Planning for Present on Admission

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AHIMA Clinical Terminology and Classification Practice Council

Starting October 1, 2007, hospitals are required to identify secondary diagnoses that are present on admission (POA). The purpose of the POA indicator is to differentiate between conditions present at admission and conditions that develop during an inpatient admission.

This practice brief provides an overview of the POA indicator and a checklist to help organizations prepare for POA reporting.

The POA Reporting Requirement

Short-term, acute care hospitals began reporting the POA code on inpatient claims with discharges beginning October 1, 2007. Critical access, Maryland waiver, long-term care, cancer, psychiatric, rehabilitation, and children's inpatient facilities are excluded from reporting the POA indicator. Healthcare organizations should check individual state requirements, as they may have different reporting requirements.

POA data will be used to trace the development of infections and other conditions in patients once admitted to the hospital. The goal is to assess when conditions occur or develop.

Although hospitals currently must report the POA code on claims, the information will not be used by claims processing systems until January 1, 2008. Beginning with January 1, 2008, discharge claims, hospitals that do not report a valid POA code for each diagnosis will be provided a remark code on the remittance advice. However, the claim will continue to process. Beginning April 1, 2008, if hospitals do not report a valid POA code for each diagnosis on a claim, the claim will be returned for the POA information.

The new POA data element was approved by the National Uniform Billing Committee on the UB-04 data set on paper claims. The 005010 version of the ANSI X12 837I electronic claim can accommodate the POA, but it has not yet been approved for use. The current version of the 837 (4010A1) claim does not accommodate the POA, and a work-around has been developed by the Centers for Medicare and Medicaid Services (CMS). These claims will use segment K3 in the 2300 loop, data element K301, which will contain the letters "POA," followed by a single POA indicator. Direct data entry screens cannot be updated to include a space for entering POA information until January 1, 2008.[1] Complete instructions are available in CMS Transmittal 1240 (released May 11, 2007).

In compliance with the Deficit Reduction Act of 2005, the Health and Human Services secretary identified two high-cost or high-volume diagnosis codes with a DRG assignment that has a higher payment weight when present with secondary diagnoses. These diagnosis codes represent conditions, including certain hospital-acquired infections, that reasonably could have been prevented through the application of evidence-based guidelines.

Key POA Dates

October 1, 2007	Short-term, acute care hospitals are required to begin reporting POA codes. Initially the information will not be used in processing claims.
January 1, 2008	Hospitals that do not submit a valid POA code will receive a remark code on the remittance advice. However, the claim will be processed.
April 1, 2008	Claims that do not include a valid POA code for each diagnosis will be returned for completion.

Starting with discharges on October 1, 2008, the DRG assigned to a discharge with the identified diagnosis codes will be assigned the DRG that does not result in higher payments based on the presence of these secondary diagnosis codes. The final conditions were selected to affect payment beginning October 1, 2008. They are:

- Serious preventable event, object left in surgery
- Serious preventable event, air embolism
- Serious preventable event, blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcers (decubitus)
- Vascular catheter-associated infection
- Mediastinitis after cardiac artery bypass grafting-surgical site infection
- Hospital-acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes)

National Guidelines

In anticipation of the implementation of the POA requirement, 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 on what is meant by present on admission. (Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered present on admission.)

The guidelines are to be used as a supplement for the assignment of the POA indicator for each diagnosis and external cause of injury code reported on claim forms. They do not replace the guidelines included in the main text.

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 pre-existing 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 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, 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 where 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, and progress and admitting notes. Other documentation that can be helpful includes:

- Conditions present and diagnosed prior to 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 won't need to be queried by a coding professional later. If the decubitus 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 impact to the DRG or the number of diagnoses coded.

Tips for Querying

Many physicians have established habits for documenting their notes on patient encounters. Education is required to allow for the documentation required to correctly assign the POA indicator. POA reporting is new for providers, and it is crucial that HIM professionals take the lead in providing the necessary education as an opportunity to affect change.

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 physician query process, see the October 2001 practice brief "Developing a Physician Query Process," available in the FORE Library: HIM Body of Knowledge at www.ahima.org.)

Examples of when a physician should be queried include:

- The lab work shows elevated potassium on admission. The physician documents hyperkalemia on day 2. Since the diagnosis was not made until day 2, it is not clear when it occurred.
- A patient is admitted with nausea and vomiting. The physician starts IV fluids for severe dehydration on admission. On day 3, 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.

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.
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 that was admitted for a coronary artery bypass surgery who postoperatively developed a pulmonary embolism. The pulmonary embolism would be assigned a POA of "N."
U	Unknown	Documentation is insufficient to determine if 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. The "U" is intended to be used only when a query is not possible and it is not possible to obtain accurate POA information.
W	Clinically undetermined	Provider is unable to clinically determine whether condition was present on admission. The "W" is used when a provider can't 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.
Unreported or blank; "1" (electronic claims)	Exempt	Status is exempt from POA reporting. The field is left blank on the UB-04; on the 4010A1, a "1" is reported, because CMS determined blanks to be undesirable on electronic submissions.

