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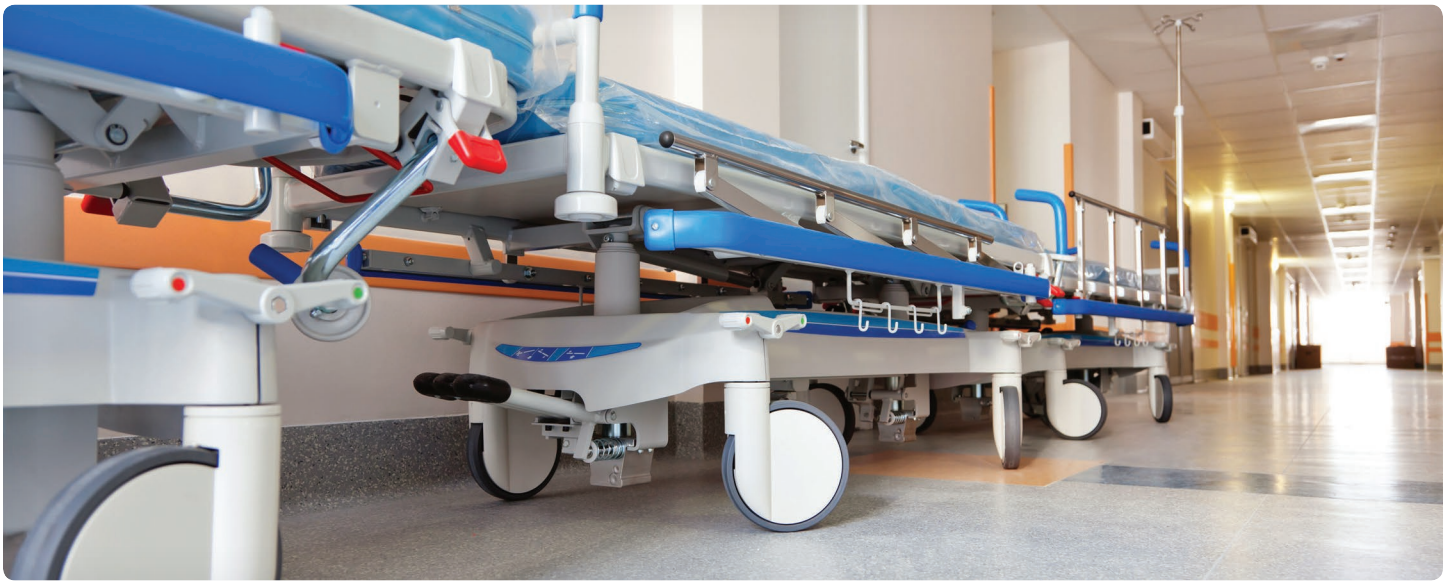
PRINT-FRIENDLY VERSION

HOSPITAL-ACQUIRED CONDITIONS AND PRESENT ON ADMISSION INDICATOR REPORTING PROVISION



Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these topics on the Hospital-Acquired Conditions (HACs) and Present on Admission (POA) Indicator Reporting provision in Acute Inpatient Prospective Payment System (IPPS) hospitals:

- Background
- HACs
- POA indicator
- Exempt hospitals
- Resources

When “you” is used in this publication, we are referring to Medicare Fee-For-Service health care providers.

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BACKGROUND

As required by the Deficit Reduction Act of 2005 (DRA), the HAC-POA Indicator Reporting provision requires a quality adjustment in Medicare Severity-Diagnosis Related Group (MS-DRG) payments for certain HACs. IPPS hospitals must submit POA information on principal and all secondary diagnoses for inpatient discharges on or after October 1, 2007. The HAC-POA payment provision under the DRA is distinct from the HAC Reduction Program mandated by Section 3008 of the 2010 Patient Protection and Affordable Care Act, which authorizes the Centers for Medicare & Medicaid Services (CMS) to make payment adjustments to applicable hospitals based on risk-adjustment quality measures.

HACs

As required by Section 5001(c) of the DRA, by October 1, 2007, the Secretary of the Department of Health & Human Services was required to identify at least two conditions that:

- Are high cost or high volume or both
- Result in the assignment of a case to an MS-DRG that has a higher payment when present as a secondary diagnosis
- Could reasonably have been prevented by applying evidence-based guidelines

For discharges occurring on or after October 1, 2008, IPPS hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (that is, the condition was not POA). The case is paid as though the secondary diagnosis is not present.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and the ICD-10 Procedure Coding System codes included in the HAC payment provision for 2018 reporting are available online via zip file.

Review the Final HAC List to find the categories and corresponding complication or comorbidity or major complication or comorbidity International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes in the HAC payment provision.

Note: As specified by statute, CMS may revise the list of conditions from time to time, as long as the list contains at least two conditions.

POA INDICATOR

POA Indicator, Description, and Payment for Fiscal Year (FY) 2018 DRA HAC Reporting

Indicator	Description	Payment
Y	Diagnosis was present at time of inpatient admission.	Payment is made for condition when a HAC is present.
N	Diagnosis was not present at time of inpatient admission.	No payment is made for condition when a HAC is present.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment is made for condition when a HAC is present.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition when a HAC is present.

