

Provider Newsblast



Amerigroup Community Care
providers.amerigroup.com/TN

Medicaid providers: 1-800-454-3730

Medicare providers: 1-866-805-4589

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TNPEC-1372-16-B1

Prior authorization required for H.P. Acthar Gel, Prialt and Retisert

Amerigroup Community Care is adding the following drugs to the 2016 Medicaid list of injectable or infusible drugs requiring prior authorization (PA). As of May 1, 2016, providers must call for PA of the drugs listed below:

- H.P. Acthar Gel (Repository Corticotropin Injection) for the treatment of infantile spasms and corticosteroid-responsive conditions where there is clear documentation of why all other well-established routes for corticosteroid therapy cannot be used.
 - Amerigroup Clinical Utilization Management Guideline CG-DRUG-24: (J0800=Injection, corticotropin, up to 40 units)
- Prialt (Ziconotide Intrathecal Infusion) for the management of severe chronic pain when intrathecal therapy is warranted and when intolerant or refractory to other treatment
 - Amerigroup Medical Policy Drug 00027: J2278=Injection, ziconotide, 1 microgram)
- Retisert (Fluocinolone acetonide intravitreal implant) for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.
 - Amerigroup Medical Policy DRUG.00032: (J7311=Fluocinolone acetonide, intravitreal implant)

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Intensity modulated radiation therapy (IMRT) codes require PA

Effective March 1, 2016, two intensity modulated radiation therapy (IMRT) codes that did not require PA will now require PA. IMRT requests must be reviewed by Amerigroup for PA for dates for service on or after March 1, 2016.

Amerigroup will require PA for the following IMRT codes beginning March 1, 2016:

- 77385: Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 : Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

PA request may be submitted by either of the following methods:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627

If you need language assistance services in a language other than English, please call us at 1-800-454-3730.

Necesita ayuda con el idioma gratuita? Llame 1-800-454-3730.

You can also dial 711 for telecommunications relay service (TRS) assistance.

If you require materials in alternate formats, please call us at 1-800-454-3730 to make such a request (e.g., provider manual, forms and newsletters in languages other than English or Spanish, braille, large font, etc.).

ICD-10 and coding for diabetes

Below is some helpful information regarding ICD-10 and how to properly bill for diabetes.

Diabetic complications in ICD-10

A benefit of ICD-10 codes is that providers can now report more clinical details concerning diabetic complications than they could in ICD-9. The increased specificity is possible because ICD-10 contains expanded combination codes for diabetic complications. A combination code describes two or more conditions within a single code. The ICD-10 code categories E08-E13 contain the combination codes for diabetic complications. The codes include type of diabetes mellitus, body system affected and complications affecting that body system. Combination codes may require additional diagnosis codes to fully describe all associated conditions. Reporting all documented conditions to the highest level of specificity on the claim form helps to promote quality and continuity of patient care. To ensure coding specificity for diabetic complications in ICD-10, medical record documentation should include:

- Type of diabetes (i.e., Type 1, Type 2, secondary)
- Complications and body systems affected (i.e., diabetic neuropathy)
- Control status (document how well diabetes is controlled over time)
- Long term use of insulin (report additional code Z79.4 on the claim)

Some examples of ICD-10-CM type 2 diabetes combination codes include:

Complication type	Correct code category
Kidney and renal	E11.2- Type 2 diabetes with kidney complications
Ophthalmic (eye/retinal)	E11.3- Type 2 diabetes with ophthalmic complications
Neurologic (nervous system)	E11.4- Type 2 diabetes with neurological complications
Circulatory (arteries)	E11.5- Type 2 diabetes with circulatory complications
Other specified (arthropathy, skin, ulcerations, oral, hypoglycemia and hyperglycemia)	E11.6- Type 2 diabetes with other specified complications

Note: Not an all-inclusive list. For a complete list consult the current ICD-10-CM coding manual.

Accurately reporting uncontrolled diabetes

Previously, diabetes mellitus codes were classified as controlled or uncontrolled. In ICD-10-CM diabetes described as not being controlled is classified as hyperglycemia which is considered a complication. When documentation contains terms such as *inadequately controlled*, *out of control* and *poorly controlled*, the index leads to diabetes with hyperglycemia (see example below). Assign as many codes that are needed to accurately describe the patient's diabetic condition(s).

