CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1380	**Date: May 2, 2014**
	Change Request 8709

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

I. SUMMARY OF CHANGES: Hospitals in Maryland operating under waivers will be required to report valid POA indicators for the principal and all secondary diagnoses and will continue to be exempt from the application of the HAC provision.

EFFECTIVE DATE: October 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Section 5001(c) of the Deficit Reduction Act of 2005 required certain Inpatient Prospective Payment System (IPPS) hospitals to begin reporting a present on admission (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 along with IPPS excluded hospitals, including CAHs, LTCHs, IRFs, IPFs, cancer hospitals, children's hospitals, RNHCIs, and the Department of Veterans Affairs/Department of Defense hospitals.

The 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 our FY 2014 rulemaking, the State of Maryland entered into an agreement with 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 that formerly operated under section 1814(b)(3) of the Act are 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.

B. Policy: CMS needs to capture a POA indicator for all inpatient admissions to general acute care hospitals including those formerly operating under section 1814(b)(3) in order to have as complete a dataset as possible to analyze trends and make further payment policy determinations, such as those authorized under section 1886(p) of the Act.

Use the UB-04 Data Specifications Manual and the ICD-9-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-9-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-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-9-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 re-sequencing of diagnoses codes prior to their transmission to CMS, also includes a re-sequencing 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-9-CM diagnosis code based on the list of exempt codes

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8709.1	Medicare Contractor shall modify current POA editing to apply to inpatient acute care hospital claims from Maryland hospitals.					X				
8709.2	Medicare contractors shall continue to code an 'X' in the end of POA indicator field for Maryland hospitals so the 3M Grouper will not apply Hospital-Acquired Condition (HAC) Diagnosis Related Group (DRG) logic to these claims.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8709.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, Cami.DiGiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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