	Reimbursement Policy	
Subject: Present on Admission Indicator for Health Care-Acquired Conditions		
Effective Date: **06/01/12**	Committee Approval Obtained: **05/02/16**	Section: **Administration**
*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://mediproviders.anthem.com/nv**.*****		
These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem). The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities. If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may: • Reject or deny the claim. • Recover and/or recoup claim payment. Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations. Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.		
Policy	Anthem requires the identification of hospital-acquired conditions and health care-acquired conditions (both referred to in this document as Health Care Acquired Conditions [HCAC]) through the submission of a Present on Admission (POA) indicator for all diagnoses on facility claims unless otherwise noted by CMS. Reimbursement is based on Medicare POA methodology. In accordance with the Deficit Reduction Act of 2005, POA indicators (see Exhibit A) are required for all inpatient discharges on or after October 1, 2007. The POA indicator is required for all primary and secondary diagnosis codes but is not required on the admitting	

	diagnosis. Failure to include the POA indicator with the primary and secondary diagnosis codes may result in the claim being denied or rejected. If the POA indicator identifies an HCAC, the reimbursement for that episode of care may be reduced or denied. We will not apply payment reduction if a condition defined as HCAC for a particular patient existed prior to the initiation of treatment for that patient by that provider. If an HCAC is caused by one provider or facility (primary), payment will not be denied to the secondary provider or facility that treated the HCAC. Anthem reserves the right to request additional records to support documentation submitted for reimbursement. **NOTE**: Claims may be subject to clinical review for appropriate reimbursement consideration.
History	• Effective **02/01/18**; Policy template updated • Biennial review approved **05/02/16**: Policy language updated • Biennial review approved **08/18/14**: Nevada exemption added; Exhibit B language updated • Audit review approved **04/22/13**: Background, disclaimer updated • Initial committee approval **03/12/12** with effective date of **06/01/2012**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts • Code of Federal Regulations (CFR) Subpart A-Payments §447.26 • Federal Register Vol. 76, No. 108-A. The Medicare Program and Quality Improvements Made in the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) and E. Section 2702 of the Affordable Care Act
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Requiring Additional Documentation • Claims Submission — Required Information for Facilities • Claims Submission — Required Information for Professional Provider • Documentation Standards for Episodes of Care • Global Surgical Package Conditions
Related Materials	• None

Exhibit A: Present on Admission Indicators and Description

Indicator	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation is insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	This code is the equivalent of a blank on the UB-04; however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1. **NOTE**: The number 1 is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for codes exempt from POA reporting.

Exhibit B: Medicare Exempt Facilities

The following facilities are exempt from the reporting requirement as indicated; this applies to Medicare and Medicaid markets using Medicare POA methodology:

- Critical access hospitals
- Long-term acute care hospitals
- Inpatient psychiatric hospitals
- Inpatient rehabilitation facilities
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Rural health clinics
- Federally qualified health centers
- Religious nonmedical health care institutions
- Veterans Administration/Department of Defense hospitals

Exhibit C: Health Care-Acquired Condition Categories

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV pressure ulcers
5. Falls and trauma
    a. Fractures
    b. Dislocations
    c. Intracranial injuries
    d. Crushing injuries

    e. Burns
    f. Electric shock
6. Manifestations of poor glycemic control
    a. Diabetic Ketoacidosis
    b. Nonketotic Hyperosmolar Coma
    c. Hypoglycemic Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-associated Urinary Tract Infection
8. Vascular catheter-associated infection
9. Surgical site infection following:
    a. Cardiac Implantable Electronic Device
    b. Coronary Artery Bypass Graft — Mediastinitis
    c. Bariatric Surgery
        i. Laparoscopic Gastric Bypass
        ii. Gastroenterostomy
        iii. Laparoscopic Gastric Restrictive Surgery
    d. Orthopedic Procedures
        i. Spine
        ii. Neck
        iii. Shoulder
        iv. Elbow
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)*
    a. Total knee replacement
    b. Hip replacement
11. Iatrogenic Pneumothorax with Venous Catheterization

* DVT/PE following total knee replacement or hip replacement in pediatric and obstetric patients are excluded from HCAC for Medicaid.