Documentation	Correct code(s)
Male patient is seen and evaluated for diabetes mellitus type 2 poorly controlled.	E11.65 Type 2 diabetes mellitus with hyperglycemia
Female patient is seen and evaluated for shooting pain and numbness in toes and feet. The provider diagnosis type 1 diabetic neuropathy inadequately controlled.	E10.40 Type 1 diabetes mellitus with diabetic neuropathy E10.65 Type 1 diabetes mellitus with hyperglycemia

Documenting to support accurate coding

Since diagnosis coding is based on provider documentation, it is critical that providers include all known details about coexisting and chronic conditions (i.e., diabetes) in the medical record for each patient encounter. Details such as the provider's assessment/evaluation of the condition, medications prescribed, recommendations, referrals and even

patient noncompliance help support accurate coding. Documenting support for all current medical conditions improves quality of care and ensures coding guidelines are followed.

ICD-10 Coding Guidelines, Section IV Diagnostic coding and Reporting Guidelines for Outpatient Services

- .I *Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions.*
- .J *Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.*

Documenting cause and effect for diabetic complications

When diabetic complications are present, it is important that medical record documentation support the cause and effect relationship between diabetes and the other conditions with linking verbiage. Examples of linking verbiage include:

- Diabetic
- Due to diabetes
- Secondary to diabetes
- Caused by diabetes

If documentation does not properly link the condition(s), a diabetes combination code should not be assigned. Each condition must be coded separately when documentation does not establish a causal link (see example below).

Documentation	Correct code
Female patient evaluated for type 1 diabetes and stage 1 chronic kidney disease. (Cause and effect not documented.)	E10.9 Type 1 diabetes mellitus <i>without complications</i> N18.1 Chronic kidney disease, stage 1
A male patient is seen and evaluated for <u>diabetic</u> chronic kidney disease-stage 3, he takes insulin on a daily basis.	E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease N18.3 Chronic kidney disease, stage 3 (moderate) Z79.4 Long-term (current) use of insulin

For complete instructions and guidelines, please refer to the current ICD-10-CM coding manual.

[Annual change in Medicaid hospice payment rates](#)

Summary: Effective January 1, 2016, CMS has changed the hospice Medicaid rates for federal fiscal year (FFY) 2016. The final Medicaid hospice rule was published on August 6, 2015 (CMS- 1629-F).

What this means to you: The rule changes the payment methodology for routine home care (RHC) to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days thereafter. It also establishes an add-on payment for services provided by a registered nurse (RN), licensed practical nurse (LPN) or social worker during the last seven days of a beneficiary’s life.



Reimbursement:

Hospice

Revenue code 0651 with applicable procedure codes will be reimbursed depending on the number of days the member is in hospice. The payment will be reduced beginning with day 61. These calculations are subject to the normal wage index. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, the patient prior hospice days will continue to follow the patient and count toward the patient days for the receiving hospice in the determination of whether the receiving hospice may bill at the high or low RHC rate, upon hospice election.

Service intensity add-on (SIA) payment is effective for hospice services with dates of service on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) SIA payment if the following criteria are met:

1. The day is a RHC level of care day.
2. The day occurs during the **last seven days** of life (and the beneficiary is discharged dead). Revenue code 0551 with HCPCS codes G0299 (RN) and G0300 (LPN) or revenue code 0561 with HCPCS code G0155 will be setup to have a max of 4 hours a day and 28 total hours.
3. Service is provided by a RN, LPN or social worker that day for at least 15 minutes and up to 4 hours total.
4. The service is not provided by a social worker via telephone.

Home Health Care

Revenue code 0551 with applicable procedure codes will be reimbursed. HCPCS code G0154 has termed as of December 31, 2015, and has been replaced with HCPCS code G0299 for RN and HCPCS code G0300 for LPN beginning January 1, 2016.

What if I need assistance?

If you have questions about this communication, please contact your local Provider Relations representative or call our Provider Services team 615-232-2160.

[New Consent for Sterilization form](#)

Summary: As communicated by the Bureau of TennCare (TennCare) on January 4, 2016, the U.S. Department of Health and Human Services has updated the expiration date on the Consent for Sterilization form. The new form has a two-year expiration date and will expire on December 31, 2018.

What this means to you: The new consent form must be utilized. We will deny claims for sterilization procedures without it. Please remind your claims or billing staff of this requirement.

