Present on Admission: Where We Are Now

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Hospitals have nearly two years of POA reporting under their belts. With time, effort, and updates, assigning POA indicators is becoming routine business for coding professionals.

For the past several years, HIM professionals have served as a conduit for a rapidly evolving pay-for-performance healthcare environment. One of the major programs introduced during this period is the present on admission (POA) reporting requirement.

HIM professionals followed the regulatory steps that established the POA requirement, the corresponding national guidelines, and the determination of which hospital-acquired conditions would, when not present on admission and meeting certain criteria, have the potential to impact the MS-DRG and result in a lower payment to the facility. They communicated, educated, and planned across departments in their facilities.

HIM professionals have had and will continue to have a key role in the POA requirement based on their responsibilities for the collection, quality, and interpretation of the POA indicators. Learning and adapting to the program has required education, communication, documentation improvement, and quality monitoring.

The Basics

The Deficit Reduction Act of 2005 mandated that providers report POA indicators for all diagnoses submitted on Medicare inpatient acute care claims for discharges beginning October 1, 2007.

Present on admission is defined as the conditions present at the time the order for inpatient admission occurs. The POA indicator is intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission.

Providers must report one of five indicators:

- 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 at the time of admission)
- W = clinically undetermined (provider is unable to clinically determine whether condition was present on admission)
- 1 (on electronic claims) or blank (for paper claims) = exempt from POA reporting

The Deficit Reduction Act also mandated financial incentives to reduce hospital-acquired conditions, or HACs, which are identified through reporting POA indicators.

Beginning with discharges occurring on October 1, 2008, acute care hospitals do not receive additional payment for Medicare cases in which a selected condition was not present on admission and the selected HAC was not the only complication/comorbidity or major complication/comorbidity (cc or mcc) on the claim.

2008 National Guideline Updates

The American Hospital Association, AHIMA, the Centers for Medicare and Medicaid Services (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 POA guidelines include general reporting requirements as well as clarification on what qualifies as present on admission.

The guidelines were updated in 2008 to address areas of confusion identified during the first year of the program. In particular, the updates address two items:

Time frame for POA identification and documentation. Providers are not required to identify or document a condition within a given time period in order for it to be classified as present on admission. In some clinical situations it may not be possible for a provider to make a definitive diagnosis at the time of admission; likewise, a patient may not recognize or report a condition immediately. In some cases it may be several days before the provider arrives at a definitive diagnosis.

Same diagnosis code for two or more conditions. When the same ICD-9-CM diagnosis code applies to two or more conditions during the same encounter (e.g., bilateral conditions or two separate conditions classified to the same ICD-9-CM diagnosis code), the POA assignment will be dependent on whether or not all of the conditions represented by the single diagnosis code were or were not present on admission.

The 2008 updates also included new examples to illustrate appropriate POA assignment in certain circumstances.

One example illustrates POA assignments based on time frames using the case of a diagnosed urinary tract infection. In the example, a urine culture is obtained on admission and the provider documents the infection once the culture results become available a few days later. This is appropriate because the diagnosis is based on a specimen obtained on admission and a definitive diagnosis required several days.

In a second example, a patient tests positive for Methicillin resistant Staphylococcus (MRSA) on a routine nasal culture on admission to the hospital. During the hospitalization the patient undergoes insertion of a central venous catheter, develops an infection, and is diagnosed with MRSA sepsis due to central venous catheter infection. The facility reports Y for the positive MRSA colonization and N for MRSA sepsis due to central venous catheter.

Two examples address POA assignments for situations associated with **fetal nuchal cord entanglement**. In the first, a pregnant female is admitted in labor, and fetal nuchal cord entanglement is diagnosed. The physician is queried but is unable to determine if the code entanglement was present on admission. In this instance, W (unknown) is assigned for the fetal nuchal cord entanglement.

In the second nuchal chord example, a birth in the hospital is complicated by nuchal cord entanglement. The hospital assigns Y for the nuchal cord entanglement, because any condition that is present at birth or that developed in utero is considered present at admission, including conditions that occur during delivery.

Although not explicitly part of the POA reporting guidelines addressed in appendix I, changes to the official coding guidelines clarified documentation requirements for reporting **pressure ulcers** and assignment of the new ICD-9-CM codes for stages of the pressure ulcers, which are subject to the HAC payment provision.

These new guidelines address appropriate ICD-9-CM diagnosis code assignment for pressure ulcer stages, unstageable pressure ulcers, bilateral pressure ulcers with the same or different stages, multiple pressure ulcers of different stages and sites, pressure ulcers documented as healing or nonhealing, and pressure ulcers evolving into another stage during the same admission.

