

Present on Admission Reporting

Audio Seminar/Webinar
February 21, 2008

Practical Tools for Seminar Learning

Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

As a provider of continuing education, the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or services(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.

The faculty has reported no vested interests or disclosures regarding this presentation.

Faculty

Gail Garrett, RHIT

Ms. Garrett is Assistant Vice President in the Regulatory Compliance Department supporting Coding Compliance for a large healthcare organization. She and her team responsibilities include company-wide program development and application in the areas of coding compliance for hospitals, ambulatory surgery centers, imaging centers, and physician practices. Ms. Garrett has many years of experience in the healthcare industry. She has also had the opportunity to serve as the co-chair for AHIMA's Practice Council on Classification and Terminology for three years and has just recently completed a book for AHIMA related to Present on Admission Reporting.

Susan Von Kirchoff, MEd, RHIA, CCS, CCS-P

Ms. Kirchoff is a member of the BKD Health Care Group. Susan has 11 years of health information experience in the areas of ICD-9-CM and CPT coding for inpatient and outpatient coding and reimbursement. She has conducted seminars nationally on compliance, coding, documentation, audits, and billing topics. She is currently president of the Arkansas Health Information Management Association.

Table of Contents

Disclaimer	i
Faculty	ii
Presentation Objectives and Description	1
National Articles on Hospital Acquired Conditions	2
Present on Admission Indicator	
Purpose of Indicator	5
Polling Question #1	5
Deficit Reduction Act of 2005 (DRA)	6
Conditions Selected by CMS	7
Billing Requirements for the Present on Admission (POA) Indicator	
Polling Question #2	8
CMS Transmittal 1240, Change Request 5499	8
Electronic Transmission of POA	9
POA Indicator Reason Codes Temporarily Deactivated	9
POA Official Guidelines	11
Documentation	13
Joint Effort Between Coder and Provider	14
General Reporting Requirements	14
Definition	15
Diagnoses	15
Reporting Options and Definitions	16
“Exempt from Reporting” List	16
Example	17
POA Reporting Parameters	17
Explicitly Documented	18
Diagnosed Prior to Inpatient Admission	18
Diagnosed During Admission by Clearly Present on Admission	19
Possible, Probable, Rule Out, Differential Diagnosis	19
Develops During Outpatient Encounter Prior to Inpatient Admission	20
Unclear Documentation	21
Polling Question #3	21
Chronic Condition with Acute Exacerbation Developed During Admission	22
Impending or Threatened Condition	22
Acute or Chronic Conditions	23
Combination Codes	24
Obstetrical Conditions	25
Perinatal Conditions	26
Congenital Conditions and Anomalies	27
External Cause of Injury Codes	27
Assigning POA	
Documentation to Review	28
Symptoms or Clinical Findings	29
Coding Specifics	30
E-Codes	31
Polling Question #4	31
Case Studies	32-40
Resources	41
Audience Questions	
Appendix	45
CE Certificate Instructions	46

Presentation Objectives

- ◆ Provide the purpose on the Present on Admission (POA) Reporting Guidelines
- ◆ Review the POA reporting requirements
- ◆ Review electronic claims work around (837 institutional)
- ◆ Illustrate POA examples

1

Presentation Description

- ◆ On April 1, 2008, acute care hospitals will begin experiencing returned claims if the Present On Admission (POA) indicator is not completed.
 - This seminar offers a foundation for the purpose of the POA guidelines with a complete review of reporting requirements with exemptions.
 - Best practices for guideline implementation are addressed, and clarification regarding when POA indicators are required on claim forms (UB-04 and 837 Institutional) is provided.

2



3

August 19, 2007

Medicare Says It Won't Cover Hospital Errors

by ROBERT PEAR

WASHINGTON, Aug. 18 — In a significant policy change, Bush administration officials say that Medicare will no longer pay the extra costs of treating preventable errors, injuries and infections that occur in hospitals, a move they say could save lives and millions of dollars.

Private insurers are considering similar changes, which they said could multiply the savings and benefits for patients.

Under the new rules, to be published next week, Medicare will not pay hospitals for the costs of treating certain "conditions that could reasonably have been prevented."

