providers.amerigroup.com

July 3, 2014

RE: Important Budget Reduction Impact for July 1, 2014

Dear Provider:

Amerigroup Community Care would like to share the attached document, which was distributed to all managed care organizations (MCOs) on July 2, 2014, by the Bureau of TennCare. Effective July 1, 2014, we have been directed to make a 1-percent reduction for the following provider services (as defined in the applicable attachments):

- Emergency and nonemergency 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 initial budget proposed a 2-percent reduction to the provider services listed above; however, a 1-percent reduction was bought back with one-time appropriations. In state fiscal year 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 requires us to include specific language in applicable provider agreements that participating providers 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.
- Magnetic Resonance Imaging (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 nonspecific 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 attached memo from the Bureau of TennCare.

Sincerely,

Edna Willingham
Chief Operating Officer
Amerigroup Community Care

Attachment

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

MEMORANDUM

TO: **TennCare Managed Care Organizations**

FROM: **Keith Gaither, Director Managed Care Operations**

DATE: **July 2, 2014**

SUBJECT: **Budget Reductions/Impacts for July 1, 2014**

This letter serves as official notice of programmatic changes to be made by the MCOs as a result of the state fiscal year 2015 budget. We have also included previous budget decisions that are to continue including previous rate reductions (see Attachment A). Below are the details:

- **1% Reduction for the following provider services:** (as identified 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)
    - DME and Medical Supplies
    - Behavioral Health Services (see Attachment E)
    - Home and Community Based Services (HCBS), Excluding Consumer Direction Services (see Attachment F)

  NOTE: The Budget proposed a 2% reduction to the provider services listed above; however, 1% has been 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% unless additional appropriations are provided to fund the budget and buy back the reduction in whole or in part.

- **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.

- **340B Pricing:** Section 2.12.9.60 of the MCO Contract requires the MCO to specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing. This requirement of the contract has been bought back by one time appropriations and therefore will not be inforced for state fiscal year 2015.

In addition to the budget reductions described above, all **previous reductions** and **limits** remain in effect. In addition to previous across the board rate reductions (see Attachment A), the previous reductions that remain in effect are as follows:

- **Cesarean and Vaginal Delivery Reimbursement (see Attachment C for Crosswalk)**

Cesarean and Vaginal Delivery Reimbursement		
SFY 2012	**SFY 2013**	
Effective July 1, 2011	**Effective July 1, 2012**	
Cesarean and vaginal deliveries will be reimbursed at the same rate effective July 1, 2011. MCOs are directed to increase their vaginal delivery rates by 17%. Additionally, MCOs are to pay the vaginal delivery rate for corresponding C-Section deliveries.	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. MCOs are directed to decrease their vaginal and corresponding C-Section delivery rate by 7% points effective July 1, 2012. This should result in an effective 10% increase from the rates paid before July 1, 2011.	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. **MCOs are directed to decrease their vaginal and corresponding C-Section delivery rate by 5% points effective July 1, 2013**. This should result in an effective 5% increase from the rates paid before July 1, 2011.

- **Emergency Department Professional Fees SFY 2012 – Effective July 1, 2011**

  Reimbursement for professional claims for non-emergency ED visits will be capped at $50. If the contracted rate is lower than $50 for the service billed, the MCO is to pay the contracted rate.

  Each MCO must provide ED providers with the MCOs policy describing your process for determining Emergent vs. Non-Emergent claims. In addition to your MCOs process for a

provider to appeal claims reimbursement, the policy must offer a front end process whereby the provider may submit documentation for review upon consideration of an initial claim.

- **DME/Back Brace Reimbursement – SFY 2014 –Effective July 1, 2013**

BACK BRACE REIMBURSEMENT		
Effective July 1, 2013		1% Reduction Effective July 1, 2014
HCPC Code	Maximum Allowed Amount	Maximum Allowed Amount
L0637	$ 379.86	$ 376.06
L0631	$ 332.31	$ 328.99
L0627	$ 133.06	$ 131.73

- **Implementation of Medicare standards for coverage of TENS and CLBP - SFY 2014 – Effective July 1, 2013**

  Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will not allow coverage of TENS for CLBP. TennCare has adopted this policy as well. MCOs are expected to implement these guidelines for dates of service July 1, 2013 and thereafter.

