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 inc

The

CPT instructions state that modifier 59 should only be used if no more descriptive modifier is available, and its use best explains the coding circumstances. Providers should use the more specific X {EPSU} modifier when appropriate CMS guidelines note that the X modifiers are more selective versions of modifier 59.

C. Definitions

- **Current Procedural Terminology (CPT)** – Codes that are issued, updated, and maintained by the American Medical Association (AMA) that provide a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** – Codes that are issued, updated, and maintained by the AMA that provides a standard language for coding and billing products, supplies, and services not included in the CPT codes.
- **Modifier** – Two-character code used along with a CPT or HCPCS code to provide additional information about the service or procedure rendered.

D. Policy

I. CareSource reserves the right to review any submission at any time to ensure correct coding standards and guidelines are met.

II. Provider claims billed with modifier 59 or X {EPSU} may be flagged for either a prepayment clinical validation or post-payment medical record coding review.
   A. For prepayment review, once the claim has been clinically validated, it is either released for payment or denied for incorrect use of the modifier.
   B. For post-payment review, once the review has been completed, a decision is made based on the submitted documentation. If the claim is not supported by the documentation, CareSource will recover the payment, when applicable.

III. It is the responsibility of the submitting provider to submit accurate documentation to