Among the conditions that will be affected are bedsores, or pressure ulcers; injuries caused by falls; and infections resulting from the prolonged use of catheters in blood vessels or the bladder.

In addition, Medicare says it will not pay for the treatment of "serious preventable events" like leaving a sponge or other object in a patient during surgery and providing a patient with incompatible blood or blood products.

Reference: <http://www.nytimes.com/>

4

Data Show Scourge of Hospital Infections

by Ceci Connolly
Washington Post Staff Writer

Excerpt

Wednesday, July 13, 2005; Page A01

Nearly 12,000 Pennsylvanians contracted infections during a hospital stay in 2004, costing an extra \$2 billion in care and at least 1,500 preventable deaths, according to state figures released yesterday that officials say represent a conservative measure of one of the deadliest problems in modern medicine.

As the first state to collect data on hospital-acquired infections, Pennsylvania has put hard numbers on a troubling phenomenon that until now has only been estimated. Even so, the true infection rate and cost is probably much higher, the report's authors said, because of underreporting by many hospitals. The actual tally could be as high as 115,000 infections, based on billing claims the hospitals submitted to insurers, the report said.....

Reference: <http://www.washingtonpost.com/wp-yn/content/article/2005/07/12/AR2005071201555.html>

5

Excerpt:

SUMMARY OF STATE ACTIVITY

- 19 states have laws requiring public reporting of infection rates.
- 2 states have laws requiring public reporting of infection information, but not specifically rates (CA, RI).
- 2 states have laws requiring confidential reporting of infection rates (NE, NV).
- 1 state has a voluntary law requiring public reporting of infection information (AR).
- All other states except WY, AZ, MT, ND have considered hospital infection reporting laws, but have not yet passed legislation.

STATES WITH LAWS REQUIRING HOSPITAL-ACQUIRED INFECTION REPORTING

Click on the state name to link to the actual law

California (2006)

This law requires hospitals to have policies in place to prevent infections, which will be checked by the Department of Health Services once every three years after 2009. The public will not know whether the hospitals are actually following their procedures. It requires public reporting based on the CDC's "Guidance to Public Reporting," but only includes process measures, relating to the rate at which prevention practices are used. The reporting requirements do not include the Guidance "outcome" measures, such as hospital infection rates, which would reveal whether hospital policies are actually reducing infections. The limited public reporting in this bill is to be done at some unspecified time (on or after Jan. 1, 2008) which is a year after we expect the same process measures to be available on the federal "Hospital Compare" website.

Reference: Prepared by
Lisa McGiffert
www.StopHospitalInfections.org

6



Jim, OR

Jim had surgery to repair and place internal hardware on his heel broken while doing roof repair on his house. The surgical site and hardware placed in his heel were infected with hospital-acquired infections that ended up almost costing him the foot. According to Jim, "I picked up 6 different infections (Super-bug Staph & Strep, E-Coli, yeast and a couple others) between the hospital and doctor office visits during the course of 5 surgeries." His treatments to fight the infections included being placed on a VAC (Vacuum Assisted Closure) machine, 120 day IV treatment with a PICC line IV treatment. It took multiple surgeries to finally clear up the infection, and today he still walks with a limp. [Read more »Share your hospital infection story.](#)

Have you or a loved one contracted a hospital infection when you went in for surgery or other illness? Over a 1000 people have shared their hospital infection experiences. We would like to hear your story. [Read their stories.](#)

7

***Present on Admission (POA)
Indicator***



8

Purpose of Present On Admission Indicator

- ♦ **Purpose:**
 - **To differentiate between conditions present on admission and conditions that developed during an inpatient admission. The focus is to assess the timing of when the condition presented.**

9

Polling Question #1

Which of the following designates how the POA indicator is utilized?

