NewsBlast

TENNESSEE – JULY 2014 TNPEC-0783-14

The following entries apply to all Tennessee Amerigroup Community Care Providers.

Important Budget Reduction Information

Amerigroup Community Care has been directed by the Bureau of TennCare to make programmatic changes effective July 1, 2014, as detailed in a document TennCare distributed to all Managed Care Organizations on June 13, 2014. A copy of the full TennCare document and the letter we sent you about it can be found on our website at providers.amerigroup.com/TN under the State Communications heading.

- One-percent reduction for the following provider services (as defined in the applicable Attachments)
  - Emergency and non-emergency transportation (defined as HCPCS codes A0000 – A0999)
  - Lab and X-ray – This includes all professional, inpatient and outpatient services (see Attachment B)
  - Home health, except respite and hospice (see Attachment D)
  - Durable Medical Equipment (DME) and medical supplies
  - Behavioral health services (see Attachment E)
  - Home- and Community-Based Services (HCBS), excluding consumer direction services (see Attachment F)

As a note, the Budget proposed a 2 percent reduction to the provider services listed above; however, 1 percent was bought back with one-time appropriations. For the next state fiscal year (SFY 2016), the reduction to the provider services listed above will be the full 2 percent unless additional appropriations are provided to fund the budget and buy back the reduction in whole or in part.

The programmatic change no longer require us to include specific language in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing. This requirement has been bought back by one-time appropriations and therefore will not be enforced for state fiscal year 2015.

Additional requirements and limits are as follows:

- Diapers – Quantities over 200 per month require prior authorization or post-payment review for medical necessity.
- MRI – Medical Necessity Criteria for Low Back Pain Diagnostic Testing - Limit spinal (cervical, thoracic and lumbar) MRIs within the first eight weeks for a primary diagnosis of non-specific spine pain (ICD-9 codes 721.xx-724.xx) in the absence of other serious coexisting diagnoses.
- Back braces – The maximum reimbursement amounts were reduced by 1 percent. See attached for clarification.

In addition to the budget reductions described above, all previous reductions and limits remain in effect, including previous across the board rate reductions (see Attachment A). For your reference, the previous reductions remaining in effect are detailed in the memo from the Bureau of TennCare posted on our website.

Reminder: Guidance for Drug Screening CPT Codes

Summary: One of the many ways we support the quality health care you give our members is by providing you with information on coding and reimbursement standards and best practices. Our Coding Validation Initiative department identified Current Procedural Terminology (CPT) codes 80100, 80101, G0430 and G0431 — drug screen, qualitative — as codes that are easily misused.

What this means to you: Adopting the nationally recognized standards below for appropriate use will result in more timely and efficient reimbursement of claims.

How should these codes be used?

Code	Description	Comments
80100*	Drug screen, qualitative; multiple drug classes chromatographic method, each procedure	This CPT code remains unchanged and is used to report all multiple drug class assays employing chromatographic methods (i.e., the unique combination of stationary and mobile phase). * There are no Clinical Laboratory Improvements Amendments (CLIA)-waived, chromatographic, qualitative drug procedures; thus 80100QW is not a payable code.
80101 or 80101QW	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class	These CPT codes are no longer covered by Amerigroup contracts that use the Centers for Medicare and Medicaid Services (CMS) fee schedule(s). The effective date of this change was April 1, 2010. A second notification on the use of these CPT codes was sent in 2013 indicating these codes will no longer be covered.
G0430 or G0430QW	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure	These CPT codes are no longer covered by Amerigroup contracts that use the CMS fee schedule(s). The effective date of this change was January 1, 2011.
G0434 or G0431	Urine drug screen; both may be billed on same day of service	These CPT codes are no longer covered in 8XXXX series (e.g., 80101). For billing urine, adhere to Medicare guidelines. **Each G code carries its own limit:** • **G0434 limits 12 per member, per year** • **G0431 limits four, per member, per year** Limits do not apply in the emergency department. This includes screens sent to an independent lab on the same date of service for the same member on the same day of an emergency. 271U will report number of screens paid and apply encounter edits if exceeded.

How can I get more information?

You can find a listing of drug screening tests approved for use for the above codes online at www.cms.gov/CLIA/downloads/waivetbl.pdf.

For more information about this initiative, please contact the Coding Validation Team by phone at 1-800-374-3631 or 1-866-696-2675, by fax at 1-888-235-9315 or by email to cvihold@amerigroup.com.

We encourage you to visit providers.amerigroup.com/TN often to check out the improvements we are making and the latest information about Amerigroup Community Care and the managed care industry.

TNPEC-0764-14

Join Us in the Million Hearts Initiative

Summary: Did you know, every 39 seconds someone dies from a heart attack or stroke? Join us and the Department of Health and Human Services (HHS) in the Million Hearts initiative to prevent 1 million heart attacks and strokes in the United States by 2017.

✦ **What this means to you:** Please share this helpful information with your patients. Together we can educate and empower Amerigroup Community Care members with the necessary information and tools to improve overall heart health and quality of life. You can start by assessing each patient using the ABCS of heart-healthy living.

The Centers for Medicare & Medicaid Services and HHS developed the following ABCS to help providers discuss heart health with their patients.

- **A: Appropriate aspirin therapy for those who need it**
  - Identify patients who would be appropriate for aspirin therapy.
- **B: Blood pressure control**
  - Discuss blood pressure control with your patients.
- **C: Cholesterol management**
  - Identify patients who are high-risk and need cholesterol management.
- **S: Smoking cessation**
  - Discuss smoking cessation with all active smokers.

What if I need assistance?

If you would like to become a partner in the Million Hearts initiative, please call our Quality Management department at 615-316-2400. For more information or patient education materials, visit www.millionhearts.hhs.gov.

TNPEC-0765-14

The following reminder applies to Behavioral Health Providers.

Tell us about the services you provide!

Summary: We're committed to finding the best ways possible to support our members and providers. You can help by letting us know about the services your practice currently performs.

✦ **What this means to you:** Your response is vital to helping us match the services your practice provides with our members' needs. Please respond to our brief five-ten minute survey by visiting www.surveymonkey.com/s/AGPTNBH

What if I need assistance?

If you have questions about the survey or need any other assistance, please call your local Provider Relations representative at 615-316-2460 or Provider Services at 1-800-454-3730.

PEC-ALL-1226-14