Updated Payment Policies: *Effective 10/1/2020*

We are happy to inform you that Home State Health is publishing its Payment Policies to inform providers about acceptable billing practices and reimbursement methodologies for certain procedures and services. We will apply these policies as medical claims reimbursement edits within our claims adjudication system. This is in addition to all other reimbursement processes that Home State Health currently employs.

Home State Health believes that publishing this information will help providers to bill claims more accurately, therefore reducing unnecessary denials and delays in claims processing and payments. These policies address coding inaccuracies including diagnosis to procedure code mismatch, inappropriately modified procedures, unbundling, incidental procedures, duplication of services, medical necessity requirements and health plan specific payment rules for procedures and services.

These policies are developed based on medical literature and research, industry standards and guidelines as published and defined by the American Medical Association's Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), and public domain specialty society guidance, unless specifically addressed in the fee-forservice provider manual published by the state of Missouri or regulations.

Visit homestatehealth.com to find the Payment Policies. The effective date for the below policies is **10/1/2020**.

Number	Policy Name	Policy Description	Line of Business (LOB)
CC.PP.065	Multiple Diagnostic Cardiovascular Procedure Payment Reduction	This policy is based on CMS reimbursement methodologies for MPPR and applies a multiple diagnostic cardiovascular procedure reimbursement reduction (MDCR) to procedures assigned a multiple procedure indicator (MPI) of 6 on the CMS National Physician Fee Schedule (NPFS). When this occurs, only the highest-valued procedure is reimbursed at the full payment allowance (100%) and payment for subsequent procedures/units is reimbursed at 75% of the allowance.	Medicaid Medicare Marketplace
CC.PP.066	Leveling of Care: Evaluation & Management Overcoding	The purpose of this policy is to ensure that the level of E&M service reported by the provider reflects the services performed. When a provider submits an E&M service that exceeds the maximum level of E&M service based on the diagnosis and other claim documentation elements, the E&M code is leveled to reflect the maximum level of E&M service.	Medicaid Medicare Marketplace
CC.MP.50	Outpatient Testing for Drugs of Abuse	For members over the age of 6, outpatient testing for drugs of abuse is medically necessary when certain criteria is met (see below). Outpatient quantitative drug testing of more than 14 drugs/drug classes is NOT medically necessary. Urine drug testing is NOT medically necessary for reasons including, but not limited to, a condition of employment or participation in a school activity, courtordered drug screenings, screening in asymptomatic patients (except what is outlined below), a component of a routine physical, same-day screening of drug metabolites in both blood and urine specimen, or specimen validity/adulteration testing.	Medicaid Marketplace

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