- *1 Hospital-acquired conditions, including Infections**
- *2 For Mortality/Complication rate studies**
- *3 State Reporting and Requirements in other Federal agendas (i.e. Pay-for-Performance/Values Based Purchasing)**
- *4 All of the above**



10

Deficit Reduction Act of 2005 (DRA)

October 1, 2007 Requirements:

1. All acute-care facilities reimbursed under the DRG model must identify diagnoses that are present at the time a patient is admitted.
2. The Secretary of Department of Health & Human Services must identify at least two conditions that meet the following criteria:
 - High cost or high volume, or both
 - Assigned to a higher paying DRG when present as a secondary diagnosis, and
 - Reasonably preventable through application of evidence based guidelines

11

Deficit Reduction Act of 2005 (DRA)

By October 1, 2008, there will be a payment impact based on the presence of identified conditions not present at the time of admission



12

Conditions Selected by CMS

Hospital Acquired Condition	Unique Code?	High Cost / High Volume	Prevention Guidelines	CC	Considerations
Catheter Associated UTI	Yes	Yes	Yes	Yes	Yes
Pressure Ulcers (Decubitus Ulcers)	Yes	Yes	Yes	Yes	Yes
Object left in Surgery	Yes	Specific Circumstances	Yes	Yes	Yes
Air Embolism	Yes	Specific Circumstances	Yes	Yes	Yes
Blood Incompatibility	Yes	Specific Circumstances	Yes	Yes	Yes
Vascular catheter assoc infections	Yes	Yes	Yes	Yes	Yes
Surgical site infections	No	Yes	Yes	Yes	Yes
Falls	No	Yes	No	No	Yes

13

Billing Requirements for the Present on Admission (POA) Indicator



14

Polling Question #2



Patient admitted 10/1/08 with simple pneumonia and experiences blood incompatibility during the hospitalization. Diagnosis codes and POA indicators 486-Y and 999.6-N would be assigned.

Which of the following MS-DRG is correct?

- *1 193 Pneumonia w/ CC/ MCC**
- *2 194 Pneumonia w/CC**
- *3 195 Simple Pneumonia w/o CC/MCC**
- *4 None of the above**

15

CMS Transmittal 1240; Change Request 5499

- ♦ **Begin reporting POA indicators for all inpatient claims on October 1, 2007.**
 - Medicare Billing Requirement
 - Many States Reporting Requirement
- ♦ **CMS will edit for POA indicators beginning January 1, 2008**
 - Remark code on remittance advice until March, 2008
 - After March, the claim will be returned to provider if valid POA indicator is not present
- ♦ **On 10/1/08, the POA will affect DRG assignment/reimbursement with the previously chosen hospital acquired conditions**

16

Electronic Transmission of POA

- Effective for discharges on or after January 1, 2008, before POA data is sent to the GROUPER input record, the standard system maintainer shall insure there are system edits on this information to insure that the number of individual POA indicators (between POA and Z or X as indicated in 5499.3) are equal to the number of principal and, if applicable, 8 other diagnoses on the claim. If not, from January 1, 2008 until March 31, 2008, providers shall be sent an informational alert using the ERA with Remark Code (to be assigned). Beginning April 1, 2008, the claim shall be returned to the provider (RTP)
- Effective for discharges on or after January 1, 2008, CWF/NCH shall create a new field to capture and store at least nine POAs and one end of POA indicator.
- Effective for discharges on or after January 1, 2008, DDE screens shall allow for the entry of POA data and one end of POA indicator.
- Effective for discharges on or after January 1, 2008, all POA information shall be included with any secondary claims transmission for Coordination of Benefits purposes.

17

Present on Admission (POA) Indicator Reason Codes Temporarily Deactivated

CMS Joint Signature Memo (JSM)-08154 (01/29/08)

On Tuesday, January 29, 2008, the reason codes associated with the POA Indicator, 34931, 34932, 34929, and 34930 were temporarily deactivated according to instructions from the Centers for Medicare & Medicaid Services (CMS).

Background

On July 20, 2007 CMS issued Change Request (CR) 5679 which specifically addressed claims for services subject to the Hospital Inpatient Prospective Payment System (IPPS). CR 5679 included instructions for fiscal intermediaries and A/B Medicare Administrative Contractors (MAC) for the processing of claims subject to the POA Indicator Requirement. According to the instructions, claims from exempt providers, claims containing keying errors and claims that contained certain other errors were returned to providers for correction. On January 17, 2008, CMS instructed FIs and A/B MACs to suspend impacted claims until further notice. On January 29, 2008, CMS issued additional instructions authorizing the deactivation of the edits to allow the suspended claims to be released for processing.