- **Benefit Limits listed in Attachment G - SFY 2014 – Effective October 1, 2013**

Attachment A
Previous Percentage Rate Reductions

State Fiscal Year	Effective Date	Proposed Budget Reduction	Actual Budget Reduction	Actual % Reduction to Date
2012	**July 1, 2011**	8.5% Reducation • MCO Admin portion of CAP • All pathology, lab, and radiological services. This includes all professional, inpatient and outpatient services. • All outpatient and professional behavioral health services. • All emergency and non emergency transportation. Defined as HCPCS Codes A0000 – A0999. • All home health services except respite, hospice, and Home and Community Based Services. • Nursing Home services. TennCare will provide updated rates to the MCOs with a July 1, 2011 effective date.	4.25% Reducation • MCO Admin portion of CAP • All pathology, lab, and radiological services. This includes all professional, inpatient and outpatient services. • All emergency and non emergency transportation. Defined as HCPCS Codes A0000 – A0999. • All home health services except respite, hospice, and Home and Community Based Services. • Nursing Home services. TennCare will provide updated rates to the MCOs with a July 1, 2011 effective date.	4.25%
2012	**January 1, 2012**	N/A	4.25% Reducation • MCO Admin portion of CAP • All pathology, lab, and radiological services. This includes all professional, inpatient and outpatient services. • All emergency and non emergency transportation. Defined as HCPCS Codes A0000 – A0999. • All home health services except respite, hospice, and Home and Community Based Services. • Nursing Home services. TennCare will provide updated rates to the MCOs with a July 1, 2011 effective date.	8.5%
2012	**January 1, 2012**	1.5% Buyback for previous cuts	1.75% Buyback for previous cuts	6.75%

Attachment B
Radiology Procedure Codes

From	To	Modifiers Included	From	To	Modifiers Included
70000	78266	All	A9535	A9567	All
78269	79999	All	A9600	A9699	All
92132	92134	All	C1080	C1083	All
92227	92228	All	C1122	C1122	All
0042T	0042T	All	C9013	C9013	All
0234T	0238T	All	G0106	G0106	All
A4641	A4642	All	G0120	G0122	All
A9500	A9505	All	G0130	G0130	All
A9510	A9512	All	G0202	G0236	All
A9516	A9516	All	G0252	G0252	All
A9517	A9517	All	G0389	G0389	All
A9521	A9521	All	Q0035	Q0035	All
A9524	A9524	All	Q9945	Q9946	All
A9526	A9526	All	Q9947	Q9957	All
A9528	A9532	All	Q9958	Q9964	All

Radiology Revenue Codes

Revenue Code	Description	Revenue Code	Description
320	Radiology Diagnostic - General	351	CT Scan - Head Scan
321	Radiology Diagnostic - Angiocardiography	352	CT Scan - Body Scan
322	Radiology Diagnostic - Arthography	359	CT Scan - Other
323	Radiology Diagnostic - Arteriography	400	Other Imaging Services - General
324	Radiology Diagnostic - Cheat X-Ray	401	Other Imaging Services - Diagnostic Mammography
329	Radiology Diagnostic - Other	402	Other Imaging Services - Ultrasound
330	Radiology Therapeutic - General	403	Other Imaging Services - Screening Mammography
331	Radiology Therapeutic - Chemotherapy - Injected	404	Other Imaging Services - Positron Emission Tomography
332	Radiology Therapeutic - Chemotherapy - Oral	409	Other Imaging Services - Other
333	Radiology Therapeutic - Radiation Therapy	610	Magnetic Resonance Technology - General
335	Radiology Therapeutic - Chemotherapy	611	Magnetic Resonance Technology - Brain
339	Radiology Therapeutic - Other	612	Magnetic Resonance Technology - Spinal Cord

Attachment B
Radiology Procedure Codes

Revenue Code	Description	Revenue Code	Description
340	Nuclear Medicine - General	614	Magnetic Resonance Technology - Other
341	Nuclear Medicine - Diagnostic	615	Magnetic Resonance Angiography - Head and Neck
342	Nuclear Medicine - Therapeitic	616	Magnetic Resonance Angiography - Lower Extremities
349	Nuclear Medicine - Other	618	Magnetic Resonance Angiography - Other
350	CT Scan - General	619	Magnetic Resonance Imaging – Other

