ICD-10 Issues Associated with Hospital-Acquired Conditions (HACs) and Present on Admission (POA) Indicators

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ICD-10
eLEARNING

Presentation Objectives

By the end of this webinar participants will be able to do (or know) the following:

- Identify the hospital-acquired conditions currently on the CMS list, their definitions, and the ICD-10-CM/PCS codes associated with each one

- Impact of HACs and POA on reimbursement

- Determine what documentation is required to support a specific POA indicator and report a HAC condition using ICD-10-CM/PCS codes

- Apply POA guidelines appropriately to assign accurate POA indicators to codes

Presentation Outline

- Review of HAC list, definitions, ICD-10-CM/PCS codes and documentation issues

- Impact of HACs on Reimbursement

- Use of HACs in CMS' Hospital Inpatient Quality Reporting Program

- POA indicators assignment and issues

Overview of Hospital-Acquired Conditions (HACs)

National Quality Forum (NQF) Never Events on HAC List

- Foreign body retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Manifestations of poor glycemic control

Procedure-Related HACs

- Catheter-associated urinary tract infection (CAUTI)
- Vascular catheter–associated infection
- Surgical site infection following:
  – Coronary artery bypass graft (CABG) - Mediastinitis
  – Cardiac device procedures
  – Bariatric surgery
  – Certain orthopedic procedures (spine, neck, shoulder, elbow)
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures (knee or hip replacement)
- Iatrogenic pneumothorax with venous catheterization procedures

Hospital-Acquired Conditions (HACs)

HAC 01: Foreign object retained after surgery

Secondary dx codes:

T81,500A – T81.69XA (with a POA indicator of "N" or "U")

- T81.5---, Complications of foreign body accidentally left in body following procedure
  - All end in A – initial encounter
  - Codes identify type of procedure (surgery, infusion, transfusion, injection, immunization, endoscopy, aspiration, puncture, catheterization, removal of catheter or packing, other and unspecified)
  - Codes identify type of complication caused by FB (adhesions, obstructions, perforation, other and unspecfied)
- T81.60XA, Unspecified acute reaction to foreign substance accidentally left during a procedure, initial encounter
- T81.61XA, Aseptic peritonitis due to foreign substance accidentally left during a procedure
- Chemical peritonitis, initial encounter
- T81.69XA, Other acute reaction to foreign substance accidentally left during a procedure, initial encounter

Hospital-Acquired Conditions (HACs)

HAC 02: Air Embolism

Secondary dx code (with POA = "N" or "U")

- T80.0XXA, Air embolism following infusion, transfusion and therapeutic injection, initial encounter

HAC 03: Blood Incompatibility

Secondary dx codes (with POA = "N" or "U")

- T80.30XA-T80.39XA , ABO incompatibility reactions due to transfusion of blood or blood products
    - Acute hemolytic transfusion reaction
    - Delayed hemolytic transfusion reaction
    - Unspecified hemolytic transfusion reaction
    - Delayed serologic transfusion reaction (DSRT) from ABO incompatibility
    - Other and unspecified ABO incompatible reaction

Hospital-Acquired Conditions (HACs)

HAC 04: Stage III and IV Pressure Ulcers

Secondary dx codes (with POA indicator = "N" or "U")

- L89.--3   (stage 3 sites)
- L89.--4   (stage 4 sites)

Results of CMS Audit on the Reporting of Pressure Ulcers (using ICD-9-CM codes)

- In FY 2010 61% of pressure ulcer cases with pressure ulcer site codes reported as secondary diagnoses did not have a stage code reported in the first 9 dx positions on the claim
- In FY 2010 12% of the cases with pressure ulcers as a principal diagnosis did not have a stage code reported in the first 9 dx positions on the claim
- Including additional secondary dx fields significantly increased the number of ulcer stage codes
- Academic medical centers had the most claims with ulcer stage codes not reported in the first 9 dx positions (68%)

Hospital-Acquired Conditions (HACs)

HAC 05: Falls and Trauma

Secondary dx codes (with POA = "N" or "U")

