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Present On Admission Indicator

Key Words

MM5499, CR5499, R1240CP, Admission, POA

Provider Types Affected

Hospitals who submit claims to Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for Medicare beneficiary inpatient services

Key Points

- The effective date of the instruction is October 1, 2007.
- The implementation date is October 1, 2007.
- Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on the admission (POA) of patients, effective for discharges on or after October 1, 2007.
- By October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will have selected at least 2 high cost or high volume (or both) diagnosis codes that:
  - Represent conditions (including certain hospital acquired infections) that could reasonably have been prevented through the application of evidence-based guidelines; and
  - When present on a claim along with other (secondary) diagnoses, have a Diagnosis Related Group (DRG) assignment with a higher payment weight.
- For acute care inpatient prospective payment system (PPS) discharges on or after October 1, 2008, while the presence of these diagnosis codes on claims could allow the assignment of a higher paying DRG, when they are present at the time of discharge (but not at the time of admission), the DRG that must be assigned to the claim will be the one that does not result in the higher payment.
- Beginning for discharges on or after October 1, 2007, hospitals should begin reporting the POA code for acute care inpatient PPS discharges. The only exception are claims that are submitted via direct data entry (DDE) should not report the POA codes until January 1, 2008, as the DDE screens will not be able to accommodate the codes until that date.

- Between October 1, 2007, and December 31, 2007, CMS will collect the information on the hospital claim but does not intend to provide any remittance or other information to hospitals if the information is not submitted correctly for each diagnosis on the claim.
- Hospitals that fail to provide the POA code for discharges on or after January 1, 2008, will receive a remittance advice remark code that informs them that they failed to report a valid POA code.
- However, beginning with discharges on or after April 1, 2008, Medicare will return claims to the hospital if the POA code is not reported, and the hospital will have to supply the correct POA code and resubmit the claim.
- In order to be able to group these diagnoses into the proper DRG, CMS needs to capture a POA indicator for all claims involving inpatient admissions to general acute care hospitals.

Note: Adjustments to the relative weight that occur because of this action are not budget neutral. Specifically, aggregate payments for discharges in a fiscal year could be changed as a result of these adjustments.

- These POA guidelines are not intended to replace any found in the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Official Guidelines for Coding and Reporting*, nor are they intended to provide guidance on when a condition should be coded.
- Providers should use them in conjunction with the UB-04 *Data Specifications Manual* and the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms (UB-04 and 837 Institutional). Information regarding the *UB-04 Data Specifications Manual* may be found at *http://www.nubc.org/become.html*.

Note: Critical access hospitals, Maryland waiver hospitals, long-term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement. Also, as noted in CR5679 (*http://www.cms.hhs.gov/Transmittals/downloads/R289OTN.pdf*), hospitals paid under a PPS, other than the acute care hospital PPS, are exempt. Therefore, psychiatric and rehabilitation hospitals are exempt.

- The following information, from the *UB-04 Data Specifications Manual*, is provided to help providers understand how and when to code POA indicators:

General Reporting Requirements

- The reporting requirements pertain to all claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.
- POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*) and the external cause of injury codes.
- Issues related to inconsistent, missing, conflicting, or unclear documentation must still be resolved by the provider.

- If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA indicator would not be reported.
- CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an "other diagnosis."

Reporting Options and Definitions

- Y - Yes (present at the time of inpatient admission)
- N – No (not present at the time of inpatient admission)
- U - Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)
- W – Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
- 1 -- Unreported/Not used – Exempt from POA reporting (This code is the equivalent of a blank on the UB-04, but blanks are not desirable when submitting data via the 4010A1.)
- The POA data element on the provider's electronic claims must contain the letters "POA", followed by a single POA indicator for every diagnosis that they report.
- The POA indicator for the principal diagnosis should be the first indicator after "POA".
- When applicable, the POA indicators for secondary diagnoses would follow. The last POA indicator must be followed by the letter "Z" to indicate the end of the data element (or FIs and A/B MACs will allow the letter "X" which CMS may use to identify special data processing situations in the future).
- On paper claims, the POA is the eighth digit of the Principal Diagnosis field (FL 67), and the eighth digit of each of the secondary diagnosis fields (FL 67 A-Q).
- On claims submitted electronically via 837, 4010 format, providers must use segment K3 in the 2300 loop, data element K301. Below is an example of what this coding should look like on an electronic claim:

  If segment K3 reads as follows: "POAYNUW1YZ," it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnosis. The principal diagnosis was POA (Y); the first secondary diagnosis was not POA (N); it was unknown if the second secondary diagnosis was POA (U); it is clinically undetermined if the third secondary diagnosis was POA (W); the fourth secondary diagnosis was exempt from reporting for POA (1); and the fifth secondary diagnosis was POA (Y).
- As of January 1, 2008, all DDE screens will allow for the entry of POA data. POA data will also be included with any secondary claims sent by Medicare for coordination of benefits purposes.
- Providers may review the complete instructions in the *UB-04 Data Specifications Manual* for more specific instructions and examples.

Note: CMS, in consultation with the Centers for Disease Control and Prevention and other appropriate entities, may revise the list of selected diagnoses from time to time, but there will always be at least two conditions selected for discharges occurring during any fiscal year. Further, this list of diagnosis codes and DRGs is not subject to judicial review.

- Providers should keep in mind that achieving complete and accurate documentation, code assignment, and reporting of diagnoses and procedures requires a joint effort between the healthcare provider and the coder.
- Medical record documentation from any provider (a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis) involved in the patient's care and treatment may be used to support the determination of whether a condition was present on admission or not.
- The importance of consistent, complete documentation in the medical record cannot be overemphasized.

NOTE: Providers, their billing office, third party billing agents, and anyone else involved in the transmission of this data must insure that any resequencing of diagnoses codes includes a resequencing of the POA indicators, prior to their transmission to CMS.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf* on the CMS website.

The official instruction (CR5499) regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1240CP.pdf* on the CMS website.

If providers have questions regarding this issue, they may contact their FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.