IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201745 NOVEMBER 7, 2017

IHCP will remove age restrictions on certain diagnosis codes and mass reprocess claims that denied inappropriately

The Indiana Health Coverage Programs (IHCP) will remove the age restriction limits in *Core*MMIS for the ICD-10 diagnosis codes listed in Table 1. According to information published by the American Medical Association (AMA), there are no age restrictions for the diagnosis codes presented. The diagnosis codes in Table 1 may apply regardless of the patient's age. As noted by the AMA, "These disorders generally have onset within the childhood or adolescent years, but may continue throughout life or not be diagnosed until adulthood."[1] The removal of age restrictions will apply retroactively to dates of service (DOS) on or after **October 1, 2016.**

Claims billed with the ICD-10 diagnosis codes in Table 1 may have denied inappropriately for explanation of benefits (EOB) 4030 – *The diagnosis given is not compatible with the member's age*. Effective December 7, 2017, claims that denied for EOB 4030 for the affected DOS will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advice (RA) statements beginning December 12, 2017, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

Table 1 – Diagnosis codes for which age restrictions will be removed, effective for DOS on or after October 1, 2016

Diagnosis Code	Description
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type
F91.0	Conduct disorder confined to family context
F91.1	Conduct disorder, childhood-onset type
F91.2	Conduct disorder, adolescent-onset type
F91.3	Oppositional defiant disorder
F91.8	Other conduct disorders

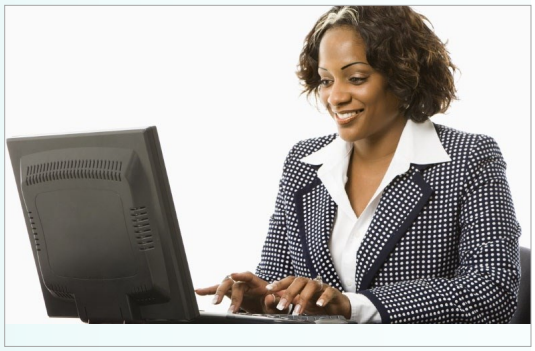
continued

Table 1 – Diagnosis codes for which age restrictions will be removed, effective for DOS on or after October 1, 2016 (continued)

Diagnosis Code	Description
F91.9	Conduct disorder, unspecified
F93.0	Separation anxiety disorder of childhood
F93.8	Other childhood emotional disorders
F93.9	Childhood emotional disorder, unspecified
F94.1	Reactive attachment disorder of childhood
F94.2	Disinhibited attachment disorder of childhood
F94.8	Other childhood disorders of social functioning
F94.9	Childhood disorder of social functioning, unspecified
F95.0	Transient tic disorder
F95.1	Chronic motor or vocal tic disorder
F95.2	Tourette's disorder
F95.8	Other tic disorders
F95.9	Tic disorder, unspecified
F98.0	Enuresis not due to a substance or known physiological condition
F98.1	Encopresis not due to a substance or known physiological condition
F98.21	Rumination disorder of infancy
F98.29	Other feeding disorders of infancy and early childhood
F98.3	Pica of infancy and childhood
F98.4	Stereotyped movement disorders
F98.5	Adult onset fluency disorder
F98.8	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F98.9	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
R62.50	Unspecified lack of expected normal physiological development in childhood
R62.52	Short stature (child)
R62.59	Other lack of expected normal physiological development in childhood
Y93.6A	Activity, physical games generally associated with school recess, summer camp and children
Z68.51	Body mass index (BMI) pediatric, less than 5th percentile for age
Z68.52	Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
Z68.53	Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age
Z68.54	Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age

[1]*American Medical Association (2016). ICD-10-CM 2017: The Complete Official Codebook.*

IHCP reminds providers of January 1 deadline to update rendering provider linkages



The Indiana Health Coverage Programs (IHCP) reminds providers that correct rendering/group provider linkages are essential to the proper adjudication of rendering provider claims. IHCP policy requires rendering providers to be linked to the specific locations where they render services for a group practice. Further, a rendering provider's services may not be billed for a service location to which he or she is not linked. **Group providers must ensure that the provider profile for each group location has the correct rendering providers linked with accurate effective and end dates**.

