PUBLICATION

Maryland Waiver Hospitals Subject to New Reporting Requirements for Present on Admission Indicators [Ober|Kaler]

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Maryland waiver hospitals (those operating under section 1814(b)(3) of the Social Security Act (SSA)) are no longer exempt from present on admission (POA) reporting. CMS Transmittal R1380OTN (Change Request 8709) notifies Maryland waiver hospitals that they must report valid POA indicators for both principal and secondary diagnoses up to 25, though they will still be exempt from the Hospital-Acquired Condition provision. The Transmittal defines *present on admission* 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."

In the past, Maryland waiver hospitals and other entities (such as cancer hospitals, children's hospitals, and hospitals excluded from the inpatient prospective payment system (IPPS)) were exempt from POA reporting. The FY 2014 final rule updating the IPPS and long term care hospital PPS established that section 1814(b)(3) does not apply to the billing requirements and other reporting requirements, however. As a result, Maryland entered into an agreement with CMS to participate in CMS's All-Payer Model, which is implemented under section 1115A of the SSA. Though CMS waived some section 1115A provisions in its agreement with Maryland, the POA reporting requirement was not among them, leaving Maryland waiver hospitals responsible for POA reporting. CMS intends to use the POA indicator data to enable analysis of trends and to support payment policy determinations.

In the Transmittal, CMS identifies guidelines for hospitals to facilitate POA reporting. CMS highlights the importance of collaboration between health care providers and coders in achieving "complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." CMS also notes that the parties involved in the transmission of billing data, including the provider, the provider's billing office, and third-party billing agents, must ensure that if diagnoses codes are re-sequenced before being transmitted to CMS, then the POA indicators are likewise re-sequenced. The Transmittal also sets forth general reporting requirements to assist providers in satisfying the POA reporting requirements; however, providers are directed to the complete set of instructions contained in the UB-04 Data Specifications Manual. The Transmittal requirements are also addressed by MLN Matters Number MM8709.