Managing the Present on Admission Reporting Process (2010 update)

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Editor's note: This practice brief replaces the November 2007 practice brief "Planning for Present on Admission."

Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to report patient secondary diagnoses that are present on admission (POA), effective for discharges on or after October 1, 2007. POA information is required by the Centers for Medicare and Medicaid Services (CMS) for both principal and secondary diagnoses. The purpose of the POA indicator is to differentiate between conditions present at admission and conditions that develop during an inpatient admission. "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 present on admission.

This practice brief provides an overview of the POA indicator and a checklist to help organizations manage compliance with POA reporting requirements.

The POA and HAC Reporting Requirement

Short-term, acute care hospitals began reporting the POA code on inpatient claims with discharges beginning October 1, 2007. The POA indicator requirement and Hospital-Acquired Conditions (HAC) payment provision apply only to inpatient prospective payment system (IPPS) hospitals. Nationally, at this time, the following hospitals are exempt from the POA indicator and HAC: critical access hospitals, long-term care hospitals, Maryland waiver hospitals, cancer hospitals, children's inpatient facilities, rural health clinics, federally qualified health centers, religious nonmedical healthcare institutions, inpatient psychiatric hospitals, inpatient rehabilitation facilities, and Veterans Administration or Department of Defense hospitals. Healthcare organizations should check individual state requirements because they may have different reporting requirements.

The POA data element was approved by the National Uniform Billing Committee on the UB-04 data set on paper claims. The current version of the American National Standards Institute X12 837 electronic claim, version 4010A1, does not accommodate the POA. Version 5010 will be able to accommodate POA reporting. Version 5010 transaction standards will replace the existing 4010A1 version of the HIPAA transaction standards, and the compliance date for this is January 1, 2012. Until version 5010 is implemented a workaround has been developed by CMS for use with the current version, 4010A1. Complete instructions are available in CMS Transmittal 1240 (released May 11, 2007). Exempt providers that report POA indicators for other business needs can find instructions in CMS Transmittal 354 on how to prevent the POA indicator from affecting payment.

POA Reporting Designations

Designation	Status	Description
Y	Yes	Present at the time of inpatient admission. The "Y" is designated for conditions that exist before hospitalization, such as asthma. "Y" is also designated for conditions diagnosed before inpatient admission and diagnosed after admission but clearly present on admission, such as a neoplasm. CMS will pay the complicating condition/major complicating condition (CC/MCC) DRG for HACs coded as "Y" for the POA indicator.

N	No	Not present at the time of inpatient admission. The "N" is designated for conditions documented by the provider as not present on admission or conditions that occurred after the order for inpatient admission was written. An example would be a patient who was admitted for coronary artery bypass surgery who postoperatively developed a pulmonary embolism. The pulmonary embolism would be assigned a POA of "N." CMS will not pay the CC/MCC DRG for HACs coded as "N" for the POA indicator.
U	Unknown	Documentation is insufficient to determine if the condition was present on admission. The "U" designation should be used only in limited circumstances and should not be routinely assigned. There is no standard for an acceptable threshold for the number of "U" designations allowed. The provider should be queried for more information if documentation is inconsistent, missing, conflicting, or unclear. CMS will not pay the CC/MCC DRG for HACs coded as "U" for the POA indicator.
W	Clinically undetermined	The provider is unable to clinically determine whether the condition was present on admission. The "W" is used when a provider cannot determine whether the condition was present on admission. A query is always indicated before a "W" is assigned, unless the provider has already specifically stated that it was clinically undetermined. CMS will pay the CC/MCC DRG for HACs coded as "W" for the POA indicator.
Unreported or blank; "1" (electronic claims)	Exempt	Status is exempt from POA reporting. The field is left blank on the UB-04. On electronic claims, CMS requires a "1" to be reported in place of a blank (per CMS Transmittal 1240, released May 11, 2007). It was determined that blanks were undesirable when reporting data via the 4010A1. CMS will not pay the CC/MCC DRG for HACs coded as "1" for the POA indicator. The "1" POA indicator should not be applied to any codes on the HAC list. These claims will be returned to the provider for correction.

For a complete list of codes on the POA exempt list, refer to appendix I of the "ICD-9-CM Official Guidelines for Coding and Reporting."

POA status is indicated with the above designations. Special rules exist for combination codes. Assign "N" if any part of a combination code was not present on admission. For example, an asthma patient who develops status asthmaticus after admission would have an "N" designation. In contrast, a "Y" would be assigned if all parts of the combination code were present on admission.

In the case of infection codes that include the causative organism, assign "Y" if the signs and symptoms of the illness were present on admission, even if the culture results may not be established until after the patient is admitted.