Laboratory/Pathology Code Ranges

From	To	Modifiers
78267	78268	All
80000	89999	All
ATP02	ATP23	All
G0027	G0027	All
G0101	G0107	All
G0120	G0124	All
G0141	G0148	All
G0235	G0235	All
G0265	G0266	All
G0306	G0307	All
G0328	G0328	All
G0430	G0431	All
P2028	P7001	All
P9612	P9612	All
P9615	P9615	All
Q0111	Q0115	All
R0070	R0076	All

Laboratory/Pathology Individual Code

Code	Description	Code	Description
300	Laboratory – General	309	Laboratory - Other
301	Laboratory - Chemistry	310	Laboratory Pathological - General
302	Laboratory - Immunology	311	Laboratory Pathological - Cytology
303	Laboratory - Renal Patient (Home)	312	Laboratory Pathological - Histology
304	Laboratory - Nonroutine Dialysis	314	Laboratory Pathological - Biopsy
305	Laboratory - Hematology	319	Laboratory Pathological - Other
306	Laboratory - Bacteriology & Microbiology	923	Other Diagnostic Services - Pap Smear
307	Laboratory – Urology	925	Other Diagnostic Services - Pregnancy Test

Attachment C

Vaginal to Cesarean CPT Crosswalk

Description	Vaginal CPT Code	Cesarean CPT Code
Global OB Care	59400	59510
Delivery Only	59409	59514
Delivery and Postpartum	59410	59515
VBAC	59610	N/A
VBAC Delivery Only	59612	59620
VBAC Delivery and Postpartum	59614	59622
Routine OB Care	59400	59618

Vaginal to Cesarean DRG Crosswalk

Vaginal Code	Description	Corresponding Cesarean Code	Description
774	Vaginal Delivery w Complicating Diagnosis	765	Cesarean with CC/MCC
775	Vaginal Delivery w/o Complicating Diagnosis	766	Cesarean w/o CC/MCC

Attachment D
Home Health Codes

From	To
T1000	T1003
T1020	T1022
T1030	T1031
T2042	T2043
90963	90970
99500	99607
99500	99607
G0151	G0162
G0320	G0327
S5035	S5036
S5180	S5181
S5108	S5116
S5497	S5502
S5517	S5523
S9122	S9131
S9208	S9209
S9211	S9214
S9490	S9504
S9529	
S9535	S9590
S9800	S9810
Revenue Codes	
From	**To**
560	609
55X with Home Health Bill Type	
64X	
66X with Home Health Bill Type	
82X with Home Health Bill Type	
84X with Home Health Bill Type	
85X with Home Health Bill Type	
88X with Home Health Bill Type	
Bill Types	
From	**To**
320	349

Attachment E Behavioral Health Codes				
Service	**Adult (X)**	**Child (X)**	**Industry Code (i.e., CPT, HCPC, Revenue Code)**	**Units of Service**
Psychiatric Inpatient Hospital (RMHI's ONLY)	X	X	0114, 0124, 0134, 0144, 0204, 1003, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90785, 90840, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99251, 99252, 99253, 99254, 99255, 99238, 99239, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90882, DRG 424-432 (payable per diem or per case) *All codes listed above may be billed with HA, HO, GT, HP, AJ, AH, HK, AM, AQ or AR modifiers.*	Day
24-Hour Psychiatric Residential Treatment	X	X	0900, 1001, 1002, H2013, T2048	Day
Outpatient Mental Health Services:			H0046, H0037HA, H2020	
*Non MD services**	X	X	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90785, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90899, 96150, 96151, 96152, 96153, 96154, 96155, 90816GT, 90819GT, 98024GT, 0300 *All codes listed above may be billed with HA, HO, GT, HP, AJ, AH, HK, AM, AQ, or AR modifiers*.	Hour
Day Treatment	X	X	H2012, 0907	Unit
Partial Hospitalization (RMHI's ONLY)	X	X	0904, 0911, 0912, H0035, G0176, G0177	Day
Applied Behavior Analyst	X	X	T1023, T2002, 99343, 99349, H0032, H2019, 0900	Visit
Crisis Services Teams* *(incl. mobile crisis, walk in, telephonic, crisis intervention, etc.)*	X	X	S9484, S9484GT, S9485, S9485GT, S9845GT, H2011, H2011GT, T2034, T2034GT	Day/Unit/ Day
Crisis Respite	X	X	H0045, H0045HF, H0043QV, S5151, S5145, H0045HT	Day
Crisis Stabilization Unit	X	X	0154	Day
Inpatient Substance Abuse Treatment (Rehab) (EXCLUDING Hospitals, except RMHI's are included)	X	X	0118, 0128, 0138, 0148, 0158, 1003 DRG 433; 521-523 (Payable per diem/case)	Day

