IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201219 MAY 29, 2012

POA indicator required for all Medicaid-enrolled hospitals effective July 1, 2012

When the Indiana Health Coverage Programs (IHCP) adopted the current Hospital Acquired Conditions (HAC) policy in October 2009 and began requiring hospitals to report present on admission (POA) indicators on their claims, not all hospitals were subject to the requirement. (See BT200928 dated August 25, 2009.) Hospitals previously exempt from POA indicator reporting were critical access hospitals, long-term acute care hospitals, inpatient psychiatric hospitals, and inpatient rehabilitation hospitals. To more fully comply with the intent of the final rule (see the *Federal Register*, Vol. 75, No. 157, Pg. 50042), the IHCP will expand its required POA indicator reporting to include all Medicaid-enrolled hospitals, including those previously exempt, effective July 1, 2012. POA reporting is required for inpatient claims with a "From" date of service on or after July 1, 2012.

Hospital-acquired condition list

The IHCP continues to follow the Centers for Medicare & Medicaid Services' (CMS') HAC determinations, including any future additions or changes to the current list of HAC categories, as well as diagnosis codes that are exempt from HAC reporting. For a list of exempt diagnosis codes, see the *ICD-9-CM Official Guidelines for Coding and Reporting* on the CMS website at cms.gov. A complete list of the HAC categories and their corresponding complication or comorbidity (CC) or major complication or comorbidity (MCC) codes, finalized for Fiscal Year 2011, is found in Table 1 on the next page.

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Table 1 – HAC categories and corresponding CC or MCC codes, Federal Register, Volume 75, No. 157, Pg. 50084-50085

Description	**Applicable ICD-9 codes** (CC – Complication or comorbidity; MCC – Major complication or comorbidity)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcers Stages III and IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma Fractures Dislocations Intracranial Injuries Crushing Injuries Burns Electric Shock	CC/MCC codes within these ranges: 800 – 829 830 – 839 850 – 854 925 – 929 940 – 949 991 – 994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC); also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control: Diabetic Ketoacidosis Nonketotic Hyperosmolar Coma Hypoglycemic Coma Secondary Diabetes with Ketoacidosis Secondary Diabetes with Hyperosmolarity	MCC codes within these ranges: 250.10 – 250.13 250.20 – 250.23 249.10 – 249.11 249.20 – 249.21 251.0 (CC)
Surgical Site Infection, Mediastinitis following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10 – 36.19

Continue

Table 1 – HAC categories and corresponding CC or MCC codes, Federal Register, Volume 75, No. 157, Pg. 50084-50085

Description	**Applicable ICD-9 codes** (CC – Complication or comorbidity; MCC – Major complication or comorbidity)
Surgical Site Infection Following Certain Orthopedic Procedures: Spine Neck Shoulder Elbow	996.67 (CC) 998.59 (CC) and one of the following procedure codes: 81.01 – 81.08 81.23 – 81.24 81.31 – 81.38 81.83 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity: Laparoscopic Gastric Bypass Gastroenterostomy Laparoscopic Gastric Restrictive Surgery	Principal diagnosis 278.01 539.01 (CC) 539.81 (CC) 998.59 (CC) and one of the following procedure codes: 44.38 44.39 44.95
Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures: Total Knee Replacement Hip Replacement	453.40 – 453.42 (MCC) 415.11 (MCC) 415.13 (MCC) 415.19 (MCC) And one of the following procedure codes: 81.54 00.85 – 00.87 81.51 – 81.52

***Note 1**: If a claim contains a hospital-acquired condition (HAC) diagnosis with a Present on Admission (POA) indicator of "U" or "N" (see definitions in Table 2), the HAC diagnosis will be suppressed when the claim processes through the diagnosis-related group (DRG) grouper. The IHCP will not pay the complication or comorbidity (CC) or major complication or comorbidity (MCC) for HACs.*

***Note 2**: Claims containing HAC diagnoses with POA indicators of "Y" or "W" (see definitions in Table 2) will process through the all patient (AP) DRG grouper and process per normal inpatient policy.*

***Note 3**: The POA indicator of "1" is applicable only to diagnoses exempt from POA reporting and should not be applied to any codes on the HAC list. Any claims using the POA indicator of "1" with a nonexempt diagnosis will deny, and providers will need to correct and resubmit the claim for reimbursement.*

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Exclusions

Effective July 1, 2012, deep vein thrombosis (DVT) and pulmonary embolism (PE) diagnoses following a total knee replacement or hip replacement for pediatric and obstetric patients are excluded from HAC and POA requirements.

- A pediatric patient is a patient younger than age 21.
- An obstetric patient is a patient with a diagnosis code of 630.00 – 679.00 or V22.0 – V23.9.

Present on admission indicator

Present on Admission (POA) is defined as a condition "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. A POA indicator must be assigned to the principal and the secondary diagnosis (as defined in *Section II* of the *Official Guidelines for Coding and Reporting*). The CMS does not require a POA indicator for an external cause of injury code unless it is being reported as an "other diagnosis." Therefore, the IHCP does not require a POA indicator in the External Cause of Injury Field Locator 72. If a POA indicator is entered in the External Cause of Injury field, it will be ignored and not used for AP DRG grouping.

