



## Medicare Disproportionate Share Hospital Fact Sheet Available

The revised (March 2007) *Medicare Disproportionate Share Hospital Fact Sheet*, which provides information about methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment and Medicare DSH payment adjustment formulas, is now available on the CMS Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/2007mdsh.pdf>.

MLN Matters Number: MM5499 **Revised**

Related Change Request (CR) #:5499

Related CR Release Date: May 11, 2007

Effective Date: October 1, 2007

Related CR Transmittal #: R1240CP

Implementation Date: October 1, 2007

## Present On Admission Indicator

**Note:** This article was revised on August 15, 2007, to show that psychiatric and inpatient rehabilitation hospitals are also exempt from reporting the Present on Admission Indicator as noted in CR5679.

### Provider Types Affected

Hospitals who submit claims to fiscal intermediaries (FI) or Part A/B Medicare Administrative Contractors (A/B MACs) for Medicare beneficiary inpatient services.

### Provider Action Needed



#### STOP – Impact to You

Effective October 1, 2007, Medicare will begin to accept a Present On Admission (POA) Indicator for every diagnosis on your inpatient acute care hospital claims. **However, providers must submit the POA on hospital claims beginning with discharges on or after January 1, 2008.** Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, psychiatric hospitals, inpatient rehabilitation facilities, and children's inpatient facilities are exempt from this requirement.



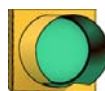
#### CAUTION – What You Need to Know

CR 5499, from which this article is taken, announces the requirement for completing a Present On Admission (POA) Indicator for every diagnosis on an inpatient acute care hospital claim beginning with discharges on or after January 1, 2008, and provides your fiscal intermediaries (FI) and A/B

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MACs with the coding and editing requirements, and software modifications needed to successfully implement this indicator. (Providers can begin to submit POAs as of October 1, 2007.)



### GO – What You Need to Do

You should make sure that your billing staffs are aware of this requirement, and that your physicians and other practitioners and coders are collaborating to ensure complete and accurate documentation, code assignment and reporting of diagnoses and procedures. Please refer to the Background section for more details

## Background

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Section 5001( c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on the admission (POA)\_ of patients effective for discharges on or after October 1, 2007. Effective for acute care inpatient prospective payment system (PPS) discharges on or after October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will have selected at least 2 high cost or high volume (or both) diagnosis codes that:

- Represent conditions (including certain hospital acquired infections) that could reasonably have been prevented through the application of evidence-based guidelines; and
- When present on a claim along with other (secondary) diagnoses, have a DRG assignment with a higher payment weight.

Then, for acute care inpatient PPS discharges on or after October 1, 2008, while the presence of these diagnosis codes on claims could allow the assignment of a higher paying DRG, when they are present at the time of discharge, but not at the time of admission, the DRG that must be assigned to the claim will be the one that does not result in the higher payment.

Beginning for discharges on or after October 1, 2007, hospitals should begin reporting the POA code for acute care inpatient PPS discharges. There is one exception, i.e., claims submitted via direct data entry (DDE) should not report the POA codes until January 1, 2008, as the DDE screens will not be able to accommodate the codes until that date.

Hospitals that fail to provide the POA code for discharges on or after January 1, 2008 will receive a remittance advice remark code informing them that they failed to report a valid POA code. However, beginning with discharges on or after April 1, 2008, Medicare will return claims to the hospital if the POA code is not reported and the hospital will have to supply the correct POA code and resubmit the claim. In order to be able to group these 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. CR 5499, from which this article is

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taken, announces this requirement (effective January 1, 2008); and provides your fiscal intermediaries (FI) and A/B MACs with the coding and editing requirements, and software modifications needed to successfully implement this indicator.

**Note: 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 these adjustments.**

These POA guidelines are not intended to replace any found in the ICD-9-CM Official Guidelines for Coding and Reporting, nor are they intended to provide guidance on when a condition should be coded. Rather, you should use them in conjunction with 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 and "other" diagnoses codes reported on claim forms (UB-04 and 837 Institutional). Information regarding the UB-04 Data Specifications may be found at <http://www.nubc.org/become.html>.

**Note: Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement. Also, as noted in CR5679 (<http://www.cms.hhs.gov/Transmittals/downloads/R2890TN.pdf>), hospitals paid under a PPS other than the acute care hospital PPS are exempt. Thus psychiatric and rehabilitation hospitals are exempt.**

The following information, from the UB-04 Data Specifications Manual, is provided to help you understand how and when to code POA indicators:

### **1. General Reporting Requirements**

- Pertain to 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.

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- 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."

## 2. 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 (documentation is insufficient to determine if condition is present at time of inpatient admission)
- W – Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
- 1 -- Unreported/Not used – Exempt from POA reporting (This code is the equivalent of a blank on the UB-04, but blanks are not desirable when submitting data via the 4010A1).

The POA data element on your electronic claims must contain the letters "POA", followed by a single POA indicator for every diagnosis that you report. The POA indicator for the principal diagnosis should be the first indicator after "POA," and (when applicable) the POA indicators for secondary diagnoses would follow. The last POA indicator must be followed by the letter "Z" to indicate the end of the data element (or FIs and A/B MACs will allow the letter "X" which CMS may use to identify special data processing situations in the future).

Note that on paper claims the POA is the eighth digit of the Principal Diagnosis field (FL 67), and the eighth digit of each of the secondary diagnosis fields (FL 67 A-Q); and on claims submitted electronically via 837, 4010 format, you must use segment K3 in the 2300 loop, data element K301.

Below is an example of what this coding should look like on an electronic claim:

*If segment K3 read as follows: "POAYNUW1YZ," it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnoses. The principal diagnosis was POA (Y), the first secondary diagnosis was not POA (N), it was unknown if the second secondary diagnosis was POA (U), it is clinically undetermined if the third secondary diagnosis was POA (W), the fourth secondary diagnosis was exempt from reporting for POA (1), and the fifth secondary diagnosis was POA (Y).*

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As of January 1, 2008, all direct data entry (DDE) screens will allow for the entry of POA data and POA data will also be included with any secondary claims sent by Medicare for coordination of benefits purposes.

See the complete instructions in the UB-04 Data Specifications Manual for more specific instructions and examples.

*Note: CMS, in consultation with the Centers for Disease Control and Prevention and other appropriate entities, may revise the list of selected diagnoses from time to time, but there will always be at least two conditions selected for discharges occurring during any fiscal year. Further, this list of diagnosis codes and DRGs is not subject to judicial review.*

Finally, you should keep in mind that achieving complete and accurate documentation, code assignment, and reporting of diagnoses and procedures requires a joint effort between the healthcare provider and the coder. Medical record documentation from any provider (a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis) involved in the patient's care and treatment may be used to support the determination of whether a condition was present on admission or not; and the importance of consistent, complete documentation in the medical record cannot be overemphasized.

*NOTE: You, your billing office, third party billing agents and anyone else involved in the transmission of this data must insure that any resequencing of diagnoses codes prior to their transmission to CMS, also includes a resequencing of the POA indicators.*

## Additional Information

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You can find the official instruction, CR5499, issued to your FI or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1240CP.pdf> on the CMS website

If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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