18

Present on Admission (POA) Indicator Reason Codes Temporarily Deactivated

(Continued)

Because of this action, claims that were suspended have been released and providers should now see these claims move through the system. These claims will pay on the currently assigned payment dates.

CMS has authorized fiscal intermediaries (FI) and Medicare Administrative Contractors (A/B MAC) to place condition code 15 (clean claim delayed in the CMS processing system) on all claims they have been holding, indicating that these claims have been held through no fault of the FI or A/B MAC.

Claims that were Returned to Providers (RTP) must be resubmitted. These claims will receive a new document control number (DCN) and a new payment date. The Fiscal Intermediary Standard System (FISS) maintainer is currently in the process of revising these edits. Providers will be notified of the changes once this revision is completed and the edits are tested and ready to be re-activated.

Posted: 01/31/2008

19

POA Official Guidelines



20

POA Official Guidelines

- ◆ **Published by the Cooperating Parties in *Coding Clinic***
- ◆ **They are NOT intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting***
- ◆ **They are NOT intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes**

21

What the POA Guidelines are:

- ◆ **Supplemental to the *ICD-9-CM Official Guidelines for Coding and Reporting***
 - **Developed to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).**

22

What the POA Guidelines are NOT:

- Not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*.
- Not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes.

23

POA Guidelines Steps

- ♦ Assign ICD-9-CM diagnosis codes according to Sections I, II, and III of the official coding guidelines.
- ♦ Assign the POA indicator to those conditions that have been coded.



24

Documentation

- ♦ 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 or not.

25

Documentation



- ♦ Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.
- ♦ It is NOT necessary for the provider to explicitly document whether a condition is present on admission or not in order to appropriately assign the POA indicator.

26

Joint Effort Between Coder and Provider



- ◆ **A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.**

27

General Reporting Requirements

- ◆ **All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.**

28

Definition



- ◆ 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 as present on admission.

29

What Diagnoses Does POA Apply To?

- ◆ Principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*)
- ◆ Includes External cause of injury codes (E-Codes)
- ◆ If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported

30

Reporting Options and Definitions

- 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 is present on admission)**
- W = Clinically undetermined (provider is unable to clinically determine whether condition was present on admission or not)**
- 1 = Unreported/Not used – (Exempt from POA reporting). Electronic claim will have a “1”**

31

“Exempt From Reporting” List

- ♦ **Leave the “present on admission” field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable.**
- ♦ **This is the only circumstance in which the field may be left blank.**

- **Refer to *ICD-9-CM Official Guidelines for Coding and Reporting* effective October 1, 2007 Page 95 of 101 for the complete list of exempt reporting codes.**

32

“Exempt” Reporting Example

- ◆ 137-139, Late effects of infectious and parasitic diseases
- ◆ 650, Normal delivery
- ◆ V03, Need for prophylactic vaccination and inoculation against bacterial diseases
- ◆ V10, Personal history of malignant neoplasm
- ◆ V55, Attention to artificial openings
- ◆ E800-E807, Railway accidents

33

POA Reporting Parameters

- ◆ Per Transmittal 1240, May 11, 2007, Pub 100-04 MCP:
- ◆ “Exempt from Reporting ” list is a number “1” instead of leaving a blank for electronic billing
 - Enter a number “1” for “present on admission” field if the condition is on the list of ICD-9-CM codes for which this field is not applicable.
 - “This code is the equivalent of a blank on the UB-04 field, however, it was determined that blanks were undesirable when submitting this data via the 4010A1”.

