


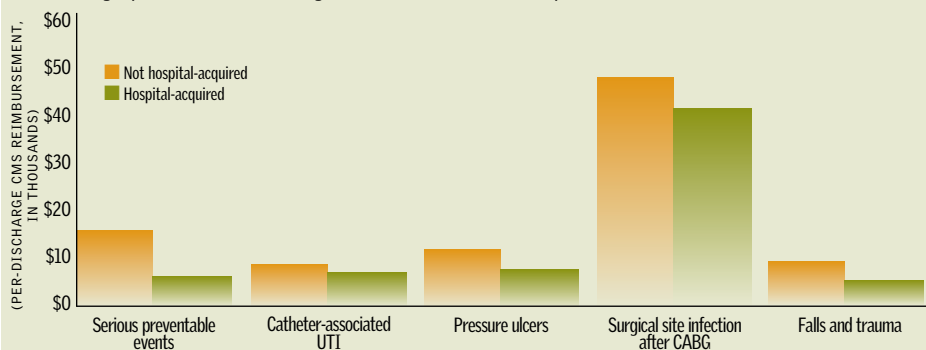
Present-On-Admission Indicators

The Centers for Medicare & Medicaid Services has proposed expanding the list of conditions that are reasonably preventable through proper care and for which CMS will no longer pay at a higher rate if the patient acquires them during a hospital stay. Such conditions—including ventilator-associated pneumonia, deep vein thrombosis, certain surgical site infections, and others—can add considerable costs to medical care and result

in significant deaths. One study estimates that under CMS rule changes regarding five preventable conditions, the total estimated reimbursement amount for all patients nationwide will be roughly \$91 million for fiscal year 2009—an average decline per hospital of more than \$23,000. Provider organizations clearly have much at stake as they develop processes for documenting conditions as present on admission. 

MEASURING THE IMPACT

The average reimbursement amount from CMS as a result of proposed changes to rules governing hospital-acquired conditions is estimated at \$4,114 per patient based on the changed MS-DRG assignment. The total estimated reimbursement amount for all patients nationwide with a hospital-acquired condition is \$91,069,025 for FY 2009—an average decline per hospital of \$23,722 based on the five relatively rare conditions below (CMS continues to add more conditions to the list, which would increase the per-hospital loss). The graphic shows the average CMS reimbursement for patients with one of the five conditions.



UNDERSTANDING THE CODES

To identify which diagnoses are present on admission, CMS has designed a set of indicators that must be assigned to every diagnosis on a claim.

POA Indicator	Definition	Long Definition
Y	Yes	Diagnosis present at the time of inpatient admission.
N	No	Diagnosis not present at the time of inpatient admission.
U	Unknown	Documentation is insufficient to determine whether condition was present at time of inpatient admission.
W	Clinically undetermined	Provider is unable to clinically determine whether condition was present at time of inpatient admission.
I	Unreported	Exempt from POA reporting. These ICD-9-CM codes are exempt from POA reporting because they represent circumstances regarding the healthcare encounter or factors influencing health status that either are not a current disease or injury or are always present on admission.

SOURCE: Centers for Medicare & Medicaid Services

DESIGNING A PROCESS THAT WORKS

Provider organizations should establish clear policies and procedures that support timely, accurate, and complete present-on-admission indicator assignment. To this end, organizations should:

- Gather leadership support of the policy and procedure with an emphasis on an interdisciplinary team approach to POA assignment.
- Educate all applicable staff members including internal, external (contract), and medical staff.
- Provide clear expectations for timely, accurate, and complete documentation.
- Develop a POA monitoring process and include a representative sampling of patients by case mix and payer mix. The process should focus on high-risk or problem areas, acute or chronic conditions, combination codes, and rule-out diagnoses.
- Prepare an audit method, which should include the time period covered, record selection process, sample size, indicators, a comparison of the retrospective versus concurrent POA reporting, data analysis techniques, tools used, qualifications of personnel performing the review, how results will be used to improve operations, and report formats for tracking and analyzing the audit results.
- Establish a process for clinical documentation improvement efforts, including a query process for inconsistent, missing, conflicting, or unclear documentation, and an auditing and monitoring process using audit methodology and tools. Organizations should monitor the response to queries and the appropriateness of the query.
- Provide education and training for identified opportunities.
- Implement tracking, trending, and reporting mechanisms.
- Establish a data integrity process for handling POA indicator corrections.

