CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 354	**Date: JUNE 13, 2008**
	Change Request 6086

SUBJECT: Hospitals Exempt from Present on Admission (POA) Reporting (i.e. non Inpatient Prospective Payment System or IPPS Hospitals) and the Affects on Grouper

I. SUMMARY OF CHANGES: Although POA reporting is not required for IPPS exempt hospitals, these claims still process through Grouper. As such, to ensure that Grouper does not apply the Hospital Acquired Condition (HAC) logic to these exempt hospitals, FISS will add an "X" to the End of POA prior to Grouper. The "X" will instruct Grouper to not apply HAC logic.

New / Revised Material
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

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:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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 obligated 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

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

100-20	Transmittal: 354	Date: June 13, 2008	Change Request: 6086

SUBJECT: Hospitals Exempt from Present on Admission (POA) Reporting (i.e. non Inpatient Prospective Payment System or IPPS Hospitals) and the Affects on Grouper

Effective Date: October 1, 2008
Implementation Date: October 6, 2008

I. GENERAL INFORMATION

A. Background: On February 8, 2006 the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the Secretary to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines.

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present. Section 5001(c) provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.

Section 5001(c) also requires hospitals to report present on admission information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.

Inpatient Hospitals (TOB 11X) that are exempt from reporting POA Indicators and End of POA Indicators are: Long Term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), Inpatient Psychiatric Facilities (IPF), Cancer Hospitals, Children's Hospitals, Critical Access Hospitals (CAH) and Maryland Waiver Hospitals. Inpatient exempt providers that report POA indicators and/or End of POA Indicator, due to other payer requirements or any other business need, must include an 'X' to indicate the End of POA reporting in the K3 segment. The 'X' is necessary so that the IPPS grouper software will not apply HAC DRG logic to these claims.

NOTE: Effective October 1, 2008, the standard system will automatically replace any reported 'Z' End of POA indicator with an 'X' for these Inpatient exempt providers above that are required to report for other payers or business needs. This alleviates the need for immediate programming logic changes for exempt providers; however, exempt providers reporting for other payers or business needs, should begin to report an 'X' to indicate the end of POA reporting as soon as possible.

B. Policy: Although exempt Inpatient hospitals are not required to report POA indictors or End of POA Indicator, their claims process as part of the Medicare Fiscal Intermediary Standard System (FISS) through Grouper. This CR instructs the CMS standard system to code an 'X' to the end of the K3 segment (DDE, hardcopy, or EMC modes of entry) so that Grouper will know not to apply the HAC DRG logic to these claims.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6086.1	If the End of POA Indicator is blank, FISS shall code an 'X' indicating the end of the series for POA indicators on exempt Inpatient facilities in the interface to Grouper, so that Grouper does not apply HAC logic to these claims.						X				
6086.2	If the End of POA Indicator is 'Z', FISS shall replace with an 'X' for indicating the end of the series for POA on exempt Inpatient facilities in the interface to Grouper, so that Grouper does not apply HAC logic to these claims.						X				
6086.3	CWF and NCH shall ensure they capture the 'X' in their systems.									X	NCH

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6086.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site 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 your 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		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: *Should" denotes a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:
6086.1	The POA exempt from reporting hospitals are: • Long Term Care Hospitals (LTCH) • Inpatient Rehabilitation Facilities • Inpatient Psychiatric Facilities • Cancer Hospitals • Children's Hospitals • Critical Access Hospitals • Maryland Waiver Hospitals
6086.1 & 6086.2	These requirements apply to all claim modes of entry (DDE, EMC, and hardcopy) in addition to 837i.

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

V. CONTACTS

Pre-Implementation Contact(s): Sarah.Shirey-Losso@cms.hhs.gov or Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

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

Section B: *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 obligated 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.