Are You Ready for POA Reporting?

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by Sue Bowman, RHIA, CCS

As of May 23, 2007, healthcare organizations must submit institutional paper claims using the UB-04 form instead of the UB-92 form. The UB-04 form, which will be phased in starting March 1, 2007, contains a new present on admission (POA) indicator, applicable to the principal and each secondary diagnosis reported on a claim. Although flagging diagnosis codes as present on admission is a new concept for many, various groups have recommended collecting this information over the past 15 years.

In 1992, the National Committee on Vital and Health Statistics (NCVHS) recommended that a POA data element be added to the Uniform Hospital Discharge Data Set. It again recommended reporting POA information in 1996, this time as part of the core health data elements, noting that this information could contribute significantly to quality assurance monitoring, risk-adjusted outcome studies, and reimbursement strategies.[1]

A 2004 report from the NCVHS work group on quality, titled "Measuring Health Care Quality: Obstacles and Opportunities," stated that a flag that can distinguish those conditions that were present on admission from those that developed during the course of hospitalization can permit the identification of potential problems in the care process that need improvement, while also serving as an important data element for risk/severity adjustment.[2] As a result of this report, NCVHS sent a letter to the Secretary of Health and Human Services in November 2004 recommending that paper and electronic claim forms be revised to facilitate POA reporting for all inpatient claim transactions.[3]

In a March 2005 report to Congress, the Medicare Payment Advisory Commission (MEDPAC) recommended that the Centers for Medicare and Medicaid Services (CMS) require hospitals to identify which secondary diagnoses were present on admission on their claim forms.[4] MEDPAC noted that this additional information would significantly enhance the ability to identify which complications are avoidable and improve risk adjustment of mortality and complication measures.

The Agency for Healthcare Research and Quality (AHRQ) issued a report in June 2006 titled "The Case for the Present-on-Admission Indicator."[5] Through a review of literature and discussions with healthcare experts, AHRQ concluded that the benefits of the POA indicator significantly outweighed any presumed barriers to its collection.

A number of studies have demonstrated that this flag brings marked improvement to hospital quality assurance activities, as well as broader quality improvement and patient safety efforts, and adds power and precision to risk adjustment and systems that classify comorbidities and complications. Specifically, the use of the POA indicator would:

- Add precision to ICD-9-CM coding in administrative data because it would distinguish between pre-existing conditions and complications
- Increase efficiency of hospital quality assurance activities by reducing the number of false positives that hospitals with patient safety programs need to investigate further
- Improve accuracy of safety and quality of care measures
- Increase validity of hospital report cards
- Improve accuracy of results in mortality risk assessment and outcomes research
- Improve design and fairness of pay-for-performance programs

POA Usage Requirements

The National Uniform Billing Committee (NUBC) convened a work group to develop definitions and usage requirements for reporting the POA indicator. The work group was cochaired by AHIMA and the National Center for Health Statistics (NCHS) and comprised broad stakeholder representation. NUBC reviewed and approved all final usage requirements.

The POA indicator applies to the principal diagnosis and each of the secondary diagnoses reported on the UB-04, including the external cause of injury codes. It was decided to apply this indicator to the principal diagnosis because the structure of codes for complications of pregnancy, childbirth, and puerperium is such that a complication identified in the principal diagnosis code could potentially be a condition that developed after admission.

The POA indicator applies to diagnosis codes for claims involving inpatient admissions to general acute care hospitals or other facilities, as required by law or regulation for public health reporting. The indicator is based on the conditions known at the time of admission as well as those conditions that were clearly present but not diagnosed until after admission. For example, a patient might be admitted with a lung mass, which is diagnosed as lung cancer. Although the diagnosis was not made until after admission, the cancer was clearly present at the time of admission.

Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter prior to a written order for inpatient admission, including an emergency department encounter, are considered present on admission.

The cooperating parties (AHIMA, the American Hospital Association, CMS, and NCHS) created a list of ICD-9-CM codes for which the POA indicator does not apply. These codes are exempt from POA reporting requirements because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

The cooperating parties also developed comprehensive POA reporting guidelines to be included as a separate section of the "ICD-9-CM Official Guidelines for Coding and Reporting." The first version of the POA guidelines (including the list of POA exempt codes) can be found in the updated official coding guidelines.[6]

The POA reporting options are:

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 was present on admission)
W = Clinically undetermined (provider is unable to clinically determine whether condition was present on admission)

Reporting option "U" should not be routinely assigned and should be used in very limited circumstances. Coding professionals should query the provider when the documentation is unclear.

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.

POA Reporting Requirements

Currently there is no national POA reporting requirement. California and New York have required reporting of this information for some time, and their experiences have shown it to be valuable for both risk adjustment and outcomes assessment. A growing number of states are adopting legislation mandating the reporting of POA information. It is anticipated that Medicare will soon require reporting of POA information in order to comply with a provision of the Deficit Reduction Act that requires hospitals submit secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

It is important to note that while the POA guidelines developed by the cooperating parties are intended to complement the UB-04 definitions and usage requirements for the POA indicator, state legislative mandates may differ. For example, some states limit the POA reporting requirement to inpatient admissions to acute care hospitals, whereas other states have expanded the requirement to other types of facilities, such as rehabilitation hospitals. Some states limit the reporting requirement to inpatient admissions, whereas other states have included certain types of outpatient encounters, such as observation and emergency department encounters. HIM professionals should familiarize themselves with the specific POA reporting requirements in their states.

It is apparent that there is a growing interest in the collection of POA information to support quality improvement strategies. However, most hospitals submit electronic-not paper-claims, and there is no POA data element on the current version of the electronic claim form. This situation presents a barrier to collect POA information via the claim submission process. While the next version of the electronic claim does support this data element, it is not ready for implementation because it has not yet undergone the rule-making process necessary to be established as a HIPAA-approved standard.

The accuracy of POA data is dependent on the amount of education provided to coding professionals and the availability of detailed coding guidelines. California's and New York's experiences regarding education needed for implementation of POA has shown that value, training, and feedback are key. AHRQ's report "The Case for the Present-on-Admission Indicator" concluded that the level of hospital and coding professional commitment to accurate POA data collection depended on the support and involvement of regional health information management associations, the amount of education provided by the state, and the availability of clearly defined coding guidelines.

Notes

1. National Committee on Vital and Health Statistics (NCVHS). "Core Health Data Elements." August 1996. Available online at www.ncvhs.hhs.gov/ncvhsr1.htm.
2. NCVHS Workgroup on Quality. "Measuring Health Care Quality: Obstacles and Opportunities." May 2004. Available online at www.ncvhs.hhs.gov/040531rp.pdf.
3. NCVHS. Letter to Secretary of Health and Human Services. November 5, 2004. Available online at www.ncvhs.hhs.gov/041105lt.htm.
4. Medicare Payment Advisory Commission. "Report to Congress." March 2005. Available online at www.medpac.gov/publications/congressional_reports/Mar05_EntireReport.pdf.
5. Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality. "The Case for the Present-on-Admission (POA) Indicator Report #2006-01." June 26, 2006. Available online at www.hcup-us.ahrq.gov/reports/2006_1.pdf.
6. National Center for Health Statistics. "ICD-9-CM Official Guidelines for Coding and Reporting." November 2006. Available online at www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.

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