Attachment E Behavioral Health Codes				
Service	**Adult (X)**	**Child (X)**	**Industry Code (i.e., CPT, HCPC, Revenue Code)**	
Inpatient Substance Abuse Treatment (Detox) (EXCLUDING Hospitals, except RMHI's are included)	X	X	0116, 0126, 0136, 0146, 0156	Day
Outpatient Substance Abuse Treatment and Detox (EXCLUDING Hospitals, except RMHI's are included)	X	X	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90785, 90840, 90845, 90847, 90849, 90853, 90857, 90862, 90812HP, 90846HP, 90847HP, 90849HP, 90853HP, 90857HP, 90862SA, 99241GT, 99242GT, 99243GT, 99244GT, 99498, 99408, 99408GT, 99409, 99409GT, G0396, G0397, G9008, G9009, *All codes listed above may be billed with AJ, AH, AQ, HA, HF, HO, HP, SA, GT modifiers*.	Hour
Mental Health Case Management				
Level 1	X	X	T1016, T1016U1, T1016U2, T1016HA, T2022U1, T2022U2, T2023, T2023U2, T2023HB, T2023HA	Unit/Month
ACT/PACT	X	X	ACT: H0039, H0040 PACT: H2015HT, H2016HT, H2016HB	ACT: Unit/Day PACT: Unit/Day
CCFT	X	X	H0036HA, H0036U1, H0037, H0037HA, H0037HK, G9002, G9001	Month/Day/ Unit
CTT	X	X	H0036HB, H0037HB, H0037HA, G0155, G0155HA	Month/Day/ Unit
Level 2	X	X	T1016U2, T1016HK, T2022U2, T2022HH, T2022HK, H0023	Unit/Month/ Day
Integrated Health Care Team	X	X	H2024HT, H0046HT	Unit/Day
Psychiatric Rehabilitation Services				
Supported Housing	X	X	H0034PV, H0043, H0044, H0043HA,H0043HB, H0043U2, H0043QV, H2016	Day/Month
Supported Employment	X	X	H2023, H2023HQ, H2024	Day/Unit
Peer Support	X	X	H0038, H0038HQ, H0038UR, H0038US	Unit
PsychoSocial Rehabilitation	X	X	H2017, H2017HQ, H2018, H2018HQ, T1015	Day/Unit
Outpatient Lab				

Attachment E Behavioral Health Codes				
Service	**Adult (X)**	**Child (X)**	**Industry Code (i.e., CPT, HCPC, Revenue Code)**	**Units of Service**
Transportation	X	X	Ambulance Svcs: A0021-A0999	Unit
Medication Management *(included under Outpt Mental Health Sevices)*				
Illness Management and Recovery	X	X	H0034, H0034HQ	Day
Intensive Outpatient	X	X	0906, 0905, S9480, H0015, H0015HF, H0015HE	Day
Subacute Care Mental Health	X	X	0190, 0191, 0192, 0193, 0194, 0199, H0046, H0008	Day
Subacute Care Substance Abuse	X	X	0190, 0191, 0192, 0193, 0194, 0199, H0008	Day
Outpatient Drug Detox	X	X	0944, 0945, H0014, H0014U2, RV919	Day
Home Health	X	X	T1022, T1030, T1030HO, T1030SA, S9127, S9127HO, 0580	Visit
ECT	X	X	90870, 0901, 00104	Episode
Psych Testing	X	X	96101, 96101HO, 96101HP, 96102, 96102HO, 96102HP, 96102SA, 96102GT, 96103, 96103HO, 96103HP, 99244HK, H0001, H0002	Hour
Neuropsych Testing	X	X	96116, 96116HP, 96118, 96118HP, 96119, 96119HP, 96119SA, 96119HO, 96120, 96120HP, 90901	Hour
23 hour OB bed (RMHI's ONLY)	X	X	0762, 99219, 99219HP, 99219HO, 99219SA	Unit
Sexual Offender Residential Treatment Service	X	X	H2028, H2029, 1001	Day
Long-term residential; stay typically longer than 30 days; no room/board	X		H0019	Day
Family Support Specialist		X	T2025, S9482	Unit
Triage Services at a Mental Health Walk-in Center	X		T1023	Unit
ANSA (Adult Needs and Strengths Assessment)	X		H0031HE	Unit
CANS (Child and Adolescent Needs and Strengths assessment)	X		H0031HK	Unit

