

The Present On Admission Indicator

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 - 2014 – HcPRO Physician Advisory Handbook
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Goals

- Describe the ICD-9-CM and ICD-10 Present On Admission and its role in measuring quality
- Explores different applications of the POA Indicator, such as:
 - Hospital-acquired conditions (HACs)
 - AHRQ's Patient Safety Indicators (PSIs)
 - Others, such as the 3M Potentially Preventable Complications
- Develop compliant concurrent and retrospective documentation and query strategies conducive to accurate PSI assignment

The Present On Admission Indicator

What Is It?

- The Present On Admission (POA) indicator is a data element on the inpatient UB-04 (paper) or the ASC X12N 837, version 5010, (electronic) formats reporting if condition reported using ICD-9-CM was present at the time that the inpatient order was written.

The image shows a portion of a UB-04 form. The top section contains a grid for Present On Admission (POA) indicators. The first row is labeled '66 DX' and contains four columns labeled 'A', 'B', 'C', and 'D'. Each of these four cells contains a red circle with a red arrow pointing to it from the right. The second row is labeled '67' and contains four columns labeled 'J', 'K', 'L', and 'M'. Below this grid are several other fields: '69 ADMIT DX', '70 PATIENT REASON DX', and '71 PPS CODE'. At the bottom, there are fields for '74 PRINCIPAL PROCEDURE CODE' and 'DATE', and two columns for 'OTHER PROCEDURE CODE' and 'DATE' labeled 'a.' and 'b.'.

POA Indicator Requirement to Report

- Since January 1, 2008, all hospitals receiving Medicare IPPS payments and all hospitals in the state of Maryland (including critical access)
- While Medicare exempts certain facilities (such as critical access hospitals), POA submission is required for all facilities (including critical access hospitals) by
 - BCBSND - <http://tinyurl.com/nrnfuwx>
 - North Dakota Medicaid (including Indian Health Service)
<http://tinyurl.com/mgptmr9>
<http://tinyurl.com/mh8jjv2>
 - Wellmark BCBS (South Dakota) <http://tinyurl.com/nt4f6va>
 - Minnesota Medicaid - <http://tinyurl.com/qyf7cpw>

What ICD-9-CM or ICD-10-CM Codes require the POA Indicator?

- All ICD-9-CM or ICD-10-CM codes (including ICD-9-CM “E-codes”) require the POA Indicator unless they are on the exempt list.
 - A list of these are available in the ICD-9-CM or ICD-10-CM Official Guidelines for Coding and Reporting

Examples of Exempt ICD-10-CM Codes

- B90–B94, Sequelae of infectious and parasitic diseases
- E64, Sequelae of malnutrition and other nutritional deficiencies
- I25.2, Old myocardial infarction
- I69, Sequelae of cerebrovascular disease
- O09, Supervision of high risk pregnancy
- O66.5, Attempted application of vacuum extractor and forceps
- O80, Encounter for full-term uncomplicated delivery
- O94, Sequelae of complication of pregnancy, childbirth, and the puerperium
- P00, Newborn (suspected to be) affected by maternal conditions that may be unrelated to present pregnancy
- Q00 – Q99, Congenital malformations, deformations and chromosomal abnormalities
- S00-T88.9, Injury, poisoning and certain other consequences of external causes with 7th character representing subsequent encounter or sequela

**Obtain a complete list from the
ICD-9-CM or ICD-10-CM Official Guidelines**

Examples of Exempt ICD-10-CM Codes

- V00- V09, Pedestrian injured in transport accident
- Except V00.81-, Accident with wheelchair (powered)
- V00.83-, Accident with motorized mobility scooter
- V10-V19, Pedal cycle rider injured in transport accident
- V20-V29, Motorcycle rider injured in transport accident
- V30-V39, Occupant of three-wheeled motor vehicle injured in transport accident
- V40-V49, Car occupant injured in transport accident
- V50-V59, Occupant of pick-up truck or van injured in transport accident
- V60-V69, Occupant of heavy transport vehicle injured in transport accident
- V70-V79, Bus occupant injured in transport accident
- V80-V89, Other land transport accidents

**Obtain a complete list from the
ICD-9-CM or ICD-10-CM Official Guidelines**

Special Caution About E-Codes

CMS Statement

- Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a State-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity.
 - If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or **payer-based requirement** about the reporting of these codes is instituted.
 - If such a requirement is instituted, it would be independent of ICD-10-CM implementation.
 - In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

<https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10QuickRefer.pdf>

Provider Preventable Procedures

CMS and ND Medicaid identifies the following provider-preventable procedures for nonpayment:

