# POA and Discharge Disposition Coding:
New Ways to Address Old Challenges

## Introduction

For many years, the Centers for Medicare & Medicaid Services (CMS) has required the assignment of Present on Admission Indicators (POAs) and Patient Discharge Status codes—otherwise known as discharge disposition (DD) codes. Despite the longevity of the requirement, healthcare organizations continue to struggle with identifying and selecting the correct codes.

This white paper examines these ongoing challenges based on actual patient scenarios and suggests best practices to alleviate the most common issues.

### Present on Admission Indicators

POAs were introduced in 2005 as part of the Deficit Reduction Act (DRA). The DRA mandated that POAs be included on all inpatient Medicare claims for hospitalization discharges on or after October 1, 2007.

POAs are used to differentiate medical conditions present at the time of an inpatient admission versus those developed between the time of admission and discharge. According to CMS, if a patient acquires a condition while hospitalized, it is considered to be a Hospital-Acquired Condition (HAC). There are five POAs from which to choose:

| CODE | INDICATOR | DESCRIPTION |
|---|---|---|
| Y | Yes | Diagnosis was present at the time of inpatient admission. |
| N | No | Diagnosis was not present at the time of inpatient admission. |
| U | Unknown | Documentation is insufficient to determine if the condition was present at the time of inpatient admission. |
| W | Clinically Undetermined | Provider was unable to clinically determine whether the condition was present at the time inpatient admission. |
| 1 | Exempt | Diagnosis is exempt from POA reporting. *The Fiscal Year 2018 POA Exempt list included 36,877 codes. i* |

[i] https://www.cms.gov/Outreach-and-Education/Medicare-Learingni-Network-MLN/MLNProducts/Downloads/wPOA-Fact-Sheet-Text-Only.pdf

While the concept of POA code assignment is straightforward, in practice it is not always simple to ascertain. The following two examples illustrate the challenge in determining whether a diagnosis was or was not present on admission.

### POA Example 1

A 90-year-old female was admitted to the emergency room with a one-week history of shortness of breath, fever, chills, productive cough and chest congestion. The patient was informed she would require inpatient admission to treat her pneumonia and new onset of atrial flutter.

While awaiting admission, the patient became increasingly confused and fell while attempting to get out of the emergency room bed. The patient complained of wrist tenderness and the emergency physician was notified. The patient was taken for X-ray and placed in soft medical wrist restraints prior to admission as an inpatient.

*What is the correct POA indicator for the fall in the emergency room?*

In this case, the fall was Y—present on admission. The POA guidelines state "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 present on admission."


800.329.0365 | www.HRScoding.com

### POA Example 2

A patient with a PICC line is admitted for treatment of cachexia due to severe malnutrition after not responding to outpatient treatment with peripheral parenteral nutrition (PPN). The PICC line was changed after admission. On the 2nd day, the patient had an elevated temperature (102.5º) and a WBC of 14,000 and 85% neutrophils. Blood cultures were positive for Staphylococcus Aureus. The discharge summary identifies the principal diagnosis as cachexia with severe malnutrition and a secondary diagnosis of a staphylococcus infection due to the PICC line.

*What is the correct POA indicator for the PICC infection?*

Documentation is insufficient to determine if the PICC infection was present on admission. Query the physician to determine if the infection was present on admission or developed after the PICC line was changed. This case could be incorrectly assigned as POA = N and reported as a Hospital Acquired Condition (HAC) in error.

## Hospital-Acquired Conditions

To encourage hospitals to reduce HACs, Section 3008 of the Patient Protection and Affordable Care Act (ACA), established the Hospital-Acquired Condition Reduction Program (HACRP). This program compiles various Patient Safety Indicators (PSI) and standardized healthcare-associated infection rates calculated by the Centers for Disease Control (CDC) to create a "Total HAC Score" for hospitals.

