

Hospital-Acquired Conditions and Present on Admission  
Indicator Reporting Listening Session

# Opening Remarks

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Hospital-Acquired Conditions and Present on Admission  
Indicator Reporting Listening Session

# Opening Remarks

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*Chief Policy Officer*

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Hospital-Acquired Conditions and Present on Admission  
Indicator Reporting Listening Session

CMS' Progress Toward  
Implementing  
Value-Based Purchasing

Thomas B. Valuck, MD, JD

*Director, CMS - Special Program Office for  
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# CMS' Quality Improvement Roadmap

- Vision: The right care for every person every time
  - Make care:
    - Safe
    - Effective
    - Efficient
    - Patient-centered
    - Timely
    - Equitable

# CMS' Quality Improvement Roadmap

- Strategies
  - Work through partnerships
  - Measure quality and report comparative results
  - Value-Based Purchasing: improve quality and avoid unnecessary costs
  - Encourage adoption of effective health information technology
  - Promote innovation and the evidence base for effective use of technology

# VBP Program Goals

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage more patient-centered care
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in effective structural components or systems
- Make performance results transparent and comprehensible
  - To empower consumers to make value-based decisions about their health care
  - To encourage hospitals and clinicians to improve quality of care

# What Does VBP Mean to CMS?

- Transforming Medicare from a passive payer to an active purchaser of high quality, efficient health care
- Tools for promoting better quality, while avoiding unnecessary costs
  - Explicit payment incentives to achieve identified quality and efficiency goals
  - Pay for reporting, pay for performance, gainsharing, and competitive bidding are all VBP tools

# Why VBP?

- Improve Quality
  - Quality improvement opportunity
    - Wennberg's Dartmouth Atlas on variation in care
    - McGlynn's NEJM findings on lack of evidence-based care
    - IOM's Crossing the Quality Chasm findings
- Avoid Unnecessary Costs
  - Medicare's various fee-for-service fee schedules and prospective payment systems are based on resource consumption and quantity of care, NOT quality or unnecessary costs avoided
    - Physician Fee Schedule and Hospital Inpatient DRGs
    - Medicare Trust Fund insolvency looms

# Support for VBP

- President's Budget
  - FYs 2006-08
- Congressional Interest in P4P and Other Value-Based Purchasing Tools
  - Medicare Modernization Act, Deficit Reduction Act, and Tax Relief and Health Care Act provisions
- MedPAC Reports to Congress
  - P4P recommendations related to quality, efficiency, health information technology, and payment reform
- IOM Reports
  - P4P recommendations in *To Err Is Human* and *Crossing the Quality Chasm*
  - Report, *Rewarding Provider Performance: Aligning Incentives in Medicare*
- Private Sector
  - Private health plans
  - Employer coalitions

# VBP Demonstrations and Pilots

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Nursing Home Value-Based Purchasing Demonstration
- Home Health Pay-for-Performance Demonstration
- ESRD Bundled Payment Demonstration
- ESRD Disease Management Demonstration

# VBP Demonstrations and Pilots

- Medicare Health Support Pilots
- Care Management for High-Cost Beneficiaries Demonstration
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations
- Better Quality Information (BQI) Pilots
- Electronic Health Records (EHR) Demo (TBA)
- Medical Home Demo (TBA)

# VBP Initiatives

- Hospital Quality Initiative: Inpatient & Outpatient
- Hospital VBP Plan & Report to Congress
- Hospital-Acquired Conditions & Present on Admission Indicator
- Physician Voluntary Reporting Program
- Physician Quality Reporting Initiative
- Physician Resource Use
- Home Health Care Pay for Reporting
- Ambulatory Surgical Centers Pay for Reporting
- Medicaid – State Partnerships

# Hospital VBP Rreport to Congress

- The Hospital VBP Report Can Be Downloaded at:

<http://www.cms.hhs.gov/center/hospital.asp>

# Value-Based Purchasing and Hospital-Acquired Conditions

- The Hospital-Acquired Conditions provision is a step toward Medicare VBP for hospitals
- Strong public support for CMS to pay less for conditions that are acquired during a hospital stay
- Considerable national press coverage of HAC has prompted dialogue of how to further eliminate healthcare-associated infections and conditions

# Statutory Authority: DRA Section 5001(c)

- CMS was required to select at least two conditions by October 1, 2007 that are:
  1. High cost, high volume, or both;
  2. Assigned to a higher paying DRG when present as a secondary diagnosis;
  3. Reasonably prevented through the application of evidence-based guidelines