- **E876.5** - *Performance of wrong operation (procedure) on correct patient (existing code)*
- **E876.6** - *Performance of operation (procedure) on patient not scheduled for surgery*
- **E876.7** - *Performance of correct operation (procedure) on wrong side/body part*

While E-codes are not mandatory, failure to report these codes and their POA indicator is reckless disregard of CMS and ND payer rules

As we will see later, other E-codes for which the POA indicator is applied can affect quality measures

POA Options

- **Y** - Diagnosis was present at time of IP admission
- **N** - Diagnosis was not present at time of IP admission.
- **U** - Documentation insufficient to determine if condition was present at the time of IP admission
 - Interpreted for payment purposes as a “No” by CMS
- **W** - Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
 - Interpreted for payment purposes as a “Yes” by CMS
- If the code is POA Exempt, the field is left blank
 - Do NOT use a “1” as was used with the 4010

<http://tinyurl.com/qhr62go>

Timing of the Inpatient Admission

The Inpatient Order

- Uniform Hospital Discharge Data Set
 - Admission date – “Month, day, and year.
Clarification is added to this data item to note that for emergency and observation type patients, **the time of admission is guided by the time that the physician gives the order to admit the patient as an inpatient.**
- <http://www.tinyurl.com/UHDDS>

Why the POA Indicator is Critical CMS Hospital Acquired Conditions

- On February 8, 2006, the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the identification of conditions that are:
 - High cost or high volume or both;
 - Result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis; and
 - Could reasonably have been prevented through the application of evidence-based guidelines. Section 5001(c) provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.
- For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission.
 - That is, the case would be paid as though the secondary diagnosis were not present.

MS-DRG Options

CCs and MCCs

MS-DRG	MDC	TYPE	MS-DRG Title	Weight	Payment Base = \$7000	Geometric Mean LOS
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	1.9492	\$13,644	6.2
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.3909	\$9,736	5.0
179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9693	\$6,785	3.7
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4491	\$10,144	4.9
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9688	\$6,782	3.8
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7044	\$4,931	2.9

Diagnosis-Related Group methodology

- CC = Comorbidity/Complication; MCC = Major CC
- Relative weight x base rate = Payment
- If a CMS-designated condition qualifies as a HAC and the POA status is “N” or “U”, then it does not qualify as a CC or MCC

CMS Hospital-Acquired Conditions ICD-10 Diagnosis Code & POA Based

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
 - Fractures
 - Dislocations
 - Intracranial injuries
 - Crushing injuries
 - Burns
 - Other injuries
- Manifestations of poor glycemic control
 - Diabetic ketoacidosis
 - Nonketotic hyperosmolar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity
- Iatrogenic pneumothorax w/venous catheterization
- **Catheter-associated** urinary tract infection (UTI)
- **Vascular catheter-associated** infection
- Surgical site infection, mediastinitis, following CABG
- Surgical site infection **following** bariatric surgery for obesity
 - Laparoscopic gastric bypass
 - Gastroenterostomy
 - Laparoscopic gastric restrictive surgery
- Surgical site infection **following** certain orthopedic procedures:
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Surgical site infection **following** cardiac implantable electronic device (CIED)
- DVT or PE **following** certain orthopedic procedures:
 - Total knee replacement
 - Hip replacement

North Dakota Medicaid HACs

Effective March 1, 2012, North Dakota Medicaid will be implementing HAC standards that mirror Medicare guidelines and will required all IPPS hospitals to submit claims with the POA indicator.

The ten hospital acquired conditions include: foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcer stages III and IV, falls and trauma, catheter-associated urinary tract infection (UTI), vascular catheter-associated infection, manifestations of poor glycemic control, deep vein thrombosis/pulmonary embolism, and surgical site infections.

When a HAC is not present on admission, but is reported as a diagnosis associated with the hospitalization, the Medicaid payment under the IPPS to the hospital may be reduced to reflect that the condition was hospital acquired. If the HAC was present on admission, the Medicaid payment under IPPS to the hospital would not be reduced. If applicable, North Dakota Medical Services will be changing the payment based on the POA indicator during a retro-review of claims.

If you have questions on the above mentioned matter, please contact North Dakota Medical Services to speak with a Medical Coding Specialist at 1-800-755-2604.

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- <http://www.tinyurl.com/UHDDS>

Caveats in POA Reporting ICD-9-CM – Pressure Ulcers

- **Coding Clinic, 4th Quarter, 2008, page 19.**
 - **Question:** A patient is admitted to the hospital with a stage II pressure ulcer of the heel. During the hospitalization, the pressure ulcer worsens and becomes a stage III.
 - Based on the new *Official Coding Guidelines*, we would be assigning the code for the highest stage for that site.
 - What would be the correct POA indicator assignment for the stage III code?
 - **Answer:** Assign "Y" to the pressure ulcer stage III code since this code is referring to a pressure ulcer that was present on admission rather than a new ulcer.

