# REIMBURSEMENT POLICY STATEMENT
# Georgia Medicaid

| Policy Name & Number | Date Effective |
|---|---|
| Coordination of Benefits- GA MCD-PY-1344 | 04/01/2023 |
| **Policy Type** | |
| | |

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.

## Table of Contents



**Summary**

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

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days of the provider's actual receipt of the primary payer's EOP date, the claim will re-deny as not being timely filed.

IV. COB Claim Submission to CareSource
   A. CareSource follows The Health Insurance Portability and Accountability Act (HIPAA) guidelines and accepts industry standard codes. It is imperative that claims are filed with the same codes that the primary payer presented on the EOB to ensure that claims are processed correctly. Claim(s) will be denied if there is a mismatch between the codes on the received claim and the primary payers EOP.
   B. CareSource applies standard claim adjustment codes.
   C. Claim Adjustment Group Codes are as follows:
      1. CO – Contractual Obligation;
      2. OA – Other Adjustment;
      3. PI – Payer Initiated Reductions; or
      4. PR –

whichever is greater. If the dispute is received within the original timely filing period or within 90 days of the original denial date:

B. CareSource will confirm whether or not the primary coverage was in effect during the date of service. If the policy was **NOT** in effect, CareSource will process the claim(s) that are within the original timely filing period. If the initial timely filing period has elapsed, then CareSource will process the claims that are within 90 days of the original denial. If the policy was in effect, the claim will remain denied for needing primary carrier's EOP. If the provider does not notify CareSource of the dispute within the original timely filing period, within 90 days of the CareSource denial, or if the provider does not submit the primary carrier's EOP within 90 days of the primary carrier's EOP date, the claim will re-deny as not being filed timely.

E. Conditions of Coverage

Reimbursement is dependent on