- Fractures (all)
- Vertebral subluxations, dislocations
- Spinal cord injuries
- Head injuries with LOC
- Crushing injuries
- Burns – 3rd degree, internal, and eyes
- Frostbite, heatstroke, sunstroke
- Asphyxiation and drowning

Hospital-Acquired Conditions (HACs)

HAC 06: Catheter-Associated Urinary Tract Infection (UTI)

Secondary dx code (with POA = "N" or "U")

- T83.51XA, Infection and inflammatory reaction due to indwelling urinary catheter, initial encounter

AND if present (with POA = "N" or "U")

- B37.41, Candidal cystitis and urethritis
- B37.49, Other urogenital candidiasis
- N10, Acute tubulo-interstitial nephritis
- N11.9, Chronic tubulo-interstitial nephritis, unspecified
- N12, Tubulo-interstitial nephritis, not specified as acute or chronic
- N13.6, Pyonephrosis
- N15.1, Renal and perinephric abscess
- N28.84, Pyelitis cystica
- N28.85, Pyeloureteritis cystica
- N28.86, Ureteritis cystica
- N30.00, Acute cystitis without hematuria
- N30.01, Acute cystitis with hematuria
- N34.0, Urethral abscess
- N39.0, Urinary tract infection, site not specified

Hospital-Acquired Conditions (HACs)

HAC 07: Vascular Catheter-Associated Infection

Secondary Dx Codes with POA = "N" or "U"

- T80.211A, Bloodstream infection due to central venous catheter, initial encounter
- T80.212A, Local infection due to central venous catheter, initial encounter
- T80.218A, Other infection due to central venous catheter, initial encounter
- T80.219A, Unspecified infection due to central venous catheter, initial encounter

Hospital-Acquired Conditions (HACs)

HAC 08: Surgical site infection – Mediastinitis after CABG

Secondary dx code (with POA = "N" or "U"

- J98.5, Diseases of mediastinum, NEC

CABG procedure code from ICD-10-PCS table: 021

Hospital-Acquired Conditions (HACs)

HAC 09: manifestation of Poor Glycemic Control

Secondary dx codes with (POA = "N" or "U")

- E08.00, Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
- E08.01,Diabetes mellitus due to underlying condition with hyperosmolarity with coma
- E08.10, Diabetes mellitus due to underlying condition with ketoacidosis without coma
- E09.00, Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
- E09.01, Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
- E09.10, Drug or chemical induced diabetes mellitus with ketoacidosis without coma
- E10.10 , Type 1 diabetes mellitus with ketoacidosis without coma
- E11.00, Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
- E11.01, Type 2 diabetes mellitus with hyperosmolarity with coma
- E13.00, Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
- E13.01, Other specified diabetes mellitus with hyperosmolarity with coma
- E13.10, Other specified diabetes mellitus with ketoacidosis without coma
- E15, Nondiabetic hypoglycemic coma

Hospital-Acquired Conditions (HACs)

HAC 10: DVT/PE with Total Knee or Hip Replacement

Secondary dx codes (with POA = "N" or "U")

- I26.02-I26.92, Pulmonary or Saddle embolisms of pulmonary embolisms with or without cor pulmonale, or

- I82.4--, Acute embolism and thrombosis of lower extremity veins

Knee or hip procedure code from ICD-10-PCS tables:

- 0SR – Replacements (sites hip (9, A, B, E, R, S) or knee (C, D, T, U, V, W)
- 0SU – Supplement (sites hip (9, A, B, E, R, S) or knee (C, D, T, U, V, W)

Hospital-Acquired Conditions (HACs)

HAC 11: Surgical Site Infection – Bariatric Surgery

Principal dx code:

- E66.01, Morbid (severe) obesity to excess calories

AND secondary dx codes (with POA = "N" or "U")

- K68.11. Postprocedural retroperitoneal abscess
- K95.01, Infection due to gastric band procedure
- K95.81, Infection due to other bariatric procedure
- T81.4XXA, Infection following a procedure, initial encounter

Bariatric surgery procedure codes from ICD-10-PCS tables

- ODI6 - Bypass of stomach
- ODV6 – Restriction of stomach

Hospital-Acquired Conditions (HACs)

HAC 12: Surgical Site Infection – Certain Orthopedic Procedures of the Spine, Shoulder and Elbow

Secondary dx codes (with POA = "N" or "U")

- T84.6—A, Infection and Inflammatory reaction due to internal fixation device, initial encounter
  - Unspecified site
  - Humerus, ulna, radius or unspecified arm bone
  - Spine
  - Other internal orthopedic prosthetic devices, implants and grafts

Certain spine, shoulder, and procedure codes from ICD-10-PCS tables for fusion or other procedures involving use of an orthopedic device.

