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POA and DRG Methodologies

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Practical Tools for Seminar Learning

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Faculty

Gail Garrett, RHIT

Gail Garrett is assistant vice president in the regulatory compliance department supporting coding compliance for a large healthcare organization. Ms. Garrett's responsibilities include company-wide program development and application in the areas of coding compliance for hospitals, ambulatory surgery centers, imaging centers, and physician practices. She is also the author of Present on Admission, published by AHIMA.

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Presentation Objectives

- **Review the POA reporting requirements, including discussion of any updated guidelines**
- **Define and recognize the conditions defined by Centers for Medicare and Medicaid Services (CMS) as hospital acquired conditions potentially impacting payment beginning October 1, 2008 (FY2009)**
- **Understand the CMS hospital acquired conditions payment provision and the important role that the POA assignment will play.**

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Present on Admission (POA) Indicator

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Present On Admission Indicator

- **Purpose:**
  - **To differentiate between conditions present on admission and conditions that developed during an inpatient admission. The focus is to assess the timing of when the condition presented.**

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Present On Admission Indicator

- **Definition:**
  - **Present on admission 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 present on admission.**

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Present on Admission

- Documentation:
  - A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

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Present on Admission

- Documentation:
  - The importance of consistent, complete documentation in the medical record cannot be overemphasized.
  - Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not.

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Reporting Requirements for the Present on Admission (POA) Indicator

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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 present on admission information.**

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Reporting Options and Definitions

Y = Yes (present at the time of inpatient admission)

N = No (not present at the time of inpatient admission)

U = Unknown (documentation is insufficient to determine if condition is present on admission)

W = Clinically undetermined (provider is unable to clinically determine whether condition was present on admission or not)

1 = Unreported/Not used – (Exempt from POA reporting). Electronic claim will have a "1"

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Billing Requirements for the Present on Admission (POA) Indicator

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CMS Transmittal 354

- **Hospitals exempt from POA reporting for billing purposes:**
  - **CMS published** *Transmittal 354* **dated June 13, 2008, that it will update the Fiscal Intermediary Shared System to recognize the following hospitals that are exempt from POA reporting:**
    - **Long-term care hospitals**
    - **Inpatient rehabilitation facilities**
    - **Inpatient psychiatric facilities**
    - **Cancer hospitals**
    - **Children's hospitals**
    - **Critical access hospitals**
    - **Maryland waiver hospitals**

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CMS Transmittal 1240; Change Request 5499

- **Begin reporting POA indicators for all inpatient claims on October 1, 2007**
  - **Medicare Billing Requirement**
  - **Many States Reporting Requirement**
- **CMS will edit for POA indicators beginning January 1, 2008**
  - **Remark code on remittance advice until March, 2008**
  - **After March, the claim will be returned to provider if valid POA indicator is not present**
- **On 10/1/08, the POA will affect DRG assignment/reimbursement with the previously chosen hospital acquired conditions**

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POA Reporting Parameters

- ◆ **Per Transmittal 1240, May 11, 2007, Pub 100-04 MCP:**
- ◆ **"Exempt from Reporting" list is a number "1" instead of leaving a blank for electronic billing**
  - • **Enter a number "1" for "present on admission" field if the condition is on the list of ICD-9-CM codes for which this field is not applicable.**
  - • **"This code is the equivalent of a blank on the UB-04 field, however, it was determined that blanks were undesirable when submitting this data via the 4010A1".**

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Electronic Transmission of POA

- ◆ Effective for discharges on or after January 1, 2008, before POA data is sent to the GROUPER input record, the standard system maintainer shall insure there are system edits on this information to insure that the number of individual POA indicators (between POA and Z or X as indicated in 5499.3) are equal to the number of principal and, if applicable, 8 other diagnoses on the claim. If not, from January 1, 2008 until March 31, 2008, providers shall be sent an informational alert using the ERA with Remark Code (to be assigned). Beginning April 1, 2008, the claim shall be returned to the provider (RTP)
- ◆ Effective for discharges on or after January 1, 2008, CWF/NCH shall create a new field to capture and store at least nine POAs and one end of POA indicator.
- ◆ Effective for discharges on or after January 1, 2008, DDE screens shall allow for the entry of POA data and one end of POA indicator.
- ◆ Effective for discharges on or after January 1, 2008, all POA information shall be included with any secondary claims transmission for Coordination of Benefits purposes.

