Managing the Present on Admission Reporting Process (2016 update)

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Editor's Note: This Practice Brief is an update of the March 2010 version, which replaced 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 primary and secondary diagnoses that are present on admission (POA), effective for discharges on or after October 1, 2007.[1] 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 as well as a checklist, information on POA guidelines, and documentation issues and tips to help organizations manage compliance with POA reporting requirements.

The POA and HAC Reporting Requirement

Short-term acute care hospitals began reporting the POA indicator 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 provision:

- Critical access hospitals
- Long-term care hospitals
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Religious non-medical healthcare institutions
- Inpatient psychiatric hospitals
- Inpatient rehabilitation facilities
- 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 (NUBC) on the UB-04 data set on paper claims. The American National Standards Institute X12 837 electronic claim, version 5010 transaction standards replaced the 4010A1 version of the Health Insurance Portability and Accountability Act (HIPAA) transaction standards effective January 1, 2012. Complete reporting instructions are available in CMS Transmittal R7560TN (released August 13, 2010). 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.

Section 5001(s) of the Deficit Reduction Act of 2005 requires the identification of conditions known as HACs.[2] 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 for identification of conditions acquired during hospitalization under the HAC payment provision.

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 (electronic claims)	Unreported/Not used	Status is exempt from POA reporting. The code is equivalent to a blank on the UB-04. CMS will not pay the CC/MCC DRG for HACs coded as blank for the POA indicator. Blank as the POA indicator should not be applied to any codes on the HAC list. For a complete list of codes on the POA exempt list, refer to the CMS website.

Note: The American Hospital Association, AHIMA, CMS, and the National Center for Health Statistics issue POA reporting guidelines in the ICD-10-CM Official Guidelines for Coding and Reporting. The guidelines include general reporting requirements, as well as clarification of what is meant by POA.

Starting with discharges on October 1, 2008 any identified HAC diagnosis codes assigned a POA indicator of N or U (see the table above for an explanation of these and other POA indicators) is not part of the DRG calculation for that inpatient visit. The claim would be paid as if the HAC diagnosis code with POA indicator N or U was not present at all. Effective October 1, 2007, hospitals began reporting on eight HAC indicators; additional HAC indicators were added in 2009 and 2013. In fiscal year 2016, the list of HAC indicators was updated to be in alignment with ICD-10-CM/PCS codes and verbiage.

The current HAC categories are:

- Foreign object retained after surgery

- Air embolism
- Blood incompatibility
- Pressure ulcer stages III and IV
- Falls and trauma
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor glycemic control
- Surgical site infection – mediastinitis after coronary by pass graft (CABG)
- Surgical site infection – certain orthopedic procedures of spine, shoulder, and elbow
- Surgical site infection – bariatric surgery (for obesity)
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) with total knee or hip replacement
- Surgical site infection following cardiac implantable electrode device (CIED) procedures
- Iatrogenic pneumothorax with venous catheterization

CMS can, in consultation with the Centers for Disease Control and Prevention, revise the list of HACs periodically as long as the list contains at least two conditions.

National Guidelines

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 assist in performing risk adjustment. The POA indicator has provided a mechanism to distinguish between preexisting conditions and complications, and add precision to ICD-10-CM coding in administrative data.

The POA guidelines 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-10-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.

Documentation that might be used to determine POA assignment includes 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
- 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

A provider that includes a pressure ulcer diagnosis in the history and physical examination performed on admission will not need to be queried later for the POA status. If the ulcer is not documented until the third day, however, the provider should note in the documentation that it was present at the time of admission or a query will need to be sent.

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

Tips for Querying

Many providers have established habits for documenting their notes on patient encounters. Providing educational opportunities that demonstrate documentation requirements for POA reporting will enable providers to modify their habits and meet the ICD-10 documentation needs. When coding professionals discover inconsistent, missing, conflicting, or ambiguous documentation, the provider must be queried. The provider is responsible for resolving the data deficiency.

Querying is an important part of the learning process for providers in building new ICD-10 documentation habits. Queries should be done in a judicious manner and should not imply a desired answer or appear to question the provider's expertise or knowledge. For additional guidance on the query process, see the January 2016 Practice Brief "Guidelines for Achieving a Compliant Query Practice (Updated)," available online in AHIMA's HIM Body of Knowledge.[3]

Examples of when a provider 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 provider starts intravenous fluids for severe dehydration on admission. On day three, the provider documents hyponatremia. Even though the dehydration was POA, it is not clear when the hyponatremia started.
- A pressure ulcer is documented in the nurses' notes but not by the provider. The documentation in the nurses' notes that a pressure ulcer is present might indicate a query to the provider. It is inappropriate for the POA to be assigned on documentation other than that made by the provider.

Checklist for Managing the POA Reporting Process

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

- Review any annual changes to the POA guidelines
- Review changes made annually to IPPS (including HAC changes)
- Read industry literature
- Provide continuing education opportunities to areas such as providers, coding professionals, clinical documentation improvement, and quality
- Include POA as a topic for discussion in local coding roundtable meetings as it relates to ICD-10-CM
- Check with AHIMA component state associations to understand state reporting requirements

POA Facility Guidelines, Reporting, Monitoring, and Improvement Processes

Organizations should continue to update their policies and procedures on a regular basis and in coordination with revised regulations or updated guidelines. Organizations should also review and update their processes for monitoring and improving POA reporting as necessary, especially in light of ICD-10. Finally, organizations should:

- Promptly communicate and educate all applicable changes to workforce members including internal, external (contract), and medical staff.
- Work with the quality department as a part of an interdisciplinary team to better understand the data being collected.
- Use their clinical documentation improvement program as a means for identifying POA-related documentation issues.

- Conduct internal/external 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; "N," "U," or "W" reported cases; acute or chronic conditions; and rule-out diagnoses.
- Maintain leadership support of the policy and procedures with an emphasis on an interdisciplinary team approach to POA assignment.
- Monitor the response to queries and the appropriateness of the queries.
- Provide continuing education and training for identified opportunities.

Communicate Changes

Communication within the facility 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** must be informed about changes to the POA indicators by HIM professionals, including changes to POA documentation and reporting requirements.
- **IT professionals** will need to be aware of system implications. 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.
- **Performance improvement liaisons** such as quality, physician advisors, case managers, 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 related to the actual indicators themselves.
- **Medical staff** needs continuing education on POA requirements. Explore mechanisms to deliver educational information on health record documentation requirements for the POA indicator assignment. Some outlets may include presentations at medical staff meetings or departmental meetings, or a provider-directed newsletter. HIM professionals should discuss with providers the need to query for clarification when documentation is incomplete or ambiguous. 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. Coding professionals also need education on diagnoses prone to coding errors.
- **Clinical documentation improvement (CDI) professionals** must be trained on POA guidelines so concurrent queries can be sent to providers as needed for accurate POA assignment. CDI professionals also need education on diagnoses coding professionals find that are prone to documentation errors for POA assignment.

Notes

[1] Centers for Medicare and Medicaid Services. "Deficit Reduction Act of 2005: All CMS Provisions As of February 28, 2006." www.cms.gov/regulations-and-guidance/legislation/legislativeupdate/downloads/dra0307.pdf.

[2] Ibid.

[3] AHIMA. "Guidelines for Achieving a Compliant Query Practice (2016 Update)." 2016. http://bok.ahima.org/doc?oid=301357.

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Article citation:
Campbell, Angela; D'Amato, Cheryl; Rugg, Donna. "Managing the Present on Admission Reporting Process (2016 update)" *Journal of AHIMA* 87, no.9 (September 2016): 54-58.
