MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - The Medicare Learning Network now has Tip Sheets available with important information on the EHR incentive programs. One tip sheet provides user friendly information about the factors which impact incentive payment amounts and provides sample payment calculations. Another provides information on how incentive payments are calculated for Critical Access Hospitals (CAHs) and how reimbursement will be reduced for CAHs which have not demonstrated meaningful use of certified EHR technology by 2015. These Tip Sheets are available at *http://www.cms.gov/EHRIncentivePrograms* on the CMS EHR Incentive Programs website. Select the Hospitals tab on the left, and then scroll to "Downloads."

MLN Matters Number: MM7024

Related Change Request (CR) #: 7024

Related CR Release Date: August 13, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R756OTN

Implementation Date: January 3, 2011

Version 5010 Implementation—Changes to Present on Admission (POA) Indicator '1' and the K3 Segment

Provider Types Affected

Hospitals who submit claims to Medicare Administrative Contractors (MACs) and/or Fiscal Intermediaries (FIs) for services to Medicare beneficiary inpatient services are affected.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7024 to alert hospitals that effective with the implementation of 5010 Inpatient Prospective Payment System (IPPS) hospitals will no longer report the POA indicator of '1'. International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are exempt from the POA reporting requirement should be left 'blank' instead of populating a '1'.

In addition, the K3 segment, which was required for reporting POA in the 4010A1 version of the 837I, is no longer to be used to report POA. The POA indicators will instead follow the diagnosis code in the appropriate 2300 HI segment.

Make certain your billing staffs are aware of these requirements 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.

Background

On February 8, 2006, the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the identification of conditions that are:

- High cost or high volume or both;
- Result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis; and
- Could reasonably have been prevented through the application of evidence-based guidelines. 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.

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.

CMS also required hospitals to report POA information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.

The table below outlines the payment implications for each of the different POA Indicator reporting options.

CMS POA Indicator Options and Definitions

Code	*Reason for Code*
Y	Diagnosis was present at time of inpatient admission. *CMS will pay the complicating condition/major complicating condition (CC/MCC) DRG for those selected Hospital Acquired Conditions (HACs) that are coded as "Y" for the POA Indicator.*
N	Diagnosis was not present at time of inpatient admission. *CMS will **not** pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.*
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. *CMS will **not** pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.*

Code	*Reason for Code*
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. *CMS **will pay** the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.*
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A. *CMS **will not pay** the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.*

Key Points of CR7024

- IPPS hospitals will no longer report the POA indicator of '1'.
- ICD-9-CM diagnosis codes that are exempt from the POA reporting requirement should be left 'blank' instead of populating a '1'.
- In addition, the K3 segment, which was required for reporting POA in the 4010A1 version of the 837I, is no longer be used to report POA.
- The POA indicators will instead follow the diagnosis code in the appropriate 2300 HI segment.

Additional Information

The official instruction associated with this CR7024, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R756OTN.pdf* on the CMS website.

You may find further information concerning HACs and POAs at *https://www.cms.gov/HospitalAcqCond/* on the CMS website. You may also want to review related MLN Matters® articles MM5499, SE0841 and MM6086, which are at: http://www.cms.gov/MLNMattersArticles/downloads/MM5499.pdf *http://www.cms.gov/MLNMattersArticles/downloads/MM6086.pdf* and http://www.cms.gov/MLNMattersArticles/downloads/SE0841.pdf respectively.

If you have questions, please contact your Medicare A/B MAC and/or FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.