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Polling Question #1

Are inpatient rehab hospitals required to submit POA indicator for billing purposes?

*1 Yes

*2 No

*3 Unknown

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POA Official Guidelines

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POA Official Guidelines

- Published by the Cooperating Parties in Coding Clinic
- They are NOT intended to replace any guidelines in the main body of the ICD-9-CM Official Guidelines for Coding and Reporting
- They are NOT intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes

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What the POA Guidelines Are:

- Supplemental to the *ICD-9-CM Official Guidelines for Coding and Reporting*
  - Developed to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

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What Diagnoses Does POA Apply To?

- ◆ **Principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*)**
- ◆ **Includes External cause of injury codes (E-Codes)**
- ◆ **If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported**

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Reporting Options and Definitions

Y = **Yes (present at the time of inpatient admission)**

N = **No (not present at the time of inpatient admission)**

U = **Unknown (documentation is insufficient to determine if condition is present on admission)**

W = **Clinically undetermined (provider is unable to clinically determine whether condition was present on admission or not)**

1 = **Unreported/Not used − (Exempt from POA reporting). Electronic claim will have a "1"**

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"Exempt From Reporting" List

- **Leave the "present on admission" field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable.**
- **This is the only circumstance in which the field may be left blank.**
  - **Refer to ICD-9-CM Official Guidelines for Coding and Reporting Effective October 1, 2008 for the complete list of exempt reporting codes.**

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"Exempt" Reporting Example

- **137-139, Late effects of infectious and parasitic diseases**
- **650, Normal delivery**
- **V03, Need for prophylactic vaccination and inoculation against bacterial diseases**
- **V10, Personal history of malignant neoplasm**
- **V55, Attention to artificial openings**
- **E800-E807, Railway accidents**

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POA Explicitly Documented

- ◆ **Assign "Y" for any condition the provider explicitly documents as being present on admission.**

- ◆ **Assign "N" for any condition the provider explicitly documents as not present at the time of admission.**

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Diagnosed prior to inpatient admission

- ◆ **Assign "Y" for conditions that were diagnosed prior to admission**

- ◆ **Example:**
  - · **hypertension,**
  - · **diabetes mellitus,**
  - · **asthma**

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Diagnosed during admission but clearly present before admission

♦ **Assign "Y" for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred**

- **Example: Patient admitted for diagnostic work-up for cachexia – final diagnosis is malignant neoplasm of lung with metastasis**

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Possible, Probable, Rule Out, Differential Diagnosis

♦ **If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was suspected at the time of inpatient admission, assign "Y."**

- **Example: Patient admitted with chest pain, possible MI. Final diagnosis is suspected acute MI.**

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Possible, Probable, Rule Out, Differential Diagnosis (cont.)

♦ **If the inconclusive final diagnosis was based on symptoms or clinical findings that were not present on admission, assign "N."**

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Develops during outpatient encounter prior to inpatient admission

♦ **Assign "Y" for any condition that develops during an outpatient encounter prior to a written order for inpatient admission**

- **Examples:**
    - **Atrial fibrillation develops after outpatient surgery and patient is subsequently admitted as an inpatient**
    - **Observation patient falls out of bed and breaks a hip and is subsequently admitted as an inpatient to treat the hip fracture**

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Unclear Documentation

- Assign "U" when the medical record documentation is unclear as to whether the condition was present on admission.
- "U" should not be routinely assigned but only used in very limited circumstances.
- Coders are encouraged to query the providers when the documentation is unclear.

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Chronic condition with acute exacerbation developed during admission

- **If the code is a combination code that identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to combination codes.**
- **If the combination code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of CHF), assign "Y."**

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Impending or Threatened Conditions

- ◆ **Assign "Y" if the diagnosis is based on symptoms or clinical findings that were present on admission**
  - • **Example:**
    A patient has a known history of coronary atherosclerosis, is status post myocardial infarction five years ago, and is now admitted for treatment of impending myocardial infarction. The final diagnosis is documented as "impending myocardial infarction."