# Statutory Authority: DRA Section 5001(c)

- Beginning October 1, 2007, hospitals must begin submitting data on their claims for payment indicating whether diagnoses were present on admission (POA)
- Beginning October 1, 2008, CMS cannot assign a case to a higher DRG based on the occurrence of one of the selected conditions, if that condition was acquired during the hospitalization
- This provision does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under the Medicare Hospital IPPS

# Hospital-Acquired Conditions

## Conditions Selected for Fiscal Year 2009 Payment Provision

Joe Kelly, MD

*Medical Officer*

*CMS - Center for Medicare Management*

# Hospital-Acquired Conditions

Section 5001(c) of Deficit Reduction Act (DRA) requires Secretary to select at least two conditions by 10/1/07 that are:

- 1) High cost or high volume or both
- 2) Assigned to a higher paying DRG when present as a secondary diagnosis
- 3) Reasonable preventable through application of evidence based guidelines

# Hospital-Acquired Conditions

- Beginning 10/1/08, the conditions will group to the lower paying DRG with the following caveats:
  - 1) The condition was not present on admission (POA).
  - 2) The condition is the only MCC/CC reported.

If other secondary dx that are MCC/CC are reported, the case will still group to the appropriate higher level DRG.

# HACs Selected for FY2009

- Object left in surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Decubitus ulcers
- Vascular catheter-associated infection
- Surgical site infection – mediastinitis after CABG
- Falls – specific trauma codes

# Hospital-Acquired Conditions

"Reasonably Preventable"

Thomas B. Valuck, MD, JD

*Director, CMS - Special Program Office for  
Value-Based Purchasing*

# Hospital-Acquired Conditions

## Coding Implications

Pat Brooks

*Senior Technical Advisor*

*CMS - Center for Medicare Management*

# Coding Implications

- To implement HAC provisions, the following are needed
  - Clear and unique ICD-9-CM code(s) for condition
  - Code must be a Major Complication or Comorbidity (MCC) or Complication or Comorbidity (CC)

# Coding Implications

- Clear and unique code for condition
  - Vascular catheter-associated infection did not have unique code
    - Was previously identified with code including infections associated with all vascular devices, implants, and grafts
    - New code 999.31 (Infection due to central venous catheter) became effective October 1, 2007
    - Condition was selected among the initial 8 HACs

# Coding Implications

- Clear and unique code for condition
  - Ventilator-associated pneumonia did not have unique code
    - Did not include condition among initial 8
    - ICD-9-CM Coordination & Maintenance Committee (C&M) discussed creation of new code at September 29, 2007 meeting
    - Will evaluate adding if new code is created on October 1, 2008

# Coding Implications

- Clear and unique code for condition
  - Methicillin-Resistant *Staphylococcus aureus* (MRSA)
    - V09.9 (Infection with microorganisms resistant to penicillins)
    - Code not unique to MRSA's
    - CDC will discuss the creation of a new code at the March 19-20, 2008 C&M meeting
    - <http://www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm>

# Coding Implications

- Clear and unique code for condition
  - Other conditions would require the use of two or more ICD-9-CM codes to clearly identify the conditions
    - Examples - catheter-associated urinary tract infections and mediastinitis after coronary bypass surgery
    - We did not exclude those requiring multiple codes; however
    - The need for multiple codes may present operational issues

# Coding Implications

- Clear and unique code for condition
  - Selection of *Staphylococcus aureus* bloodstream infection would require the use of two or more ICD-9-CM codes to clearly identify the condition
    - Would need to carefully identify the codes that should be considered
  - Other potential HACs could present similar challenges

# Coding Implications

- Code capturing HAC must be a MCC or CC
  - Serious preventable event – surgery on wrong body part, patient, or wrong surgery
    - Code E876.5 (performance of inappropriate operation) is not a MCC or CC
    - Code does not effect payment
    - Was not selected as one of the initial 8 HACs

# Coding Implications

- The selection of future HACs must consider these coding implications
  - Clear and unique ICD-9-CM code(s) are needed for the condition
  - Code must be a MCC or CC

# Hospital-Acquired Conditions

## Evidence-Based Guidelines For Prevention of Hospital-Acquired Conditions

Chesley Richards, MD, MPH

*Deputy Director, CDC -*

*Division of Healthcare Quality Promotion*

# IPPS FY2008 Proposed Rule

- Section 5001(c) of Pub. L. 109-171 requires the Secretary to identify, by October 1, 2007, at least **two conditions** that are
  - high **cost** or high **volume** or both,
  - result in the assignment of a case to a DRG that has a **higher payment when present as a secondary diagnosis**
  - could **reasonably have been prevented** through the application of evidence-based guidelines.