34

POA Explicitly Documented

- ◆ **Assign Y for any condition the provider explicitly documents as being present on admission.**
- ◆ **Assign N for any condition the provider explicitly documents as not present at the time of admission.**



35

Diagnosed Prior to Inpatient Admission

- ◆ **Assign “Y” for conditions that were diagnosed prior to admission**
- ◆ **Example:**
 - **hypertension,**
 - **diabetes mellitus,**
 - **asthma**

36

Diagnosed During Admission but Clearly Present Before Admission

- ♦ **Assign “Y” for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred**
 - **Example: Patient admitted for diagnostic work-up for cachexia – final diagnosis is malignant neoplasm of lung with metastasis**

37

Possible, Probable, Rule Out, Differential Diagnosis

- ♦ **If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was suspected at the time of inpatient admission, assign “Y.”**
 - **Example: Patient admitted with chest pain, possible M.I. Final diagnosis is suspected acute M.I.**

38

Possible, Probable, Rule Out, Differential Diagnosis (cont.)

- ◆ **If the inconclusive final diagnosis was based on symptoms or clinical findings that were not present on admission, assign "N."**



39

Develops During Outpatient Encounter Prior to Inpatient Admission

- ◆ **Assign "Y" for any condition that develops during an outpatient encounter prior to a written order for inpatient admission**
 - **Examples:**
 - **Atrial fibrillation develops after outpatient surgery and patient is subsequently admitted as an inpatient**
 - **Observation patient falls out of bed and breaks a hip and is subsequently admitted as an inpatient to treat the hip fracture**

40

Unclear Documentation



- ◆ Assign “U” when the medical record documentation is unclear as to whether the condition was present on admission.
- ◆ “U” should not be routinely assigned but only used in very limited circumstances.
- ◆ Coders are encouraged to query the providers when the documentation is unclear.

41

Polling Question #3



Which of the following choices would be appropriate to assign “W” POA indicator?

- *1 Documentation is insufficient to determine if condition is present on admission
- *2 Provider is unable to clinically determine whether condition was present on admission or not
- *3 The coder queries whether the diagnosis was POA and the physician states they are not sure if the condition was present or not.
- *4 Both 2 and 3

42

Chronic Condition with Acute Exacerbation Developed During Admission

- ♦ **If the code is a combination code that identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to combination codes.**

- ♦ **If the combination code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of CHF), assign "Y."**

43

Impending or Threatened Conditions

- ♦ **Assign "Y" if the diagnosis is based on symptoms or clinical findings that were present on admission**
 - **Example:**
A patient has a known history of coronary atherosclerosis, is status post myocardial infarction five years ago, and is now admitted for treatment of impending myocardial infarction. The final diagnosis is documented as "impending myocardial infarction."

44

Impending or Threatened Conditions (cont.)

- **Assign “N” if the diagnosis is based on symptoms or clinical findings that were not present on admission.**
 - **Example: A patient is admitted to the hospital for prostate surgery. Postoperatively, the patient developed chest pain and the final diagnosis includes “impending myocardial infarction.”**



45

Acute and Chronic Conditions

- ♦ **Assign “Y” for acute conditions that are present at time of admission and “N” for acute conditions that are not present at time of admission.**
- ♦ **Assign “Y” for chronic conditions, even though the condition may not be diagnosed until after admission (e.g., lung cancer diagnosed during hospitalization)**
- ♦ **If a single code identifies both an acute and chronic condition, see the POA guidelines for combination codes.**

46

Combination Codes

- ♦ Assign "N" if any part of the combination code was not present on admission (e.g., obstructive chronic bronchitis with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).
- ♦ Assign "Y" if all parts of the combination code were present on admission (e.g., patient with diabetic nephropathy is admitted with uncontrolled diabetes)

47

Combination Codes (cont.)

- ♦ If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign "Y."
- ♦ For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later.)

48

Obstetrical Conditions



- ♦ Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.
- ♦ If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign "Y."

49

Obstetrical Conditions (cont.)

- ♦ If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign "N."
- ♦ If the obstetrical code includes more than one diagnosis, and any of the diagnoses identified by the code were not present on admission, assign "N."
(e.g., Code 642.7x, Pre-eclampsia or eclampsia superimposed on pre-existing hypertension.)

50

Obstetrical Conditions (cont.)

- ♦ If the obstetrical code includes information that is not a diagnosis, do not consider that information in the POA determination.
- ♦ Example: Code 652.1x, Breech or other malpresentation successfully converted to cephalic presentation should be reported as present on admission if the fetus was breech on admission but was converted to cephalic presentation after admission (since the conversion to cephalic presentation does not represent a diagnosis, the fact that the conversion occurred after admission has no bearing on the POA determination.)