What is the impact of this change? Providers should use the updated sterilization form and review the instructions, which have also been revised to align fields [2, 6, 13 and 17] for clarity and ease in completion:

tn.gov/assets/entities/tenncare/attachments/sterilizationconsentform.pdf

Only forms approved by TennCare will be reimbursed for abortion, sterilization and hysterectomy services. Forms must be filled out correctly and in their entirety. Use of unapproved forms will result in claim denials.

What if I need assistance? You can access the updated Consent for Sterilization form, both English and Spanish, through TennCare's website: tn.gov/tenncare/topic/miscellaneous-provider-forms.



Missing information affecting claims payments

Background: According to the Affordable Care Act (ACA), the appropriate claim form must include the national provider identifier (NPI) for ordering, prescribing, or referring (OPR) provider and their first and last name.

What this means to you: Claims submitted without an NPI number and first and last name for Independent Labs (POS 81) for the OPR provider will be rejected and returned. Resubmission will be necessary with the appropriate codes on the CMS-1500 and UB-04 claim forms within the timely filing deadline.

Why is this change necessary? Amerigroup Community Care requires all claims, both paper and electronic, to be submitted with the NPI numbers, and first and last name in the appropriate boxes on the claim forms. For more information, see <https://www.amerigroupcorp.com>.

Supported housing guidelines

Program description

Supported housing (SH) services are wrap-around behavioral health/psychiatric rehabilitation services that prepare individuals experiencing a severe and persistent mental illness (SPMI) for independent living in the community while allowing them to live in community settings. SH refers to the services rendered at a facility staffed 24 hours a day, 7 days a week by an awake direct care staff. SH **does not** include room and board payment.

The facilities offer a highly structured setting that is safe and secure and promotes the principles of recovery including hope, empowerment, self-management and rejoining/rebuilding a life in the community. Due to SH being a transitional service, every effort is made for members to receive these services near their family, support systems and places of residence.

SH services are responsible for facilitating and providing comprehensive coordination of behavioral health services, increasing member's strengths, and addressing needs to increase overall functioning and ability to contribute positively to society. Functions include:

1. Supporting PCP engagement
2. Crisis intervention
3. Monitoring to promote adherence to prescribed medications
4. Facilitating behavioral health appointments
5. Promoting overall wellness
6. Assisting in development of employment/housing plans
7. Identification of resources
8. Assisting with symptom management to prevent negative impact on employment and housing goals
9. Promoting education and advocacy with employers and potential landlords regarding the service process, role of medication and symptom management
10. Building skills (including independent living, employment, and recreational and social skills)

The receipt of SH services and level one and level two case management is considered duplication of service and should not occur simultaneously. Case management should only be involved to assist with transition out of the SH services no more than 90 days prior to discharge.

Admission Criteria:

SH services must meet medical necessity criteria per TennCare Rule 1200-13-16-.05.

- A. Services must be ordered by a licensed behavioral health clinician (e.g., licensed clinical social worker, clinical social worker, licensed professional counselor, licensed psychologist or psychiatrist) or a PCP who has assessed the member within 30 days of the request for authorization.
- B. All elements of this section are required for authorization of SH:
 - 1. Current primary DSM V diagnosis
 - 2. Significant function impairment as a result of mental illness as evidenced by Global Assessment of Functioning (GAF) score below 50 or DSM V assessment
 - 3. Must be 18 years of age or older
 - 4. Must require supervision in structured setting due to mental health symptomology that prevent independent living and personal and community safety such as
 - i. Health care and personal hygiene
 - ii. Finances
 - iii. Healthy diet and food preparation
 - iv. Home maintenance
 - v. Community service's needs (legal, transportation, housing, etc.)

Exclusion: The primary problem cannot be social, economic or of a physical nature without a concurrent major psychiatric condition.

- 5. Must be able to perform basic activities of daily living (ADL) (i.e., eating and bathing) with appropriate prompting
- 6. Must be able to participate in and benefit from services; members who have experienced traumatic brain injury (TBI), mental retardation, dementia, etc., may not be appropriate for SH service if their cognitive impairment precludes their ability to participate in and benefit from services
- 7. Physical health status must not impair the ability to participate and engage in SH services
Example: Members who are bed ridden, have significant paralysis or require ongoing assistance with ADL living due to physical limitations
- 8. Must be able to recognize (or be taught to recognize) danger and threat to personal safety; chronic conditions such as pica, fire setting, impulsive self-harm and sexually inappropriate behaviors would not be appropriate for this level of care
- 9. Must be actively engaged and/or stepping down from service and/or recovery services (including therapy and medication management)
- 10. Must not have been deemed inappropriate for SH services due to behaviors more than twice in the past six months (includes significant property destruction and assaultive behaviors)
- 11. Must have consented to SH service as evidenced by written consent
- 12. Must have a means to pay room and board, or the provider agrees to provide room and board at no cost
- 13. Must have targeted symptoms and behaviors that can be addressed with SH and assist in moving toward a less restrictive environment as evidenced by preliminary service goals

