CareSource | NETWORK Notification

Notice Date: July 31, 2026
To: CareSource Ohio Medicaid
From: CareSource
Subject: Billing Guidance
Effective Date: September 1, 2026

Summary
CareSource is communicating important reimbursement initiatives aligned with Ohio Administrative Code (OAC) and CMS rules aimed at ensuring claims are processed in compliance with regulatory guidance. These initiatives support proper reimbursement practices and reduce payment of claims that do not meet OAC and CMS rule requirements. Providers serving Ohio Medicaid members are reminded to adhere strictly to these rules to avoid claim denials.

Impact
These initiatives reflect specific areas where discrepancies between paid claims and OAC and CMS regulations have been identified. Providers should review their billing practices to align with the detailed OAC and CMS policies below to prevent payment interruptions and ensure compliance. CareSource reserves the right to recover claims paid in error.

Importance
Adherence to OAC and CMS rules benefits both providers and members by promoting correct billing practices, reducing administrative burden of overpayments recovery and supporting the integrity of the Medicaid programs. Compliance will minimize claim denials and delays in payment processing.

The below sets forth links to certain OAC, CMS and billing guidelines, along with a brief summary of each. This is meant as an outline only. For complete requirements of these specific rules, please be sure to review the applicable rule in its entirety. This Network Notification is to ensure Providers serving Ohio Medicaid members remain in compliance with applicable billing requirements. Accordingly, this list does not include all code sections associated with billing and should not be viewed as encompassing all applicable requirements.

Services and Supporting Guidance:

CareSource remains committed to timely and accurate claims processing consistent with all regulatory requirements. Providers must ensure all claims submitted comply with applicable OAC and CMS policies. CareSource may perform claim reviews, and any payments found not in compliance with OAC and CMS rules may be subject to recovery. Contract-specific exclusions remain applicable.

1. Laboratory Services in Hospital Setting

Ohio Administrative Code (OAC) Rule 5160-11-11

"Medicaid reimbursement for laboratory services is payable only when the laboratory service is medically necessary, appropriately ordered, and eligible for separate payment under program guidelines. Laboratory tests included as part of hospital diagnostic services are not separately reimbursable."

"Payment for the clinical diagnostic procedures themselves is based on the clinical laboratory fee schedule published by CMS; and payment for the clinical pathology interpretation is based on the physician fee schedule relative value file published by CMS. (The procedure code for the clinical pathology interpretation consists of a professional component modifier appended to the relevant clinical diagnostic procedure code."

CMS Claims Processing Manual

"Clinical laboratory tests are generally paid under the Clinical Laboratory Fee Schedule. Services furnished by a hospital outpatient laboratory are generally paid on a reasonable cost basis or as part of a comprehensive outpatient service. Payment for clinical laboratory services on hospital outpatient bills should only be made when the laboratory service is performed independent of the hospital outpatient services."

2. Fluoride Varnish Frequency

Rule 5160-4-33 - Ohio Administrative Code | Ohio Laws

"Fluoride varnish applications are a covered benefit for eligible children under age 21, limited to a maximum of two applications per year unless medically necessary and supported by clinical documentation."

3. Physician Interpretation Only Codes

CMS Medicare Claims Processing Manual (Search “professional and technical components“)

"Radiology services may be reported with separate technical and professional components. The professional component (modifier -26) includes interpretation and report, and the technical component (modifier -TC) includes equipment use and technician services. Claims containing only professional interpretation codes must not be billed with technical components."

4. GZ Modifier Usage

CMS Medicare Claims Processing Manual

"Modifier GZ indicates a service expected to be denied as not reasonable and necessary, and for which the provider does not have an Advance Beneficiary Notice (ABN). Claims submitted with GZ will be reviewed accordingly and may be denied."

5. Hospital Add-On Procedure Coding

CMS Medicare and Medicaid NCCI Coding Policy Manual

"Add-on codes describe procedures that are always performed in conjunction with the primary procedure. They cannot be reported as standalone services. The presence of an appropriate primary procedure code is required for add-on codes to be reimbursed."

6. Inpatient Code Specificity

ICD-10-CM Official Guidelines for Coding and Reporting

"Codes are to be assigned to the highest level of specificity. Unspecified codes are to be reported only when there is no greater specificity that can be applied based on available documentation."

CMS Transmittal R11059CP

"Unspecified codes exist in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classification for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. However, in the inpatient setting, there should generally be very limited and rare circumstances for which the laterality (right, left, bilateral) of a condition is unable to be documented and reported."

If you have questions, please contact CareSource Provider Services at 800-488-0134.

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