policies/Rules

G. Review/Revision History

DATES		ACTION
Date Issued	04/29/2020	New policy
Date Revised	10/26/2022	No changes to content. Updated references
Date Effective	03/01/2023	
Date Archived		

H. References

1. Indiana Administrative Code (2022, March30). 405 IAC 5-27-1 Reimbursement limitations. Retrieved 10/03/2022 from www.law.cornell.edu.
2. Indiana Administrative Code (2022, March 30). 405 IAC 5-18-3 Inpatient and outpatient laboratory facilities; limitations. Retrieved 10/03/2022 from www.law.cornell.edu.