POA HAC

Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals

October 2008

PRESENT ON ADMISSION (POA) INDICATOR REPORTING AND HOSPITAL-ACQUIRED CONDITIONS (HAC)

Visit the HAC & POA web page at *http://www.cms.hhs.gov/HospitalAcqCond/* on the CMS website.

Overview

The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payments for certain hospital-acquired conditions. CMS has titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC & POA). Inpatient Prospective Payment System (IPPS) hospitals are required to submit POA information on diagnoses for inpatient discharges on or after October 1, 2007.

Affected Hospitals

The Present on Admission Indicator Reporting requirement applies only to IPPS hospitals.

At this time, the following hospitals are EXEMPT from the POA indicator requirement:

- Critical Access Hospitals (CAHs)
- Long-Term Care Hospitals (LTCHs)
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Facilities
- Rural Health Clinics
- Federally Qualified Health Centers (FQHCs)
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities (IRFs)
- Veterans Administration/Department of Defense Hospitals

Implementation of POA Reporting

April 1, 2008
Claims that are submitted for payment that do not contain proper POA indicator(s) will be returned to the provider for correct submission of the POA information.

General Reporting Requirements

- The POA indicator is required for all claims involving Medicare inpatient admissions to general IPPS acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission indicator information.
- POA 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 POA.
- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *ICD 9-CM Official Guidelines for Coding and Reporting*).
- Issues related to inconsistent, missing, conflicting, or unclear documentation must 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."

Coding

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" diagnosis codes reported on the UB-04 and ASC X12N 837 Institutional (837I).

This fact sheet is not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*. The POA indicator 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 health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Table 1 includes a list of the POA indicator reporting options, descriptions, and Medicare payment based on Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates Final Rule.

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 support the determination of whether a condition was present on admission. In the context of the official coding guidelines, the term "provider" means 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 anyone else involved in the transmission of this data must ensure that any resequencing of diagnosis codes prior to their transmission to CMS also includes a resequencing of the POA indicators.

Table 1. CMS POA Indicator Reporting Options, Description, and Payment

Indicator	Description	Medicare Payment
Y	Diagnosis was present at time of inpatient admission.	Payment made by Medicare, when an HAC is present
N	Diagnosis was not present at time of inpatient admission.	No payment made by Medicare, when an HAC is present
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment made by Medicare, when an HAC is present
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment made by Medicare, when an HAC is present
1	Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.	Exempt from POA reporting

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. In other words, report the applicable POA indicator (Y, N, U or W) for the principal and any secondary diagnoses and include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting.

Electronic Claims

Using the 837I, submit the POA indicator in segment K3 in the 2300 loop, data element K301.

Example 1. POA indicators for an electronic claim with one principal and five secondary diagnoses should be coded as **POAYNUW1YZ**

POA	"POA" is always required first, followed by a single indicator for every diagnosis reported on the claim.
Y	The principal diagnosis is always the first indicator after "POA." In this example, the principal diagnosis was present on admission.
N	The first secondary diagnosis was not present on admission, designated by "N."
U	It was unknown if the second secondary diagnosis was present on admission, designated by "U."
W	It is clinically undetermined if the third secondary diagnosis was present on admission, designated by "W."
1	The fourth secondary diagnosis was exempt from reporting for POA, designated by "1."
Y	The fifth secondary diagnosis was present on admission, designated by "Y."
Z	The last secondary diagnosis indicator is followed by the letter "Z" to indicate the end of the data element.

Example 2. POA Indicator for an electronic claim with one principal diagnosis without any secondary diagnosis should be coded as **POAYZ**

POA	"POA" is always required first, followed by a single indicator for every diagnosis reported on the claim.
Y	The principal diagnosis is always the first indicator after "POA." In this example, the principal diagnosis was present on admission.
Z	The letter "Z" is used to indicate the end of the data element.

For More Information

The HAC POA web page at *http://www.cms.hhs.gov/HospitalAcqCond/* provides further information, including the links to the law, regulations, change requests (CRs), and educational resources including presentations, MLN articles, and fact sheets.