

Attachment – One-Time Notification

(Business Requirements Template for use with One-Time Notification Change Requests)

Pub. 100-	Transmittal:	Date:	Change Request: 5499
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SUBJECT (Change Request Title): Present On Admission Indicator

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: Per Section 5001(c) of Public Law 109-171, the Deficit Reduction Act of 2005, effective for discharges on or after October 1, 2007, the Secretary is required to identify at least 2 high cost or high volume (or both high cost and high volume) diagnosis codes with a DRG assignment that has a higher payment weight when present with secondary diagnoses. These diagnosis codes represent conditions, including certain hospital acquired infections, that could reasonably have been prevented through the application of evidence-based guidelines. Effective for acute care inpatient PPS discharges on or after October 1, 2008, the DRG assigned to a discharge with the identified diagnosis codes will be the DRG that does not result in higher payments based on the presence of these secondary diagnosis codes. This assignment of the lower paid DRG applies to discharges, where, at the time of the patient's admission, the beneficiary had none of the identified diagnosis codes. Adjustments to the relative weight that occur because of this action are not budget neutral. Specifically, aggregate payments for discharges in a fiscal year could be changed as a result of such adjustments. The list of selected diagnoses may be revised from time to time as long as there are at least two conditions selected for discharges occurring during any fiscal year. The Secretary is required to consult with the Centers for Disease Control and Prevention and other appropriate entities when selecting and revising the identified diagnosis codes. The list of diagnosis codes and DRGs are not subject to judicial review.

B. Policy: In order to group diagnoses into the proper DRG, CMS needs to capture a Present On Admission (POA) indicator for all claims involving inpatient admissions to general acute care hospitals. Use the UB-04 Data Specifications Manual and the ICD-9-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the Present on Admission (POA) indicator for each principal diagnosis, other diagnoses and external cause of injury code 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 insure that any resequencing of diagnoses codes prior to their transmission to CMS, also includes a resequencing of the POA indicators as well.

- C. 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 UHDDS 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”.

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
- 1 = Unreported/Not used – Exempt from POA reporting - This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable when submitting this data via the 4010A1.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A / B M A C	D M M A C	F I I E R	C A R R I C E R	D M R R I C	R H H I	Shared-System Maintainers				OTHER	
						F I S S	M C S	V M S	C M W F				
5499.1	On UB-04 paper claims the POA is the eighth digit of FL 67, Principal Diagnosis and the eighth digit of each of the secondary diagnosis fields FL 67 A-Q. This data shall be captured and included with other data sent to MCE and GROUPER programs.	x		x					x			x	NCH
5499.2	Claims submitted electronically via 837, 4010 format, shall use segment K3 in the 2300 loop, data element K301. The data element shall contain the letters "POA", followed by a single POA indicator for every diagnosis reported on the claim. The POA indicator for the principal diagnosis should be the first indicator after "POA". POA indicators for secondary diagnoses would follow next, if applicable. The last POA indicator for principal and, if applicable, other diagnoses shall be followed by the letter "Z" to indicate the end of POA indicators for principal and, if applicable, other diagnoses or the letter "X" to indicate the end of POA indicators for principal and, if applicable, other diagnoses in special data processing situations that may be identified by CMS in the future. This data shall be captured and included with other data sent to MCE and GROUPER programs.	x		x					x			x	NCH
5499.2.1	The standard system maintainer shall edit the information in K3 to insure that the number of individual POA indicators (between POA and Z or X as indicated in 5499.2) is equal to the number of principal and, if applicable, other diagnoses on the claim. If not, the claim shall be returned to the provider (RTP). A 3 month grace period will be allowed before this edit becomes effective. RTPs will not begin until January 1, 2008.								x				
5499.2.2	The letter "X" indicating the end of the data element shall always be accepted as valid even								x				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I I E R	C A R R I C E R	D M R R I C	R E H I	Shared-System Maintainers			
							F I S S	M C S	V M S	C W F	
	if CMS has not identified any special processing situations.										
5499.3	CWF/NCH must create a new field to capture and store at least nine POAs and one end of POA indicator.										
5499.4	DDE screens shall allow for the entry of POA data.	x		x				x			
5499.5	All POA information shall be included with any secondary claims transmission for Coordination of Benefits purposes.	x		x				x			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I I E R	C A R R I C E R	D M R R I C	R E H I	Shared-System Maintainers			
							F I S S	M C S	V M S	C W F	
5499.1	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction shall be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	x		x							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5499.2	As an example, segment K3 might read as follows: "POAYNUW1YZ" It would represent the POA indicators for a claim with 1 principal and 5 secondary diagnoses. No more, no less. The principal diagnosis was POA. The first secondary diagnosis was not POA. It was unknown if the second secondary diagnosis was POA. It is clinically undetermined if the third secondary diagnosis was POA. The fourth secondary diagnosis was exempt from reporting for POA. The fifth secondary diagnosis was POA.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Stu Barranco, 410-786-6152

Post-Implementation Contact(s): Stu Barranco, 410-786-6152

VI. FUNDING

A. For TITLE XVIII Contractors, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC), use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.