51

Perinatal Conditions

- ♦ Newborns are not considered to be admitted until after birth. Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned "Y." This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal.)

52

Congenital Conditions and Anomalies

- ◆ Assign “Y” for congenital conditions and anomalies. Congenital conditions are always considered present on admission.
- ◆ Examples: Congenital hydrocephalus, congenital absence of ear lobe, patent ductus arteriosus



53

External Cause of Injury Codes

- ◆ Assign “Y” for any E code representing an external cause of injury or poisoning that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission.)
- ◆ Assign “N” for any E code representing an external cause of injury or poisoning that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission.)

54

Assigning POA



55

Documentation to Review

- ♦ **Entire chart**
- ♦ **Specifically:**
 - ED notes – condition diagnosed or in workup
 - H&P – condition diagnosed or worked up – PMH – current meds
 - Progress notes – follow-up on diagnosing initial condition – new findings of existing conditions
 - Consults – for management of other conditions than that needing surgery
 - Nursing admission, OR admission, Anesthesia work-up
 - Lab and x-ray reports

56

Symptoms or Clinical Findings

- ◆ **Conditions diagnosed during the admission but clearly present before admission**
 - Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.

57

Symptoms or Clinical Findings

- ◆ **If the inconclusive final diagnosis was based on symptoms or clinical findings that were not present on admission, assign "N."**



58

Coding Specifics

	POA Indicator
<ul style="list-style-type: none"> ♦ Combination code <ul style="list-style-type: none"> • Identifies both the chronic condition and the acute exacerbation <ul style="list-style-type: none"> • Both present on admission <ul style="list-style-type: none"> – Ex: Diabetic nephropathy is admitted with uncontrolled diabetes • One or more components of the combination code not present on admission <ul style="list-style-type: none"> – Ex: Gastric ulcer that does not start bleeding until after admission <ul style="list-style-type: none"> Asthma patient develops status asthmaticus after admission • Identifies the chronic condition and not the acute exacerbation <ul style="list-style-type: none"> • Ex: Acute exacerbation of CHF ♦ Possible, probable, suspected, or yet to be rule out diagnoses <ul style="list-style-type: none"> • Diagnosis suspected at the time of inpatient admission • Diagnosis based on symptoms or clinical findings that were not present on admission 	<p>Y</p> <p>N</p> <p>Y</p> <p>Y</p> <p>N</p>

59

Coding Specifics

	POA Indicator
<ul style="list-style-type: none"> ♦ Impending or threatened diagnosis <ul style="list-style-type: none"> • Based on symptoms or clinical findings that were present on admission • Based on symptoms or clinical findings that were not present on admission ♦ Comparative or contrasting diagnoses <ul style="list-style-type: none"> • Both present, or suspected, at the time of admission ♦ Infection codes that include the causal organism <ul style="list-style-type: none"> • Infection (or signs of the infection) present on admission, even though the culture results may not be known until after admission <ul style="list-style-type: none"> • Ex: Patient admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later 	<p>Y</p> <p>N</p> <p>Y</p> <p>Y</p>

60

E-Codes

- | | POA Indicator |
|--|---------------|
| <ul style="list-style-type: none"> ♦ External cause of injury or poisoning occurred prior to inpatient admission <ul style="list-style-type: none"> • Ex: Patient fell out of bed at home Patient fell out of bed in emergency room prior to admission | Y |
| <ul style="list-style-type: none"> ♦ External cause of injury or poisoning occurred during inpatient hospitalization <ul style="list-style-type: none"> • Examples: Patient fell out of hospital bed during hospital stay or Patient experienced an adverse reaction to a medication administered after inpatient admission | N |

61

Polling Question #4

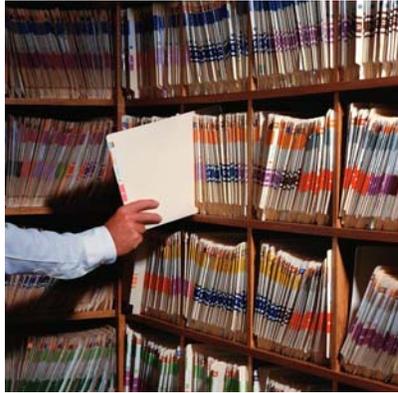
Which of the following scenarios would be appropriate to assign "U" POA indicator?