# Guidelines for Preventing HACs

- Where
  - Professional organizations, Task Forces, Government agencies, academic institutions
- What
  - Scientific evidence for a particular intervention
- Who
  - Scientists, clinicians, policy makers

# Healthcare Infection Control Practices Advisory Committee (HICPAC)

- For the Secretary...and the Director, Centers for Disease Control and Prevention
  - provide advice and guidance regarding the practice of infection control and strategies for surveillance, prevention, and control of healthcare-associated infections ... in settings ... including hospitals, long-term care facilities, and home health agencies.
  - ...periodic updating of existing guidelines, development of new guidelines, guideline evaluation; and other policy statements regarding the prevention of healthcare-associated infections and healthcare-related conditions.

# HICPAC Members

- The Committee shall consist of 14 public members, including the Chair.
- Knowledgeable in the fields of infectious diseases, healthcare-associated infections and healthcare-related events, epidemiology, health policy, health services research, public health, and related fields.
- Non-voting Federal representatives from the
  - Agency for Healthcare Research and Quality
  - Food and Drug Administration
  - Centers for Medicare and Medicaid Services
  - Health Resources and Services Administration
  - National Institutes of Health

# HICPAC Members

- Non-voting liaison representatives from the
  - Association of Professionals in Infection Control and Epidemiology, Inc.
  - Society for Healthcare Epidemiology of America
  - Association of Perioperative Registered Nurses
  - American Hospital Association
  - American Health Care Association
  - American College of Occupational and Environmental Medicine
  - Joint Commission on Accreditation of Healthcare Organizations
  - Advisory Council for the Elimination of Tuberculosis
  - Other nonvoting liaison representatives as the Secretary deems necessary

# HICPAC Publications

- [Guideline for Isolation Precautions, 2007](#)
- [Management of Multidrug-Resistant Organism 2006](#)
- [Influenza Vaccination of Health-Care Personnel](#)  
MMWR February 2006
- [Guidance on Public Reporting of Healthcare-Associated Infections](#) AJIC February 2005
- [Guidelines for Preventing Healthcare Associated Pneumonia](#)  
Published 2004
- [Guidelines for Environmental Infection Control in Health-Care Facilities](#)  
Published 2003
- [Recommendations for Using Smallpox Vaccine in a Pre-Event Vaccination Program](#)  
Published 2003

# HICPAC Publications

- [Guidelines for Preventing Intravascular Device-Related Infections](#)  
Published 2002
- [Guidelines for Hand Hygiene in Healthcare Settings](#)  
Published 2002
- [Guideline for Infection Control in Healthcare Personnel](#)  
Published 1998
- [Guideline for the Prevention of Surgical Site Infections](#)  
Published 1999
- [Immunization of Health Care Workers](#)  
Published 1997
- [Recommendations for Preventing the Spread of Vancomycin Resistance](#)  
Published 1995

# Categories of Recommendations

- **Category IA.** Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.  
**Category IB.** Strongly recommended for implementation and supported by certain clinical or epidemiologic studies and by strong theoretical rationale.  
**Category IC.** Required for implementation, as mandated by federal or state regulation or standard.  
**Category II.** Suggested for implementation and supported by suggestive clinical or epidemiologic studies or by strong theoretical rationale.
- **No recommendation; unresolved issue.** Practices for which insufficient evidence or no consensus exists about efficacy.

# Challenges for Implementation

- Evidence...or lack of it
- Implementation
- Single recommendations versus multiple recommendations
- Performance versus outcome
- Guideline updates
  - Incorporating new evidence for prevention

# Hospital-Acquired Conditions

## HACs Under Consideration

Chesley Richards, MD, MPH

*Deputy Director, CDC -*

*Division of Healthcare Quality Promotion*

# IPPS FY2008 Proposed Rule

- Section 5001(c) of Pub. L. 109-171 requires the Secretary to identify, by October 1, 2007, at least **two conditions** that are
  - high **cost** or high **volume** or both,
  - result in the assignment of a case to a DRG that has a **higher payment when present as a secondary diagnosis**
  - could **reasonably have been prevented** through the application of evidence-based guidelines.

