REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Temporary Codes-MP-PY-1413	04/01/2024
Policy Type	
REIMBURSEMENT	

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.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

Table of Contents

A. Subject
Temporary Codes

B. Background
Reimbursement policies are designed to assist providers 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 office staff are encouraged to use self-service channels to verify member 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.

Temporary codes exist in both CPT and HCPCS manuals and are updated throughout the year. T codes (ie, Category III codes) are temporary CPT codes for emerging technologies, services, and procedures, which support data collection to substantiate widespread use and/or provide documentation for the Food and Drug Administration (FDA) approval process. Many of these codes have not been proven medically necessary and are considered to be experimental or investigational based on a lack of peer-reviewed scientific literature. A variety of temporary HCPCS codes exist. Temporary HCPCS codes may be established by the Centers for Medicare and Medicaid Services (CMS) to report drugs, biologicals, devices, and procedures, to identify services and procedures under FDA review or address miscellaneous services, procedures, and supplies. Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) may develop temporary HCPCS codes to report supplies and other products for which a national code has not yet been developed. Temporary HCPCS codes may also be developed by commercial payers to report drugs, services, and supplies. Coverage of these services is under the discretion of local carriers.

C. Definitions
NA

D. Policy
I. CareSource considers temporary codes medically necessary when **ALL** the following criteria are met:
   A. Documentation in the medical record supports the use of the code.
   B. A more specific code is not available to describe the service/procedure.
   C. The service provided is within the scope of the member's benefit plan.

II. CareSource will use current industry standard procedure codes (HCPCS CPT I and Category II codes) throughout the processing systems. HIPAA Transaction & Code

Set Rule requires providers use the procedure code(s) that are valid at the time the service is provided.

III. Providers must use industry standard code sets and must use specific HCPCS CPT I and Category II codes when available unless otherwise directed through the provider's contract.

IV. If specific codes are not available, unlisted codes require plan preauthorization.

E. State-Specific Information

NA

F. 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.

G. Related Policies/Rules

NA

H. Review/Revision History

	DATE	ACTION
Date Issued	02/01/2023	New policy
Date Revised	01/17/2024	Annual review: updated references, approved at Committee.
Date Effective	04/01/2024	
Date Archived		

I. References

1. American Academy of Professional Coders. What is HCPCS? Accessed January 2, 2024. www.aapc.com
2. *CPT Professional 2024*. American Medical Association; 2024.
3. HCPCS Codes – Temporary Codes for Use with Outpatient Prospective Payment System. Accessed January 2, 2024. www.hcpcs.codes
4. Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule. American Medical Association. Accessed January 2, 2024. www.assets.ama-assn.org