- *1 Documentation is insufficient to determine if condition is present on admission
- *2 Provider is unable to clinically determine whether condition was present on admission or not
- *3 The coder queries whether the diagnosis was POA and the physician does not respond.
- *4 Both 1 and 3



62

Case Studies



63

Case Example – 1

- ◆ **Patient is admitted for diagnostic work-up for cachexia. The final diagnosis is malignant neoplasm of lung with metastasis.**
 - *Assign "Y" on the POA field for the malignant neoplasm. The malignant neoplasm was clearly present on admission, although it was not diagnosed until after the admission occurred.*

64

Case Example – 2

- ♦ **A patient with severe cough and difficulty breathing was diagnosed during his hospitalization to have lung cancer.**
 - *Assign “Y” on the POA field for the lung cancer. Even though the cancer was not diagnosed until after admission, it is a chronic condition that was clearly present before the patient’s admission.*

65

Case Example – 3

- ♦ **A patient is admitted with high fever and pneumonia. The patient rapidly deteriorates and becomes septic. The discharge diagnosis lists sepsis and pneumonia. The documentation is unclear as to whether the sepsis was present on admission or developed shortly after admission.**
 - *Query the physician as to whether the sepsis was present on admission, developed shortly after admission, or it cannot be clinically determined as to whether it was present on admission or not.*

66

Case Example – 4

- ♦ **A patient is admitted for repair of an abdominal aneurysm. However, the aneurysm ruptures after hospital admission.**
 - *Assign “N” for the ruptured abdominal aneurysm. Although the aneurysm was present on admission, the “ruptured” component of the code description did not occur until after admission.*

67

Case Example – 5

- ♦ **A patient with viral hepatitis B progresses to hepatic coma after admission.**
 - *Assign “N” for the viral hepatitis B with hepatic coma because part of the code description did not develop until after admission.*

68

Case Example – 6

- ♦ **A patient with a history of varicose veins and ulceration of the left lower extremity strikes the area against the side of his hospital bed during an inpatient hospitalization. It bleeds profusely. The final diagnosis lists varicose veins with ulcer and hemorrhage.**
 - *Assign “Y” for the varicose veins with ulcer. Although the hemorrhage occurred after admission, the code description for varicose veins with ulcer does not mention hemorrhage.*

69

Case Example – 7

- ♦ **A female patient was admitted to the hospital and underwent a normal delivery.**
 - *Leave the “present on admission” (POA) field blank. Code 650, Normal delivery, is on the “exempt from reporting” list.*

70

Case Example – 8

- ◆ Patient admitted in late pregnancy due to excessive vomiting and dehydration. During admission patient goes into premature labor
 - *Assign “Y” for the excessive vomiting and the dehydration. Assign “N” for the premature labor*

71

Case Example – 9

- ◆ Patient admitted in active labor. During the stay, a breast abscess is noted when mother attempted to breast feed. Provider is unable to determine whether the abscess was present on admission
 - *Assign “W” for the breast abscess.*

72

Case Example – 10

- ♦ **A single liveborn infant was delivered in the hospital via Cesarean section. The physician documented fetal bradycardia during labor in the final diagnosis in the newborn record.**
 - *Assign "Y" because the bradycardia developed prior to the newborn admission (birth).*

73

Case Example – 11

- ♦ **A newborn developed diarrhea which was believed to be due to the hospital baby formula.**
 - *Assign "N" because the diarrhea developed after admission*

74

Case Example – 12

- ◆ **Patient is admitted from the ED for a diagnostic work up for chest pain. The final diagnosis was myocardial infarction.**
 - *Assign “Y” in the POA field for the myocardial infarction. Although not identified on admission, diagnostic work up confirmed the final diagnosis*