Caveats in POA Reporting

ICD-9-CM – Pressure Ulcers

- **Question:** A patient on admission has a pressure ulcer of her ankle due to a previously placed internal fixation device. Over several days, it was noted that the ulcer further deteriorated to stage 4.
 - Later in the stay the patient developed another pressure ulcer in the sacrum, Because of the patient’s debilitated state, the sacral ulcer progressed to stage 4.
 - The POA indicators for the sacral decubitus and stage 4 are “N”. However, the POA indicators for the stage 4 ankle ulcer are both “Y”.
 - How is the POA indicator captured for stage 4 pressure ulcers of different sites?
- **Answer:** Report the POA indicator “N” for the ulcer stage.
 - There is no ideal answer for this situation; however, due to the constraints of the classification, this is the most appropriate approach.
 - The *Official Guidelines for Coding and Reporting* indicate that ICD-9-CM diagnosis codes may not be reported twice on the same admission.
 - This problem will be addressed with ICD-10-CM, since information about the site and stage is included in a single code.

Coding Clinic, Second Quarter 2010 Pages: 17-18

Diagnostic Criteria For DKA and Hyperosmolar State

	DKA			HHS
	Mild (plasma glucose >250 mg/dl)	Moderate (plasma glucose >250 mg/dl)	Severe (plasma glucose >250 mg/dl)	Plasma glucose >600 mg/dl
Arterial pH	7.25–7.30	7.00 to <7.24	<7.00	>7.30
Serum bicarbonate (mEq/l)	15–18	10 to <15	<10	>18
Urine ketone [*]	Positive	Positive	Positive	Small
Serum ketone [*]	Positive	Positive	Positive	Small
Effective serum osmolality [†]	Variable	Variable	Variable	>320 mOsm/kg
Anion gap [‡]	>10	>12	>12	Variable
Mental status	Alert	Alert/drowsy	Stupor/coma	Stupor/coma

Diabetes Care July 2009, vol. 32 no. 7, 1335-1343

Iatrogenic Pneumothorax with Venous Catheterization

- Qualifying Diagnoses and Procedure
 - 512.1 – Iatrogenic pneumothorax (CC)
 - 38.93 – Venous catheterization NEC
- Caveats
 - Coding Clinic, First Quarter 2011 Page: 14
 - If a physician documents “iatrogenic pneumothorax” or the pneumothorax was due to a procedure, **the coder must code 512.1**
 - Coding Clinic, Third Quarter 2003 Page: 19
 - Since pneumothorax is a known risk associated with most thoracic surgeries, **it would be inappropriate to assign an additional code for the iatrogenic pneumothorax, based on an x-ray finding alone, without physician concurrence.**

Definition of a Complication in Coding Clinic

- It is important to note that not all conditions that occur during or following surgery are classified as complications.
 - First, there must be more than a routinely expected condition or occurrence, **and**
 - There must be a cause-and-effect relationship between the care provided and the condition, **and**
 - **Differentiation between surgical/pharmaceutical care and diseases**
 - There is indication in the documentation that it is a complication.
- The coder cannot make the determination whether something that occurred during surgery is a complication or an expected outcome.
 - Only a physician can diagnose a condition, and the physician must explicitly document whether the condition is a complication.
 - **If it is not clearly documented, the coder should query the physician for clarification.**

Source: **Coding Clinic, First Quarter 2011 Pages: 13-14**

ICD-9-CM Official Guidelines for Coding and Reporting

Effective October 1, 2011

Narrative changes appear in bold text

Items underlined have been moved within the guidelines since October 1, 2010

18. Documentation of Complications of care

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

ICD-9-CM - http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf

ICD-10-CM - http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf

Medicare Public Reporting

Hospital_Name	AHRQ_PSI_90_Score	Total_HAC_Score
ST ALEXIUS MEDICAL CENTER	8	6.05
TRINITY HOSPITALS	9	6.725
SANFORD HEALTH SYSTEM	3	4.625
SANFORD MEDICAL CENTER BISMARCK	2	3.95
ALTRU HOSPITAL	10	4.8
P H S INDIAN HOSP AT BELCOURT-QUENTIN N BURDICK	7	7
STANDING ROCK INDIAN HEALTH SERVICE HOSPITAL	Not Available	Not Available
ESSENTIA HEALTH	9	9

