REIMBURSEMENT POLICY STATEMENT
Arkansas PASSE

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,

B. Advanced notification will occur 60 days in advance of recovery.
C. If the recovery occurs outside of original claim timely filing limits, the corrected claim submission timeframe is 60 days from the date of the recovery. Normal timely filing limits apply to corrected claims being submitted within original claim timely filing guidelines.

IV. Retro Active Eligibility Recoveries
A. Lookback period is 18 months from date CareSource is notified by Medicaid of the updated eligibility status.
B. Advanced notification will occur 60 days in advance of recovery.

V. Management of Claim Credit Balances
A. Regular and routine business practices, including, but not limited to, the updating and/or maintenance of a provider's record, can create claim credit balances on a provider's record. This may result in claim adjustments, both increases and/or decreases in claim paid amounts, and/or forward balancing may move a provider's record into a negative balance in which funds would be owed to CareSource. This information will be displayed on the EOP in the PLB section.
B. Negative balance status and the associated reconciliation of that balance that is the result of a claim adjustment that increased the claim paid amount is not considered to be an overpayment recovery and does not fall under the terms of this policy.
1. Claim Adjustment Example
a. A claim paid $10 previously but was updated to pay $12. The adjustment created a $10 negative balance and paid the provider the full $12 when adjusted, instead of the $2 difference.
b. The $10 negative balance is not considered to be an overpayment subject to the guidelines outlined in section D.I – D.IV.
2. Overpayment Example
a. A claim previously paid $12 but is updated to pay $10. The claim adjustment with the $2 reduced payment is subject to the guidelines outlines in section D.I – D.IV.

VI. In the event of any conflict between this policy and any written agreement between the provider and CareSource, that written agreement will be the governing document.

E. 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.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	03/30/2022	New policy
Date Revised	10/26/2022 02/14/2024	

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

NA