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Impending or Threatened Conditions (cont.)

- • ***Assign "N" if the diagnosis* is based on symptoms or clinical findings that were** not **present on admission.**
  - • **Example: A patient is admitted to the hospital for prostate surgery. Postoperatively, the patient developed chest pain and the final diagnosis includes "impending myocardial infarction."**

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Acute and Chronic Conditions

- Assign "Y" for acute conditions that are present at time of admission and "N" for acute conditions that are not present at time of admission.

- Assign "Y" for chronic conditions, even though the condition may not be diagnosed until after admission (e.g., lung cancer diagnosed during hospitalization)

- If a single code identifies both an acute and chronic condition, see the POA guidelines for combination codes.

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Combination Codes

- Assign "N" if any part of the combination code was not present on admission (e.g., obstructive chronic bronchitis with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).

- Assign "Y" if all parts of the combination code were present on admission (e.g., patient with diabetic nephropathy is admitted with uncontrolled diabetes)

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Combination Codes *(cont.)*

- ◆ **If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign "Y."**

- ◆ **For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later.)**

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Obstetrical Conditions

- ◆ **Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.**

- ◆ **If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign "Y."**

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Obstetrical Conditions *(cont.)*

- **If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign "N."**

- **If the obstetrical code includes more than one diagnosis, and any of the diagnoses identified by the code were not present on admission, assign "N." (e.g., Code 642.7x, Pre-eclampsia or eclampsia superimposed on pre-existing hypertension.)**

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Obstetrical Conditions *(cont.)*

- **If the obstetrical code includes information that is not a diagnosis, do not consider that information in the POA determination.**

- **Example: Code 652.1x, Breech or other malpresentation successfully converted to cephalic presentation should be reported as present on admission if the fetus was breech on admission but was converted to cephalic presentation after admission (since the conversion to cephalic presentation does not represent a diagnosis, the fact that the conversion occurred after admission has no bearing on the POA determination.)**

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Perinatal Conditions

- **Newborns are not considered to be admitted until after birth. Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned "Y." This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal.)**

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Congenital Conditions and Anomalies

- **Assign "Y" for congenital conditions and anomalies. Congenital conditions are always considered present on admission.**

- **Examples: Congenital hydrocephalus, congenital absence of ear lobe, patent ductus arteriosus.**

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External Cause of Injury Codes

- **Assign "Y" for any E code representing an external cause of injury or poisoning that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission.)**

- **Assign "N" for any E code representing an external cause of injury or poisoning that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission.)**

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Case Studies

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Case Example

- **Patient is admitted for diagnostic work-up for cachexia. The final diagnosis is malignant neoplasm of lung with metastasis.**
  - *Assign "Y" on the POA field for the malignant neoplasm. The malignant neoplasm was clearly present on admission, although it was not diagnosed until after the admission occurred.*

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Case Example

- **A patient with severe cough and difficulty breathing was diagnosed during his hospitalization to have lung cancer.**
  - *Assign "Y" on the POA field for the lung cancer. Even though the cancer was not diagnosed until after admission, it is a chronic condition that was clearly present before the patient's admission.*

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Case Example

- ◆ **A patient is admitted with high fever and pneumonia. The patient rapidly deteriorates and becomes septic. The discharge diagnosis lists sepsis and pneumonia. The documentation is unclear as to whether the sepsis was present on admission or developed shortly after admission.**
    - • *Query the physician as to whether the sepsis was present on admission, developed shortly after admission, or it cannot be clinically determined as to whether it was present on admission or not.*

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Case Example

- ◆ **A patient is admitted for repair of an abdominal aneurysm. However, the aneurysm ruptures after hospital admission.**
    - • *Assign "N" for the ruptured abdominal aneurysm. Although the aneurysm was present on admission, the "ruptured" component of the code description did not occur until after admission.*

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Case Example

- ◆ **A patient with a history of varicose veins and ulceration of the left lower extremity strikes the area against the side of his hospital bed during an inpatient hospitalization. It bleeds profusely. The final diagnosis lists varicose veins with ulcer and hemorrhage.**
  - *Assign "Y" for the varicose veins with ulcer. Although the hemorrhage occurred after admission, the code description for varicose veins with ulcer does not mention hemorrhage.*

