CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 289	**Date: JULY 20, 2007**
	Change Request 5679

SUBJECT: Present on Admission Indicator Systems Implementation

I. SUMMARY OF CHANGES: Implementation Change Request (CR) – The Centers for Medicare and Medicaid Services (CMS) will require the completion of a Present On Admission (POA) Indicator for every diagnosis on an inpatient acute care hospital claim beginning October 1, 2007.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 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:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 289	Date: July 20, 2007	Change Request: 5679

SUBJECT: Present on Admission Indicator Systems Implementation

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: 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. By October 1, 2007, the Secretary must select at least 2 conditions that are: 1) high cost or high volume or both; 2) assigned to a higher paying DRG when present as a secondary diagnosis; and 3) reasonably preventable through application of evidence based guidelines. Effective for acute care inpatient PPS discharges on or after October 1, 2008, the Secretary cannot assign cases with these conditions to a higher paying DRG unless they were present on admission. This instruction will require hospitals to begin reporting the POA code on claims with discharges beginning on or after October 1, 2007. Although hospitals must report the POA code on the claim, the information will not be used by claims processing systems until January 1, 2008. Beginning with claims with discharges on or after January 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will continue to process. However, hospitals will be provided with a remark code on their remittance advice advising them that they did not correctly submit the POA code on the claim. Beginning April 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will be returned to the hospital for correct submission of POA information. Direct data entry (DDE) screens cannot be updated to include a space for entering POA information until January 1, 2008. Therefore, hospitals that submit claims via DDE will be unable to submit the POA indicator on October 1, 2007. These hospitals must begin submitting the POA indicator on January 1, 2008.

B. Policy: In order to group diagnoses into the proper DRG, CMS needs to capture a 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 POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional. The law requires that these POA indicators be reported on all claims for inpatient admissions to general acute care hospitals with discharge dates on or after October 1, 2007. Critical Access Hospitals, Maryland Waiver Hospitals, LTCH, Cancer Hospitals and Children's Inpatient Facilities are exempt from this requirement as are all hospitals paid under any other type of PPS system than the acute care hospital PPS system.

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.
>
> 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
- 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 MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5679.1	This CR contains all relevant information on POA claims processing so that all appropriate systems modifications can be made with a complete understanding of the total project requirements. The purpose of this CR is to implement the following business requirements on January 1, 2008.	x		x				x			x	NCH, GRPR, MCE
5679.2	Effective for discharges on or after October 1, 2007, 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.	x		x				x			x	NCH, GRPR, MCE
5679.2.1	Effective for discharges on or after January 1, 2008, this data shall be captured and included with other data sent to MCE and GROUPER programs.							x				GRPR, MCE
5679.2.2	Because the MCE and GROUPER software is installed in October, the input and output records between GROUPER and FISS shall be synchronized with the new data fields by October 1, 2007.							x				GRPR, MCE
5679.3	Effective for discharges on or after January 1, 2008, claims submitted electronically via 837, 4010A1 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,	x		x				x			x	NCH, GRPR, MCE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	other diagnoses in special data processing situations that may be identified by CMS in the future.											
5679.3.1	Effective for discharges on or after January 1, 2008, this data shall be captured and included with other data sent to MCE and GROUPER programs.							x				GRPR, MCE
5679.3.2	Because the MCE and GROUPER software is installed in October, the input and output records between GROUPER and FISS shall be synchronized with the new data fields by October 1, 2007.							x				GRPR, MCE
5679.4.1	Effective for discharges on or after January 1, 2008, for EMC claims, the standard system maintainer shall insure there are Medicare edits on this information to insure that the number of individual POA indicators (between POA and Z or X as indicated in 5679.3) are equal to the number of principal and, if applicable, other diagnoses on the claim and that all POA indicators are valid.	x		x				x				
5679.4.2	Effective for discharges on or after January 1, 2008, before POA data is sent to the GROUPER input record, the standard system maintainer shall insure there are system edits on this information to insure that the number of individual POA indicators (between POA and Z or X as indicated in 5679.3) are equal to the number of principal and, if applicable, 8 other diagnoses on the claim.	x		x				x				
5679.4.2.1	If Requirement 4.2 is not met, from January 1, 2008 until March 31, 2008, providers shall be sent an informational alert using the ERA with Remark Code (to be assigned). Beginning April 1, 2008, the claim shall be returned to the provider (RTP).	x		x				x				
5679.4.3	Effective for discharges on or after January 1, 2008, the letter "X" indicating the end of the data element shall always be accepted as valid even if CMS has not identified any special processing situations.							x				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5679.5	Effective for discharges on or after January 1, 2008, CWF/NCH shall create a new field to capture and store at least nine POAs and one end of POA indicator.	x		x				x			x	NCH
5679.6	Effective for discharges on or after January 1, 2008, DDE screens shall allow for the entry of POA data and one end of POA indicator.	x		x				x				
5679.7	Effective for discharges on or after January 1, 2008, all POA information shall be included in the Coordination of Benefits Agreement Crossover claims transmission for Coordination of Benefits purposes.	x		x				x				
5679.8	FISS shall expand the claim record to enable all aspects of this CR.							x				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	N/A											

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:
5679.1	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

X-Ref Requirement Number	Recommendations or other supporting information:
	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): For questions related to compliance with Section 5001(c) of Public Law 109-171 and the effective dates for reporting POA codes, Patricia Brooks, 410-786-5318.
For questions related to systems requirements implementation, Stu Barranco, 410-786-6152.

Post-Implementation Contact(s): For questions related to compliance with Section 5001(c) of Public Law 109-171 and the effective dates for reporting POA codes, Patricia Brooks, 410-786-5318.
For questions related to systems requirements implementation, Stu Barranco, 410-786-6152.

VI. FUNDING

A. ***For TITLE XVIII Contractors*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

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.