# Unintended Consequences

- Code substitution
  - Septicemia NOS vs. Staphylococcal Septicemia vs. *Staph aureus* Septicemia
- Increased use of present on admission, including those with high risk for infection
  - Corollary: increased and potentially unnecessary use of diagnostic tests on admission
- Confusion between events
  - Pneumonia on admission may lead to mechanical ventilator, and subsequent hospital acquired VAP
- Risk adjustment issues
  - APR DRGs and POA are helpful but may not be enough for some infections

# Questions to Address

- Burden
  - Frequency, cost, mortality
- Preventability
  - Guidelines/interventions exist
  - Application can prevent these infections
    - Interpretation of the term “...reasonably...”
- Measurement
  - Are these events easily and appropriately detected using ICD-9 codes

# Hospital-Acquired Conditions

## Category 2 Conditions

# Ventilator-Associated Pneumonia

- Do prevention interventions exist?
  - CDC/HICPAC, professional organizations
- How effective are prevention interventions?
  - Individual interventions recommended and have effects
  - Prevention impact less clear cut than with surgical site infection and bloodstream infection
  - Reasonably vary by patient population
  - Impact from bundles under study presently (Keystone)
- Can we identify?
  - New code
  - VAP definitions difficult to apply and clinicians differ on diagnosis
  - Low likelihood that we can measure accurately using ICD 9/10 codes, even if present on admission variable in place

# *Staphylococcus aureus* Septicemia

- How common?
  - 44,000 as principal diagnosis
  - 109,000 as any diagnosis
  - Not all hospital acquired
- Do prevention interventions exist?
  - Prevention of bloodstream infection guideline (HICPAC)
- How effective are prevention interventions?
- Can we identify?
  - Code 038.11

# Deep Venous Thrombosis/ Pulmonary Thromboembolism

- How common?
  - CMS data: 1% of all Medicare hospitalizations
  - Probably, underestimated
  - Post discharge
- Do prevention interventions exist?
  - Guidelines for prophylaxis
- How effective are prevention interventions?
  - Varies by underlying condition
- Can we identify?
  - Clinical suspicion, evaluation

# Hospital-Acquired Conditions

## Category 3 Conditions

# Methicillin-Resistant *Staphylococcus aureus*

- How common?
  - 250,000 hospital discharges with MRSA
  - Not all are hospital acquired
  - MRSA vs. Staphylococcus
- Do prevention interventions exist?
  - CDC/HICPAC, professional organizations
- How effective are prevention interventions?
  - Implementation of HICPAC guidelines
  - Reducing inappropriate/unneeded antibiotic use
  - Colonization versus infection
- Can we measure?
  - Code
  - Infection

# *Clostridium difficile*-Associated Disease (CDAD)

- How common?
  - 60,000-178,000 hospital discharges with CDAD
  - Not all are hospital acquired
- Do prevention interventions exist?
  - CDC/HICPAC, professional organizations
  - Infection control precautions play an important role
  - Antibiotic exposure
- How effective are prevention interventions?
  - Reducing inappropriate/unused antibiotic use
  - Many patients will receive good quality care, yet develop CDAD
- Can we identify?
  - Laboratory tests
  - Colonization (not ill) vs. clinical disease

# Hospital-Acquired Conditions

- Category #2 and #3 proposed conditions all have potential disadvantages
- Impact of prevention remains a legitimate area for discussion
- Unintended consequences need to be monitored and addressed
- Despite these limitations, the HAC effort has increased attention on preventing the selected conditions

# Hospital-Acquired Conditions

Public Comment Session

# Present on Admission Indicator

## Definitions, Coding, and Reporting

Donna Pickett, RHIA, MPH

*Medical Systems Administrator*

*CDC – National Center for Health  
Statistics*

# POA Indicator Timeline

- 1992 - 2005: Health care industry recommendations regarding need for POA indicators
- 2006: NUBC approval of UB-04 POA indicator/definitions
- May 2007: UB-04 fully implemented for all institutional paper claims
- May 2007: CMS issues Medicare instructions for POA reporting

# National Uniform Billing and Coding (NUBC) UB-04 POA Timeline

- UB-04 adopted by NUBC February 2005
- UB-04 approved by OMB 8/28/06
- Implementation milestones
  - March 1, 2007
    - Receivers (health plans, clearinghouses)
  - March 1 – May 22, 2007
    - Submitters (health care providers) e.g., hospitals, skilled nursing facilities, hospice) can use either
  - May 23, 2007
    - All institutional paper claims must use UB-04

# POA Indicator General Requirements

- 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.

