IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201240 OCTOBER 2, 2012

POA indicator reporting changes with the implementation of HIPAA 5010

When the Indiana Health Coverage Programs (IHCP) adopted the current Hospital Acquired Conditions (HAC) policy in October 2009, Inpatient Prospective Payment System (IPPS) hospitals were required to report a present on admission (POA) indicator of "1" on claims for diagnoses exempt from POA reporting. With the implementation of the *Health Insurance Portability and Accountability Act* (HIPAA) 5010 in January 2012, IPPS hospitals were no longer required to report the POA indicator of "1." International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are exempt from the POA reporting requirement should now be left blank instead of populating with a "1."

Claims that were submitted to the IHCP in compliance with previous requirements that have been denied for the edits 4250-4276 will be mass reprocessed – see the list of edits on the table on the following page.

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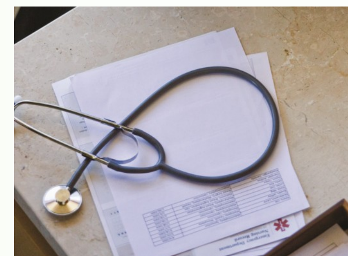
Claims denied for edits 4250-4276 to be mass reprocessed

Edit	Description
4250	Principal diagnosis POA missing or invalid
4251	The first secondary diagnosis POA indicator missing or invalid
4252	Second secondary diagnosis POA missing or invalid
4253	Third secondary diagnosis POA missing or invalid
4254	Fourth secondary diagnosis POA missing or invalid
4255	Fifth secondary diagnosis POA missing or invalid
4256	Sixth secondary diagnosis POA missing or invalid
4257	Seventh secondary diagnosis POA missing or invalid
4258	Eighth secondary diagnosis POA missing or invalid
4259	Ninth secondary diagnosis POA missing or invalid
4260	Tenth secondary diagnosis POA missing or invalid
4261	Eleventh secondary diagnosis POA missing invalid
4262	Twelfth secondary diagnosis POA missing or invalid
4263	Thirteenth secondary diag POA missing or invalid
4264	Fourteenth secondary diag POA missing or invalid
4265	Fifteenth secondary diag POA missing or invalid
4266	Sixteenth secondary diag POA missing or invalid
4267	Seventeenth secondary diagnosis POA missing or invalid
4268	Eighteenth secondary diag POA missing or invalid
4269	Nineteenth secondary diag POA missing or invalid
4270	Twentieth secondary diag POA missing or invalid
4271	Twenty-first secondary diag POA missing or invalid
4272	Twenty-second secondary diag POA missing or invalid
4273	Twenty-third secondary diag POA missing or invalid
4274	Twenty-fourth secondary diag POA missing or invalid
4275	Twenty-fifth secondary diag POA missing or invalid
4276	The POA of "1" or blank is not acceptable

The reprocessed claims will begin appearing on the October 16, 2012, Remittance Advice (RA) and are identified with internal control numbers (ICNs) that begin with region codes 80 and 82.



If the adjustment finds a claim was underpaid, the net difference will be paid and reflected on the RA. If the claim was overpaid, the net difference will establish an accounts receivable.

Edit 4034 to adjudicate based on days, months, and years of age

As announced in banner BR201233, effective September 26, 2012, the Indiana Health Coverage Programs (IHCP) implemented changes to the code editing logic for edit 4034 – *Procedure code billed not compatible with recipient's age. Please verify and resubmit.*

Previously, edit 4034 considered years of age only. For claims received on or after September 26, 2012, the code editing logic for edit 4034 adjudicates claims based on days, months, and years of age. Edit 4034 posts when a member's days, months, and years of age are not compatible with the age designation of the IHCP-covered Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®[1]) code billed. The edit applies the minimum and maximum date ranges as follows:

- **Years** – The member's maximum age in years includes the entire year up to and including the last day of the year. For example, for members 0 to 5 years of age, a procedure is covered for members age 5 years plus 364 days (the day before the member's sixth birthday).
- **Months** – The member's maximum age in months includes the entire month up to and including the last day of the month. For example, for members 0 to 12 months of age, a procedure is covered for members age 11 months up to and including the last day in the 11th month (the day before the member turns 12 months of age).
- **Days** – The member's maximum age in days includes the exact count in days. For example, for members 0 to 365 days of age, a procedure is covered for members up to and including 365 days from the date of birth (the day before the member turns 366 days of age).

For procedure codes with age ranges in days, providers could experience issues with inappropriate denials during a leap year related to the age edit 4034 – *Procedure code billed not compatible with the recipient's age. Please verify and resubmit*, because the leap year will have 366 days instead of 365 days. If the provider receives denials related to a leap year and would like reconsideration of the age editing, he or she must submit a review request by completing an IHCP Programs Inquiry form or writing a letter stating the reason for disagreement with the denial or amount of reimbursement. The IHCP Programs Inquiry form is available on the Forms page of indianamedicaid.com.

[1] *CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Provider education

2012 IHCP Annual Provider Seminar now just three weeks away

Have you reserved your space at the 2012 IHCP Annual Provider Seminar? The annual seminar, scheduled for October 23-25 in Indianapolis, will be the first at the Caribbean Cove Hotel and Conference Center. Seminar sessions cover a wide range of topics from billing and reimbursement to roundtables with managed care entities (MCEs) to overviews of various Indiana Health Coverage Programs (IHCP) offerings. Don't miss it – sign up today!

For more information and to register, visit the Provider Education page on indianamedicaid.com.

Minimum Data Set 3.0 Case Mix Audit Review and Supportive Documentation Guidelines

HP Enterprise Services will host training sessions on the Minimum Data Set (MDS) 3.0 Case Mix Audit Review and the Supportive Documentation Guidelines (SDGs). The training will be presented online using an HP Virtual Room (website) combined with an audio conference telephone number. Training dates are:

- October 4, 2012, 10-11 a.m.
- October 31, 2012, 10-11 a.m.
- November 1, 2012, 10-11 a.m.

For more information and to register, visit the MDS 3.0 page on indianamedicaid.com.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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