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Case Example

- ◆ **A female patient was admitted to the hospital and underwent a normal delivery.**
  - *Leave the "present on admission" (POA) field blank. Code 650, Normal delivery, is on the "exempt from reporting" list.*

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Case Example

♦ **Patient admitted in late pregnancy due to excessive vomiting and dehydration. During admission patient goes into premature labor**

  • *Assign "Y" for the excessive vomiting and the dehydration. Assign "N" for the premature labor.*

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Case Example

♦ **A single liveborn infant was delivered in the hospital via Cesarean section. The physician documented fetal bradycardia during labor in the final diagnosis in the newborn record.**

  • *Assign " Y" because the bradycardia developed prior to the newborn admission (birth).*

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Case Example

- ◆ **Patient is admitted from the ED for a diagnostic work up for chest pain. The final diagnosis was myocardial infarction.**

  Assign "Y" in the POA field for the myocardial infarction. Although not identified on admission, diagnostic work up confirmed the final diagnosis.

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Case Example

- ◆ **A patient is admitted to undergo an inpatient total hip surgery. Following surgery the patient develops a fever and is treated aggressively with IV antibiotics. The physician lists a secondary diagnosis of possible post-operative infection.**

  Assign "N" in the POA field for post-operative infection because symptoms or clinical findings related to possible, probably, or rule out diagnoses that were not present on admission should be reported as no.

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Polling Question #2

Does documentation have to be in the medical record within 48 hours of admission for a POA indicator of "Y- Yes" to be assigned?

*1 Yes – it must be documented within 48 hrs of admission for the POA to be "Y- Yes"

*2 The timeframe of the documentation in the medical record is not the determining factor for the POA indicator assignment.

*3 If the documentation is not there in 48 hrs than obviously the condition was not present on admission and an assignment of "N-No" should be assigned.

*4 I don't know

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Hospital Acquired Conditions

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"It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm."

- Florence Nightingale, Notes on Hospitals, 1859

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- The Hospital-Acquired Conditions payment provision is a step toward Medicare VBP for hospitals
- Strong public support for CMS to pay less for conditions that are acquired during a hospital stay
- Considerable national press coverage of HACs has prompted dialogue on how to further eliminate healthcare-associated infections and conditions

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What are Hospital Acquired Conditions?

- **Conditions that are:**
  - high cost or high volume or both;
  - result in the assignment of a case to a 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.
- **Required by the Deficit Reduction Act (DRA) of 2005.**
- **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 and the selected HACs are the only MCCs and CCs present on the claim.**
- **The** POA (Present on Admission) indicator **will aide in identifying HAC cases that will have a reimbursement impact.**

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Hospital Acquired Conditions – Finalized in FY08 IPPS Rule – with some coding changes

- **Air embolism**
- **Deliver of ABO-incompatible blood products**
- **Object left in during surgery**
- **Catheter-associated UTI**
- **Vascular catheter-associated infections**
- **Mediastinitis after CABG**
- **Falls/fractures, dislocations, intracranial and crushing injury/burns**
- **Pressure ulcers**

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Hospital Acquired Conditions Candidates Proposed Rule

- Iatrogenic pneumothorax
- Legionnaire's Disease
- **Surgical site infections**
- Ventilator-associated pneumonia
- Staph Aureus septicemia
- Clostridium Difficile-associated disease (CDAD)
- Delirium
- **Glycemic control**
- **DVT/PE**

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Hospital Acquired Conditions- New conditions for FY09

- **In last year's final rule, CMS listed eight preventable conditions for which it would not make additional payments. In this year's proposed rule, CMS identified nine potential categories of conditions, but based on public comments, is finalizing three of these. The new additional conditions in this year's final rule include:**
  - **Surgical site infections following certain elective procedures, including certain orthopedic surgeries, and bariatric surgery for obesity**
  - **Certain manifestations of poor control of blood sugar levels**
  - **Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures**

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Deeper Dive into the Hospital Acquired Conditions Selected by CMS

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Hospital Acquired Conditions Selected by CMS