Table 2 – POA indicators and definitions for nonexempt HAC diagnosis codes

POA	Description	For nonexempt HAC diagnosis codes
Y (yes)	Present at the time of inpatient admission	Diagnosis is used for AP DRG grouping.
N (no)	Not present at the time of inpatient admission	Diagnosis is suppressed from AP DRG Grouping.
U (unknown)	The documentation is insufficient to determine if the condition was present at the time of inpatient admis-	Diagnosis is suppressed from AP DRG Grouping.
W (clinically undetermined):	The provider is unable to clinically determine whether the condition was present at the time of inpatient admission.	Diagnosis is used for AP DRG grouping.
1 (one – unreported/not used)	Diagnosis is exempt from POA reporting. *Note: The* International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-9-CM) Official Guidelines for Coding and Reporting *includes a list of diagnosis codes that are exempt from POA reporting. Use POA indicator "1" only for codes on the exempt list.*	POA indicator "1" should not be used for nonexempt HAC diagnosis codes.

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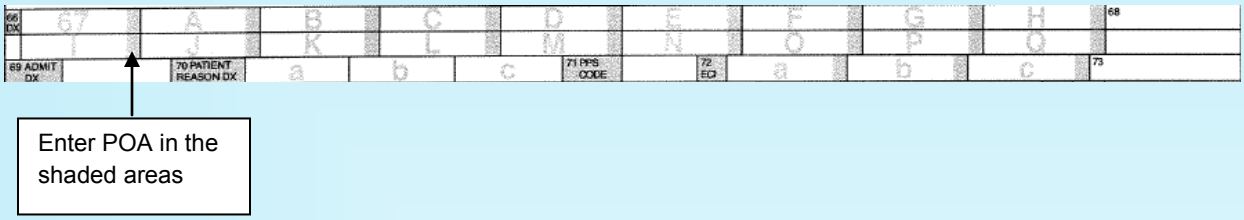
Claim billing requirements

Paper claim forms

On the UB-04 paper claim form, the POA indicator should follow the diagnosis code using the shaded area of the diagnosis code field in locators 67 and 67-A through Q.

Figure 1 – UB-04 paper claim form



Web interChange

For billing on Web interChange, an additional field identified as “POA” is used for the POA indicator for each diagnosis.

