PROVIDER BULLETIN
#17-2017

TO: Participating hospitals that provide covered services to AmeriHealth Pennsylvania members

FROM: Provider Network Services

DATE: September 6, 2017

SUBJECT: Change to requirements for billing with POA indicator

AmeriHealth HMO, Inc. (AmeriHealth) follows and enforces industry standards for claims processing, including the present on admission (POA) indicator billing requirements and claims processing policies for acute care hospitals. Claims submitted without a valid POA indicator (as applicable) will be rejected. Except for the exempt facility types listed on the next page, all hospitals are required to follow instructions from the Centers for Medicare & Medicaid Services (CMS) regarding identification of the POA indicator for all diagnosis codes for inpatient claims submitted on the UB-04 and ASC X12N 837 Institutional (837I) claim forms.

Change to billing requirements

CMS modifies diagnosis and procedure codes (including POA indicators) annually, and the number of these modifications has increased as a result of the implementation of ICD-10. To avoid disruption in claim reimbursement due to the increase in modifications, **effective October 1, 2017**, AmeriHealth will require acute care hospitals to bill claims with the applicable ICD-10 diagnosis and procedure codes — including applicable POA indicator — **that apply as of the date of the hospital admission.**

Please ensure that your Information Systems department and/or your software vendor are aware of this updated requirement to reduce rejections and/or claim denials.

For more information

The POA indicator reporting instructions are included on the next page for your reference.

If you have any questions about a claim, please use the NaviNet® web portal to access self-service tools, such as Claim Investigation and Claim Status Inquiry. User guides are available in the NaviNet Resources section of our Provider News Center at www.amerihealth.com/pnc/navinet and have detailed instructions on how to use these transactions.

continued on next page

We encourage you to share this information with appropriate members of your staff.

Present on Admission (POA) Indicator Reporting Instructions

POA indicator code definitions

The following grid outlines POA indicator codes and their definitions:

Code	Reason for code
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation 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.

Electronic claims

For electronic claims submitted via the 837I Health Care Claim, document the POA indicator (as applicable) in the HIXX-9 field "Yes/No condition or response code." List an applicable POA indicator with each related diagnosis code on the claims submission.

Note: The POA field should be **left blank** for codes exempt from POA indicator reporting.

Paper claims

On the UB-04 Claim Form, report the applicable POA indicator (Y, N, U, or W) for the principal diagnosis code and any secondary diagnosis code:

- Record the applicable POA indicator as the eighth digit in the Principal Diagnosis field (FL 67) for the principal diagnosis.
- Record the applicable POA indicator as the eighth digit in the secondary fields (FL 67, A through Q) for each secondary diagnosis.

Note: If the diagnosis code is exempt from POA indicator reporting, report "1" as the eighth digit for principal and secondary diagnoses.

Exempt facility types

We exempt the same facility types from the POA indicator requirements as CMS. The following facility types are exempt:

- critical access hospitals
- long-term care hospitals
- cancer hospitals
- children's inpatient facilities
- inpatient rehabilitation facilities
- psychiatric hospitals