- **Foreign Body Retained After Surgery**

- **998.4 (CC)**
- **998.7 (CC)**

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Hospital Acquired Conditions Selected by CMS

- **Air Embolism**
- **999.1 (MCC)**

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Hospital Acquired Conditions Selected by CMS

- **Blood Incompatibility**
- **999.6 (CC)**

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Hospital Acquired Conditions Selected by CMS

- **Pressure Ulcer Stages III and IV**
- **707.23 (MCC)**
- **707.24 (MCC)**

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Hospital Acquired Conditions Selected by CMS

- **Falls and Traumas resulting in Injury**
- **Codes within these ranges on the CC/MCC list:**
  - **800-829**
  - **830-839**
  - **850-854**
  - **925-929**
  - **940-949**
  - **991-994**

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Hospital Acquired Conditions Selected by CMS

- **Catheter-Associated Urinary Tract Infection (UTI)**

- **996.64 (CC)**
- **And 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)**

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Hospital Acquired Conditions Selected by CMS

- **Vascular Catheter-Associated Infection**

- **999.31 (CC)**

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Hospital Acquired Conditions Selected by CMS

- **Manifestation of Poor Glycemic Control**

- **250.10-250.13 (MCC)**
- **250.20-250.23 (MCC)**
- **251.0 (CC)**
- **249.10-249.11 (MCC)**
- **249.20-249.21 (MCC)**

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Hospital Acquired Conditions Selected by CMS

- **Surgical site infection, mediastinitis, following CABG**

- **519.2 (MCC)**
- **And one of the following procedure codes:**
  - **36.10-36.19**

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Hospital Acquired Conditions Selected by CMS

- **Surgical Site Infection following certain orthopedic procedures**

- **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**

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Hospital Acquired Conditions Selected by CMS

- **Surgical Site Infection following bariatric surgery for obesity**

- **Principal Diagnosis – 278.01**
- **Secondary Diagnosis – 998.59 (CC)**
- **And one of the following procedure codes:**
  - **44.38**
  - **44.39**
  - **44.95**

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Hospital Acquired Conditions Selected by CMS

- ◆ **Deep Vein Thrombosis and Pulmonary Embolism following certain orthopedic procedures**

- ◆ **415.11 (MCC)**
- ◆ **415.19 (MCC)**
- ◆ **453.40-453.42 (CC)**
- ◆ **And one of the following procedure codes:**
  - · **00.85-00.87**
  - · **81.51-81.52**
  - · **81.54**

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Understanding the HAC Payment Methodology

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CMS′ Hospital Acquired Condition Payment Provision

- **The POA (Present on Admission) indicator is essential** in identifying whether CMS′ defined hospital acquired conditions occurred during the hospitalization.
- **POA indicators identifying hospital acquired:**
  - **N – No – Indicates that the condition was not present on admission**
  - **U – Unknown – Indicates that the documentation is insufficient to determine if the condition was present at the time of admission**
- **POA indicators identifying non-hospital acquired or present on admission:**
  - **Y – Indicates that the condition was present on admission**
  - **W – Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.**

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CMS′ Hospital Acquired Condition Payment Provision

- **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 <u>and</u> the selected HAC is the only MCCs and CCs present on the claim.**

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CMS' Hospital Acquired Condition Payment Provision - Examples

Principal Diagnosis	ODX/POA Assignment	DRG Paid
Intracranial hemorrhage	None	Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC - MS-DRG 066
Intracranial hemorrhage	Dislocation of patella-open due to a fall (code 836.4 (CC) – POA "Y"	Intracranial hemorrhage or cerebral infarction (stroke) with CC - MS-DRG 065
Intracranial hemorrhage	Dislocation of patella-open due to a fall (code 836.4 (CC)) – POA "N"	Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC - MS-DRG 066

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CMS' Hospital Acquired Condition Payment Provision - Examples

