Analysis of POA and Hospital- Acquired Conditions Data, Part 1

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On October 1, 2007, hospitals began reporting secondary diagnoses that were present on admission (POA). The POA indicator can be reported as Y, present on admission; N, not present on admission; U, unknown; or W, clinically undetermined.

Beginning October 1 of this year, N and U indicators will affect Medicare payment on eight hospital-acquired conditions selected by the Centers for Medicare and Medicaid Services (CMS). Advocate Health Care, an integrated healthcare delivery system of seven acute care hospitals in metropolitan Chicago, was interested in analyzing the impact. It analyzed data on its reporting of the POA indicator and the subsequent change in Medicare reimbursement in the fourth quarter of 2007.

This is the first in a two-part series. Part 2 of this article, which will be published in the July issue, will review the 10 most frequent principal diagnoses reported with N or U for the non-Medicare population and the 10 most frequent secondary diagnoses reported with N or U for all patients.

Data Analysis of Hospital-Acquired Conditions

The eight selected conditions were reported as N or U a total of 51 times in 48 patients out of a total of 13,100 Medicare beneficiaries discharged from the seven Advocate acute care hospitals. (Three patients had two conditions reported as N or U during the same admission.) The table [below], "Frequency of Hospital-Acquired Conditions," shows the number of occurrences per condition.

Frequency of Hospital-Acquired Conditions

The eight conditions selected by CMS were reported as N or U a total of 51 times in 48 patients out of a total of 13,100 Medicare beneficiaries.

Hospital-Acquired Condition	Total Number of Occurrences
Pressure ulcers	24
Vascular catheter associated infection	21
Hospital acquired injuries (fracture, laceration from falls)	4
Catheter associated UTI	2
Mediastinitis after CABG	0
Object left in surgery	0
Air embolism	0
Blood incompatibility reaction	0

The next step was to consider whether the MS-DRG would change in any of these 48 patients.

Medicare noted in the IPPS final rule that the provision will only apply when the selected conditions are the only secondary diagnosis present on the claim that will lead to higher payment. Therefore, if a nonselected secondary diagnosis that leads to the same higher payment is on the claim, the case will continue to be assigned to the higher-paying DRG and there will be no savings to Medicare from the case.

Medicare stated any savings associated with this provision will not be realized until FY 2009. Medicare estimated the provision will save $20 million per year beginning October 1, 2008.

Advocate patients generally have multiple secondary diagnoses coded for a hospital stay. Patients having one major complication/comorbidity (MCC) or complication/comorbidity (CC) will frequently have additional conditions that also lead to higher payment. Therefore, it was expected that only a small percentage of the cases would report only one secondary diagnosis leading to higher payment.

In the Advocate cases reviewed, only three MS-DRG changes had payment impact among the 48 patients. As of October 1, 2008, this hospital-acquired condition would have been ignored and therefore no MCC or CC present for the higher-weighted MS-DRG assignment would have been reported.

The financial impact to Advocate was minimal, less than $5,000. However, the consistent message in the three cases was the problem of identifying whether or not the decubitus ulcer was present on admission. This diagnosis will be an area of focus to avoid future losses.

The table “Case-by-Case Analysis” offers detail on the three cases and how changes in MS-DRG assignment would have affected Advocate’s payment.

Case-by-Case Analysis

Of the cases reviewed, only three would have had a financial impact under the upcoming payment changes. The MS-DRG assignment for each of the cases below changed due to the POA indicator, which represented a financial impact of less than $5,000.

Original MS-DRG and Codes	Changed MS-DRG	Financial Impact
Case 1 **Original MS-DRG:** 0309, Cardiac Arrhythmia and Condition Disorders with CC, weight 0.8233 **Principal diagnosis:** paroxysmal atrial tachycardia **Number of diagnoses coded:** 12 **CC reported:** 707.09, Decubitus ulcer	0310, Cardiac Arrhythmia and Condition disorders without CC/MCC, weight 0.6439	Given a hypothetical hospital rate of $4,500, the change to MS-DRG 0310 would have been a loss to the hospital of $807.30.
Case 2 **Original MS-DRG:** 0469, Major Joint Replacement or Reattachment of Lower Extremity with MCC, weight 2.6664 **Principal diagnosis:** fracture of neck of femur that was surgically repaired **Number of diagnoses coded:** 13	0470, Major Joint Replacement or Reattachment of Lower Extremity without MCC, weight 1.9871	Given a hypothetical hospital rate of $4,500, the change to MS-DRG 0470 would have been a loss to the hospital of $3056.85.

MCC reported: 707.05, Decubitus ulcer of buttock		
Case 3 **Original MS-DRG:** 0811, Red Blood Cell Disorders with MCC, weight 1.0006 **Principal diagnosis:** chronic blood loss anemia **Number of diagnoses coded:** 11 **MCC reported:** 707.07, Decubitus ulcer of heel	0812, Red Blood Cell Disorders w/o MCC, weight 0.7780	Given a hypothetical hospital rate of $4,500, the change to MS-DRG 0812 would have been a loss to the hospital of $1001.70.

Next: Improving Documentation, Coding

The fourth quarter 2007 was a time of learning for Advocate's coders, physicians, and data analysts. No serious preventable events have occurred, but the collection and reporting of whether or not a condition was present on admission continued to challenge hospital coders. Coders will continue to put any account coded with one of the eight selected hospital-acquired conditions reported with a POA indicator of N or U or a possible W on prebill hold for a secondary coding review. Coders will continue to query cases with U and W reported.

Advocate will focus on physician documentation of pressure ulcers. Coders have reported that nursing staff do an excellent job of describing the patient's skin integrity on admission to support a stage I or greater pressure ulcer present. However, physicians do not document in an unequivocal manner, hence coders must report the status indicator as not present on admission or they must query. Coding guidelines state this documentation of the condition must be provided by the physicians. Coders will continue to query the physicians when there appears to be missing documentation.

Advocate will also develop specific POA criteria to help physicians document certain conditions reported later on in the stay (e.g., two or three days after the admission date) instead of relying upon POA lab values.

Developing internal guidelines to provide coders with clinical guidance as to when a condition is present on admission will assist in accurate reporting. However, the guidance must be carefully applied to the POA indicator only and not to determine whether the condition is coded.

For example, a guideline indicating how lab values can be used to determine that hypokalemia was present on admission is acceptable, but the actual diagnosis of hypokalemia must be documented by the physician in order to be coded (e.g., on day two or three after admission).

Advocate's coding staff will also meet with physicians formally in department meetings or informally one on one to discuss POA reporting. Just like physician queries to clarify coding issues, physician queries regarding POA reporting are likely to be an everyday occurrence.

Physicians are becoming more interested in how their documentation affects present on admission, hospital-acquired conditions, consumer access to provider information, and value-based purchasing. Any day a doctor is interested in improving documentation is a good day for coders.

Illinois Mandated POA Reporting

Although most hospitals began reporting the POA indicator due to the final rule of the acute care hospital IPPS, Illinois hospitals had additional impetus to begin reporting the indicator. The Illinois administrative rule covering the "Consumer Guide" was adopted in 2007 and evolved out of legislation passed in 2005 under the Health Finance Reform Act.

The Consumer Guide for Illinois had three major components: expansion of hospital reported data, including the POA indicator; publicly available performance information by hospitals and ambulatory surgical treatment centers; and release of provider data at a nonidentifiable patient level. All hospitals in Illinois, including those exempt from Medicare's reporting, must report the POA indicator for all inpatient discharges.

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