| DESCRIPTION | NO COMPLICATION | CURRENT PAYMENT W/ COMPLICATION | SIMULATED ADJUSTMENT HOSPITAL ACQUIRED CONDITION (HAC) |
|---|---|---|---|
| Principal Diagnosis | Atrial Fibrillation | Atrial Fibrillation | Atrial Fibrillation (POA) |
| Secondary Diagnosis | | Stage IV Pressure Ulcer, Ankle | Stage IV Pressure Ulcer, Ankle (Not POA) |
| Procedures | Temporary Pacemaker | Temporary Pacemaker | Temporary Pacemaker |
| | | Mechanical Ventilator | Mechanical Ventilator |
| Medicare DRG | 310 - Cardiac Arrhythmia w/o CC/MCC | 308 - Cardiac Arrhythmia w/MCC | 310 - Cardiac Arrhythmia w/o CC/MCC |
| Medicare Relative Weight | 0.5625 | 1.1885 | 0.5625 |
| Reimbursement (x Blended rate $5,962) | $3,354 | $7,086 | $3,354 |

Beginning in fiscal year 2015, the HACRP required the Department of Health and Human Services (HHS) "to adjust payments to hospitals that rank in the worst-performing quartile of all subsection (d) non-Maryland hospitals with respect to risk-adjusted HAC quality measures. Hospitals in the worst-performing quartile will be subject to a 1 percent payment reduction."

In mid-July 2017, CMS reported the FY 2017 HACRP results. Nationwide, a total of 751 hospitals fell into the worst-performing quartile, resulting in a 1 percent reduction in their FY 2018 Medicare payments.

### Patient Discharge Status/Discharge Disposition Codes

Patient discharge status codes, referred to as discharge disposition (DD) codes, are required on all Medicare billing claims. These codes were initiated in 1975 when the National Uniform Billing Committee (NUBC) was created to "develop and maintain a single billing form and standard data set to be used nationwide by institutional, private and public providers and payers for handling healthcare claims."

Patient discharge status codes were created to streamline billing. They are two-digit codes that identify where the patient is at the conclusion of a healthcare facility encounter—a visit or an actual inpatient stay. Correct reporting of these codes is critical. An omission or incorrect code is considered a claim billing error, which can lead to a claim rejection or cancellation, resulting in denied payment. The NUBC patient status code list was updated on October 18, 2017 and now includes 40 codes.
Here are two scenarios that present challenges in selecting the appropriate DD code:

### D/C Disposition Example 1

A patient with O2 dependent COPD is discharged to home after an incisional hernia repair. The hospital where the hernia repair was performed was unaware the patient had continuous home healthcare for his COPD. The bill was returned to the facility by the Fiscal Intermediary because it had the wrong DD code. The claim had to be modified and resubmitted with the correct DD code Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care (06).

### D/C Disposition Example 2

A patient is discharged from the hospital to home and scheduled to see his physician the same day. After the office visit, the patient's physician admits the patient to another hospital.

Based on the information available, the correct DD was to Home (01). The facility was unaware of the admission at the second facility and had to modify the submitted claim DD code to Discharged/Transferred to a Short-term General Hospital for Inpatient Care (02) to show the patient was later admitted on the same day.

## Risks of Incorrect POA or DD Code Selection

Organizations face potential risks when incorrect POA and/or DD codes are submitted on patient billing claims.

### Incorrect POA

Identifying whether a condition was present on admission can be a challenge. For example, a patient admitted with a chronic condition that flares up and becomes acute during hospitalization may have different outcomes. Depending on the condition, the coder may have to code the condition as POA or may be able to code the chronic condition as POA and the acute condition as not POA.

Another patient may be admitted with signs and symptoms of an infection that three days later is identified as sepsis. The physician must clearly document the link between the signs and symptoms and sepsis. Otherwise, it will be considered a HAC and affect the hospital's Total HAC Score, which in turn can lead to the hospital potentially falling into the worst-performing quartile and being subjected to a 1 percent payment reduction.

### Incorrect DD

Selecting the wrong DD carries three potential negative impacts for an organization:

- Delayed payment
- Denied payment
- Rescinded payment

Also, the Office of Inspector General (OIG) may audit a hospital experiencing a high number of adjusted claims due to incorrect DD codes. If the audit determines the hospital received overpayments, the OIG will demand repayment, which can represent significant financial impact for an organization.