75

Case Example – 13

- ◆ **A patient undergoes outpatient surgery for a hernia. During recovery, the patient develops atrial fibrillation and is admitted to the hospital**
 - *Assign “Y” in the POA field for atrial fibrillation since it developed prior to an inpatient admission order.*

76

Case Example – 14

- ♦ **A patient is admitted to undergo an inpatient total hip surgery. Following surgery the patient develops a fever and is treated aggressively with IV antibiotics. The physician lists a secondary diagnosis of possible post-operative infection.**
 - *Assign “N” in the POA field for post-operative infection because symptoms or clinical findings related to possible, probably, or rule out diagnoses that were not present on admission should be reported as no.*

77

Case Example – 15

- ♦ **A patient with a severe cough and difficult breathing is admitted from a private physician’s office. Following hospital work up the patient is diagnosed with a malignant neoplasm of the lung.**
 - *Assign “Y” on the POA field for the malignant neoplasm. Although not identified until after admission it is clearly a chronic condition that was present on admission.*

78

Case Example – 16

- ♦ **A patient is admitted for coronary artery bypass surgery. Postoperatively the patient has a stroke.**
 - *Assign “N” for the stroke. This is an acute condition that was not present on admission.*

79

Case Example – 17

- ♦ **A patient with high blood sugars is admitted through the ED. After work-up, on day three, the physician documents newly diagnosed uncontrolled diabetes mellitus.**
 - *Assign “Y” . The diagnosis of diabetes does not happen overnight.... Good discussion point for those combination codes.....*

80

Resource/Reference List

Present on Admission, Gail Garrett, RHIT, AHIMA publication, 2007

- <https://imis.ahima.org//orders/productDetail.cfm?pc=AB121207>

Online Coding Assessment and Training Solutions Program (CATS)

- ***Present on Admission and UB-04***
 - http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html#poa

AHIMA Practice Brief:

Planning for Present on Admission:

- http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_035869.hcsp?dDocName=bok1_035869

81

Resource/Reference List

ICD-9-CM Official Guidelines for Coding and Reporting

AHA Coding Clinic for ICD-9-CM

MLN Matters Number: MM5499 Revised

- ***Related Change Request (CR) #:5499 Date: May 11, 2007***

Centers for Medicare & Medicaid Services (CMS)

- ***Pub 100-04 Medicare Claims Processing, Transmittal 1240, Date: May 11, 2007***

82

Audience Questions



Audio Seminar Discussion



*Following today's live seminar
Available to AHIMA members at
www.AHIMA.org*

*Click on Communities of Practice (CoP) – icon on top right
AHIMA Member ID number and password required – for members only*

Join the [Coding Community](#) from your Personal Page
Under Community Discussions, choose the
Audio Seminar Forum

You will be able to:

- Discuss seminar topics
- Network with other AHIMA members
- Enhance your learning experience

AHIMA Audio Seminars

Visit our Web site

<http://campus.AHIMA.org>

for information on the
2008 seminar schedule.

While online, you can also register
for seminars or order CDs and
pre-recorded Webcasts of
past seminars.



Upcoming Seminars/Webinars

Coding for Lymphoma

Faculty:

Faculty:

Miriam P. Rogers, EdD, RN, AOCN, CNS and
Kimberly R. Yelton, RHIA

February 28, 2008



Wound Care Coding

Faculty:

Gloryanne Bryant and
Ella James, MEd, RHIA, CCS, CCS-P

Postponed to April 24, 2008

Thank you for joining us today!

**Remember – sign on to the
AHIMA Audio Seminars Web site
to complete your evaluation form
and receive your CE Certificate online at:**

<http://campus.ahima.org/audio/2008seminars.html>

**Each person seeking CE credit must complete the
sign-in form and evaluation in order to view and
print their CE certificate**

**Certificates will be awarded for
AHIMA Continuing Education Credit**



Appendix

CE Certificate Instructions	46
-----------------------------------	----



To receive your

CE Certificate

Please go to the Web site

<http://campus.ahima.org/audio/2008seminars.html>

click on

"Complete Online Evaluation"

You will be automatically linked to the CE certificate for this seminar after completing the evaluation.

Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.