REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Interest Payments-OH MCD- PY-1324	09/01/2022
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.

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A. Subject

Interest Payments

B. Background

Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

C. Definitions

- **Adjusted Claim** – An adjusted claim is the result of a request by the provider or CareSource to change historical data or reimbursement of an original claim.
- **Clean Claim** – A clean claim is a claim that can be processed without obtaining additional information from the provider of a service or from a third party. Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party. A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
- **Original Claim** – The initial complete claim for one or more benefits on an application form.
- **Prompt Payment** – Prompt payment is defined by Ohio's Medicaid Prompt Payment rules and contract.

D. Policy

I. We strictly adhere to all regulatory guidelines relating to interest. We follow the guidelines outlined in Prompt Payment regulations.

II. In alignment with the Ohio Administrative Code and Medicaid Provider Agreement, CareSource does not pay interest on Ohio Medicaid claims.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

NA

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

G. Review/Revision History

	DATE	ACTION
Date Issued	03/31/2021	New Policy
Date Revised	01/05/2022 04/27/2022	Updated language and references per Legal. No change; did for review cycle consistency
Date Effective	09/01/2022	
Date Archived		

H. References

1. Ohio Medicaid Contract. Retrieved April 20, 2022 from www.medicaid.ohio.gov
2. Ohio Medicaid Contract, Appendix J, § 4. A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or from a third party. Retrieved April 20, 2022 from www.managedcare.medicaid.ohio.gov
3. Ohio Revised Code § 5164.01(C). Definitions. Retrieved April 20, 2022 from www.managedcare.medicaid.ohio.gov
4. Electronic Code of Federal Regulations (e-CFR). CFR § 447.45(b). Timely claims payment. Definitions. Retrieved April 20, 2022 from www.law.cornell.edu
5. Electronic Code of Federal Regulations (e-CFR). CFR § 447.45(d). Timely claims payment. Timely processing of claims. Retrieved April 20, 2022 from www.law.cornell.edu

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