ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Claims Editing and Review-IN MCD-AD-1183	09/01/2022-08/31/2023
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.

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A. Subject

Claims Editing and Review

B. Background

All health care providers are expected to utilize the same standard coding sets and rules to codify the services provided during encounters with patients. This codification is used to bill insurance carriers for reimbursement, known as a "claim". In the codification process, there are rules that must be followed to appropriately codify the encounter into a claim, which is then sent to the insurance carrier for reimbursement.

All claims submitted to CareSource for reimbursement consideration are subject to claims editing. This ensures that appropriate coding sets are used and rules are applied in billing by the provider. This also ensures the appropriate reimbursement is made to the provider for the services rendered. This policy is to outline the source of edits and rules used by CareSource, but not limited to.

C. Definitions

NA

D. Policy

I. To ensure appropriate and timely reimbursement for services rendered to enrollees, CareSource utilizes automated claims editing to enforce appropriate coding and billing practices by providers when submitting claims.
   A. Appropriate coding and billing of claims allows for the accurate adjudication and reimbursement for services rendered to a CareSource enrollee.
   B. All claims submitted to CareSource are subject to this editing.

II. CareSource models edits and rules on:
   A. Industry standard coding rules, manuals, guidelines, directives, and relevant state and federal regulations for claims editing.
   B. Resources used to source these coding and billing standards include, but are not limited to, the following list:
      1. X12 or ASC X12 - The Accredited Standards Committee (ASC) X12 - claim submission rules and edits applied to inbound electronic claims - www.x12.org.
      2. WEDI SNIP or SNIP - Workgroups for Electronic Data Interchange Strategic National Implementation Process – claim submission rules and edits applied to inbound electronic claims related to HIPAA compliant file exchanges.
      3. Current Procedural Terminology (CPT) Manual from AMA (American Medical Association).
      4. HCPCS - Healthcare Common procedure Coding System – Level II coding guidelines.
      5. UB Editor - Manual from the American Hospital Association (AHA) Coding directives.
      6. ICD-10-CM manual.

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

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7. Center for Medicare and Medicaid (CMS) rules and notifications:
   a. CMS Billing rules and instructions (www.cms.gov).
   b. Medicare NCCI Instructions/ Manual.
   c. Medicaid NCCI Instructions/ Manual.
   d. NCD & LCD Bulletins.
   e. National Physician Fee Schedule (NPFS) instructions.
8. Food and Drug Administration (FDA) guidelines (www.fda.gov).
9. Center of Disease Control (CDC) guidelines (www.cdc.gov).
10. U.S. Preventive Services Task Force (www.uspreventiveservicestaskforce.org).
11. State Agencies (as appropriate for enrollee's coverage)
    a. Ohio Department of Medicaid (medicaid.ohio.gov).
    b. Ohio Department of Insurance (insurance.ohio.gov).
    c. Georgia Department of Community Health (dch.georgia.gov).
    d. Georgia Office of Insurance and Safety (oci.georgia.gov).
    e. Indiana Department of Insurance (in.gov/idoi).
    f. Kentucky Department of Insurance (insurance.ky.gov).
    g. West Virginia Offices of the Insurance Commissioner (wvinsurance.gov).
    h. Arkansas Department of Human Services (humanservices.arkansas.gov).
12. State and National recognized Medical Association and Specialty Experts including, but not limited to:
    a. American College of Radiology.
    b. American Academy of Pediatrics.
    c. Ohio State Chiropractic Association.
    d. American College of Obstetricians and Gynecologists.
13. CareSource's Website (www.caresource.com)
    a. Policies.
    b. Provider Manuals.
    c. Provider Notifications.

III. CareSource strives to keep our editing current with all changes as they occur; as such, edits may be added, modified, or removed based on changes, clarifications and new directives received from these resources and any other resources that may become applicable.

IV. CareSource sends providers the outcomes of the edits through the standard Explanation of Payment (EOP) process. Providers' EOP's indicate the failures by the use of industry standard CARC and RARC coding system. The provider can obtain additional details information via CareSource's Provider Portal (www.CareSource.com) and reviewing the Provider Manual on-line, as well.

V. Providers may file a dispute and provide additional information to support the provider's position for reconsideration of reimbursement. Instruction to file a dispute related to a denial or reject of a claim can be found at our website (www.CareSource.com), please refer to the Provider Manual, under "Claim Dispute Process."

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E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/27/2022	New policy
Date Revised		
Date Effective	09/01/2022	
Date Archived	08/31/2023	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
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