Two of the following must be met:

- 1. A history of hospitalization in an acute psychiatric or psychiatric residential service setting within the past three months
- 2. Step down from acute psychiatric hospitalization or psychiatric residential service meets all of criteria B where no other placement options are available i.e. family, group home or any other lower level housing placement.
- 3. Step down from Enhanced SH when admissions criteria are met.
- 4. Upon release from incarceration where significant mental health issues have been noted

Exclusion:

- A. SH service needs shall not be based solely on homelessness and/or incarceration
- B. A major change in other social factors that have decreased the member's ability to function independently or within the current support system; this would include challenges in sustaining housing or maintaining a safe living environment due to a mental illness

CCR criteria: All criteria below must be met.

- A. Updated assessment within the past three weeks of the current request of the member's overall functioning that continues to meet Sections B of Admission Criteria and necessitate service
- B. Individualized service plan with specific time-limited and measurable goals specific to strengths and needs identified in Sections B and C of Admission Criteria
- C. Evidence of willing and active participation in the program by the member as evidenced by updated clinical information, progress notes and service plan
- D. SH services are required to maintain stability as evidenced by e service planning and time limited goals documented by the provider. **(Amerigroup Community Care may request an updated copy of the service plan with time-limited and measurable goals. Amerigroup reserves the right to request assessments related to DSM V diagnosis)**
- E. SH is the least restrictive setting that will adequately meet the member's needs. (Amerigroup may request a copy of the housing individualized service plan)
- F. At a minimum of fifteen hours weekly of behavioral health and/or psychiatric rehabilitation are required for each member as a part of the SH per diem and cannot be billed separately as psychiatric rehabilitation.

Discharge criteria:

- A. The member meets all elements of this section.
 - 1. Lack of acute psychiatric or residential hospitalization in the last three months
 - 2. Lack of crisis services or emergency response intervention in the last three months
 - 3. Time-limited and measurable service goals have been met by the member and/or provider; the clinical documentation demonstrates member has met the individualized goals as evidenced by service plan updates
 - 4. Evidence that existing issues and needs can be met by a lower level of care
Example: A member requiring his or her representative payee to manage finances can be managed in psychosocial rehabilitation services versus SH
 - 5. Increased level of functioning and/or support that demonstrates an ability to remain safe and stable within the community

OR

- B. The member declines services and/or refuse to participate or engage.

SH program requirements:

- 1. The SH program must have a comprehensive, individualized service plan completed with the member that includes:
 - a. Current DSM-IV TR/DSM-V diagnosis, current level of functioning assessment and highest level of functioning in the past year provided by the licensed behavioral health professional practicing within the scope of their licensure*
 - b. Current clinical information including severity of symptoms as evidenced by DSM-V assessments*
 - c. Current medications*
 - d. Current risk factors and risk history impacting current placement (e.g., fire setting) *
 - e. Current safety and crisis plan for identified risks
 - f. History of substance abuse (if applicable)
 - g. History of physical and/or sexual abuse (if applicable)

