KAISER PERMANENTE®

Present on Admission Indicators for Inpatient Claims: Provider Q&A

What is Present on Admission?

International Classification of Diseases, Clinical Modification (ICD-10 CM) Official Guidelines for Coding and Reporting (PDF), issued by the National Center for Health Statistics and the Centers for Medicare and Medicaid Services (CMS), defines Present on Admission (POA) as:

> "… present at the time the order for inpatient admission occurs. (C)onditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission."

As part of the Deficit Reduction Act, CMS now requires hospitals to enter POA indicators on all inpatient acute-care hospital claims. This requirement, effective January 1, 2008, is intended to identify certain diagnoses that are:

- High in cost, high in volume, or both.
- Assigned to a higher paying diagnostic related group (DRG) when present as a secondary diagnosis.
- Reasonably preventable through application of evidence-based medicine.

How does this affect Kaiser Foundation Health Plan of Washington?

For discharges after October 1, 2008, hospitals may not receive additional payment for cases in which one of the selected conditions was not POA, penalizing hospitals when a certain diagnosis is present on discharge but not on admission. For example:

- Serious preventable events, such as objects left in surgery, air embolism, or blood incompatibility
- Catheter-associated urinary tract infections
- Decubitus ulcers
- Vascular catheter-associated infections
- Surgical site infections
- Hospital falls

What can I do?

For every diagnosis code that hospital coders assign from the inpatient record, they assign an indicator to denote whether that condition was POA. These coders review your documentation in progress notes, admitting history and physical, pre-operative history and physical, consult notes, anesthesia notes, and other notes to determine POA status.

Clear documentation is critical. Key documentation points include:

- Completely document all conditions that are clinically POA and conditions that manifest after admission but can be traced back to the presenting signs and symptoms.
- Link diagnoses with symptoms. For example, a patient is admitted with low blood pressure. On day two, the physician identifies that the low blood pressure is due to septic shock. If the physician does not link the two, it will appear as though the septic shock occurred after the patient was admitted.
- Document any ruled out, possible, and suspected conditions POA or ruled out conditions that developed during the hospital stay.
- Clearly identify chronic conditions with acute exacerbations. In these circumstances, coders must follow special guidelines for assigning POA indicators.
- Document infections POA and the causal organism, if known.
- Document the cause of any injury or poisoning and include where it occurred.

Reporting accurate diagnoses for an inpatient stay is a joint effort between the provider and the coder. However, CMS has stated that the provider is legally accountable for establishing the patient's diagnosis and for determining whether a diagnosis was POA.

POA indicators and definitions

Y	Yes. Any condition the provider explicitly documents as being present at the time of inpatient admission.
N	No. Not represent at the time of inpatient admission.
U	Unknown. Medical record documentation is unclear (to coders).
W	Clinically undetermined. Medical record documentation indicates that it cannot be clinically determined whether or not the condition was present at time of inpatient admission.
1	Unreported/Not used. Coding category exempt from POA reporting (codes that do not represent a current disease or injury).

For detailed information on POA indicators, see the Medicare Claims Processing Manual, Change Request 5499, May 11, 2007 (PDF).