In January 2018, the OIG published the report of a Medicare Compliance Review of Carolinas Medical Center. The audit covered a period of two years and was conducted on a random sample of 240 inpatient claims representing over $3 million in Medicare payments. The audit determined that 83 of the 240 claims did not comply with Medicare billing requirements. Several billing issues were identified that totaled $1,659,619 in estimated overpayments. $98,781 came from 29 claims with Incorrectly Billed Patient Discharge Status Codes.

## Best Practices to Alleviate POA and DD Code Issues

POA and DD coding issues can be avoided by focusing on two specific areas: documentation and education.

### Documentation

*POA*

- Complete and thorough documentation is the key to accurate POA code assignments. A strong Clinical Documentation Improvement (CDI) program helps ensure clinicians appropriately note pertinent signs and symptoms, the rationale for ordering tests and procedures, and the significance of test results.

*DD*

- Issues often arise because there is no designated location in the record to document the patient's discharge destination. Case Management and CDI teams must work together to make the final determination and decide which team is responsible for proper documentation.
- Compile, maintain and share an electronic list of all area facilities to which patients are discharged and identify the appropriate DD code for each. This is especially important when patients are discharged to facilities that have two types of care such as SNF and rehabilitation.

- Designate one "place of truth" within the EHR to document DD. The encoder or abstracting system must support a process that ensures DD and POA codes are present prior to dropping a bill. The most effective way to achieve this is through hard edits within the EHR to prevent coders from finalizing the discharge if a required code is missing.

The following two documentation best practices can help support both accurate POA and DD Coding.

- Conduct internal audits to identify potential issues and pinpoint vulnerabilities, which allows for quick remediation.
- Develop a query template within the EHR that enables CDI and coding staff to efficiently query clinicians regarding POA and DD issues. Coders must have a means to follow up on these critical items.

### Education

*POA*

- Provide routine documentation updates to the medical staff. One method is to periodically compile and share the number of POA queries—due to inadequate/incomplete documentation—issued by case management, CDI and coding over a specific period of time. Conduct one-on-one meetings with physicians who have an excessive number of POA queries. Provide guidance on the type of documentation required to avoid quality issues.
- Conduct ongoing education to the coders using case scenarios and round table discussions.

*DD*

- Ensure the electronic list of area facilities is maintained and updated with the appropriate DD codes, consistently adding new facilities.
- Designate a facility arbiter with the authority to make the final determination if case management and coding staff disagree on the appropriate DD for a case. Document and share the final determination so all staff understand rationale for the final code selection.
- Delegate someone within the coding area to monitor and share all DD code updates with coding staff.
- Create a process to ensure the DD is correct when patients are discharged. This is particularly important for facilities that routinely send interim bills for long-term patient stays. The process should include updating "temporary place holder" DD codes used during the concurrent coding process.

## Next Steps

Review the proposed best practices and identify those that should be implemented in your facility. If you are unsure about which ideas to implement, conducting an audit is a valuable first step. Audit results identify issues that need to be addressed and provide a baseline for moving forward.

HRS offers full-service consulting, auditing and education programs to pinpoint your challenges and opportunities and develop an effective improvement plan.

**Give HRS a call at 800-329-0365 to discuss how we can help improve your POA and DD coding.**

## References

"HAC Reduction Program Hospital Results for FY 2017." QualityNet.
"Medicare Claims Processing Manual." Centers for Medicare and Medicaid Services. August 18, 2017.
"FY 2013, FY 2014, and FY 2015 Final HAC List." Centers for Medicare and Medicaid Services.
"Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision." MLN Fact Sheet. Centers for Medicare and Medicaid Services. October 2017.
"ICD-10-CM Official Guidelines for Coding and Reporting FY 2017." Centers for Disease Control and Prevention. October 1, 2016 – September 30, 2017.
"Hospital-Acquired Condition Reduction Program Fiscal Year 2018 Fact Sheet." Centers for Medicare and Medicaid Services.
"Hospital-Acquired Condition (HAC) Reduction Program: Payment Adjustment." Quality Net.
Ellison, Ayla. "CMS cuts payments to 751 hospitals for patient injuries: 6 things to know." Becker's Hospital Review. December 22, 2017.
"About the NUBC." National Uniform Billing Committee (NUBC.org).
"Medicare Compliance Review of Carolinas Medical Center." Department of Health and Human Services, Office of Inspector General, January 2018.