Attachment F HCBS Codes							
Service	**HCPCs Service Description**	**HCPCS Code**	**Revenue Code**	**Modifier**	**Unit Rate**	**2015 1% Rate Reduction**	**Comments**
Adult Care Home - Level 2 Day	For: Vent Dependent (Level 2 Per diem)	T2033	3109	U1	$450.00	$445.50	
Adult Care Home - Level 2 Day	For: Traumatic Brain Injury (TBI) (Level 2 Per diem)	T2033	3109	U2	Level I $129 Level II $139	Level I $127.71 Level II $137.61	
Adult Care Home - Level 1 Month	See Service Code Definition tab for description (Level 1 Per Month)	T2032	3109	U1	N/A		There will be no monthly rates. Presently, there are no approved Level I per diem rates either.
Adult Care Home - Level 2 Month	See Service Code Definition tab for description (Level 2 Per Month)	T2032	3109	U2	N/A		There will be no monthly rates. Presently, there are no approved Level I per diem rates either.
Adult day care	Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.	S5100	0570		$2.50	$2.48	
Assisted Care Living Facility - Day	Personal care services, homemaker services and medication oversight (to the extent permitted under State law) provided in a home-like environment in a licensed Assisted Care Living Facility. Coverage shall not include the costs of room and board.	T2031	3109		$36.17	$35.81	
Assisted Care Living Facility - Month	Personal care services, homemaker services and medication oversight (to the extent permitted under State law) provided in a home-like environment in a licensed Assisted Care Living Facility. Coverage shall not include the costs of room and board.	T2030	3109		$1,100.00	$1,089.00	
Assistive technology	Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment.	T2029	0590	U4	N/A		

Attachment F HCBS Codes							
Service	**HCPCs Service Description**	**HCPCS Code**	**Revenue Code**	**Modifier**	**Unit Rate**	**2015 1% Rate Reduction**	**Comments**
Attendant care	Intermittent provision of direct assistance with the activities such as toileting, bathing, dressing, personal hygiene, eating, meal preparation (excluding the cost of food), budget management, attending appointments, and interpersonal and social skill. Light housekeeping added 7/1/12	S5125	0570	modifiers for multiple services in one day: U1, U2, U3, U4, U5	$4.37	$4.33	7/1/12 benefit limit increased with the inclusion of homemaker services
Home-delivered meals	Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the individual POC when ordered by the Enrollee's physician.	S5170	0590	Single Meals - U1 or U1 & UD Bulk Meals - U2 or U2 & UD	Single $7.00 Bulk $6.00	Single $6.93 Bulk $5.94	7/1/12 - The rate for single meals, delivered daily is $7.00. Home Delivered Meals that are drop-shipped in bulk on a periodic basis are reimbursed at $6.00 per meal.
In-home respite care	Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.	S5150	0660	modifiers for multiple services in one day: U1, U2, U3, U4, U5	$4.07	$4.03	
In-patient respite care	Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.	S5151	0660		$103.44	$102.41	
Minor home modifications	Provision and installation of certain home mobility aids (e.g., ramps, rails, non-skid surfacing, grab bars, and other devices and minor home modifications which facilitate mobility) and modifications to the home environment to enhance safety.	S5165	0590		N/A		

Attachment F HCBS Codes							
Service	**HCPCs Service Description**	**HCPCS Code**	**Revenue Code**	**Modifier**	**Unit Rate**	**2015 1% Rate Reduction**	**Comments**
Personal care visits	Services provided to assist the enrollee with activities of daily living, and related essential household tasks (e.g. making the bed, washing soiled linens or bedclothes that require immediate attention), and other activities that enable the enrollee to remain at home.	T1019	0570	modifiers for multiple services in one day: U1, U2, U3, U4, U5	$5.13	$5.08	
Personal Emergency Response System - Installation	Installation of an electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the help button is activated.	S5160	0590		$52.55	$52.02	
Personal Emergency Response System - Monthly Fee	Monthly fees associated with an electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the help button is activated.	S5161	0590		$29.95	$29.65	7/1/12 monthly rate decreased to $29.95.
Pest control	The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps, mice, rats and other species of pests into the household environment thereby removing an environment issue that could be detrimental to the enrollee's health and physical well-being.	S5121	0590	U1	$50.00	$49.50	
Skilled Nursing / Visit	A Physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.	G0154	0551		N/A	Reduce Negotiated Rates by 1%, see "Home Health"	Added due to Cost Neutrality

