REIMBURSEMENT POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Coding Guidelines-AR PASSE-PY-1836	11/01/2026
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. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are 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.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Coding Guidelines

B. Background
Code assignment for claims is based upon the provider's (ie, physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis) documentation outlining the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. There must be a cause-and-effect relationship between the care provided and the condition.

ICD-10 guidelines are a set of rules regarding the classification of diagnoses and reasons for health care visits in all settings based on the statistical classification of disease published by the World Health Organization. These guidelines are approved by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS). Under the Health Insurance Portability and Accountability Act (HIPAA), adherence to these guidelines is mandatory.

In addition to general coding guidelines outlined by the ICD-10 manual, additional guidelines are provided within for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings.

The Current Procedural Terminology (CPT) is the official code set for compliance mandated by HIPPA for healthcare procedures and services. These codes are developed and maintained by the American Medical Association (AMA). These codes and their guidelines are designed to communicate as a statistical classification of clinically recognized and generally accepted services provided by healthcare professionals. The use of these codes and guidelines simplifies the reporting and processing of services for advanced analytics of these procedures.

CPT includes the use of modifiers to clarify the service that is being reported. Using modifiers increases reimbursement accuracy and coding consistency. In billing, medical necessity is demonstrated by the diagnosis code assigned (ie, ICD-10) and whether the documented elements are consistent with the problems addressed (ie, CPT).

The Medicaid National Correct Coding Initiative (NCCI) aims to reduce improper payments. It includes edits for Procedure-to-Procedure (PTP), Medically Unlikely Edits (MUE), and Add-on Code (AOC). Claims denied by NCCI edits are based upon a determination of inappropriate coding and not on the basis of medical necessity. Clinical judgment is not needed to deny a claim based on correct coding.

C. Definitions
- **Claim** – A bill for services, a line item of services, or all services for one recipient within a bill.
- **Claim Adjustment** – A claim that has been incorrectly submitted or, as the result of an updated payment policy, payment amount can be changed.

- **Clean Claim** – A claim received by CareSource for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by CareSource.

D. Policy

I. Claims are to be submitted in accordance with NCCI and the coding standards set forth in the following guides:
   A. the healthcare common procedure coding system
   B. the current procedural terminology codebook
   C. the current dental terminology codebook
   D. the internal classification of diseases handbook

II. When adjudicating claims, CareSource utilizes code editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately, and efficiently. The software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure. The edits utilized may include the following:
   A. Medicaid NCCI Policy Manual
   B. ICD-10 guidelines
   C. CPT guidelines
   D. HCPCS guidelines
   E. CMS published materials, as applicable
   F. state and federal statutes and regulations

III. Per ICD-10 guidelines, there must be a cause-and-effect relationship between the care provided and the condition. As such, the ICD-10 diagnosis and the CPT/HCPCS code demonstrate this through analytics in coding software. Claims may be denied due to an improper grouping of codes.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	08/12/2026	Approved at Committee.
Date Revised		
Date Effective	11/01/2026	
Date Archived		

H. References

1. *ICD-10-CM Official Guidelines for Coding and Reporting*. AAPC; 2026.
2. CPT®. American Medical Association. Accessed July 16, 2026. www.ama-assn.org

3. *Current Procedural Coding Expert*. American Medical Association; 2026.
4. *HCPCS Level II Expert*. AAPC; 2026.
5. *Medicaid NCCI Coding Policy Manual*. Centers for Medicare and Medicaid Services; 2025.