TN Division of Health Care Finance & Administration

MEMO

TO: TennCare Managed Care Organizations

FROM: Keith Gaither, Director Managed Care Operations

DATE: June 30, 2017

SUBJECT: Budget Reductions/Impacts for July 1, 2017

Each year we update this Budget Memo in order to provide guidance based on the most current budget appropriations for the state fiscal year. Often times our guidance includes procedure codes in an effort to be clear and consistent among all MCOs for system configurations.

As you are aware, CMS updates CPT and HCPC codes on an annual basis (October 1/January 1 respectively). Our Budget Memos are not intended to be inconsistent with correct coding guidance as provided by CMS. It is our expectation that as referenced codes are deleted and replaced by CMS that each MCO will make the update in order to be consistent with correct coding requirements. We also expect that all updates to referenced codes will be made in such a manner as to remain consistent with the intent of the Budget Memo. We will continue to work closely with you in an effort to keep the memo updated and current with budget appropriations and CMS coding changes.

This memo serves as official notice of programmatic changes to be made by the MCOs as a result of the state fiscal year 2018 budget. We have also included previous budget decisions that are to continue.

CHANGES are as follows:

- **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 continued to be bought back by one time appropriations and therefore will not be enforced for state fiscal years 2015, 2016, 2017 and 2018.

In addition to the budget reductions and/or buybacks as described above, all **other 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**	**SFY 2014**	**SFY 2015 - Forward**
Effective July 1, 2011	**Effective July 1, 2012**	**Effective July 1, 2013**	**Effective July 1, 2014**
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.	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. Payment 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**

- **Diapers – SFY 2015 - Effective July 1, 2014**

  Quantities over 200 per month require Prior Authorization or Post Payment Review for Medical Necessity.

- **MRI – SFY 2015 - Effective July 1, 2014**

  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.

- **Assay Drug Testing Limit –** Effective October 1, 2015, Limit benefit frequency to two (2) services per year (each) for the services listed in Attachment H.

- **Therapy Code Reimbursement –** Effective July 1, 2015, Therapy Codes included in Attachment I shall be reimbursed at the lesser of 1) the MCOs current reimbursement amount for therapy codes, or 2) the current published CMS Medicare reimbursement amount.

- **E&M/Therapy Same Day** –Do not pay a provider for an Evaluation and Management code on the same date of service for which Therapy Services are paid to that same provider.

- **Pharmacy Related Reductions (MCO Provider Education)**

  - **<u>Compounded Prescriptions</u> Effective July 1, 2015**
    As a result of the State of Tennessee's Budget reductions beginning July 1, 2015, TennCare will be implementing clinical criteria and will require prior authorization on compounded prescription medications to ensure that all compounded prescriptions are medically necessary. Effective July 1, 2015, compounds will be approved only when the indication, therapeutic amount, and route of administration of each of the active ingredients in the compound are FDA-approved or CMS-recognized compendia supported. Further details will be available after June 15, 2015 on Magellan Medicaid Administration's website at: https://tenncare.magellanhealth.com.

- **Immunotherapy Guidelines – SFY2017 - Effective October 1, 2016**

  The initial immunotherapy allergen treatment supply claim should be billed with a -GD modifier. Extract refill claims should be billed without the modifier. Initial and refill supplies shall be as medically necessary; however, payment should not be made for more than a three month supply at a time.

  Additionally providers must follow practice guidelines according to the following:

  - **Joint Task Force on Practice Parameters of the American Academy of Allergy, Asthma, and Immunology;**
  - **American College of Allergy, Asthma, and Immunology; and**
  - **Joint Council of Allergy, Asthma, and Immunology.**

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% Reduction • 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% Reduction • 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% Reduction • 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%

State Fiscal Year	Effective Date	Proposed Budget Reduction	Actual Budget Reduction	Actual % Reduction to Date
2015	**July 1, 2014**	2% Reduction • 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 and hospice. • DME and Medical Supplies • Home and Community Based Services (HCBS), Excluding Consumer Direction Services.	1% Reduction • 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 and hospice. • DME and Medical Supplies Home and Community Based Services (HCBS), Excluding Consumer Direction Services.	**7.75%** (Total for Services included in 2015 with previous reductions) **1%** • All outpatient and professional behavioral health services. • DME and Medical Supplies • Home and Community Based Services (HCBS), Excluding Consumer Direction Services.)
2016	**July 1, 2015** ________ **July 1, 2016** ________ **July 1, 2017**	1% Reduction (Bought Back 2015) • 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 and hospice. • DME and Medical Supplies Home and Community Based Services (HCBS), Excluding Consumer Direction Services.	1% Buyback for proposed cuts 1% Buyback for proposed cuts 1% Buyback for proposed cuts, permanently bought back July 1, 2017	Same as Above

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
G0299	G0300
G0320	G0327
S5035	S5036
S5180	S5181
S5108	S5116
S5497	S5502
S5517	S5523
S9122	S9124
S9127	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 ***(EXCLUDING Hospitals, except RMHI's are included)***	X	X	0904, 0911, 0912, 0913, 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

Attachment E
Behavioral Health Codes

Service	Adult (X)	Child (X)	Industry Code (i.e., CPT, HCPC, Revenue Code)	Units of Service
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
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, T2022, 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

Attachment E Behavioral Health Codes				
Service	**Adult (X)**	**Child (X)**	**Industry Code (i.e., CPT, HCPC, Revenue Code)**	**Units of Service**
PsychoSocial Rehabilitation	X	X	H2017, H2017HQ, H2018, H2018HQ, T1015	Day/Unit
Outpatient Lab				
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

Attachment E **Behavioral Health Codes**				
Service	**Adult (X)**	**Child (X)**	**Industry Code (i.e., CPT, HCPC, Revenue Code)**	**Units of Service**
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		$1,100.0 0	$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
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

Attachment F
HCBS Codes

Service	HCPCs Service Description	HCPCS Code	Revenue Code	Modifier	Unit Rate	2015 1% Rate Reduction	Comments
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	64490	Limit of 4 Diagnostic Medial Branch Block Injections	MCO to define supporting

Attachment G
Benefit Limits Effective October 1, 2013 for Adults
(Effective October 1, 2016 use codes in the Chart on the next page)

Description	Codes	Policy	Comments
Branch Block Injections	64491 64492 64493 64494 64495	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	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, 2016 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	62320 62321 62322 62323 62324 62325 62326 62327 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, 2016 for Adults

Description	Codes	Policy	Comments
Urine Drug Screens **(Effective January 1, 2016 use codes in the Chart on the next page)**	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.