Attachment F HCBS Codes							
Service	**HCPCs Service Description**	**HCPCS Code**	**Revenue Code**	**Modifier**	**Unit Rate**	**2015 1% Rate Reduction**	**Comments**
Skilled Nursing / Hour - RN	A Physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.	S9123	0552		N/A	Reduce Negotiated Rates by 1%, see "Home Health"	TennCare benefit (not CHOICES), added due to Cost Neutrality
Skilled Nursing / Hour - LPN	A Physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.	S9124	0552		N/A	Reduce Negotiated Rates by 1%, see "Home Health"	TennCare benefit (not CHOICES), added due to Cost Neutrality
Home Health Aide / Visit	Any of the services identified in 42 CFR 440.70 and delivered in accordance with the provisions of 42 CFR 440.70. "Part-time or intermittent nursing services" and "home health aide services" are covered only as defined specifically in these rules.	G0156	0571		N/A	Reduce Negotiated Rates by 1%, see "Home Health"	TennCare benefit (not CHOICES), added due to Cost Neutrality
Home Health Aide / Hour	Any of the services identified in 42 CFR 440.70 and delivered in accordance with the provisions of 42 CFR 440.70. "Part-time or intermittent nursing services" and "home health aide services" are covered only as defined specifically in these rules.	S9122	0572		N/A	Reduce Negotiated Rates by 1%, see "Home Health"	TennCare benefit (not CHOICES), added due to Cost Neutrality
Private Duty Nursing	Nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period.	T1000	0589		N/A	Reduce Negotiated Rates by 1%, see "Home Health"	TennCare benefit (not CHOICES), added due to Cost Neutrality

Attachment G
Benefit Limits Effective October 1, 2013 for Adults

Description	Codes	Policy	Comments
Facet/Medial Branch Block Injections	64490 64491 64492 64493 64494 64495	Limit of 4 Diagnostic Medial Branch Block Injections per Calendar Year Therapeutic Facet/Medial Branch Block Injections Not Covered Must be performed by a physician/practitioner as required by State law (Public Chapter No. 961/SB No. 1935 http://www.tn.gov/sos/acts/107/pub/pc0961.pdf	MCO to define supporting documentation that shall be required to accompany a claim in order to be processed. The supporting documentation must demonstrate that the service and provider qualify for payment. 271U will report number of Diagnostic Medical Branch Block Injections paid and apply encounter edits if exceeded
Trigger Point Injections	20552 20553	Limit of **4** per muscle group in any period of **6** consecutive months (counting will start with the first shot on or after October 1)	Post Medical Necessity Review 271U will report number of injections paid for MCO informational purposes to prompt Medical Necessity Review but TennCare will not apply edits
Epidural Steroid Injections	62310 62311 62318 62319 64479 64480 64483 64484	Limit of **3** in any period of **6** consecutive months (counting will start with the first shot on or after October 1)	Limits will not apply in conjunction with Labor and Delivery (codes for L&D should be different) 271U will report number of injections paid and apply encounter edits if exceeded

Attachment G
Benefit Limits Effective October 1, 2013 for Adults

Description	Codes	Policy	Comments
Urine Drug Screens	G0434 G0431	G0434 - Limit of **12** per calendar year G0431 - Limit of **4** per calendar year Limits do not apply in the emergency department (Note: this includes urine drug screens that are sent to an independent lab on the same date of service for the same enrollee on the same day of an emergency department visit.)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Do Not Cover Urine Drug Screens Under 8xxxx series CPT codes Each G code carries its own limit: G0434 = limited to 12 units per member, per calendar year G0431 = limited to 4 units per member in addition to the 12 for G0434 and may be billed on the same date of service 271U will report number of urine drug screens paid and apply encounter edits if exceeded
TENS Units	E0730	Non-Covered for Chronic Low Back Pain (NOTE: This includes multiple specific diagnoses for the symptom of chronic low back pain)	Prior Auth Or Post Medical Necessity Review

Note: 1) Please remember with Benefit Limits, you must provide a Notice of Limit (EOB) to members once a service is billed that exceeds a limit.

2) If a service is requested after a limit is exceeded, a Grier notice of denial must be sent.