Figure 2 – Primary Web interChange entry window

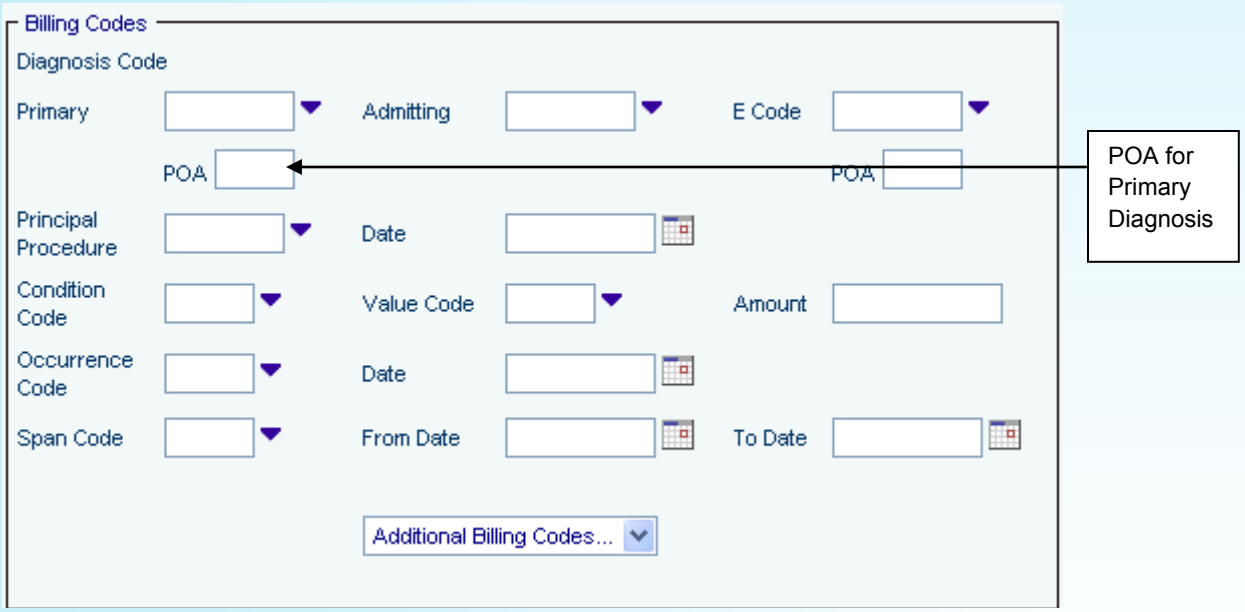


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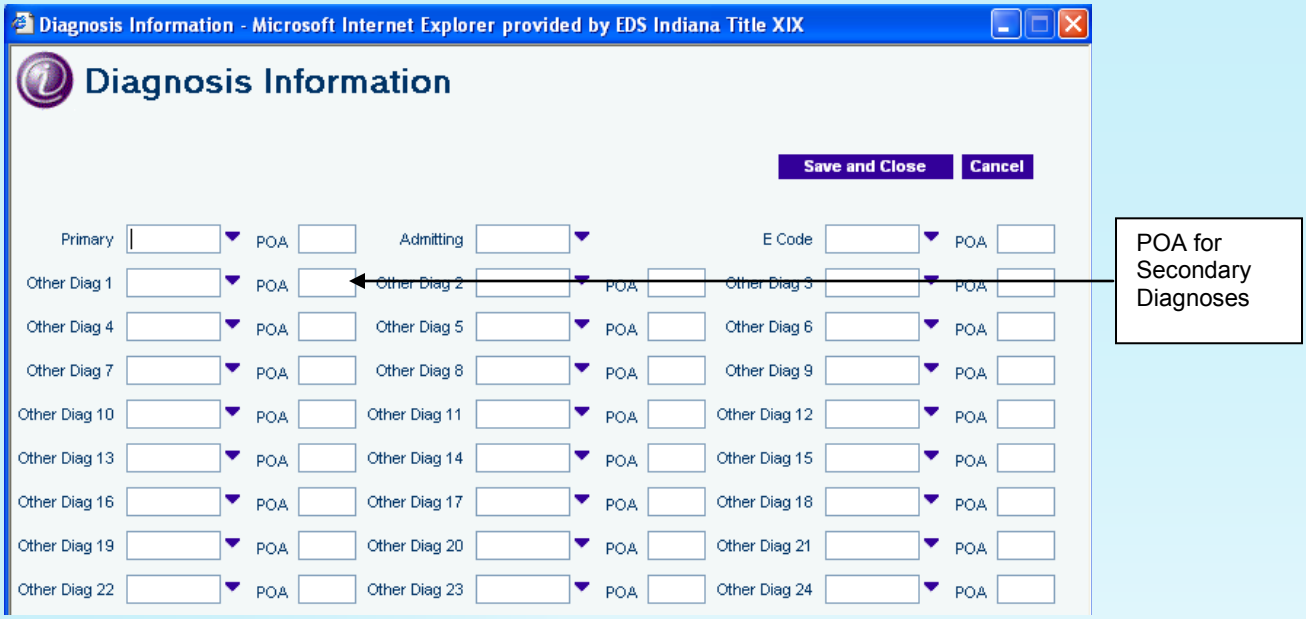
Figure 3 – Diagnosis Web interChange entry window under additional billing codes



Electronic data interchange (EDI)

For institutional claims, the hospital-acquired condition (HAC) logic reads from the following location in the 837I:

The POA indicator is reported in the appropriate HI segment (diagnosis information) in Loop 2300.

Common POA explanation of benefits (EOB) codes

For a list of common POA explanation of benefits (EOB) codes, see the following Table 3. For the location of the POA indicator in the claim file, see the 837I Health Care Claim: Institutional Transaction 5010 on the IHCP Companion Guides page on indianamedicaid.com.

Table 3 – Common POA explanation of benefits (EOBs) codes

COB code	EOB description
4250	*The Principal Diagnosis POA Indicator is Missing or Invalid* – This edit will post to the claim when the provider has omitted the POA or submitted an invalid POA indicator.
4251-4275	*The Secondary Diagnosis POA is Missing or Invalid* – These edits will post to the claim for secondary diagnoses (1-24) if the POA is missing or invalid. The specific diagnosis field will be identified in the EOB message. Example: 4251 – *First Secondary Diagnosis POA Missing or Invalid* 4252 – *Second Secondary Diagnosis POA Missing or Invalid*

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Provider preventable conditions (PCC)

The CMS issued Change Request (CR) 6405 to instruct hospitals how to bill for erroneous surgeries. Effective July 1, 2012, the IHCP will adopt CMS' rule and will not cover a surgical or other invasive procedure to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously, including:

- Incorrect surgical or other invasive procedures
- Surgical or other invasive procedures on the wrong body part
- Surgical or other invasive procedures on the wrong patient

The IHCP will also not cover hospitalizations and other services related to these noncovered procedures. **All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.**

The IHCP will deny payments to providers for inpatient, inpatient crossover, outpatient, outpatient crossover, physician, and physician crossover claims when provider preventable conditions (PPC) are performed on a patient. These institutional and physician claims will deny when submitted with the following E codes:

- E876.5 – *Performance of wrong operation (procedure) on correct patient (existing code)*
- E876.6 – *Performance of operation (procedure) on patient not scheduled for surgery*
- E876.7 – *Performance of correct operation (procedure) on wrong side/body part*

The following PPC modifiers must be submitted on physician and physician crossover claims indicating errors:

- PA – Surgery wrong body part
- PB – Surgery wrong patient
- PC – Wrong surgery on patient

For more information

Additional information on Hospital Acquired Conditions is available on the CMS website at medicaid.gov.

QUESTIONS?

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