Download the FY 2018 Present on Admission (POA) Exempt List via a zip file. Refer to ICD-9-CM Official Guidelines for Coding and Reporting ("Official Guidelines") for a list of ICD-9-CM codes on the POA exempt list.

General Reporting Requirements

This list provides some POA general reporting requirements:

- Include the POA indicator on all claims that involve Medicare inpatient admissions to general IPPS acute care hospitals or other facilities, and you are subject to a law or regulation that mandates the collection of POA indicator information.
- POA is defined as being 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 POA.
- Assign the POA indicator to principal and all secondary diagnoses as defined in Section II of the "Official Guidelines."
- Resolve issues related to inconsistent, missing, conflicting, or unclear documentation.
- Do not report the POA indicator if a condition is not coded and reported based on Uniform Hospital Discharge Data Set definitions and current "Official Guidelines."
- CMS does not require a POA indicator for the external cause of injury code unless you are reporting it as an "other diagnosis."

Coding

This list provides coding information:

- The "UB-04 Data Specifications Manual" and "Official Guidelines" can help you assign the POA indicator for each "principal" diagnosis and "other" ICD-10-CM diagnosis codes reported on the UB-04 (paper claims) and ASC X12N 837 Institutional (837I) (electronic transmissions). Visit the National Uniform Billing Committee website for more information about the "UB-04 Data Specifications Manual."
- This publication is not intended to replace any guidelines in the main body of the "Official Guidelines" or provide guidance on when to report a condition. Rather, it provides information on how to apply the POA indicator to the final set of ICD-10-CM diagnosis codes assigned according to Sections I, II, and III of the "Official Guidelines." Assign the POA indicator to those conditions for which an ICD-10-CM diagnosis code has been assigned.
- As stated in the Introduction to the "Official Guidelines," a joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting diagnoses and procedures.

Documentation

You should consistently and completely document furnished services in the medical record. Medical record documentation from any provider involved in the care and treatment of the patient determines whether a condition is POA. In the context of the "Official Guidelines," a "provider" is a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

Note: Providers, their billing offices, third-party billing agents, and others involved in the transmission of this data must ensure that any resequencing of ICD-10-CM diagnosis codes prior to their transmission to CMS also includes a resequencing of POA indicators.

Billing

Paper Claims

On the UB-04, the POA indicator is the eighth digit of Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL 67 A–Q. Report the applicable POA indicator (Y, N, U, or W) for the principal diagnosis and any secondary diagnoses as the eighth digit. Enter 1 if the diagnosis is exempt from POA reporting.

Electronic Claims

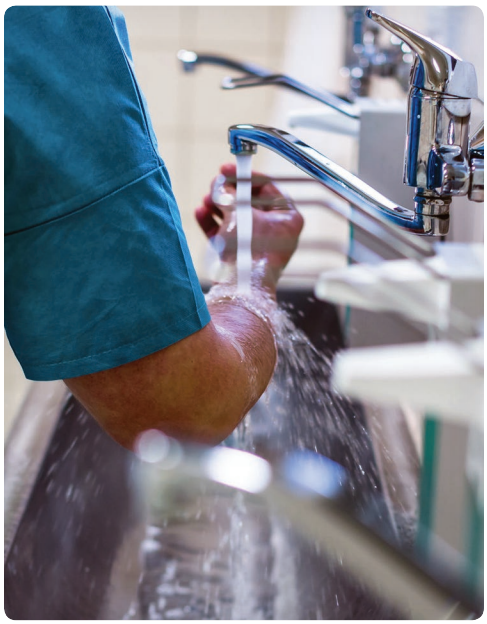
Submit the POA indicator on the 837I in the appropriate Health Care Information Codes segment as directed by the "UB-04 Data Specifications Manual."

EXEMPT HOSPITALS

Because the HAC-POA payment provision applies only to IPPS hospitals, all of these hospitals are exempt from the provision:

- Critical Access Hospitals
- Long Term Care Hospitals
- Maryland Waiver Hospitals*
- Cancer Hospitals
- Children's Inpatient Facilities
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities
- Veterans Administration/Department of Defense Hospitals

* Maryland Waiver Hospitals must report the POA indicator on all claims.



RESOURCES

POA Reporting by Acute IPPS Hospitals Resources

For More Information About…	Resource
HACs (POA Indicator)	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond
ICD-10-CM Official Guidelines for Coding and Reporting	CDC.gov/NCHS/Data/ICD/10CMguidelines_FY2018_final.pdf
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and the ICD-10 Procedure Coding System Codes	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY-2018-Hospital-Acquired-Conditions-List.zip
Final HAC List	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2013_Final_HACsCodeList.pdf
FY 2018 Present on Admission (POA) Exempt List	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY-2018-Present-On-Admission-POA-Exempt-List-.zip
ICD-9-CM Official Guidelines for Coding and Reporting	https://www.cdc.gov/nchs/data/icd/icd9cm_guidelines_2011.pdf
National Uniform Billing Committee	http://www.nubc.org/subscriber
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf