



Provider Inquiry Assistance

Version 5010 Implementation—Changes to Present on Admission (POA) Indicator '1' and the K3 Segment – JA7024

Related CR Release Date: August 13, 2010

Date Job Aid Revised: August 23, 2010

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Key Words MM7024, CR7024, R756OTN, 5010, POA, K3

Contractors Affected

- Fiscal Intermediaries (FIs)
- Part A/B Medicare Administrative Contractors (A/B MACs)

Provider Types Affected Hospitals who submit claims to MACs and/or FIs for services to Medicare beneficiary inpatient services are affected.



Change Request (CR) 7024 alerts hospitals that effective with the implementation of 5010 Inpatient Prospective Payment System (IPPS) hospitals will no longer report the POA indicator of '1'.

<p>Provider Needs to Know...</p>	<ul style="list-style-type: none"> • International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are exempt from the POA reporting requirement should be left 'blank' instead of populating a '1'. • In addition, the K3 segment, which was required for reporting POA in the 4010A1 version of the 837I, is no longer be used to report POA. • The POA indicators will instead follow the diagnosis code in the appropriate 2300 HI segment. <p>POA Indicator Payment Implications</p> <ul style="list-style-type: none"> • The table in the background section of MM7024 outlines the payment implications for each of the different POA Indicator reporting options.
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<p>Background</p>	<ul style="list-style-type: none"> • On February 8, 2006, the President signed the Deficit Reduction Act (DRA) of 2005. • Section 5001(c) of the DRA requires the identification of conditions that are: <ul style="list-style-type: none"> • High cost or high volume or both; • Result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis; and • Could reasonably have been prevented through the application of evidence-based guidelines. Section 5001(c) provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions. • For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. • That is, the case would be paid as though the secondary diagnosis were not present. • CMS also required hospitals to report POA information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.
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<p>Operational Impact</p>	<p>N/A</p>
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Reference
Materials

The related MLN Matters® article can be found at
<http://www.cms.gov/MLN MattersArticles/downloads/MM7024.pdf> on the CMS website.

The official instruction (CR7024) issued regarding this change may be viewed at
<http://www.cms.gov/Transmittals/downloads/R756OTN.pdf> on the CMS website.

Further information concerning Hospital Acquired Conditions and POAs may be viewed at
<https://www.cms.gov/HospitalAcqCond/> on the CMS website.

Related MLN Matters® articles MM5499, MM6086, and SE0841 may be review at:
<http://www.cms.gov/MLN MattersArticles/downloads/MM5499.pdf>,
<http://www.cms.gov/MLN MattersArticles/downloads/MM6086.pdf>, and
<http://www.cms.gov/MLN MattersArticles/downloads/SE0841.pdf> respectively.