*Required items

- h. Functional impairments and supports (itemized) *
 - i. Job and/or school information and history
 - j. Housing barriers and goals including proposed modifications of housing environment to accommodate needs of member and successful adaptation to the living environment
 - k. Co-occurring medical and physical conditions (itemized including date of onset if known) *
 - l. Family history of mental illness
 - m. Medical and behavioral service history including anything of significance within the past 12 months
 - n. Measurable and time-limited service goals specific to the psychiatric condition necessitating SH services*
 - o. Projected discharge date, plan, and expected barriers*
 - p. Independent living goals
 - q. Expected outcome and prognosis for SH services*
 - r. Documentation and managed care organization (MCO) approval if SH is expected to be used as an alternative to long-term subacute regional mental health institute placement*
 - s. Inclusion of family or social supports in initial, concurrent and discharge service planning (requires the member's written consent or refusal)
 - t. Inclusion of other treating providers with the member's written consent
 - u. Documentation of the provision and education regarding available community resources
 - v. Daily documentation of the member's behaviors in the milieu
2. A comprehensive individualized service plan must be completed and available to Amerigroup upon request within 30 days of the member's admission.
 3. Service plans must be formulated for SH services with evidence of collaboration with other behavioral health services including but not limited to psychosocial rehabilitation services.
 4. SH services are responsible for care coordination and shall not occur in conjunction with case management services due to duplication unless approved by the MCO.
 5. The individualized service plan must be updated every month or more frequently if clinically appropriate.
 6. The individualized service plan must be completed face-to-face with the member with evidence of the member's desired recovery goals and written consent.
 7. Direct care staff supports must be awake and available 24/7.
 8. Members shall not be required to leave the SH facility as a condition for services receipt for non-treatment services (i.e., outings, shopping, etc.)
 9. Members shall be allowed to independently leave the SH facility if part of their individualized service plan and if no safety risks have been identified; if risk has been identified, member must have a current safety plan.
 10. SH services must provide or procure a physical examination, including routine screening and special studies as determined by the examining physician within 30 days of admission.
Exception: The member has had a physical examination within 90 days of admission. Documentation of physical examinations must be available in the member's record and include the name of the examining physician and clinic or hospital.
 11. All facility and direct care staff must be trained in accordance with standards established by the Tennessee Department of Mental Health (TDMH)
 12. SH must meet the minimum program TDMH requirements for licensure.
 13. CCR to be completed at least 15 days prior to the end of the authorized period
 14. Notification of any transitions between SH services including changes in locations due to milieu disruptions must be provided to Amerigroup prior to transition.

*Required items

Enhanced supported housing (ESH)

Admission criteria

In addition to meeting the admission criteria for regular SH services, member must meet two or more of the following:

- A. Must be transitioning from the hospital/subacute setting or **must be** at risk for placement in subacute settings.
- B. Must have correctable physical limitations (e.g., requiring the use of walkers and/or wheelchairs).

Exclusion: Members who are unable to ambulate

- C. Must have a medical condition requiring additional assistance (e.g., eating disorders, diabetes, cancer, TBI and wounds).
- D. Must have a co-occurring condition such as lower cognitive functioning as evidenced by clinical diagnosis/records.
- E. Must require a more secure setting due to elopement.
- F. Must be unable to be maintained in regular SH services due to a lack of medication adherence, increased symptomology and problematic behaviors in the community.

Program requirements

In addition to meeting the program requirements for regular SH services, ESH services must meet the following requirements:

1. Staff must be under the supervision of a licensed mental health professional.
2. Must be equipped to handle members with current elopement behaviors as evidenced by locked outside doors and/or having alarm systems available.
3. Must have access to additional direct care staff as needed during waking hours.
4. Must be able to collaborate and accommodate the service provision of other service providers such as home health.

Supported community living (SCL) – program expectations

Expectation of SCL is to be a transition for continued stabilization and community living and not to be considered permanent housing placement option.

- A. Member must be transitioning from ESH/SH or must be at risk for placement in ESH/SH.
- B. Placement is appropriate for members who do not require intense supervision (i.e., medication adherence, at risk for elopement, aggressive behaviors etc.).
- C. SCL is a transitional level of services and supports used to prepare members for independent or less supervised living (i.e., group home, boarding home, etc.).
- D. Members should be able to learn and/or perform ADLs daily (i.e., cooking, bathing, cleaning, laundry, etc.).
- E. Member should demonstrate these basic independent living skills daily.
- F. Member should be able to be unsupervised daily for a minimum of five hours unless working/volunteering outside of the SCL environment.
- G. Member should be able to demonstrate ownership of his or her healthcare as evidence by the ability to schedule and attend medical and behavioral health appointments independently, includes planning/scheduling of transportation.

Exclusions:

SCL is not to be utilized for permanent housing.

Medicaid policies updates

On November 5, 2015, the Amerigroup Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies. These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing. The medical policies were made publicly available on the Amerigroup provider website on the effective date listed in the following chart.

Visit medicalpolicies.amerigroup.com/search to search for specific policies. Existing precertification requirements have not changed.

