

Present on Admission Requirements and the Impact on Acute Care Hospitals

By:

Cherilyn G. Murer, JD, CRA

Present on Admission Overview

Starting October 1, 2007, many hospitals were 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. 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.

However, healthcare organizations should check individual state requirements, as they may have different reporting requirements. While CMS currently exempts specialty hospitals from the POA reporting requirements, it is possible that the trend will change in the near future. Some states are already requiring POA tracking for all hospitals, including specialty hospitals. Thus it is crucial for all hospitals, including those exempted from the federal mandates to become aware of the POA guidelines and begin planning for documenting present on admission issues.

POA Background

The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Diagnosis Related Group (DRG) payments for certain hospital-acquired conditions. CMS has titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC & POA). Inpatient Prospective Payment System (IPPS) hospitals were required by law to submit POA information on diagnoses for inpatient discharges on or after October 1, 2007. The DRA requires that POA indicator be collected for all Medicare patients beginning October 1, 2007 with the following exceptions: critical access, Maryland waiver, long-term care, cancer, psychiatric, rehabilitation, and children's inpatient facilities. 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.

Final 2008 IPPS Rule for Hospitals

The DRA also requires CMS to begin excluding those infections from the calculation of the DRG when they are identified as not present on admission, beginning October 1, 2008. The 2008 Final IPPS Rule implements Section 5001(c) of the Deficit Reduction Act of 2005 (DRA), which requires the secretary to select at least two conditions that are

(a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines by October 1, 2007. Below is the list of conditions that CMS selected in the FY 2008 final rule:

- Serious Preventable Event — Object Left in Surgery
- Serious Preventable Event — Air Embolism
- Serious Preventable Event — Blood Incompatibility
- Catheter-associated Urinary Tract Infections
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter-Associated Infection
- Surgical Site Infection — Mediastinitis After Coronary Artery Bypass Graft (CABG) Surgery
- Hospital-Acquired Injuries — Fractures, Dislocations, Intracranial Injury, Crushing Injury, Burn and Other Unspecified Effects of External Causes

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. In other words, the case will be paid as though the secondary diagnosis was not present. Reduced reimbursement in the form of a lower-paying DRG for one of the selected hospital-acquired conditions will only occur when the selected conditions are the only MCCs and CCs present on the claim. If the patient has other secondary diagnoses that an MCC or CC, the case will continue to be assigned to the higher-paying MCC or CC DRG and there will be no savings to Medicare from that case.

General Present on Admission Reporting Requirements

- **The POA indicator is required for all claims involving Medicare inpatient admissions to general acute care hospitals.**
- **POA 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 POA.**
- **POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *ICD 9-CM Official Guidelines for Coding and Reporting*).**
- **Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.**
- **If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA indicator would not be reported.**

Documentation

The addition of the POA reporting requirement has placed even more emphasis on the importance of accurate and complete medical documentation. POA depends on accurate physician documentation that the condition was present on admission. 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

The MS-DRGs are even more dependent on accurate documentation of complications and comorbidities present on admission or otherwise because the severity depends on accurate reflection of clinical complexity. If the condition, complication, or comorbidity is not documented, coders cannot code it by coding guidelines as specified by the federal government. It is also important to understand the POA codes that will be reported to CMS and will eventually be used for payment/reimbursement purposes by CMS.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. 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.

The Benefits of POA Reporting

- 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

© Murer Consultants, Inc.

Coding

The hospital must provide oversight of the coding process to ensure proper handling of the POA indicator reporting processes. Specific coding applications have changed to accommodate the reporting of the POA indicators and must be reviewed and utilized by the coding department of the hospital. As the changes are developed and implemented all hospitals, including specialty hospitals, should update policies and procedures to reflect the new coding processes. In order to successfully and accurately report it is crucial for hospitals to work with their coding department as a joint effort to achieve accurate and complete documentation, code assignment and reporting in a timely manner.

Quality

Since these new requirements focus on hospital quality improvement and risk management, it is important for quality programs to play a role in the POA reporting process. Hospital quality programs should initiate an analysis of admissions in which any of the targeted conditions were present to allow for the identification and assessment of areas where the risk of hospital-acquired complications is greatest. The quality program should also closely monitor the coding and documentation processes to ensure that both are being handled efficiently and areas where improvement may be needed are identified and addressed immediately.

Conclusion

Although the CMS program applies only to IPPS hospitals and not to all specialty hospitals, exempt providers may fall under a state developed POA reporting program. Some states such as New York and California already require the reporting of POA indicators while other states are developing similar programs such as Massachusetts and Texas.

As a result of the Present on Admission rule developments on both a federal and state wide level, it shall benefit all acute care hospitals to start an action plan to address the POA indicator reporting requirements and all the relevant changes that hospitals must implement to be in compliance. The reporting requirements will directly impact coding, documentation and quality processes thus the more efficiently a hospital responds by improving accurate documentation and coding of conditions present on admission, the more prepared a facility shall be, as the healthcare industry moves towards an emphasis on the direct relationship between quality outcomes and reimbursement.

About the Author:

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Group, a legal based healthcare management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on her web site: <http://www.murer.com>