Section 5001(s) of the Deficit Reduction Act of 2005 requires the identification of conditions known as hospital-acquired conditions (HACs). According to this act, conditions that can be identified as a HAC are high cost, high volume, or both; are assigned to a higher paying MS-DRG when present as a secondary diagnosis (that is, conditions under the MS-DRG system that are CCs or MCCs); and could reasonably have been prevented through the application of evidence-based guidelines. Collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision. Starting with discharges on October 1, 2008, the DRG assigned to a discharge with any identified HAC diagnosis codes is not affected by the identified code if POA indicator N or U is reported. In other words the claim will be paid as if the HAC diagnosis code with POA indicator N or U was not present at all. CMS can, in consultation with the Centers for Disease Control and Prevention, revise the list of HACs from time to time, as long as the list contains at least two conditions. October 1, 2007 hospitals began reporting on eight HAC indicators. For fiscal year 2009, additional HAC indicators were selected, and there were no changes to the HAC categories for fiscal year 2010. The current HAC categories are:

- Foreign object retained after surgery

- Air embolism
- Blood incompatibility
- Pressure ulcer stages III and IV
- Hospital-acquired injuries including:
    - fractures, dislocations, intracranial injury, crushing injury, burn, and electric shock)
- Catheter-associated urinary tract infection
- Catheter-associated vascular infection
- Manifestations of poor glycemic control
- Surgical site infection after coronary artery bypass graft
- Surgical site infection after certain orthopedic procedures
- Surgical site infection after bariatric surgery for obesity
- Deep vein thrombosis and pulmonary embolism after certain orthopedic procedures

National Guidelines

The American Hospital Association, AHIMA, CMS, and the National Center for Health Statistics issued POA reporting guidelines in appendix I of the ICD-9-CM Official Guidelines for Coding and Reporting. The guidelines include general reporting requirements, as well as clarification of what is meant by POA. Also included in appendix I is a list of ICD-9-CM diagnosis codes that are exempt from POA reporting.

The Benefits of POA Reporting

Many groups, including the National Committee on Vital and Health Statistics, believe the POA information will improve the ability of administrative claims data to assess quality of care and help perform risk adjustment.

The POA indicator is expected to provide a mechanism to distinguish between preexisting conditions and complications and add precision to ICD-9-CM coding in administrative data. It is also expected to:

- Reduce the number of false positives in quality assessments
- Improve the accuracy of patient safety and quality care measurements
- Provide a mechanism to increase the validity of hospital report cards
- Provide a mechanism and stepping stone for the pay-for-performance initiative
- Allow the expansion of code sets for use in outcomes reporting
- Improve the accuracy in mortality risk assessment research

The guidelines in appendix I are not intended to provide advice on when a condition should be coded; rather, they serve as guidance for the assignment of the POA indicator to the set of diagnoses that has been identified and coded. If a condition would not be coded according to the ICD-9-CM Official Guidelines for Coding and Reporting, including the Uniform Hospital Discharge Data Set definitions, then the POA indicator would not be reported.

The guidelines stress that consistent and complete documentation is necessary to determine whether a condition is present on admission. This documentation must come from the provider. A provider is defined by the guidelines as a physician or qualified healthcare practitioner who is legally responsible for establishing the patient's diagnosis. As with determining the reported diagnoses, POA information may not be gleaned from nonprovider documentation such as nurses' notes or dietician reports. A query should be initiated in cases in which documentation is inconsistent, missing, conflicting, or unclear.

Documentation Issues

The provider should document the POA status or the diagnosis at the time of an inpatient admission or in a timely fashion so that it is evident that the diagnosis is present on admission. Therefore, the best source for POA information is provider documentation at the time of admission.

Examples of types of documentation that might be used to determine POA assignment include emergency room notes, history and physical examination results, and progress and admitting notes. Other documentation that can be helpful includes:

- Conditions present and diagnosed before admission
- Conditions diagnosed as existing during the admission process and therefore present before admission
- Any suspected, possible, probable, or to-be-ruled-out conditions
- Differential diagnoses
- Underlying causes of any sign or symptom present on admission
- Specific identification of acute or chronic status of any condition
- External causes (the "how" and "where") of any injury or poisoning in the physician's notes

For example, a provider that includes a decubitus ulcer diagnosis in the history and physical examination performed on admission will not need to be queried by a coding professional later. If the ulcer is not documented until the third day, the physician should note in the documentation that it was present at the time of admission.

The documentation should be complete, allowing the coder to evaluate each diagnosis for POA status. All coded conditions should include accurate POA assignments, regardless of the effect on the DRG or the number of diagnoses coded.

Tips for Querying

Many physicians have established habits for documenting their notes on patient encounters. Providing educational opportunities that demonstrate documentation requirements for POA reporting will enable physicians to modify their habits and meet the documentation needs. When coding professionals discover inconsistent, missing, conflicting, or unclear documentation, the provider must be queried. The physician is responsible for resolving the data deficiency.

Querying is an important part of the learning process for physicians in building new documentation habits. Queries should be done in a judicious manner and should not imply a desired answer. In addition, coding professionals should be careful not to appear to be questioning the physician's expertise or knowledge. (For additional guidance on the query process, see the October 2008 practice brief "Managing an Effective Query Process," available in the AHIMA Body of Knowledge at www.ahima.org.)

