Hospital-Acquired Conditions (Present on Admission Indicator)

Overview

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 would 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 was 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 payment information for discharges on or after October 1, 2007.

CMS has titled this statutory implementation Hospital Acquired-Conditions (HAC) and Present on Admission (POA) Indicator.

Beginning October 1, 2007, all Inpatient Prospective Payment System (IPPS) Hospitals are required to submit Present on Admission (POA) Indicator information for all primary and secondary diagnoses.

CMS will be using a phased implementation for the POA Indicator. All IPPS Hospitals should familiarize themselves with the following POA Indicator timeline:

October 1, 2007 IPPS Hospitals are required, by law, to submit the POA Indicator on all primary and secondary diagnoses.

January 1, 2008 CMS will begin processing POA Indicator data and will provide feedback to IPPS hospitals on reporting errors. During the period of January 1, – March 31, 2008 hospitals will be educated on reporting errors and will NOT be subject to returned claims.

April 1, 2008 Claims that are submitted for payment that do not contain proper reporting of the POA Indicator will be RETURNED.

Reporting

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 the POA Indicator.
• 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 as POA.
• 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."

Affected Hospitals

The Present on Admission (POA) Indicator requirement and Hospital-Acquired Conditions (HAC) payment provision only apply to **Inpatient Prospective Payment Systems (IPPS) Hospitals.**

At this time, the following hospitals are **EXEMPT** from the POA Indicator and HAC:
1. Critical Access Hospitals (CAHs)
2. Long-term Care Hospitals (LTCHs)
3. Maryland Waiver Hospitals
4. Cancer Hospitals
5. Children's Inpatient Facilities

Category	Conditions
Conditions selected for implementation • These conditions will have payment implications beginning in October 1, 2008.	• Serious Preventable Events • o Object left in during surgery (998.4 CC) o Air embolism (999.1 MCC) o Blood incompatibility (999.6 CC) • Catheter Associated Urinary Tract Infection, 996.64 CC & one of the following specific infection codes: 112.2, 590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 590.9, 595.0, 595.3, 595.4, 595.81, 590.89, 595.9, 597.0, 597.80, 599.0 • Pressure Ulcers (707.00-.01 & 7-7.09 CCs; 707.02-09 MCCs) • Vascular Catheter Associated Infection (999.31 CC) • Surgical Site Infection – Mediastinitis after Coronary Artery Bypass Graft (CABG) Surgery (519.2 MCC &

	36.10-.19) • Falls and Trauma – Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, and Burns (Codes will be considered in FY2009 IPPS Proposed Rule)
Conditions being considered for FY2009 IPPS rulemaking • These conditions raise one or more implementation or policy issues that need to be resolved before they can be selected. CMS will work to address these issues and propose to reconsider these conditions during the FY 2009 IPPS rulemaking process.	• Ventilator Associated Pneumonia (VAP) (Codes will be considered in FY2009 IPPS Proposed Rule) • Staphylococcus Aureus Septicemia (038.11 + 995.91, 998.59, 999.3 MCCs) • Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) (DVT: 453.40-.42 CCs; PE: 415.10 & 415.19 MCCs)
Conditions needing further analysis • After exhaustive consideration, CMS determined that further analysis is required before considering these conditions.	• Methicillin Resistant Staphylococcus Aureus (MRSA) (Codes will be considered in FY2009 IPPS Proposed Rule) • Clostridium Difficile-Associated Disease (CDAD) (008.45 CC) • Wrong Surgery (Codes will be considered in FY2009 IPPS Proposed Rule)