



# IMA INSIGHTS

## Hospital-Acquired Conditions and Present on Admission Indicator Reporting (HAC and POA)

To our Healthcare Clients and Friends:

In this edition of *IMA Insights*, we will discuss the Centers for Medicare and Medicaid Services (CMS) policy requiring inpatient prospective payment system (IPPS) hospitals to report conditions Present on Admission (POA). We will also talk about the correlation with Hospital-Acquired Conditions (HAC) and the potentially significant financial implications for these IPPS hospitals. The CMS HAC and POA Indicator Reporting policy was developed as a result of a mandate in the Deficit Reduction Act (DRA) of 2005. The Congressional Budget Office (CBO) estimated the hospital quality improvement provisions in Section 5001 of the DRA would reduce Medicare spending by \$800 million during the 2006 through 2015 period. Since other payers frequently follow CMS' lead in such policy matters, and since the list of HACs has expanded since the initial CBO assessment, that estimate may prove to be very conservative as it applies to IPPS hospital reimbursement.

### BACKGROUND

Section 5001 (c) of the DRA requires a quality adjustment in Medicare Diagnosis Related Group (DRG) payments for increased costs associated with treating a Medicare beneficiary for some infections acquired during the hospitalization. The Act mandated the Secretary of Health and Human Services to identify at least two sets of two or more DRGs that typically cause a case to be assigned to a higher-paying DRG when there is a secondary diagnosis resulting from infections acquired during the hospitalization.

In an Issue Paper entitled *U.S. Department of Health and Human Services Medicare Hospital Value-Based Purchasing Plan Development - 1<sup>st</sup> Public Listening Session – January 17, 2007*, CMS has articulated a vision for healthcare quality: the right care for every person, every time. CMS is committed to care that is safe, effective, timely, patient-centered, efficient, and equitable. This value-based purchasing (VBP) plan is designed to link payment more directly to quality and is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care. CMS' VBP goals are to improve quality; reduce adverse events, and improve patient safety; and to avoid unnecessary costs in the delivery of care. Hospital Acquired Conditions – Present on Admission is just one segment of CMS' VBP plan. Medicare is assuming an active role that is value-based by reducing reimbursement for eight hospital-acquired conditions, unless the condition was present prior to the time the admission order was written. Events present while a patient was an outpatient qualify for being POA, such as those occurring in the ED, those occurring while the patient was in Observation or those occurring during Outpatient surgery. The eight (8) conditions identified include the following:

- Object left in patient following surgery
- Blood incompatibility
- Stage III and IV pressure ulcers
- Surgical infection (mediastinitis after coronary artery bypass graft)
- Falls and trauma (fractures, burns, crushing injuries, dislocations, intracranial injuries)
- Air embolism
- Catheter associated urinary tract infections
- Vascular catheter associated infections

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Five of the eight (pressure ulcers, air embolism, blood incompatibility, object left in patient following surgery, and patient falls) are also National Quality Forum (NQF) endorsed “never events.” CMS is working with the Agency for Healthcare Research and Quality (AHRQ) and the NQF to identify which of the 28 serious preventable errors (often called “never events”) identified by the NQF should be subject to the HAC provisions. CMS is also considering the addition of another nine conditions to the list above, so POA reporting will almost certainly have a greater financial impact in the future.

On August 22, 2007, CMS published a final rule in the *Federal Register* with the stated goal of improving the quality of patient care by eliminating preventable complications. The intent was to identify and eventually impose payment limitations on conditions that: (a) are high cost, high volume, or both, (b) result in a DRG assignment that has a higher payment when the conditions are present as a secondary diagnosis, and (c) are reasonably preventable, in accordance with evidence-based guidelines.

Medicare has defined a phased-in approach for POA reporting, delaying the full financial implications until late 2008. CMS requires hospitals to report POA information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007. In a December 2007 Department of Health and Human Services POA/HAC document, facilities listed as exempt from the CMS POA reporting requirement included cancer hospitals, children’s inpatient facilities, Maryland waiver hospitals, long-term care hospitals, critical access hospitals, inpatient rehabilitation facilities, and psychiatric hospitals. Beginning October 1, 2008, Medicare will stop paying a higher DRG reimbursement rate for certain conditions that were acquired after admission. Effective for acute inpatient PPS discharges on or after that date, Medicare cannot assign cases with these conditions to a higher paying DRG unless the conditions were present on admission. The importance of accurately capturing and reporting POA information becomes immediately obvious.