- 0RU: Supplemental   (sites involving the spine, shoulder or elbow)
- 0RG and 0SG: Fusion (sites involving the spine shoulder or elbow)
- 0RQ: Repair (sites involving shoulder and elbow

Hospital-Acquired Conditions (HACs)

HAC 13: Surgical site infection following cardiac device procedures

Secondary dx codes (with POA = "N" or "U")

- K68.11, Postprocedural retroperitoneal abscess
- T81.4XXA, Infection following a procedure, initial encounter
- T826. XXA,Infection and inflammatory reaction due to cardiac valve prosthesis, initial encounter
- T82. 7XXA, Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, initial encounter

Cardiac device procedure code from ICD-10-PCS tables:

- 02H or 0JH: Insertion (sites of the abdomen and chest subcutaneous tissue abdomen, coronary vessels, heart)
- 02P or 0JP: Removal (sites of the abdomen and chest subcutaneous tissue abdomen, coronary vessels, heart)
- 02W, or 0JW: Revision (sites heart and trunk subcutaneous tissue)

Hospital-Acquired Conditions (HACs)

HAC 14: Iatrogenic pneumothorax with venous catheterization procedures

Secondary dx code (with POA = "N" or "U")

- J95.811, Post procedural pneumothorax

Venous catheterization procedure codes:

- 05HM33Z, Insertion of Infusion Device into Right Internal Jugular Vein, Percutaneous Approach

- 05HN33Z, Insertion of Infusion Device into Left Internal Jugular Vein, Percutaneous Approach

- 05HP33Z, Insertion of Infusion Device into Right External Jugular Vein, Percutaneous Approach

- 05HQ33Z, Insertion of Infusion Device into Left External Jugular Vein, Percutaneous Approach

- 0JH63XZ, Insertion of Vascular Access Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach

