REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICARE ADVANTAGE

Policy Name		Policy Number	Effective Date
Interest Payments		PY-1323	07/01/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: 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.

Table of Contents

A. Subject

Interest Payments

B. Background

Reimbursement policies are designed to assist you 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 their 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 has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment. A provider submits a clean claim by providing the required data elements on the standard claims forms that are accurate at the time of payment, along with any attachments and additional elements, or revisions to data elements, attachments and additional elements, of which the provider has knowledge.
- **Original Claim** – The initial complete claim for one or more benefits on an application form.
- **Prompt Payment** – Prompt payment is defined by State and/or Federal regulation defining timeliness and interest requirements.

D. Policy

I. We strictly adhere to all regulatory guidelines relating to interest. We follow the guidelines outlined in Prompt Payment regulations. (O.C.G.A. § 33-24-59.5, O.C.G.A. § 33-21A-7 (Second Pass))

II. Payment of interest on original claims is made when CareSource fails to adjudicate original claims within the applicable state and federal prompt pay timeframes on clean claims.

III. Payment of interest on adjusted claims starts on the date the provider disputes the original payment with CareSource.

IV. CareSource considers interest payment on claims that were not paid accurately on prior processing attempts. If CareSource had the information to pay the claim correctly on a previous payment but failed to do so, CareSource will pay the claim

within the allotted timeframe from Prompt Pay and Interest Regulations. Interest will begin accruing when payment is not made within the Prompt Pay timeframe.

V. CareSource only pays interest on claim payment that is occurring under prompt pay regulations. A contractual adjustment of a claim is not subject to state and federal regulations for interest payment.

VI. CareSource performs regular reviews of our paid claims to correct claim payment.

A. Reviews can include items such as retroactive eligibility updates, authorization updates, COB updates, and fee schedule updates.

B. Reviews include proactive measures to correct claim payment when it has been determined that a systemic issue has paid claims incorrectly.

C. Claims are not subject to interest payment when CareSource takes proactive measures to pay claims correctly.

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

G. Review/Revision History

	DATE	ACTION
Date Issued	03/31/2021	New Policy
Date Revised		
Date Effective	07/01/2021	
Date Archived		

H. References

1. Legal Information Institute. 42 CFR § 422.520 - Prompt payment by MA organization. Retrieved 16 February 2021 from www.law.cornell.edu
2. Social Security Association. Sec 1816(c)(2)(B. Retrieved 16 February 2021 from www.ssa.gov
3. Social Security Association. Sec 1842(c)(2)(B). Retrieved 16 February 2021 from www.ssa.gov
4. United States Government Publishing Office. Title 31, Section 3902. Retrieved 16 February 2021 from www.govinfo.gov
5. United States Government Publishing Office. Title 42, Section 7109. Retrieved 16 February 2021 from www.govinfo.gov
6. Federal Register. Prompt Payment Interest Rate; Contract Disputes Act. Retrieved 16 February 2021 from www.fiscal.treasury.gov

7. Bureau of the Fiscal Service. (2013, January- 2021, June). Interest Rates. Retrieved 16 February 2021 from www.fiscal.treasury.gov
8. Centers for Medicare & Medicaid Services. (2019, January). Notice of New Interest Rate for Medicare Overpayments and Underpayments - 2nd Qtr. Retrieved 16 February 2021 from www.cms.gov
9. Justia US Law. (2021). 2010 Georgia Code Title 33 – Insurance Chapter 21A - Medicaid Care Management Organization § 33-21A-7 - Bundling of provider complaints and appeals. Retrieved 16 March 2021 from https://law.justia.com/codes/georgia/2010/title-33/chapter-21a/33-21a-7/

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