<https://data.medicare.gov/data/hospital-compare> - Accessed 2/25/2015

PSI 12 and PSI 15

Hospital Name	PSI_12_POSTOP_PULMEMB_DVT	PSI_15_ACC_LAC
ST ALEXIUS MEDICAL CENTER	No Different than the National Rate	No Different than the National Rate
TRINITY HOSPITALS	No Different than the National Rate	Worse than the National Rate
SANFORD MEDICAL CENTER FARGO	Better than the National Rate	No Different than the National Rate
SANFORD MEDICAL CENTER BISMARCK	No Different than the National Rate	No Different than the National Rate
ALTRU HOSPITAL	Better than the National Rate	Worse than the National Rate
P H S INDIAN HOSP AT BELCOURT-QUENTIN N BURDICK	NA	No Different than the National Rate
ESSENTIA HEALTH-FARGO	Better than the National Rate	Worse than the National Rate

What are AHRQ PSIs?

- The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth.
 - The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.
 - Pediatric measures are also in place

http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NQF-approved PSI 90 – Composite

Patient Safety for Selected Indicators (PSI #90) 531

PSI #03 - Pressure Ulcer Rate	478
PSI #06 - Iatrogenic Pneumothorax Rate	346
PSI #07 - Central Venous Catheter-Related Blood stream Infection Rate	
PSI #08 - Postoperative Hip Fracture Rate	
PSI #12 - Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate	450
PSI #13 - Postoperative Sepsis Rate	
PSI #14 - Postoperative Wound Dehiscence Rate	368
PSI #15 - Accidental Puncture or Laceration Rate	345

Pediatric Patient Safety for Selected Indicators (PDI #19) 532

PDI #01 - Accidental Puncture or Laceration Rate	344
PDI #02 - Pressure Ulcer Rate	337
PDI #05 - Iatrogenic Pneumothorax Rate	348
PDI #10 - Postoperative Sepsis Rate	
PDI #11 - Postoperative Wound Dehiscence Rate	367
PDI #12 - Central Venous Catheter-Related Blood stream Infection Rate	

<http://tinyurl.com/NQF-PSIs>

PSI – Intended Uses

- Help hospitals identify potential adverse events that might need further study;
- Provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record;
- Include indicators for complications occurring in hospital that **may** represent patient safety events
 - Includes area level analogs designed to detect patient safety events on a regional level

PSI Methodology

- PSIs are based ONLY on ICD-9-CM codes and other elements of the UB-04 (e.g. procedure dates, patient age)
 - No clinical abstraction is performed like on does for the NCDR, STS, or other clinical databases
- The key to getting PSIs right is to know how there are constructed, ascertain that provider documentation is congruent with the patient's clinical circumstances and follows ICD-9-CM rules, guidelines, and official advice



General

PQI Resources

IQI Resources

PSI Resources

PDI Resources

Patient Safety Indicators Overview

The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

Patient Safety Indicators Resources

Technical Specifications

- [Individual Measure Technical Specifications](#)
- [Log of Coding Updates and Revisions](#)
- [Parameter Estimates](#)
- [Benchmark Data Tables](#)

Development

- [Brochure](#)
- [AHRQ QI Development](#)
- [AHRQ Composite Measures Work Group](#)
- [The Quality Indicator Software can be found here.](#)

http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx

When all
else fails,
read the
directions

Patient Safety Indicators Technical Specifications - Version 4.5, May 2013

- All Patient Safety Indicators Technical Specifications, Version 4.5 (Zip File)
 - EXP 01 Rate of Complications of Anesthesia
 - EXP 02 Obstetric Trauma Rate - Cesarean Delivery
 - PSI 02 Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)
 - PSI 03 Pressure Ulcer Rate
 - PSI 04 Death Rate among Surgical Inpatients with Serious Treatable Conditions
 - PSI 05 Retained Surgical Item or Unretrieved Device Fragment Count
 - PSI 06 Iatrogenic Pneumothorax Rate
 - PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate
 - PSI 08 Postoperative Hip Fracture Rate
 - PSI 09 Perioperative Hemorrhage or Hematoma Rate
 - PSI 10 Postoperative Physiologic and Metabolic Derangement Rate
 - PSI 11 Postoperative Respiratory Failure Rate
 - PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
 - PSI 13 Postoperative Sepsis Rate
 - PSI 14 Postoperative Wound Dehiscence Rate
 - PSI 15 Accidental Puncture or Laceration Rate
 - PSI 16 Transfusion Reaction Count
 - PSI 17 Birth Trauma Rate—Injury to Neonate
 - PSI 18 Obstetric Trauma Rate—Vaginal Delivery With Instrument
 - PSI 19 Obstetric Trauma Rate-Vaginal Delivery Without Instrument
 - PSI 21 Retained Surgical Item or Unretrieved Device Fragment Rate
 - PSI 22 Iatrogenic Pneumothorax Rate
 - PSI 23 Central Venous Catheter-Related Blood Stream Infection Rate
 - PSI 24 Postoperative Wound Dehiscence Rate
 - PSI 25 Accidental Puncture or Laceration Rate
 - PSI 26 Transfusion Reaction Rate
 - PSI 27 Postoperative Hemorrhage or Hematoma Rate
 - PSI 90 Patient Safety for Selected Indicators
 - PSI Appendices