SOURCE: American Health Information Management Association

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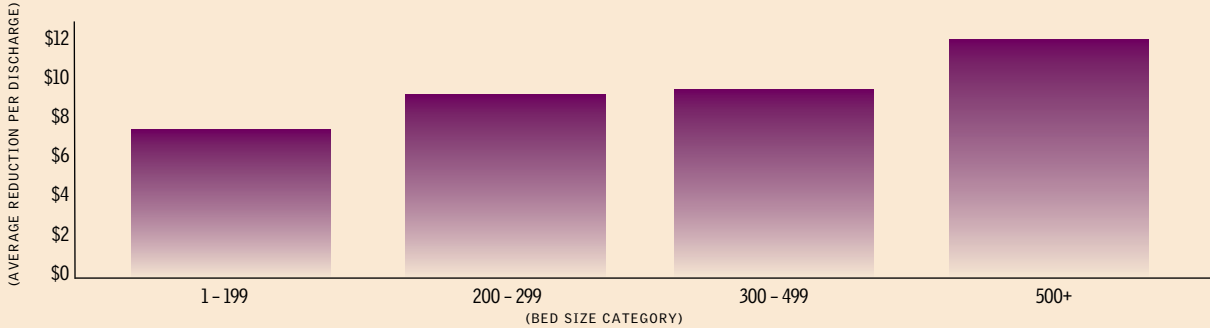
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WHO WILL FEEL THE GREATEST EFFECTS?

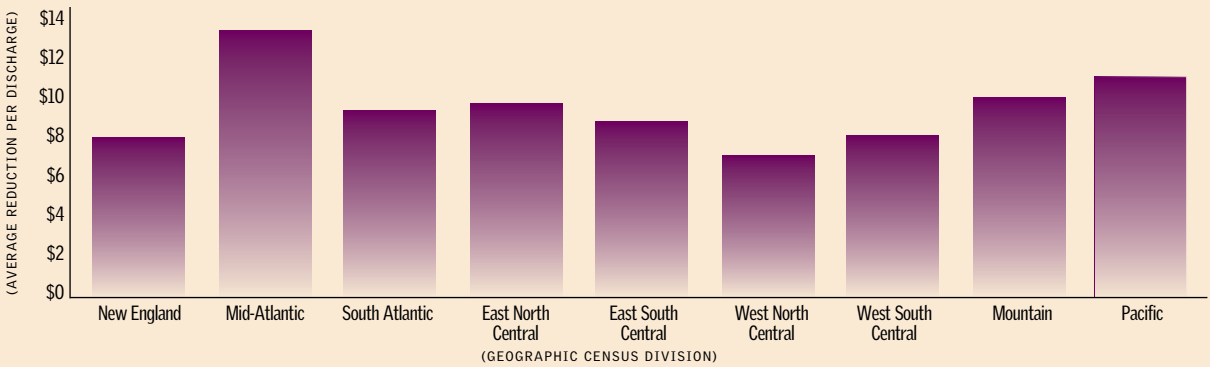
Size

The largest hospitals—those with 500 beds or more—will be most affected by CMS' changes to rules governing the five conditions referenced in the "Measuring the Impact" graphic, with an average reimbursement reduction per discharge of about \$12. Smaller hospitals will be less affected with an average impact per discharge of around \$7.



Region

The mid-Atlantic region will see the greatest financial impact, with an average reduction per discharge of about \$14. This is compared to the next highest region, the Pacific, with an average impact per discharge of about \$11.



Ownership

While government, nonfederal hospitals will see the most impact, all hospitals will be affected financially regardless of ownership.



Teaching status

Teaching hospitals will see more of a financial impact than non-teaching hospitals, with an average estimated impact per discharge of about \$11 compared to \$8 for nonteaching hospitals.