### IMPLEMENTATION TIMELINE

The phased-in approach gives hospitals the opportunity to evaluate POA reporting, issues, and reduced reimbursement. The following matrix lists the IPSS POA implementation time line, notes the high-level hospital impact, and offers suggestions for action during each phase:

<b>POA Implementation Matrix</b>			
<b>Date</b>	<b>Implementation Step</b>	<b>Impact</b>	<b>Action</b>
October 1, 2007	IPSS hospitals must submit POA information on all primary and secondary diagnoses on Medicare claims.	Hospital expense to implement POA reporting	Develop a Task Force including Medical Staff; Coding Professionals; Quality Director; Revenue Cycle Director; Compliance Officer, IT Professionals, Senior Leadership and Nursing Staff. Ensure coders are educated on reporting POA. Increase hospital awareness of required documentation for all healthcare providers.
January 1, 2008	CMS to begin processing POA data and will provide feedback on POA errors.	Hospital expense to address CMS feedback	Assess CMS feedback on POA data, including the number of claims cited for incomplete documentation. Perform a concurrent coding review of charts to identify incomplete documentation. Establish a regular forum for reporting of data. Identify critical issues and develop an action plan(s).

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<b>POA Implementation Matrix</b>			
<b>Date</b>	<b>Implementation Step</b>	<b>Impact</b>	<b>Action</b>
April 1, 2008	CMS will return claims that have improper POA data to provider.	Delay in payment. Increased AR	Trend data, assess returned claims due to improper POA documentation; assess incidence of HACs. Measure effectiveness of processes, and adjust as necessary.
October 1, 2008	CMS will not assign cases with certain medical conditions to a higher DRG unless they were POA.	Reduced DRG reimbursement rate for specified HACs	Continue Task Force. Quantify losses. Ensure effective quality and patient safety programs are in place. Prepare for CMS' plan to add other conditions to the initial eight identified.

### INSIGHTS

IPPS Hospitals must strategically plan for the changes brought about by this policy through education and communication. They need to be proactive by assembling a Task Force consisting of a multidisciplinary team that is responsible for monitoring and auditing all activity related to POA reporting. Auditing is critical to success and can provide information that can be used to develop action plans.

Although the changes brought about by this policy create a mechanism to help ensure quality care, they also force providers to improve documentation. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission. The following provides an example of the ways in which individuals in various hospital positions may contribute to the POA reporting effort:

- Case managers play a critical role by collaborating with physicians to identify those conditions POA, and by the severity-adjusted diagnoses in their documentation. A preformatted checklist identifying common complications may be useful in identifying and appropriately expanding diagnoses.
- Front-line Access staff members likewise play a role in POA documentation when receiving information about an admission. Probing questions need to be asked during the intake process if POA conditions are to be identified in a timely manner. For example, a patient may be admitted with a wound infection. It is important to know the site and cause of the infection. The Admitting Staff should ask if this patient had a prior injury, surgery, or if the patient is a diabetic. Another example would be a high-level assessment of the patient's risk for injury or of an existing injury, based on diagnoses such as altered mental state, gait dysfunction, syncope, etc.
- Obtaining complete diagnoses during the intake process serves to guide the Admitting Nurse, during his or her assessment, toward development and initiation of a quality plan of care. The clinical nurse team must thoroughly evaluate and document its findings, as the coding staff may use this source document for clarification of POA during the coding review.



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- Medical Record/Health Information Management coders should participate in a concurrent review of the clinical chart to identify and clarify documentation prior to coding. Inconsistent, missing, and/or conflicting documentation requires the coder to return to the provider for a resolution. Coders will be analyzing various components of the chart, such as history and physicals, physician orders, discharge summary, nursing admission notes and records, surgical service records, consultations, and pathology reports. Coders and healthcare providers need to align forces to ensure complete and accurate documentation, code assignment, and reporting of diagnoses and procedures is evident in the medical record. This documentation will help determine whether or not a condition was POA, and directly impacts financial performance.

### SUMMARY

While reimbursement is the main driver for POA compliance, hospitals must recognize their reputation for quality care may be directly impacted by their response to the POA reporting requirements. Failure to obtain POA information could result in a patient erroneously appearing to have been made more ill by the hospital's failure to take appropriate precautions and to provide appropriate care. At a time when information concerning the quality of care is becoming more and more available, negative public relations could well be part of the price paid for non-compliance with the POA reporting requirements. Reduced DRG reimbursement rates represent the other half of the equation, and are potentially a very high price to pay for non-compliance.

Compliance with POA reporting requirements will require a hospital-wide effort, involving clinicians and non-clinicians alike. Multidisciplinary teams will have to work collaboratively to identify, address, and resolve the challenges of this CMS policy. Ongoing communication and training will be necessary. Regular monitoring of processes and CMS payment information will be needed. Hospitals have become accustomed to changes resulting from CMS mandates. With a concerted effort, POA reporting requirements can be successfully mastered as well.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance with POA reporting, please contact either Betsy Keating at 484-832-8149 or me at 410-692-2400.

Yours very truly,

*Chris*

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