

The
**Present on Admission
Training Handbook**

*Answers to Your Coding
and Documentation Questions*

JAMES S. KENNEDY, MD, CCS

+CPro

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HCPPro

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Section 1: Introduction to POA



Why are present on admission indicators so important?



The present on admission (POA) indicator designates whether a condition is present at the time an inpatient admission occurs.

It is an ICD-9-CM metric that the Cooperating Parties implemented in the United States in 2007. The Centers for Medicare & Medicaid Services' (CMS) use of the POA indicator will be an integral part of its transition to a more active purchaser of quality healthcare services in its value-based purchasing strategy. Ultimately, the goal for Medicare as well as other payers in using the POA indicator is to improve the quality of care, encourage the efficient use of resources, and provide information to beneficiaries to assist them in making medical choices.

This handbook will address national POA guidelines and reporting requirements. Note that these requirements may not apply to your specific state reporting requirements. Each state may have its own initiatives; thus, readers should turn to state hospital associations, public health departments, or similar agencies for more information. For example, one interesting difference between California reporting requirements and national requirements is that California labels POA

Section 1

as present *at* admission rather than present *on* admission. Refer to the search feature on the following Web site for more information: www.oshpd.ca.gov.



What are the benefits of POA data?



There are many benefits to accurately reporting POA data, including the following:

- Encourages providers to revise inconsistent, missing, or unclear documentation regarding the circumstances of an inpatient admission
- Adds precision to ICD-9-CM coding by distinguishing between preexisting conditions (i.e., POA conditions) and hospital-acquired conditions (HACs) or complications (i.e., those that are not POA)
- Increases the efficiency of hospital quality-improvement activities by:
 - Differentiating between ICD-9-CM complication codes and other high-risk events (e.g., postoperative respiratory failure or acute blood loss anemia) relative to the current admission
 - Reducing investigation time in selecting records for quality or physician peer review by providing a rapid screening tool for HACs using the ICD-9-CM administrative database

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- Providing a relatively simple method for measuring the number and nature of provider-specific HACs
- Enhancing the accuracy of ICD-9-CM-based databases (e.g., The Delta Group, Thomson Medstat, and CareScience) in modeling risk-adjusted outcomes
- Improves the accuracy of safety and quality-of-care measures by:
 - Identifying designated preventable HACs (CMS does not want to pay for preventable events that it deems to be the result of poor hospital care)
 - Enhancing the Agency for Healthcare Research and Quality (formerly AHCPR) patient-safety indicators for responsible reporting of complication data
- Increases the validity of publicly available physician and hospital report cards
- Improves the accuracy of severity-of-illness and risk-of-mortality algorithms (these algorithms require a differentiation between POA conditions and HACs)
- Enhances the design and fairness of pay-for-performance programs