HACs and Payment
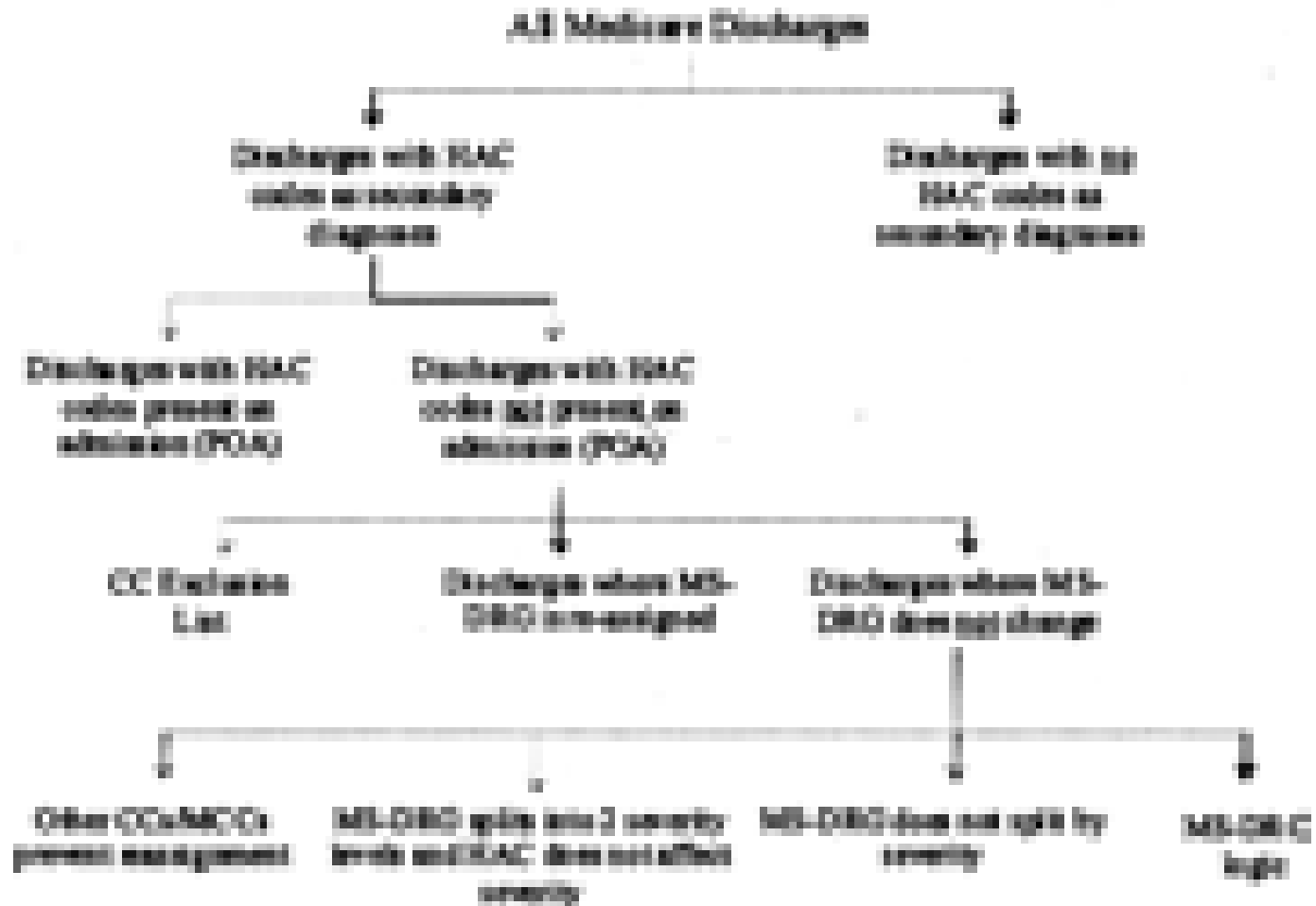
HAC Diagnosis Frequency and Impact

Chart C—Discharge Frequencies of Current CMS HACs October 2010 Through September 2011

Reasons HACs Did Not Change MS-DRGs

HACs Included in the Hospital Inpatient Quality Reporting Program (IQRP)

HACs included in the IQRP

- Foreign object retained after surgery

- Air embolism

- Blood incompatibility

- Pressure ulcer stages III and IV

- Falls and trauma

- Vascular catheter-associated infection

- Catheter-associated urinary tract infection

- Manifestations of poor glycemic control

Hospital-Acquired Conditions Reduction Program

HAC Reduction Program

- New program mandated by the Affordable Care Act

- Effective October 1, 2014

- Includes all IPPS hospitals

- CMS will calculate a total HAC score for each hospital based on the ratio of HACs to eligible patients for specific measures.

  - Domain 1 – Composite PSI-90 (AHRQ measure) (score 1-10) weighted 35% of total score

  - Domain 2 - Catheter associated urinary tract infections and Central line associated blood stream infection (score 1-10) weighted 65% of score

- Hospitals ranked in the bottom 25% of all IPPS hospitals will receive only 99% of the their Medicare payments in FY 2015

Hospital-Acquired Conditions Reduction Program

AHRQ Composite Measure PSI-90 Patient Safety for Selected Indicators

Composite measure includes:

- PSI #03 Pressure ulcer

- PSI #06 Iatrogenic pneumothorax

- PSI #07 Central venous catheter-related bloodstream infections

- PSI #08 Postop hip fracture

- PSI #09 Postop hemorrhage or hematoma

- PSI #10 Postop physiologic and metabolic derangements

- PSI #11 Postop respiratory failure

- PSI #12 Postop PE or DVT

- PSI #13 Postop sepsis

- PSI #14 Postop wound dehiscence

- PSI #15 Accidental puncture or laceration

POA Indicator

What is a "POA Indicator"?

