CareSource Provider Coding and Reimbursement Guidelines

CareSource strives to be consistent with all ODJFS (Ohio), MDCH (Michigan), Medicare, and national commercial standards regarding the acceptance, adjudication, and payment of professional (CMS-1500) claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either hard copy or electronically. We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA compliant code sets (HCPC, CPT, ICD-9). Specific contract language stipulating the receipt, processing, and payment of specific codes and modifiers is honored as would be any aspect of a provider contract. When referenced in a contract, ODJFS or MDCH reimbursement rules as set forth in the Ohio Administrative Code (OAC) or Michigan rules are followed, depending on the state at issue. In addition, the Center for Medicare and Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing NCCI National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the listed links for details:

Medicare: http://www.cms.hhs.gov/home/medicare.asp

OH Medicaid: http://jfs.ohio.gov/ohp/bhpp/FeeSchdRates.stm

MI Medicaid: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87515--,00.html

CareSource uses coding industry standards such as the AMA CPT manual, CCI, and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPC code or modifier usage

CareSource seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts, or the use of modifiers. This review will take into consideration all the previously mentioned ODJFS (MDCH), Medicare, CCI, and national commercial standards when considering the appeal. In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the CareSource appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.