Examples of when a physician should be queried include:

- The laboratory work shows elevated potassium level on admission. The physician documents hyperkalemia on day two. Since the diagnosis was not made until day two, it is not clear when it occurred.
- A patient is admitted with nausea and vomiting. The physician starts intravenous fluids for severe dehydration on admission. On day three, the physician documents hyponatremia. Even though the dehydration was POA, it is not clear when the hyponatremia started.
- A decubitus ulcer is documented in the nurse's notes but not by the physician. The documentation in the nurse's notes might indicate a query to the physician. It is inappropriate for the POA to be assigned on documentation other than that made by the provider.

One approach to the POA query process is to use a check-box format, which the physician initials or signs. Many facilities are implementing clinical documentation improvement programs to establish clear, consistent documentation.

Checklist for Managing the POA Reporting Process

To remain current on POA reporting requirements, HIM directors or designees should:

- Review the POA guidelines
- Review changes made annually to IPPS
- Read industry literature
- Provide continuing education opportunities
- Include POA as a topic for discussion in local coding roundtable meetings
- Check with component state associations to understand state reporting requirements

Maintain Current Facility Guidelines

Each facility should establish clear written and approved policies and procedures that support timely, accurate, and complete POA indicator assignment. To this end, organizations should:

- Gather leadership support of the policy and procedure with an emphasis on an interdisciplinary team approach to POA assignment
- Educate all applicable staff members including internal, external (contract), and medical staff
- Provide clear expectations for timely, accurate, and complete documentation
- Establish a process for clinical documentation improvement efforts, including a query process for inconsistent, missing, conflicting, or unclear documentation and an auditing and monitoring process using audit methodology and tools
- Implement tracking, trending, and reporting mechanisms
- Establish a data integrity process for handing POA indicator corrections

Organizations should also update their policies and procedures on a regular basis and in coordination with revised regulations or updated guidelines for POA reporting.

POA Reporting Monitoring and Improvement Process

Organizations should outline the process for monitoring and improving POA reporting. In preparing to outline the process for monitoring and improving POA reporting, organizations should:

- Evaluate concurrent documentation opportunities and address the need for complete documentation by developing a strategy to improve documentation concurrently.
- Consider implementing a clinical documentation improvement program and include POA-related documentation as a focus if a need to improve documentation in this area is identified.
- Conduct internal reviews to determine appropriate selection of POA indicator on the basis of documentation and guidelines. Include a representative sampling of patients by case mix and payer mix. The process should focus on high-risk or problem areas, “U” or “W” reported cases, acute or chronic conditions, combination codes, and rule-out diagnoses.
- Prepare an audit method that delineates:
    - Time period covered
    - Record selection process
    - Sample size
    - Sample indicators
    - A comparison of the retrospective versus concurrent POA reporting
    - Data analysis techniques and tools used
    - Qualifications of personnel performing the review
    - How results will be used to improve operations
    - Report formats for tracking and analyzing the audit results
- Monitor the response to queries and the appropriateness of the queries.
- Provide education and training for identified opportunities.
- Train new staff and contract coders on the POA requirements, including the collection of the POA within the system.
- Work with the quality department to understand the data being collected.
- Perform IT testing to make sure that the POA indicator is transferring appropriately.

Communicate Changes

Communication within the facility and the local HIM community regarding any changes to the POA reporting process is essential. At a minimum, the following key individuals are considered stakeholders in the POA reporting process:

- **Senior management.** HIM professionals should ensure senior management is informed about changes to the POA indicators, including changes to POA documentation and reporting requirements.

- **IT professionals** will need to be aware of the system implications. The anticipated changes for POA reporting as a result of implementing version 5010 in 2012 and ICD-10-CM in 2013 will involve any system that currently contains ICD-9-CM diagnosis codes. Internal and external system focus will need to be directed toward the DRG and grouper software, billing systems (internal and payers), abstracting system, and clinical data reporting. If there is a state reporting requirement, there may need to be a crosswalk from the billing guidelines to the state requirements if they are different.
- **Performance improvement liaisons** such as quality, physician advisors, and nursing staff. HIM professionals must ensure that others within the organization fully understand and appreciate the richness of data that the collection of the POA indicator will provide to facilitate performance improvement initiatives.
- **Compliance officers.** HIM professionals should work with the compliance officer and monitor the compliance program in regard to the collection and reporting of the POA indicator.
- **Finance and billing staff**. HIM professionals should provide education on any changes to guidelines for POA assignment.
- **Medical staff** need continuing education on the POA requirements. Explore mechanisms to deliver educational information on the medical record documentation requirements for the POA indicator assignment. Some outlets may include presentations at medical staff meetings or departmental meetings or a physician-directed newsletter. HIM professionals should discuss with providers the need to query for clarification when documentation is incomplete or unclear. HIM professionals should also discuss problem diagnoses that must be routinely queried for POA information.
- **Coding professionals** must be trained on changes to the POA reporting requirements. Coders also need education on diagnoses prone to coding errors.

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