DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8709 **Related Change Request (CR) #: CR 8709**

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Related CR Transmittal #: R1380OTN **Implementation Date: October 6, 2014**

Present on Admission (POA) Indicator Editing for Maryland Waiver Hospitals

Provider Types Affected

This MLN Matters® Article is intended for Maryland Waiver Hospitals submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8709, which advises hospitals in Maryland operating under waivers that they will be required to report valid Present on Admission (POA) indicators for the principal and all secondary diagnoses and will continue to be exempt from the application of the Hospital-Acquired Conditions (HAC) provision. Make sure that your billing staffs are aware of these changes.

Background

Section 5001(c) of the Deficit Reduction Act of 2005 required certain Inpatient Prospective Payment System (IPPS) hospitals to begin reporting a POA indicator for the principal diagnosis and all secondary diagnoses assigned to patients effective with discharges on or after October 1, 2007. Historically, hospitals in Maryland operating under the waiver under section 1814(b)(3) of the Act were exempt from POA reporting.

The fiscal year (FY) 2014 IPPS/LTCH PPS final rule determined that the provisions of section 1814(b)(3) of the Act apply to the amount paid to providers of services, and does not extend to billing requirements and other reporting requirements. Hospitals in Maryland are required to submit Medicare claims for Medicare payment and also to submit the same information on their Medicare claims as hospitals in other parts of the country paid under the IPPS. Subsequent to the FY 2014 rulemaking, the State of Maryland entered into an agreement with the Centers for Medicare & Medicaid Services (CMS), effective January 1, 2014, to participate in CMS' new Maryland All-Payer Model. This model is being implemented under section 1115A of the Act, as added by section 3021 of the Affordable Care Act. Although CMS has waived certain provisions of the Act for Maryland hospitals, as set forth in the agreement between CMS and Maryland and subject to Maryland's compliance with the terms of the agreement, CMS has not waived the POA indicator reporting requirement.

Therefore, hospitals in Maryland operating under waivers were required to report valid POA indicators for each diagnosis code, including the principal and all secondary diagnoses up to 25 and will continue to be exempt from the application of the HAC payment provision. The Medicare claims processing system was able to accept POA indicators from Maryland hospitals, effective October 1, 2013; however, the claims processing system was not ready to implement edits of the POA data at that time. CMS needs to capture a POA indicator for all inpatient admissions to general acute care hospitals operating under the Maryland waiver in order to have as complete a dataset as possible to analyze trends and make further payment policy determinations, such as those authorized by section 1886(p) of the Act, as added under Section 3008 of the Affordable Care Act for the Hospital Acquired Condition (HAC) Reduction Program.

You should use the UB-04 Data Specifications Manual and the ICD-10-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. These guidelines are not intended to replace any guidelines in the main body of the ICD-10-CM Official Guidelines for Coding and Reporting. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-10-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-10-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines,

the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis. NOTE: The provider, their billing office, third party billing agents and anyone else involved in the transmission of this data shall ensure that any resequencing of diagnoses codes prior to their transmission to CMS, also includes a resequencing of the POA indicators as well.

The following information is an excerpt from the UB-04 Data Specifications Manual and is provided to assist hospitals in understanding how and when to code POA indicators. See the complete instructions in the UB-04 Data Specifications Manual when more specific instructions or examples are necessary.

General Reporting Requirements

- 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.
- Present on admission 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."

CMS 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 = the documentation is insufficient to determine if the condition was present at the time of inpatient admission
- W = Clinically Undetermined = the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not
- Blank = Exempt ICD-10-CM diagnosis code based on the list of exempt codes

Additional Information

The official instruction, CR 8709, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1380OTN.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.