It is a flag assigned to each diagnosis code or E-code to identify if that particular diagnosis or external cause of injury event was present on admission **(comorbidity)** or if occurred or developed after admission **(complication or newly developed condition).**

POA Indicator

What is the purpose of the POA Indicator?

To make ICD-9-CM coding more precise and more useful for a variety of hospital, payer and regulatory activities

Uses (benefits) of POA Information:

- Increase the efficiency of hospital QA activities
- Improve accuracy of safety & quality measures
- Improve accuracy of results in mortality risk assessment and outcomes research
- Improve case-mix measurement & severity (risk) adjustment systems
- Improve design and fairness of pay-for-performance (P4P) and (Value Based Purchasing) programs

Accuracy of Reporting POA Indicator

CMS contractor looked at 5 HACS:

- CAUTI
- VCAI,
- Stage III and IV Pressure Ulcers
- DVT/PE
- Falls and trauma

Results of Audit

- Hospitals reported POA correctly   91% of cases
- Hospitals reported POA incorrectly   8% of cases

(Problem areas: Under reporting CAUTI, and applying coding guidelines to progressing pressure ulcers[Coding Clinic Fourth Quarter 2008, page 194].)

POA Indicator

Reporting Options

Y = Yes, present at the time of inpatient admission

N = No, not present at the time of inpatient admission

U = Unknown, documentation is insufficient to determine if condition is POA

W = Clinically undetermined, provider is unable to clinically determine whether condition was present on admission or not

Blank = Unreported/Not Used – Exempt from POA reporting

POA Indicator

POA Guidelines

The guidelines for assigning POA are in **Appendix I** of the *ICD-10-CM Official Coding And Reporting Guidelines*, which can be downloaded from the CDC's National Center for Health Statistics (NCHS) website:

http://www.cdc.gov/nchs/icd/icd10cm.htm

Guidelines Approved by :

- American Health Information Management Association (AHIMA)
- American Hospital Association (AHA)
- Center for Medicare and Medicaid Services (CMS)
- National Center for Health Statistics (NCHS)

Definition of "Present at Admission"

- 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.

Whose documentation can you use to help determine the POA status of a diagnosis?

- 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 or not.

- In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

Appendix I:
Present on Admission Reporting Guidelines

Assign "Y" if:

- Condition explicitly documented as present at admission

Example:

"Patient was in acute respiratory failure at the time of admission…"

"Patient fell at home hitting his head. He was still unconscious and unresponsive from the concussion when he was admitted to hospital."

Assign "Y" if:

- Condition diagnosed prior to inpatient admission

Conditions that are chronic or long lasting such as diabetes, hypertension, cancer, arthritis COPD, HIV, atherosclerosis, etc. cannot develop quickly (i.e. during an inpatient stay) and are therefore, considered present at admission.

Assign "Y" if:

- Condition diagnosed prior to inpatient admission

Acute short-term conditions (trauma, pneumonia, cellulitis, hernia, etc.) that occurred or were diagnosed prior to admission in MD offices, EDs, clinics, etc. are considered present on admission.

It is essential that acute-short term conditions that are POA be clearly documented in the admitting notes, ED record, H&P or other intake document to avoid confusion and controversy.

Assign "Y" if:

- Condition is diagnosed during the admission but clearly present before admission

Example:

Patient admitted with severe cough and difficulty breathing. Diagnostic work up revealed that the symptoms were due to a malignant tumor in the lower lobe of the left lung.

Final Dx: Lung carcinoma

Assign "Y" if:

- Condition is diagnosed during the admission but clearly present before admission

Pre-existing, asymptomatic conditions (unruptured aneurysm, mitral valve prolapse, positive HIV status, tumors, etc.) that the patient or physician may not even be aware of until they are discovered or diagnosed while the patient is in the hospital are considered present on admission.

Assign "Y" if:

- Condition is diagnosed during the admission but clearly present before admission

  Diagnoses subsequently confirmed after admission are considered present at admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that was present at admission.

Assign "Y" if:

- Condition is diagnosed during the admission but clearly present before admission

Example:

90 year old patient admitted for treatment of urinary tract infection. Routine blood work done at admission revealed that she was also anemic. Patient was started on IV antibiotics for the UTI and iron supplements to boost her hemoglobin count.

