CareSource | NETWORK Notification

Notice Date: January 29, 2026
To: All Marketplace Providers
From: CareSource
Subject: Prepay Auditing Update
Effective Date: March 2, 2026

Summary

As part of our continuing effort to ensure compliant and accurate claims coding and provider reimbursement, starting March 2, 2026, CareSource will begin implementing additional enhancements to our claims processing systems to enable medical record auditing in support of correct coding documentation. The goal of this endeavor is to ensure adherence to state and federal coding guidelines and correct claims that may otherwise be paid in error. In many cases, this will involve a request for medical records documentation to support the services billed.

These claims processing enhancements will take into consideration guidelines from the following sources:

- Centers for Medicare & Medicaid Services' (CMS) medical coding policies
- American Medical Association's (AMA) Current Procedural Terminology (CPT) coding guidelines
- American Hospital Association's (AHA) coding guidelines
- Local and regional Medicaid & Medicare policies
- CareSource Medical, Administrative and Reimbursement policies for your state

Impact

The CareSource payment standards in focus for these enhancements are listed below. However, other claims coding areas may also be reviewed as part of this program to align with industry standards. **This is not a medical necessary review**, but rather an administrative audit to validate that documentation supports the code(s) billed.

- Medicare & Medicaid: National Correct Coding Initiative (NCCI) I CMS
- Modifier usage
- Correct CPT and HCPCS code assignment
- Documentation standards for levels of service and medical decision making
- Service requirements for referrals and physician orders
- Applicable rules for billing service units

As part of this process, certified coders will review claims data and medical records documentation to confirm appropriate claims coding and billing. CareSource sends an electronic Explanation of Payment (EOP) to providers with a message indicating the reason code BB1 or PJR. BB1 or PJR indicates a claim has been flagged for needing medical record review. Medical records can be submitted through the CareSource Provider Portal using Submission Reason "Pre Pay Claim Review – Notes Required."

The provider's submission of medical records is not a guarantee of payment. CareSource reviews the medical records within 30 calendar days of receipt and may conclude that the billed code(s) will be denied. CareSource will then communicate to the provider the reason(s) for the denial in an EOP code. If CareSource does not receive the requested records, the claim will remain denied until records are received (up to 365 days from the date of claim receipt).

Documents requested for each type of service (not all inclusive)	Behavioral Health (e.g., E&M, psychotherapy)	Skilled Therapy (e.g., SLP, PT, OT)	DME POS	Lab & Imaging	Medical (e.g., E&M or other medical services)
Treatment Plan / Plan of Care	✓	✓			
Signed Orders or CMN / referrals as applicable	✓	✓	✓	✓	✓
Consent to Treatment	✓	✓			✓
Consent to Telehealth, if applicable	✓	✓			✓
Progress note(s)	✓	✓	✓	✓	✓
Diagnostic/Lab/Screening/Testing reports/Reports/documentation (e.g., EKG, PHQ-9), if applicable	✓	✓		✓	✓
Operative Report, if applicable					✓
Proof of Delivery, for 3rd-party shipping/tracking slip or return postage paid delivery invoice OR, when member receives DME in office, member signature for DME receipt			✓		

Disputes

Providers have dispute rights on all medical record review decisions. Please refer to your Provider Manual for additional dispute instructions.

Questions?

For questions about this update, please contact Provider Services at **1-800-230-2101** Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

Multi-EXC-P-5041448