Principal Diagnosis	ODX/POA Assignment	DRG Paid
Intracranial hemorrhage	Stage III Ulcer (707.23) – MCC - POA Y	Intracranial hemorrhage or cerebral infarction (stroke) with MCC - MS-DRG 064
Intracranial hemorrhage	Stage III Ulcer (707.23) – MCC - POA N	Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC - MS-DRG 066
Intracranial hemorrhage	Hemiplegia (342.90) – CC – - POA Y Stage III Ulcer (707.23) – MCC - POA N	Intracranial hemorrhage or cerebral infarction (stroke) with CC - MS-DRG 065
Intracranial hemorrhage	Hemiplegia (342.90) – CC – - POA Y Stage III Ulcer (707.23) – MCC - POA N Acute Respiratory Failure (518.81)- MCC – POA N	Intracranial hemorrhage or cerebral infarction (stroke) with MCC - MS-DRG 064

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Present on Admission/Hospital Acquired Conditions Future Considerations

- **State Reporting Requirements**
- **Other Payers, including Medicaid**
- **Other Treatment Settings**
- **Rate Adjustment for HAC payment provision**
- **Collecting HAC rates**
- **I-10**
- **Additional Potential HAC Candidates**

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Polling Question #3

Would the DRG reimbursement be impacted based on the secondary diagnosis of PE (415.11 Iatrogenic pulmonary embolism and infarction) that occurred during the hospitalization during the post-op period of a CABG?

*1 DRG Reimbursement would be based on DRG 235 - Coronary bypass without cardiac cath <u>with</u> MCC.

*2 DRG Reimbursement would be based on DRG 236 - Coronary bypass without cardiac cath <u>without</u> MCC.

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Resource/Reference List

- **Present on Admission, Gail Garrett, RHIT**
  - *https://imis.ahima.org//orders/productDetail.cfm?pc=AB121207&bURL=%2Forders%2FSearchAction%2Ecfm%3F*
- **Online Coding Assessment and Training Solutions Program (CATS)**
  - **Present on Admission and UB-04**
    - *http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html#poa*
- **AHIMA Practice Brief: Planning for Present on Admission:**
  - *http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_035869.hcsp?dDocName=bok1_035869*
- **ICD-9-CM Official Guidelines for Coding and Reporting**
- **AHA *Coding Clinic for ICD-9-CM***
- **MLN Matters Number: MM5499 Revised**
  - **Related Change Request (CR) #:5499 Date: May 11, 2007**
- **Centers for Medicare & Medicaid Services (CMS)**
  - **Pub 100-04 Medicare Claims Processing, Transmittal 1240, Date: MAY 11, 2007**

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Resource/Reference List

- **Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 rates**
- **http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390F.pdf**

- **ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2008**
- **http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf**

- **Hospital-Acquired Conditions (Present on Admission Indicator)**
- **http://www.cms.hhs.gov/HospitalAcqCond/**

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Audience Questions

Audio Seminar Discussion

Following today's live seminar
Available to AHIMA members at
www.AHIMA.org

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http://campus.AHIMA.org
for information on the
2008 seminar schedule.
While online, you can also register
for seminars or order CDs and
pre-recorded Webcasts of
past seminars.

AHIMA
Distance Education

Upcoming Seminars/Webinars

FY09 ICD-9-CM Diagnosis Code Updates

September 11, 2008

FY09 Rehabilitation Coding and IRF PPS Update

September 16, 2008

FY09 ICD-9-CM Procedure Code Updates

September 18, 2008

Thank you for joining us today!

Remember – **sign on to the
AHIMA Audio Seminars Web site
to complete your evaluation form
and receive your CE Certificate online at:**

http://campus.ahima.org/audio/2008seminars.html

**Each person seeking CE credit must complete the
sign-in form and evaluation in order to view and
print their CE certificate**

**Certificates will be awarded for
AHIMA Continuing Education Credit**

Appendix

Appendix

Resource/Reference List

https://imis.ahima.org//orders/productDetail.cfm?pc=AB121207&bURL=%2Forders%2FSearchAction%2E cfm%3F

http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html#poa

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_035869.hcsp?dDocName=bok1_03 5869

http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390F.pdf

http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf

http://www.cms.hhs.gov/HospitalAcqCond/

AHIMA
Distance Education

To receive your

CE Certificate

Please go to the AHIMA Web site

http://campus.ahima.org/audio/2008seminars.html
click on the link to
"**Sign In and Complete Online Evaluation**"
listed for this seminar.

You will be automatically linked to the
CE certificate for this seminar <u>after</u> completing
the evaluation.

Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.