The updates also address documentation requirements for reporting the pressure ulcer staging codes. Code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient such as nurses, who often document the pressure ulcer stages. However, the associated diagnosis, such as pressure ulcer, must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

The pressure ulcer stage codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the pressure ulcer stage codes should be assigned only when they meet the definition of a reportable additional diagnosis (see

section III, "Reporting Additional Diagnoses").

The ICD-9-CM Official Guidelines for Coding and Reporting, including POA guidelines and questions and answers, will be reviewed and updated as needed on an ongoing basis.

Challenges in Education and Documentation

It will soon be two years since CMS required the collection and reporting of the POA indicator for each diagnosis code submitted on an acute care Medicare inpatient claim, and the process should be part of the coding department routine. By now, HIM professionals (as well as many other disciplines such as quality, medical staff, nursing, and administration) should also be familiar with how the POA indicator facilitates the measurement of patient quality of care and CMS's HAC payment methodology.

Part of gaining that familiarity has been identifying and addressing challenges raised by POA reporting and the HAC payment provision.

Physician and Hospital Clinical Staff Education

Successfully implementing POA reporting required educating physicians and hospital staff on their roles in appropriate POA assignment. For physicians, documentation is clearly the aspect of their work that supports proper POA assignment, and hospitals typically addressed this through documentation improvement initiatives (discussed in the following section).

Clinical staff education has focused on understanding the POA indicator and its importance. Additionally, clinical staff had to become skilled in interpreting POA information and incorporating it into their patient care performance improvement efforts.

Documentation Improvement Initiatives

The best source for POA information is provider documentation at the time of admission. To strengthen this practice, hospitals have enhanced processes at the point of patient admission, such as documentation of a comprehensive physical examination. They have designed new medical record forms and established processes for concurrent clinical documentation improvement efforts.

Complete documentation is necessary for the coder to evaluate each diagnosis for POA status. When coding professionals discover inconsistent, missing, conflicting, or unclear documentation for a definitive POA assignment, they must query the provider. The physician is responsible for resolving the insufficiency.

In an informal poll of coders, several noted two queries commonly posed to physicians to ensure accurate POA assignment:

- The relationship between symptoms that were present on admission and a condition that was diagnosed later in the hospital stay
- Confirmation from the obstetrician that a nuchal cord entanglement was present on admission, not present, or unable to be clinically determined

In order to address queries, coding staff must work with the medical staff to explain why it is important to provide the documentation necessary for accurate POA reporting. This can include one-on-one discussions, medical staff meetings, and physician liaison discussion directly with the physicians with high percentages of queries.

Coder Adjustments

There was certainly a learning curve for the coding professionals as they adjusted to their responsibility for POA collection. However, it appears that the long-term impact may not be as great as initially expected. Anecdotally, coding professionals have said that once they became familiar with the reporting guidelines and acceptable documentation, the adjustment was easier than they thought it would be. They also reported that POA submission has had minimal impact on productivity.

Coders will require ongoing effort to remain current with POA guidelines and to monitor reporting to fulfill their obligations for this requirement.

Quality Control Monitoring

Like other coded data, the POA indicator is increasingly used for multiple purposes—reimbursement, financial planning, clinical research, and quality of care evaluation. It is more important than ever for these data to be reliable. Ongoing coding quality reviews are essential to validate accuracy.

Hospitals therefore must include the present on admission indicator in routine coding quality reviews. This monitoring should be formalized through incorporation into the HIM or coding compliance program. Results should be trended.

Any issues identified by the reviews should be addressed through ongoing education for the coding staff, clinical staff, and medical staff.

What's Next?

As emphasis continues on value-based purchasing and pay-for-performance initiatives, it is likely that CMS will add to the list of hospital-acquired conditions. In addition, state reporting agencies and other payers are increasingly considering or already requiring the submission of POA indicators.

Coding professionals should monitor CMS's annual update of the ICD-9-CM Offical Coding and Reporting Guidelines for POA guidelines changes, new examples, and other clarification. The proposed Inpatient Prospective Payment System should also be reviewed, as it may address POA use or changes to the HAC payment provision.

Inaccuracies in the POA assignment can misrepresent analyses of patient outcomes and determinations of hospital reimbursement. This is an opportunity for HIM professionals to reaffirm our commitment to data integrity that supports quality patient care and appropriate reimbursement.

Reference and Related Material

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