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Hospital-Acquired Conditions and
Present on Admission Indicator Reporting Provision

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information 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; and
- ◈ Resources.

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

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 the 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 described in Section 3008 of the Affordable Care Act of 2010, which authorizes the Centers for Medicare & Medicaid Services (CMS) to make payment adjustments to applicable hospitals based on risk-adjustment quality measures.

HOSPITAL-ACQUIRED CONDITIONS (HACS)

As required by Section 5001(c) of the DRA, by October 1, 2007, the Secretary of the United States 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; and
◈ Could reasonably have been prevented through the application of evidence-based guidelines.

For discharges occurring on or after October 1, 2007, 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 present on admission). The case is paid as though the secondary diagnosis is not present.

The chart below provides the categories and corresponding complication or comorbidity (CC) or major complication or comorbidity (MCC) International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) codes included in the HAC payment provision for fiscal years (FY) 2014 and 2015.

FYs 2014 and 2015 Categories and CC/MCC Codes

HAC Category	CC/MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)

FYs 2014 and 2015 Categories and CC/MCC Codes (cont.)

HAC Category	CC/MCC (ICD-9-CM Codes)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: • Fracture • Dislocation • Intracranial Injury • Crushing Injury • Burn • Other Injuries	Codes within these ranges on the CC/MCC list: 800–829 830–839 850–854 925–929 940–949 991–994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)

FYs 2014 and 2015 Categories and CC/MCC Codes (cont.)

HAC Category	CC/MCC (ICD-9-CM Codes)
Vascular Catheter-Associated Infection	999.31 (CC) 999.32 (CC) 999.33 (CC)
Manifestations of Poor Glycemic Control: • Diabetic Ketoacidosis • Nonketotic Hyperosmolar Coma • Hypoglycemic Coma • Secondary Diabetes with Ketoacidosis • Secondary Diabetes with Hyperosmolarity	250.10–250.13 (MCC) 250.20–250.23 (MCC) 251.0 (CC) 249.10–249.11 (MCC) 249.20–249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures: • Spine • Neck • Shoulder • Elbow	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01–81.08, 81.23, 81.24, 81.31–81.38, 81.83, or 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity: • Laparoscopic Gastric Bypass • Gastroenterostomy • Laparoscopic Gastric Restrictive Surgery	Principal diagnosis: 278.01 539.01 (CC) 539.81 (CC) 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95

FYs 2014 and 2015 Categories and CC/MCC Codes (cont.)

HAC Category	CC/MCC (ICD-9-CM Codes)
Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	996.61 (CC) 998.59 (CC) And one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98, 37.74, 37.75, 37.76, 37.77, 37.79, or 37.89
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures: • Total Knee Replacement • Hip Replacement	415.11 (MCC) 415.13 (MCC) 415.19 (MCC) 453.40–453.42 (CC) And one of the following procedure codes: 00.85–00.87, 81.51–81.52, or 81.54
Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) And the following procedure code: 38.93

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.

PRESENT ON ADMISSION (POA) INDICATOR

The chart below provides POA indicator, description, and payment information for FY 2015.

POA Indicator, Description, and Payment

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.

To find the list of ICD-9-CM codes on the POA exempt list, refer to the "ICD-9-CM Official Guidelines for Coding and Reporting" ("Official Guidelines") located at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm on the Centers for Disease Control and Prevention (CDC) website. To find the list of International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) codes on the POA exempt list, refer to http://www.cms.gov/Medicare/Coding/ICD10/Downloads/Detailed-List-of-Codes-Exempt-from-POA.zip on the CMS website.

General Reporting Requirements

The following list provides some POA general reporting requirements:

❖ You must 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;

- The POA indicator is assigned to the principal and all secondary diagnoses as defined in Section II of the "Official Guidelines";
- You must resolve issues related to inconsistent, missing, conflicting, or unclear documentation;
- You should 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"; and
- CMS does not require a POA indicator for the external cause of injury code unless you are reporting it as an "other diagnosis."

Coding

- The "UB-04 Data Specifications Manual" and "Official Guidelines" can help you assign the POA indicator for each "principal" diagnosis and "other" ICD-9-CM diagnosis codes reported on the UB-04 (paper claims) and ASC X12N 837 Institutional (837I) (electronic transmissions). For more information about the "UB-04 Data Specifications Manual," visit http://www.nubc.org/subscriber on the National Uniform Billing Committee website;
- 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-9-CM diagnosis codes assigned in accordance with Sections I, II, and III of the "Official Guidelines." The POA indicator should be assigned to those conditions for which an ICD-9-CM diagnosis code has been assigned; and
- 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

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 determine 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-9-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. You should 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

You should 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, the following 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; and
- ◈ Veterans Administration/Department of Defense Hospitals.

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

RESOURCES

The chart below provides POA reporting by acute IPPS hospitals resource information.

POA Reporting by Acute IPPS Hospitals Resources

For More Information About…	Resource
Hospital-Acquired Conditions (Present on Admission Indicator)	http://www.cms.gov/HospitalAcqCond on the CMS website
All Available Medicare Learning Network® (MLN) Products	"MLN Catalog" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Patients	http://www.medicare.gov on the CMS website

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