# POA Indicator General Requirements

- 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.
- 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.

# POA Indicator General Requirements

- POA indicator is assigned to
  - principal diagnosis
  - secondary diagnoses
  - external cause of injury codes (**Medicare requires reporting only if E-code is reported as an additional diagnosis**)

# POA Indicator Reporting Options

## POA Indicator Options and Definitions

<b>Code</b>	<b>Reason for Code</b>
<b>Y</b>	Diagnosis was present at time of inpatient admission.
<b>N</b>	Diagnosis was not present at time of inpatient admission.
<b>U</b>	Documentation insufficient to determine if condition was present at the time of inpatient admission.
<b>W</b>	Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission or not.
<b>1</b>	Unreported/Not used. Exempt from POA reporting. This code is equivalent code of a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A.

# POA Indicator Reporting Options

## Assigning POA indicator **(Y)**

- Condition explicitly documented as present at the time of inpatient admission
- Condition diagnosed prior to admission (e.g., diabetes, hypertension)
- Diagnosed during admission but clearly present (e.g., work up reveals malignancy)
- Condition develops during an outpatient encounter prior to a written order for inpatient admission (e.g., atrial fibrillation develops after outpatient surgery and patient is subsequently admitted as an inpatient)

# POA Indicator Reporting Options

## Assigning POA indicator **(N)**

- Provider explicitly documents condition as not present at the time of admission.
- If the inconclusive final diagnosis was based on symptoms or clinical findings that were not present on admission, assign "N".

# POA Indicator Reporting Options

## Assigning POA indicator **(W)**

- When the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission (e.g., the provider may not be able to determine whether an infection developed after admission or was present at the time of admission).

# POA Indicator Reporting Options

## Assigning POA indicator **(U)**

- When the medical record documentation is unclear as to whether the condition was present on admission.
- Should not be routinely assigned and used only in very limited circumstances.
- Coders are encouraged to query the providers when the documentation is unclear.

# ICD-9-CM POA Reporting Guidelines

- Comprehensive POA reporting guidelines as well as list of exempt codes developed by the ICD-9-CM Cooperating Parties.  
Published 10/06 and updated 10/07
  - American Hospital Association
  - American Health Information Management Association
  - Centers for Medicare and Medicaid Services
  - National Center for Health Statistics/CDC

# ICD-9-CM POA Reporting Guidelines

- POA guidelines to be used as a supplement to the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim form (UB-04)

# POA Indicator Coding and Reporting Guidelines

- Guidelines not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting* (<http://www.cdc.gov/nchs/datawh/ftpserve/ftp/cd9/icdguide07.pdf> *guidelines begin on page 92*).
- POA guidelines 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 that have been assigned in accordance with Sections I, II, and III of the official coding guidelines.

# POA Indicator Coding and Reporting Guidelines

- Assigning POA indicator
  - Acute and chronic conditions
  - Impending conditions
  - Combination codes
  - Obstetrical conditions
  - Perinatal conditions
  - Congenital conditions and anomalies
  - External cause of injury codes

# POA Indicator Coding and Reporting Guidelines

- 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).

# POA Indicator Coding and Reporting Guidelines

- Combination Codes
  - Assign “**N**” if any part of the combination code was not present on admission
  - Example:
    - 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
    - Viral hepatitis B progresses to hepatic coma after admission

# POA Indicator Coding and Reporting Guidelines

- Combination Codes (cont.)
  - Assign “Y” if all parts of the combination code were present on admission.
  - Example: Patient admitted with diabetic nephropathy.

# POA Indicator Coding and Reporting Guidelines

- Categories/Codes exempt from reporting
  - POA reporting is unnecessary because the categories/codes do not represent a current disease or injury or are always present on admission
  - List developed to assist with creation of system edits (not for memorization)

*These exempt categories have no relationship to “exempt unit” and “exempt hospital” status*

# POA Indicator Coding and Reporting Guidelines

- Exempt Reporting Examples:
  - 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.