Medical policy effective date	Medical policy number	Medical policy	Medical policy (new/revised)
November 23, 2015	DRUG.00079	Bendamustine Hydrochloride (TREANDA®)	New
November 9, 2015	DRUG.00080	Mepolizumab (Nucala®)	New
January 5, 2016	THER-RAD.00011	Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT)	New
November 23, 2015	DRUG.00039	Trastuzumab (Herceptin®)	Revised
November 9, 2015	GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	Revised
January 5, 2016	LAB.0031	Advanced Lipoprotein Testing	Revised
January 5, 2016	MED.0103	Automated Evacuation of Meibomian Gland	Revised
January 5, 2016	MED.00113	Therapeutic Apheresis	Revised
January 5, 2016	SURG.00024	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Revised
January 5, 2016	THER-RAD.00008	Neutron Beam Radiotherapy	Revised
January 5, 2016	DME.00035	Electric Tumor Treatment Field (TTF)	Revised
January 5, 2016	MED.00080	Cryopreservation of Oocytes or Ovarian Tissue	Revised

Category changes

The following three medical policies have changed category placement. They were not reviewed at the November 5, 2015, MPTAC meeting. The new category is listed below.

Previous category and number	New category and number
RAD.00014	THER-RAD.00001 Brachytherapy for Oncologic Indications
RAD.00016	THER-RAD.00003 Intravascular Brachytherapy (Coronary and Non-Coronary)
RAD.00056	THER-RAD.00009 Intraocular Epiretinal Brachytherapy

[Clinical Utilization Management Guidelines update](#)

On November 5, 2015, the Amerigroup MPTAC approved the following Clinical Utilization Management (UM) Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the Clinical UM Guidelines adopted by the Medical Operations Committee for the Government Business Division on November 18, 2015.

On November 5, 2015, the clinical guidelines were made publicly available on the Amerigroup Medical Policies and Clinical UM Guidelines subsidiary website. Visit medicalpolicies.amerigroup.com/search to search for specific policies. Existing precertification requirements have not changed.



Effective date	Clinical UM Guideline number	Clinical UM Guideline title	Revised or new
January 1, 2016	CG-DME-37	Air Conduction Hearing Aids	New
January 5, 2016	CG-MED-53	Cervical Cancer Screening for Women Under 21 Years of Age	New
January 5, 2016	CG-MED-54	Strapping	New
January 5, 2016	CG-SURG-52	Level of Care: Hospital-Based Ambulatory Surgical Procedures, including Endoscopic Procedures	New
January 5, 2016	CG-THER-RAD-01	Fractionation and Radiation Therapy: Bone Metastases and Whole-Breast Irradiation Following Breast-Conserving Surgery	New
January 5, 2016	CG-THER-RAD-02	Special Radiation Physics Consult and Treatment Procedure	New
January 5, 2016	CG-DRUG-45	Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)	Revised
January 5, 2016	CG-SURG-43	Knee Arthroscopy	Revised
January 5, 2016	CG-SURG-46	Myringotomy and Tympanostomy Tube Insertion	Revised
January 5, 2016	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	Revised

For additional information, refer to the Preadmission Services for Inpatient Stays Reimbursement Policy at providers.amerigroup.com and click on Quick Tools.

[Amendments to statewide contract](#)

Summary of change: The below changes are in accordance with Amendment Number 3 Statewide Contract between State of Tennessee (TennCare) and Amerigroup effective January 1, 2016; therefore, the changes will be reflected in the next revision of your Amerigroup provider manual.

What this means to you: These changes should be implemented as of January 1, 2016.

Behavioral Health Services Chart

Service	Benefit limit prior to January 2016	Benefit limit effective January 1, 2016
Inpatient, Residential and Outpatient Substance Abuse Benefits	Medicaid/Standard Eligible, age 21 and older: Limited to 10 days detox, \$30,000 in medically necessary lifetime benefits unless otherwise described in the 2008 Mental Health Parity Act as determined by TennCare.	Medicaid/Standard eligible, age 21 and older: Covered as medically necessary.
	Medicaid/Standard Eligible, under age 21: As medically necessary.	Medicaid/Standard Eligible, under age 21: As medically necessary.

When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.



Cultural Competency

With the increasing diversity of the American population, it is important for us to work in cross-cultural situations. Your ability to communicate with your patients has a profound impact on the effectiveness of the health care you provide. Your patients must be able to communicate symptoms clearly and understand your recommended treatments. You should promote the delivery of services in a culturally competent manner to all patients, including those with limited English proficiency, disabilities, non-traditional communications styles and diverse cultural and ethnic backgrounds regardless of a patient's gender, sexual orientation or gender identity. You must ensure physical access, accommodations and accessible equipment for the furnishing of services to a patient with physical or mental disabilities.

