

SUBJECT: Notice of TennCare Rate Reduction

Dear Provider:

This letter serves as official notice of rate reductions/reimbursement changes to be made by all TennCare MCOs as a result of the proposed state fiscal year 2012 budget. In order to address the expiration of one time federal funding and the continued impact of the national economic downturn on Tennessee state revenues, TennCare's proposed budget includes provider and plan reimbursement reductions of 4.25% for some services/providers. However, with the renewal of the Hospital Assessment Fee, and its inclusion in the Governor's proposed budget, it appears some of the originally proposed cuts will not be necessary.

However some reductions must still be made. As a result, there are three categories of budget reduction items to be implemented by the MCOs: A 4.25% reimbursement reduction for some services/providers, changes to vaginal and cesarean delivery reimbursement, and changes to reimbursement for non-emergency professional services in an Emergency Department. Below are the details:

- **4.25% Reimbursement Reduction** - The reimbursement level for services/providers not "bought back" by the hospital fee or otherwise restored in the Governor's budget will be reduced by 4.25% from the contracted amount each provider currently receives. This reduction will be applied to services performed on or after July 1, 2011. The possibility exists that the TennCare Bureau may change the rate of reduction for some services. We will communicate with you if and when any changes to this rate occur. Attachment A to this letter is a list of affected services and related coding methodology. A sample calculation is also provided in Exhibit 1 to help determine your revised rate that will be applied effective July 1, 2011.
- **Cesarean and Vaginal Delivery Reimbursement** - Cesarean and vaginal deliveries will be reimbursed at the same rate effective July 1, 2011. MCOs have been directed to increase their vaginal delivery rates by 17%. Additionally, MCOs are to pay the vaginal delivery rate for corresponding C-Section deliveries. A sample calculation is provided in Exhibit 1 to help determine your revised vaginal and cesarean delivery rate that will be applied effective July 1, 2011. In Attachment C, we have provided a crosswalk of Delivery codes by type that will be impacted by this rate change.
- **Emergency Department Professional Fees** - Reimbursement for professional claims for non-emergency Emergency Department 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.

TennCare will promulgate emergency rules before July 1, requiring that these cuts be made. Promulgation of these rules will make these reductions part of State law and

regulation. Your provider agreement incorporates state laws and regulations, therefore these changes will be effective in your provider agreements on July 1. It is possible that changes could be made in the budget as the legislative session progresses. We will communicate those to you as soon as possible.

The complete listing of codes/services scheduled to be reduced will also be located on our website at the following location:

<http://www.uhccommunityplan.com/health-professionals/TN/provider-bulletins>

**Attachment A**

- All pathology, lab, and radiological services. This includes all professional, inpatient and outpatient services. This includes the codes in Attachment B.
- 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. This includes the codes listed in Attachment D
- Nursing Home services. TennCare will provide updated rates to the MCOs with a July 1, 2011 effective date.

**Attachment B**

**Radiology Procedure Codes**

<b>From</b>	<b>To</b>	<b>Modifiers Included</b>	<b>From</b>	<b>To</b>	<b>Modifiers Included</b>
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**

<b>Revenue Code</b>	<b>Description</b>	<b>Revenue Code</b>	<b>Description</b>
320	Radiology Diagnostic - General	351	CT Scan - Head Scan
321	Radiology Diagnostic - Angiocardiology	352	CT Scan - Body Scan
322	Radiology Diagnostic - Arthrography	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

<b>Revenue Code</b>	<b>Description</b>	<b>Revenue Code</b>	<b>Description</b>
			- Spinal Cord
340	Nuclear Medicine - General	614	Magnetic Resonance Technology - Other
341	Nuclear Medicine - Diagnostic	615	Magnetic Resonance Angiography - Head and Neck
342	Nuclear Medicine - Therapeutic	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**

<b>From</b>	<b>To</b>	<b>Modifiers</b>
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

<b>Code</b>	<b>Description</b>	<b>Code</b>	<b>Description</b>
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**

<b>From</b>	<b>To</b>
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
<b>Revenue Codes</b>	
<b>From</b>	<b>To</b>
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	
<b>Bill Types</b>	
<b>From</b>	<b>To</b>
320	349

## Exhibit 1

### Calculating Rate Adjustments

#### 1. Cesarean and Vaginal Delivery Reimbursement

Multiply your current vaginal delivery rate by 1.17. This rate applies to the vaginal delivery CPT codes listed in the table below. The product of that calculation is the new rate for vaginal and corresponding C-section deliveries effective July 1, 2011.

For example, if the current vaginal delivery rate for 59400 is \$1,000, then:

\$	1,000.00	Current vaginal delivery rate
	<u>X 1.17</u>	Rate adjustment
	<b>1,170.00</b>	<b>New rate for CPT 59400 (vaginal delivery) and CPT 59510 (Cesarean section) effective July 1</b>

<b>Vaginal Delivery CPT Codes</b>	<b>Cesarean Section delivery CPT Codes</b>
<b>59400</b> – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	<b>59510</b> – Routine obstetric care including antepartum care, cesarean delivery and postpartum care
<b>59409</b> – Vaginal delivery only (with or without episiotomy and/or forceps)	<b>59514</b> – Cesarean delivery only
<b>59410</b> - Vaginal delivery only (with or without episiotomy and/or forceps including postpartum care	<b>59515</b> - Cesarean delivery only including postpartum care
<b>59610</b> – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	N/A
<b>59612</b> – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	<b>59620</b> – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
<b>59614</b> – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	<b>59622</b> – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
<b>59400</b> – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	<b>59618</b> – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

<b>DRG – Vaginal</b>	<b>DRG – Cesarean section</b>
<b>774</b> - Vaginal delivery w complicating diagnoses	<b>765</b> - Cesarean section w CC/MCC
<b>775</b> - Vaginal delivery w/o complicating diagnoses	<b>766</b> - Cesarean section w/o CC/MCC

## **2. 4.25% Reimbursement Reduction**

Multiply your current contracted provider rate for services NOT “bought back” by the Hospital Assessment by .0425. Subtract that amount by the current rate. The result of that calculation is the new rate for these services effective July 1, 2011. For example, a service that currently pays \$500 today:

\$	500.00	Current rate for a service not “bought back”
	<u>X .0425</u>	<u>Rate reduction of 4.25%</u>
	<b>21.25</b>	<b>Subtract this amount from current rate</b>
\$	500.00	Current rate
	<u>- 21.25</u>	<u>Dollar equivalent of 4.25% reduction</u>
\$	<b>478.75</b>	<b>Revised rate effective July 1</b>