

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – The Centers for Medicare & Medicaid Services (CMS) has reevaluated the revalidation requirement in the Affordable Care Act, and believe it affords the flexibility to extend the revalidation period for another 2 years. Revalidation notices will now be sent through March 2015. **IMPORTANT:** This does not affect providers who have already received a revalidation notice. If you received a revalidation notice from your contractor, respond to that request. Remember, institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) must submit the application fee with their revalidation. CMS will post a list of providers who were sent requests to revalidate on the [Medicare Provider-Supplier Enrollment web page](#). [MLN Matters® Special Edition Article #SE1122](#) also provides important information on the fee payment and revalidation processes. Notification will be sent via a CMS electronic mailing list when this information is posted. If you are signed up for your Medicare contractor's listserv you will get a notice that way. You may also sign up for a [national Fee-For-Service electronic mailing list](#).

MLN Matters® Number: MM7680

Related Change Request (CR) #: 7680

Related CR Release Date: January 25, 2012

Effective Date: October 1, 2011

Related CR Transmittal #: R10190TN

Implementation Date: July 2, 2012

Update to the Fiscal Year (FY) 2012 List of Codes Exempt from Reporting Present on Admission (POA)

Provider Types Affected

Hospitals who submit claims to A/B Medicare Administrative Contractors (MACs) and Fiscal Intermediaries (FIs) for services to Medicare beneficiary inpatient services are affected.

Provider Action Needed

This article is based on Change Request (CR) 7680, which informs you about the update to the Fiscal Year (FY) 2012 International Classification of Diseases 9th Edition Clinical Modification (ICD-9-CM) codes exempt from reporting Present on Admission (POA).

Disclaimer

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Hospitals (billing 5010 or Direct Data Entry) should report a POA indicator of 'W' for the codes listed in the background section below instead of a 'blank' as a workaround to allow claims to process until July 1, 2012. Make certain that your billing staffs are aware of these requirements.

Background

Present on Admission

The Deficit Reduction Act of 2005 requires the Secretary of Health and Human Services to identify conditions that are: (a) high cost or high volume or both, (b) 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 (c) could reasonably have been prevented through the application of evidence-based guidelines.

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 was not present.

The Centers for Medicare & Medicaid Services (CMS) also requires hospitals to report present on admission indicators for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007. Some diagnosis codes are exempt from POA reporting.

The following ICD-9-CM codes have either been added or deleted from the list of diagnosis codes exempt from reporting a POA indicator effective October 1, 2011. Hospitals that received reason code 34931 should report a POA indicator of 'W' (should they choose) as a workaround until the POA exempt list is updated in Medicare systems on July 2, 2012. A complete list of codes is available in the CR7680 instruction accessible at the Web address shown in the Additional Information section below.

ICD-9-CM diagnosis codes exempt from reporting POA, added to the list, effective October 1, 2011:

747.31
747.32
747.39
V12.21
V12.29
V12.55
V13.81
V13.89
V15.9

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V19.11
V19.19
V23.42
V23.87
V54.82
V58.68
V88.21
V88.22
V88.29

ICD-10 codes

CMS has provided the converted ICD-10-CM codes, listed below, for the additional codes only.

ICD -10 codes

Q25.5
Q25.6
Q25.7
Z47.89
Z78.9
Z79.899
Z83.5
Z86.39
Z86.71
Z87.898
O09.291
O09.292
O09.293
O09.299
O09.891
O09.892
O09.893
O09.899

ICD-9-CM diagnosis codes exempt from reporting POA, terminated from the list, effective October 1, 2011:

747.3
V12.2
V13.8
V19.1

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Additional Information

The official instruction associated with this CR7680, issued to your Medicare A/B MAC and FI regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R1019OTN.pdf> on the CMS website.

If you have questions, please contact your Medicare A/B MAC or FI at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash - Flu Season is Here! While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Healthcare workers, who may spread the flu to high risk patients, should get vaccinated too. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu.** Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-2012 Provider Seasonal Flu Resources](#) and [Immunizations](#). For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp.

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