home state health

An important message from Provider Relations



Updated Payment Policies
Effective October 1, 2017

Home State Health has Payment & Clinical Policies to guide how claims for certain services are adjudicated and paid. These policies provide clinically based rule content to evaluate claims against payment and clinical policies to ensure accurate reimbursement. This is in addition to all other reimbursement processes that Home State Health currently employs. The policies that dictate the coding and billing rules applied are based on industry standards and guidelines as published and defined in the Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), and public domain specialty society edits, unless specifically addressed in the fee-for-service provider manual published by the MO HealthNet or regulations.

The effective date for the policies listed below is **October 1, 2017.** These policies apply to all Home State Health products, unless otherwise noted.

The policies can be found on Home State Health's web site:

https://www.homestatehealth.com/providers/tools-resources.html

Number	Policy Name	Policy Description	Line of Business (LOB)
CC.PP.050	E&M Medical Decision-Making	The policy discusses the appropriate assignment of moderate to high complexity E&M services with an emphasis on medical decision making as a key component of the assignment process.	Medicaid, Medicare, Ambetter
CP.MP.140	EpiFix Wound Treatment	This policy describes the medically necessary indications for EpiFix wound treatment.	Medicaid, Medicare, Ambetter
CP.MP.139	Low-Frequency Ultrasound Wound Therapy	The policy provides a statement of medical necessity for low-frequency ultrasound wound therapy.	Medicaid, Ambetter
CP.MP.144	Mechanical Stretch Devices	This policy describes the medically necessary indications for mechanical stretching devices for joint stiffness and contracture.	Medicaid, Medicare, Ambetter
CP.MP.143	Wireless Motility Capsule	The policy provides a statement of medical necessity for wireless motility capsule (WMC).	Medicaid, Medicare*, Ambetter
CC.PP.048	Robotic Surgery	This policy defines payment criteria for robotic surgeries to be used in making payment decisions and administering benefits.	Medicaid, Ambetter
MP.PP.018	Inpatient Only Procedures- *Ambetter only*	The purpose of this policy is to serve as a reference guide on procedures that will reimbursed as inpatient only services for Ambetter only.	Ambetter

* Medicare will be implemented via prior authorization for Wireless Motility Capsule.

Questions?
Contact Provider Relations at 1-855-694-4663.

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The table below contains explanation codes for Payment and Clinical policy denials:

Explanation Code	Definition	Description of Claims Edit
w7	Preventable Readmission Recoupment	Represents an overpayment of a previously reimbursed claim. Depending on the provider's contract, the overpayment is collected either by an offset from a future payment to the provider or as a direct refund from the provider.
xE	Procedure Code is Disallowed with Diagnosis code(s) per plan policy	The procedure code is not reimbursable when billed with a diagnosis code that does not support medical necessity.
xL	Procedure Code Unbundled per State Rules, Contract or Payment Policy	Multiple procedure codes are billed for the component parts of a procedure, service or item, when there is a single CPT code that includes the complete procedure, service or related items.
xP	Service is denied according to a payment or coverage policy	The procedure code billed is considered not medically necessary. For example, the procedure code is considered experimental, investigational or unproven.
xS	Readmission Denied After Medical Record Review	After clinical review of the medical records, the readmission was determined to be preventable; therefore the denial is upheld.
ym	Potential Preventable Readmission Submit all Medical Records	Represents a denial for a potentially preventable readmission. Provider must submit all medical records within the readmission time period (15 or 30 day) depending on health plan rules. Records are clinically reviewed by the health plan's Medical Management team.
yv	Outpatient services included in inpatient admission per CMS/Plan Guidelines	The technical component of all outpatient diagnostic and non-diagnostic services are bundled into the inpatient hospitalization when those services occur during the 1-day or 3 days preceding the inpatient admission.

➤ **Secure Portal Registration:** If you haven't already do so, please go to www.HomeStateHealth.com to register for our Secure Portal. Functions on the portal include: Verification of eligibility, submission of claims, entering authorizations, viewing patient care gaps, etc. Use of the portal is FREE for all services!

➤ **Electronic Funds Transfer / Electronic Remittance Advice**

- Home State Health Plan partners with PaySpan Health for EFT/ERA services.
- Please register with PaySpan Health at www.payspanhealth.com

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