Both the UTI and the anemia were POA even though the anemia was not diagnosed until after admission.

Example:

A known hemophiliac was brought to the ED by girlfriend with complaint of watery eyes, runny nose and continuous sneezing. While in the ED he had a particularly violent sneezing fit and developed an uncontrolled nose bleed. Patient was admitted for treatment of the nosebleed. While in the hospital it was determined that the his allergy symptoms were caused by exposure to his girlfriend's new perfume.

Final Dx:

　　　Epistaxis

　　　Hemophilia

　　　Allergic Rhinitis

Assign "Y" if:

- An infection (or signs of it) was present on admission, even though the culture results identifying the exact organism may not be known until after admission.

Example:

Patient admitted with pneumonia. Sputum culture taken at admission grew pseudomonas on the third day.

Final dx: Pseudomonas Pneumonia

Assign "Y" if:

- Final diagnosis contains a possible, probable, suspected or rule out diagnosis at the time of discharge, and the diagnosis was suspected at the time of admission.

Example:

Patient with recent history of duodenal ulcers was admitted vomiting blood. Before cause of bleeding could be determined patient became hypotensive and died. Physician documented final diagnosis as "probable duodenal ulcer with perforation and hemorrhage."

Appendix I:
Present on Admission Reporting Guidelines

Assign "Y" if:

- Final diagnosis contains an impending or threatened diagnosis, and the diagnosis is based on symptoms or clinical findings that were present on admission.

Example:

Patient responsive and vocal but disoriented and weak on left side. Admitted with dx of "impending CVA". Monitored overnight in ICU and transferred to University Hospital for further work up and treatment.

Appendix I:
Present on Admission Reporting Guidelines

Assign "Y" for:

- Conditions that are present at birth, developed in utero, or developed during delivery for a newborn

   Newborns are not considered admitted until after birth. Therefore, anything that happens before birth in utero or during delivery (injuries, meconium aspiration,etc.) is considered present at admission.

Assign "Y" if:

- Congenital condition or congenital anomaly

  All congenital conditions and anomalies are considered present on admission.

Enter "N" if:

- Provider explicitly documents that condition was not POA

- **Final diagnosis contains a possible, probable suspected, or ruled out diagnosis, and this diagnosis is based on symptoms or clinical findings that were not POA**

- Final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were not POA.

Combination Codes

- ICD-10-CM codes composed of a combination of conditions or complications

- All parts of the combination must be present to use the code

- Always use combination codes when applicable. It is never appropriate to "unbundle" diagnoses into separate codes when a combination code is available.

Combination Codes

Examples

- E10.10, Type 1 diabetes mellitus with ketoacidosis without coma

- G40.B11, Juvenile myoclonic epilepsy, intractable, with status epilepticus

- J10,82, Influenza due to other identified influenza virus with myocarditis

- K21.0, Gastro-esophageal reflux disease with esophagitis

- K70.11, Alcoholic hepatitis with ascites

Combination Codes

Assign "Y" if:

- All parts of a condition covered by a combination code are present on admission

Example:

Patient with Type 1 diabetes mellitus is admitted with ketoacidosis

E10.10, Type 1 diabetes mellitus with ketoacidosis without coma

Combination Codes

Assign "N" if:

- If one or more parts of the combination code are not present at the time admission, and don't develop until sometime during the stay

Example:

Patient with Type 1 diabetes mellitus was admitted with ketoacidosis which did not respond to treatment. Patient's status worsened and he became comatose during the night and expired the next day.

E10.11, Type 1 diabetes mellitus with ketoacidosis with coma

Acute and Chronic Conditions – Separate Codes

If patient has the acute and chronic form of the same condition

Assign "Y" if:

- Acute condition is POA and has its own code
- Chronic condition has its own code *(chronic conditions are always POA)*
- Acute and chronic share a code and acute form is POA *(Follows same rule as combination codes)*

Assign "N" if:

- Acute condition is not POA and has its own code
- Acute and chronic share a code and acute was not POA *(Follows same rule as combination codes)*

Acute and Chronic Condition with Combined code

Example:

Patient with chronic diastolic heart failure is admitted for acute exacerbation of his heart failure.

