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

DATE: September 23, 2013

TO: TennCare Managed Care Organizations

FROM: Keith Gaither, Director of Managed Care Operations

SUBJECT: **Budget Reduction's Effective July 1, 2013 and October 1, 2013**

This memo serves to outline each of the budget reduction items that were included in the 2014 Budget that was passed by the General Assembly. All items have been previously discussed and provided in writing to your organization; however, this document incorporates both the items that were to be implemented effective July 1, 2013 and items that must be implemented October 1, 2013.

I. Budget Reductions Effective July 1, 2013

a. Cesarean and Vaginal Delivery Reimbursement

Cesarean and Vaginal Delivery Reimbursement		
Effective July 1, 2011	Effective July 1, 2012	**Effective July 1, 2013**
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.

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

b. DME/Back Brace Reimbursement

BACK BRACE REIMBURSEMENT	
HCPC Code	Maximum Allowed Amount
L0637	$ 379.86
L0631	$ 332.31
L0627	$ 133.06

c. Implementation of Medicare standards for coverage of TENS and CLBP

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.

II. Budget Reductions 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 T.C.A. 63-7-126	No Pre-authorization required. All claims for these procedures must be submitted with the attached certification form to be considered for payment. Claims submitted without the certification form will be denied.
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)	No Pre-Authorization Required Post Medical Necessity Review
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)	No Pre-Authorization Required Limits will not apply in conjunction with Labor and Delivery (codes for L&D should be different)
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.)	No Pre-Authorization Required 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
TENS Units	E0730	Non-Covered for Chronic Low Back Pain (NOTE: This includes multiple specific diagnoses for the symptom of chronic low back pain)	No Pre-Authorization Required