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.

If a condition is on the list of ICD-9-CM codes that are exempt from POA reporting then 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.

Operational Considerations

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.
- Develop a POA monitoring process and 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, which should include the time period covered, record selection process, sample size, indicators, a comparison of the retrospective versus concurrent POA reporting, data analysis techniques, tools used, qualifications of personnel performing the review, how results will be used to improve operations, and report formats for tracking and analyzing the audit results.
- 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. Organizations should monitor the response to queries and the appropriateness of the query.
- Provide education and training for identified opportunities.
- 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 Preparation Checklist

Reporting the POA indicator for diagnoses is a new responsibility for most hospitals. As with any new requirement, organizations must plan to make a smooth transition.

POA planning and implementation require communication and significant collaboration with key stakeholders outside of HIM, including those in clinical areas, facility leadership, and information technology. Organizations should begin by identifying key leaders in several healthcare disciplines. Some important points to consider in preparing for POA collection are included in the following checklist.

Lead the Charge—Learn about POA

HIM professionals have the opportunity to become the facility and industry experts on POA collection and reporting. HIM leaders must plan for this role. This is an excellent opportunity for HIM professionals to become the experts within their organizations, demonstrate the knowledge of the steps and processes necessary to make this transition, and showcase leadership skills.

In preparation for this task, HIM directors or designees should:

- Review the POA guidelines
- Read industry literature
- Attend educational offerings
- Include POA as a topic for discussion in local coding roundtable meetings
- Check with state component associations to understand state reporting requirements

Create Awareness

Creating awareness within the facility and the local HIM community is essential, as is communicating any changes. Initiating an awareness campaign with executives, IT professionals, and other department leaders to foster baseline knowledge throughout the organization is crucial.

At a minimum, the following key individuals will need to be consulted on the POA reporting requirement:

- **Senior management.** HIM professionals should explain to senior management the POA indicator, the documentation requirements, and the progression to the new method to measure the delivery of quality healthcare and appropriate reimbursement.
- **IT professionals** will need to be aware of the system implications. The anticipated changes for POA reporting will involve any system that currently contains ICD-9-CM diagnosis codes. This field will need to be expanded to include another one-character digit. 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 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 POA indicator will provide to facilitate performance improvement initiatives.
- **Compliance officers.** HIM professionals should assess the compliance environment in preparation for the collection of the POA indicator.
- **Finance and billing staff**. HIM professionals should provide education on the guidelines for POA assignment.
- **Medical staff** will need education on the POA requirements. Explore avenues 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.

- **Coding professionals** must be trained on the POA reporting requirements. Organizations should begin educational sessions with the inpatient coders relative to the POA indicator (billing guidelines or state reporting requirements). They should schedule an internal coding meeting to discuss the POA coding and reporting guidelines and assess medical record documentation to determine adequacy to support POA assignment. They should provide system training on the collection of the POA indicator.

HIM professionals should also discuss the new requirements with nursing and other healthcare professionals to ensure understanding of the documentation requirements.

Plan for Operational Implementation

Organizations must also outline a plan for operational implementation. Organizations should:

- Evaluate concurrent documentation opportunities and address the need for complete documentation by developing a strategy to improve documentation concurrently.
- Assess how the POA reporting requirement will affect coder productivity.
- Assess how physicians will respond to queries. Based on quality improvement organizations' direction, the response from the physician must be documented either in the traditional medical record documentation or on the query form. As this is a billing requirement, it is recommended that claims with outstanding queries be held until a response is received.
- Consider implementing a clinical documentation improvement program.
- Perform IT testing to make sure that the POA indicator is transferring appropriately.

Prior to "go-live" organizations should:

- Assess any necessary additional staff educational needs, including contract coders
- Implement any changes in processes, policies, and procedures
- Assess gaps in medical record documentation
- Continue emphasizing medical staff responsibilities

After implementation, organizations and HIM professionals should:

- Keep abreast of CMS reporting timeframes and plans to return to provider beginning in April 2008
- Continue to increase familiarity with indicator assignment
- Monitor medical record documentation practices
- Assess the impact of the new indicator
- Educate data users (e.g., case management, quality, data analysis)
- Conduct internal reviews to determine appropriate selection of POA indicator based on documentation and guidelines
- Train new staff and contract coders on the POA requirements, including the collection of the POA within the system
- Work with the facility finance area to evaluate potential future reimbursement impact
- Work with the quality department to understand the data being collected
- Continue to monitor operational impact and potential areas for improvement within the HIM and coding processes
- Continue to work with physicians on accurate and complete documentation

Note

1. Centers for Medicare and Medicaid Services. "Present On Admission (POA) Indicator." *MLN Matters* MM5499. Available online at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf.

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