I50.33, Acute on chronic diastolic heart failure (POA= Y)

Example:

Patient with chronic systolic heart failure is admitted for treatment of severe anemia due to cancer and goes into acute systolic heart failure during stay

I50.32, Acute on chronic systolic heart failure (POA=N)

Pregnancy Codes

Assign "Y" if:

- All pregnancy complication or obstetrical conditions described by code are present on admission

Example:

Pt. admitted for scheduled C-section. She is having a very large baby (>10 lbs) and is unable to deliver due to fetopelvic disproportion.

O33.411, Maternal care for disproportion due to unusually large fetus

Pregnancy Codes

Assign "N" if:

- At least one of the pregnancy complication or obstetrical conditions described by code is not present on admission

Example:

Pregnant patient with known coagulation defects admitted to deliver. Six hours after admission patient started to hemorrhage due to her coagulation problem. Underwent an emergency C-section to deliver baby.

O67.0, Intrapartum hemorrhage with coagulation defect

Multiple Condition Codes

- ICD-10-CM codes that have more than one condition assigned to them.

- Only one of the conditions assigned to the code needs to be present for the code to be used.

- If a patient has more than one condition classified to the same multiple condition code, that code can only be reported once on the record.

Multiple Condition Codes

Examples:

- **I80.221, Phlebitis and thrombophlebitis of left popliteal vein**

- **K12.2, Cellulitis and abscess of mouth**

- **T80.212, Local infection due to central venous catheter**
  Exit or insertion site infection
  Local infection due to Hickman catheter
  Local infection due to peripherally inserted central catheter (PICC)
  Local infection due to portacath (port-a-cath)
  Local infection due to triple lumen catheter
  Local infection due to umbilical venous catheter
  Port or reservoir infection
  Tunnel infection

Multiple Condition Codes

Assign "Y" if:

- If ALL of the patient's conditions that are classified to a multiple condition code are present at admission

Example:

Patient admitted with cellulitis and necrosis of nose

*J34.0, Abscess, furuncle and carbuncle of nose

*This code is used for both cellulitis and necrosis of nose..

Multiple Condition Codes

Assign "N" if:

- At least one of the patient's conditions that are classified to a multiple condition code was present at admission

Example:

Patient was receiving a 6 week course IV antibiotics via PICC line as an outpatient for acute myocarditis. The patient developed an infection at the insertion site and was brought in to have PICC line removed and continue treatment for his myocarditis as an inpatient. A second central line catheter was inserted through his other arm at admission, and that one also became infected at the insertion site.

T80.212, Local infection due to central venous catheter

External Cause of Injury Codes

- POA on external cause of injury code should match the POA indicator of the associated injury or poisoning

Assign "Y" if:

- The corresponding injury or poisoning that goes with the external cause of injury code has a POA = Y

Assign "N" if:

- The corresponding injury or poisoning that goes with the external cause of injury code has a POA = N

POA Indicator for Principal Diagnosis

- Situations where the POA Indicator for the PDX is "N":

  – Pdx classified to a combination code and part of the combination did not happen until after admission

    Example: Admitted with acute appendicitis which ruptured after admission.

    Pdx: K35.2 , Acute appendicitis with generalized peritonitis

  – OB cases where the Pdx explains the reason for the method of delivery, and that reason did not develop until after admission

    Example: Spontaneous normal delivery of full term infant with 3rd degree laceration of the perineum

    Pdx: O70.2 Third degree laceration during delivery

Appendix I:
Present on Admission Reporting Guidelines

Assign "U" if:

- Documentation is unclear as to whether the condition was present on admission

Assign "W" if:

- Documentation indicates that it cannot be clinically determined whether or not the condition was present on admission

Leave POA Indicator BLANK if:

- Code is on the official list of codes exempt from POA reporting

Codes and Categories Exempt from POA

- Late effect (sequela) codes that provide information about a previous disease or reason for healthcare

- Z-codes that provide information about a patient's current health status, family history or reason for healthcare encounter by a non-ill patient

- External cause of injury codes that identify an event or location that are outside any type of health care facility

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