CareSource

REIMBURSEMENT POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Modifiers-MyCare OH FIDE-PY-1692	08/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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 agreements, 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan 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 or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we 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
Modifiers

B. Background
Reimbursement modifiers are a 2-character codes that are used by providers to indicate that a service or procedure has been altered due to a specific circumstance. Modifiers can be found in the appendices of both Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) manuals. Use of a modifier does not change the code or the code's definition. Examples of modifier use include

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same procedure.
- To indicate that a procedure was performed on the left side, right side, or bilaterally.
- To report multiple procedures performed during the same session by the same health care provider.
- To indicate multiple health care professionals participated in the procedure.
- To indicate a subsequent procedure due to a complication of the initial procedure.

Although CareSource accepts the use of modifiers, use does not guarantee reimbursement. Some modifiers increase or decrease the reimbursement rate, while others do not affect the reimbursement rate. CareSource may verify the use of any modifier through prepayment or post-payment edit or audit. Inappropriate use of a modifier can result in a claim denial or incorrect reimbursement for a product or service. All information
regarding the use of these modifiers must be made available upon CareSource's request.

C. Definitions

- **Current Procedural Terminology (CPT)** – Codes that are issued, updated and maintained by the American Medical Association (AMA) that provide a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** – Codes that are issued, updated and maintained by the American Medical Association (AMA) that provide a standard language for coding and billing of products, supplies, and services not included in the CPT codes.
- **Modifier** – Two-character codes used along with a CPT or HCPCS code to provide additional information about the service or supply rendered.

D. Policy

I. CareSource reserves the right to review any submission at any time to ensure that correct coding standards and guidelines are met.

II. Provider claims billed with a modifier may be flagged for either a prepayment or post-payment coding review.

III. It is the responsibility of the submitting provider to submit accurate documentation to substantiate coding of the claim. Failure to submit accurate and complete

documentation may result in a denial. If the documentation does not support the claim submission, this will also result in a claim denial.

IV. Providers are expected to use the most accurate and appropriate CPT or HCPCS code(s) for the product or service that is being provided according to the following industry standard guidelines (may not be all-inclusive):
   A. National Correct Coding Initiative (NCCI) editing guidelines
   B. American Medical Association (AMA) guidelines
   C. American Hospital Association (AHA) billing rules
   D. *Current Procedural Terminology* (CPT)
   E. *Healthcare Common Procedure Coding System* (HCPCS)
   F. *The International Classification of Diseases and Related Health Problems*, Tenth Edition (ICD-10-CM and ICD-10-PCS)
   G. National Drug Codes (NDC)
   H. Diagnosis Related Group (DRG) guidelines

V. The inclusion of a code in a policy does not imply any right to reimbursement or guarantee claims payment.

VI. Other CareSource policies may overlap with this topic. Consult the current catalogue of policies for this market.

E. Conditions of Coverage

I. Reimbursement policies are designed to assist providers when submitting claims to CareSource and 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 a member's eligibility.

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

III. Providers must follow proper billing, industry standards, and state compliant codes on all claim submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, CareSource policies apply to both participating and nonparticipating providers and facilities.

IV. In the event of any conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	07/16/2025	New policy. Approved at Committee.
Date Revised	04/22/2026	Periodic review. Moved D.I and D.II from Section B to Section D, updated D.III for clarity, added D.VI, updated references. Approved at Committee.
Date Effective	08/01/2026	
Date Archived		

H. References

1. *2026 AMA CPT Professional*. American Medical Association; 2025.
2. *2026 HCPCS Level II Expert*. AAPC; 2025.
3. *2026 ICD-10-CM Official Coding Guidelines for Coding and Reporting*. AAPC; 2025.
4. Fee Schedule and Administration and Coding Requirements. *Medicare Claims Processing Manual*. Centers for Medicare and Medicaid Services; 2026. Publication # 100-04. Accessed March 30, 2026.
5. General Correct Coding Policies. *Medicaid National Correct Coding Initiative Policy Manual*. Centers for Medicare and Medicaid Services; 2026. Accessed March 31, 2026. www.cms.gov
6. General Correct Coding Policies. *Medicare National Correct Coding Initiative Policy Manual*. Centers for Medicare and Medicaid Services; 2026. Accessed March 30, 2026. www.cms.gov
7. *Medicaid National Correct Coding Initiative Technical Guidance Manual*. Centers for Medicare and Medicaid Services; 2026. Accessed March 31, 2026. www.cms.gov

Approved by ODM 05/15/2026