# POA Indicator Reporting

## CMS' Implementation of POA Indicator Reporting

Marc Hartstein

*Acting Deputy Director, CMS - Employer  
Policy and Operations Group  
Center for Beneficiary Choice*

# Need for POA Indicator

- In order to apply the hospital-acquired conditions provision, CMS needs to capture a POA indicator for all claims involving inpatient admissions to general acute care hospitals.

# POA Indicator Reporting Options

## POA Indicator Options and Definitions

<b>Code</b>	<b>Reason for Code</b>
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<b>1</b>	Unreported/Not used. Exempt from POA reporting. This code is equivalent code of a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A.

# POA Indicator Phased Implementation

- **October 1, 2007 - Ongoing**
  - Inpatient Prospective Payment System (IPPS)  
Hospitals are required to submit Present on Admission (POA) Indicator information for all primary and secondary diagnoses

# POA Indicator Phased Implementation

- **October 1, 2007 - December 31, 2007**
  - CMS will process all Present on Admission indicator data, but will not be providing feedback on receipt of successful reporting

# POA Indicator Phased Implementation

- **January 1, 2008 - March 31, 2008**
  - CMS will begin processing POA indicator data and will provide feedback to IPPS hospitals on reporting errors.
  - Hospitals will be educated on reporting errors and will NOT be subject to returned claims.

# POA Indicator Phased Implementation

- **April 1, 2008 - Ongoing**
  - Claims that are submitted for payment that do not contain proper reporting of the POA indicator will be RETURNED

# POA Indicator Reporting

## Successful Documentation of the Present on Admission Indicator

Susan Nedza, MD, MBA FACEP

*Medical Officer*

*CMS - Special Program Officer for Value-  
Based Purchasing*

# The Goal: Successful Documentation

“ 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.”

*ICD-9-CM Official Guidelines for Coding and Reporting*

# Who is the Provider?

“Provider” means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.

# What is the Best Source of Information?

- Provider Documentation at Time of Admission
  - ED notes
  - History and Physical
  - Progress
  - Admitting Notes

# Documentation: Where do your Admits come from?

- Present at the time the order for inpatient admission occurs
  - May develop during outpatient encounter
    - Emergency department
    - Observation status
    - Outpatient surgery
  - Transfers?
  - Elective Cases?
  - Direct Admits?

# Documentation Best Practices

- Communicate, Communicate, Communicate
  - Build Awareness
  - Provide Guidance
  - Standardize Procedures
  - Monitor Implementation
  - Close the Loop

# Best Practices: Build Awareness

- Communicate across the healthcare system
- Medical staff education and input
- Educate patients and their families

# Best Practices: Provide Guidance

- Clear, concise guidance for each audience
  - Leadership
  - Staff
  - Medical staff
  - IT professionals
  - Compliance Officers
  - Coding Professionals
  - Quality Improvement Department
  - Contractors

# Best Practices: Standardize Procedures

- Map current operation related to hospital acquired conditions
- Seek agreement on where and how to document
- Standardize across hand-offs
- Formal Query Process

# Best Practices: Resolve Documentation Issues

- Will Require Provider Input:
  - Inconsistent
  - Missing
  - Conflicting

# Best Practices: Close the Loop

- Hospital Leadership (C-Suite)
- Board of Trustees
- Stakeholders
- Medical Staff
- Community

# Final Documentation Thoughts

- Allows Medicare to move from passive payer to active purchaser of care
- Supports Medicare efforts to pay for high quality, patient-centered, and efficient care
- Accurate documentation and coding will support the same transformation in the hospital environment

# HAC & POA Indicator Reporting

## Outreach & Education

Lisa Grabert

*Health Insurance Specialist*

*CMS - Special Program Officer for Value-  
Based Purchasing*

# HAC & POA Indicator Reporting

- The best resource for information is the HAC & POA Indicator website

<http://www.cms.hhs.gov/HospitalAcqCond/>

# HAC & POA Indicator Reporting

## Public Comment Session

# HAC & POA Indicator Reporting

## Closing Remarks

Thomas B. Valuck, MD, JD  
*Director, CMS - Special Program Office for  
Value-Based Purchasing*

# Opportunities for Public Comment

- Listening Session
  - Verbal Statements
  - Written Comments
    - E-Mail: [hacpoa@cms.hhs.gov](mailto:hacpoa@cms.hhs.gov)
- IPPS Rulemaking
  - Proposed Rule
    - April of every calendar year
    - Instructions for submitting comments
  - Final Rule
    - August of every calendar year
- Listserv Messages
- Updates to the webpage
- Open Door Forums