In *Banner Page* BR201731, the IHCP announced that denials for explanation of benefits (EOB) 1010 – *Rendering provider is not an eligible member of billing group or the group provider number is reported as rendering provider. Please verify provider and resubmit,* would be temporarily converted to a "post-and-pay" status through December 31, 2017. A "post-and-pay" status means the claim-processing system allows claims and claim details with this issue to pay, even though the EOB 1010 message continues to post on the Remittance Advice (RA). This conversion was made to allow providers time to submit enrollment updates to appropriately link rendering providers to group locations.

Providers are reminded that effective January 1, 2018 the EOB 1010 edit will revert to a denial status. Providers should review their RAs in detail, note any EOB 1010 messages, and update rendering providers in service location profiles as necessary. (*BR201731* summarizes the steps for completing this process in the Portal.) Providers are encouraged to submit updates as soon as possible to allow for processing before the January 1, 2018 deadline.

IHCP delays changes to taxonomy code requirements on claims for attending, operating, and OPR providers

In *Bulletin* BT201768, the Indiana Health Coverage Programs (IHCP) stated that effective October 29, 2017, taxonomy codes would no longer be required for attending and operating providers on institutional claims, and for ordering, prescribing, or referring (OPR) providers on any claim type. This change has been temporarily delayed. Watch future IHCP publications and this website for information about a revised implementation date for this change.

IHCP corrects inpatient hospital services code table on website

The Indiana Health Coverage Programs (IHCP) identified an error in the Inpatient Hospital Services Codes posted at indianamedicaid.com. The table – *Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours* – has an incorrect list of procedure codes associated with it. The correct procedure codes are identified in Table 2.

Effective immediately, the incorrect list of procedure codes and descriptions will be replaced with the correct list published here. The error did not impact the claim-processing system so no claims were affected. Coverage, reimbursement, and billing guidance for the codes in Table 2 remain unchanged.

continued

Table 2 – Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours

Procedure Code	Description
00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position
00670	Anesthesia for extensive spine and spinal cord procedures (e,g., spinal instrumentation or vascular procedures)
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy
01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee
20661	Application of halo, including removal; cranial
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (list separately in addition to code for primary procedure)
21347	Open treatment of nasomaxillary complex fracture (Lefort II type); requiring multiple open approaches
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (list separately in addition to code for separate proced
22585	Arthrodesis, ant or antitrl, ea additional interspace (list sep in add to single lvl arthrodesis)
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2) with bone graft and/or internal fixation
22600	Arthrodesis, posterior technique, cervical below C2 segment, local bone or bone allograft and/or int
22630	Arthrodesis, post interbody technique, w/ local bone or bone allograft and/or int wire fixation, lum
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure)
22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)
22846	Anterior instrumentation; 4 to 7 vertebral segments (list separately in addition to code for primary procedure)
22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)
22852	Removal of posterior segmental instrumentation

continued

Table 2 – Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours (continued)

Procedure Code	Description
22855	Removal of anterior instrumentation
23472	Arthroplasty with glenoid and proximal humeral replacement
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation
27280	Arthrodesis, sacroiliac joint (including obtaining graft)
27445	Arthroplasty, knee, total; prosthetic (eg, Walldius type)
27447	Arthroplasty, knee, condyle and plateau; medical and lateral compartments w/ or w/out pa (see CPT4 bk)
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed
31725	Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside
35400	Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (list separately in addition to code for primary procedure)
35741	Exploration; popliteal artery
38724	Cervical lymphadenectomy (modified radical neck dissection)
50040	Nephrostomy, nephrotomy with drainage
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, req. sal. and/or ooph., abd. or vag. app
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), cervical, each additional segment

QUESTIONS?

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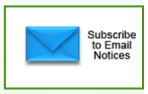

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