Attachment G

Effective January 1, 2016, CMS updated codes related to Urine Drug Screens as follows:

Description	Codes	Code Descriptions	Policy	Comments
Urine Drug Screens **(Effective January 1, 2017 use codes in the Chart on the next page)**	G0477 or G0478	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service. Drug tests, presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument - assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation's when performed, per date of service.	Limit of **12** per member, per calendar year (Any combination of G0477 and G0478 combined limited to a total of 12)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Do Not Cover Urine Drug Screens Under 8xxxx series CPT codes G0477 or G0478 (any combination) = limited to 12 units total per member, per calendar year
	G0479	Drug tests, presumptive, any number of drug classes; any number of devices or procedures by instrumental chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MA LDI, LDTD, DES I, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Limit of **4** per member, 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.)	G0479 = limited to 4 units per member in addition to the 12 for G0477/G0478 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

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.

Attachment G

Effective January 1, 2017, CMS updated codes related to Urine Drug Screens as follows:

Description	Codes	Code Descriptions	Policy	Comments
Urine Drug Screens	80305 or	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	Limit of **12** per member, per calendar year (Any combination of 80305 and 80306 combined limited to a total of 12)	Adhere to Medicare Guidelines for billing Urine Drug Screens. Crosswalk 80305 to G0477,
	80306	Drug tests, presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument - assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation's when performed, per date of service.		80306 to G0478, 80307 to G0479 80305 or 80306 (any combination) = limited to 12 units total per member, per calendar year
	80307	Drug tests, presumptive, any number of drug classes; any number of devices or procedures by instrumental chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MA LDI, LDTD, DES I, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Limit of **4** per member, 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.)	80307 = limited to 4 units per member in addition to the 12 for 80305/80306 (G0477/G0478) 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

<u>Note:</u> 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.

Attachment H

Benefit Limits for Assay Drug Testing – Effective October 1, 2015 for Adults

Description	Codes/Descriptions	Policy
Assay of Opiates	G6056 – Opiate(s), drug and metabolites, each	Limit to two (2) per calendar year
Assay of Methadone	G6053 – Methadone	Limit to two (2) per calendar year
Assay of Amphetamines	G6042 – Amphetamine or methamphetamine	Limit to two (2) per calendar year
Assay of Phencyclidine	83992 Phencyclidine	Limit to two (2) per calendar year
Assay of Cocaine	G6044 – Cocaine or metabolite	Limit to two (2) per calendar year
Assay of Dihydromorphinone	G6046 – Dihydromorphinone	Limit to two (2) per calendar year
Assay of Barbiturates	G6043 – Barbiturates, not elsewhere specified	Limit to two (2) per calendar year
Assay of Dihydrocodeinone	G6045 Dihydrocodeinone	Limit to two (2) per calendar year
Assay of Metanephrines	83835 Metanephrines	Limit to two (2) per calendar year
Assay of Urine Alkaloids	G6041 – Alkaloids, urine, quantitative	Limit to two (2) per calendar year

NOTE: Your policies should prohibit providers from using the 8xxxx codes in instances where CMS has provided a G code. Codes listed above should not be used after December 31, 2015, see chart below.

Effective January 1, 2016, CMS updated codes related to Assay Drug Testing as follows:

Description	Codes	Code Description	Policy
Assay Drug Testing	G0480	Drug tests, definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS [any type, single or tandem and excluding immunoassays (e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g. alcohol dehyrdrogenase)]; qualitative or quantitative, all sources, include specimen validity testing, per day, 1-7 drug classes, including metabolites if performed	Limit to two (2) per calendar year.
	G0481	8-14 drug classes, including metabolites if performed	Limit to two(2) per calendar year
	G0482	15-21 drug classes, including metabolites if performed	Limit to two (2) per calendar year
	G0483	22 or more drug classes, including metabolites if performed	Limit to two (2) per calendar year

Note: Your policies should prohibit providers from using the 8xxxx codes in instances where CMS has provided a G code.

Attachment I

Therapy Code List/Reimbursement Limit – Effective July 1, 2015

Therapy Code List	Description
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); GROUP, TWO OR MORE INDIVIDUALS
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92597	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC DEVICE TO SUPPLEMENT ORAL SPEECH
92607	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; FIRST HOUR
97002*	PHYSICAL THERAPY RE-EVALUATION
97004*	OCCUPATIONAL THERAPY RE-EVALUATION
97012	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION, MECHANICAL
97016	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN BATH
97022	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY (EG, MICROWAVE)
97026	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES
97033	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
97034	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97112	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES
97116	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)
97124	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), ONE OR MORE REGIONS, EACH 15 MINUTES
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL, FUNCTIONAL CAPACITY), WITH WRITTEN REPORT, EACH 15 MINUTES
97761	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITY(S), EACH 15 MINUTES
G0283	ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE

* Effective January 1, 2017 code 97002 is deleted and replaced by code 97164 and code 97004 is deleted and replaced by code 97168.