Accidental Lacerations

AHRQ QI™ Version 4.5, Patient Safety Indicators #15, Technical Specifications,
Accidental Puncture or Laceration Rate
www.qualityindicators.ahrq.gov

Accidental Puncture or Laceration Rate Technical Specifications

Patient Safety Indicators #15 (PSI #15)

AHRQ Quality Indicators™, Version 4.5, May 2013

Provider-Level Indicator

Type of Score: Rate

Description

Accidental punctures or lacerations (secondary diagnosis) during procedure per 1,000 discharges for patients ages 18 years and older. Excludes cases with accidental puncture or laceration as a principal diagnosis, cases with accidental puncture or laceration as a secondary diagnosis that is present on admission, spinal surgery cases, and obstetric cases.

PSI 15 Criteria

ICD-9-CM Accidental puncture or laceration during a procedure diagnosis codes:

E8700	ACC CUT/HEM IN SURGERY	E8706	ACC CUT/HEM W HEART CATH
E8701	ACC CUT/HEM IN INFUSION	E8707	ACC CUT/HEM W ENEMA
E8702	ACC CUT/HEM-PERFUSN NEC	E8708	ACC CUT IN MED CARE NEC
E8703	ACC CUT/HEM IN INJECTION	E8709	ACC CUT IN MED CARE NOS
E8704	ACC CUT/HEM W SCOPE EXAM	9982	ACCIDENTAL OP LACERATION
E8705	ACC CUT/HEM W CATHERTIZ		

Denominator

Surgical and medical discharges, for patients ages 18 years and older. Surgical and medical discharges are defined by specific DRG or MS-DRG codes.

See *Patient Safety Indicators Appendices*:

- Appendix B – Medical Discharge DRGs
- Appendix C – Medical Discharge MS-DRGs
- Appendix D – Surgical Discharge DRGs
- Appendix E – Surgical Discharge MS-DRGs

PSI 15 Criteria Exclusions

AHRQ QI™ Version 4.5, Patient Safety Indicators 15, Technical Specifications,
Accidental Puncture or Laceration Rate
www.qualityindicators.ahrq.gov

Exclude cases:

- with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission) for accidental puncture or laceration during a procedure (see above)
- with any-listed ICD-9-CM procedure codes for spine surgery
- MDC 14 (pregnancy, childbirth, and puerperium)
- with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

See *Patient Safety Indicator Appendices*:

- Appendix L –Spine Surgery Procedure Codes

Coding Clinic for ICD-9-CM

2nd Quarter, 2013, pages 29-30

- **Clarification on the use of external cause and unspecified codes in ICD-10-CM**

The following statement was approved and posted by the four Cooperating Parties in May 2013 and is now reproduced in its entirety.

- **External Cause Codes**

- **Just as with ICD-9-CM**, there is no national requirement for mandatory ICD-10-CM external cause code reporting.
- Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required.
- **If a provider has not been reporting ICD-9-CM external cause codes, the provider will not be required to report ICD-10-CM codes in Chapter 20, unless a new state or payer-based requirement regarding the reporting of these codes is instituted.**
- Such a requirement would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

Choose one:

DURAL TEAR

- 1. ACCIDENTAL PUNCTURE/LACERATION DURING A PROCEDURE
- 2. INCIDENTAL (INADVERTENT)
- 3. NONTRAUMATIC
- 4. OTHER/UNSPECIFIED

PROCEDURE WAS

- 1. ** DO NOT WISH TO CODE CIRCUMSTANCE (E CODES)
- 2. SURGICAL OPERATION
- 3. INFUSION OR TRANSFUSION
- 4. KIDNEY DIALYSIS OR OTHER PERFUSION
- 5. INJECTION OR VACCINATION
- 6. ENDOSCOPIC EXAMINATION
- 7. ASPIRATION OF FLUID OR TISSUE (puncture/catheterization, except of heart)
- 8. HEART CATHETERIZATION
- 9. ENEMA
- A. REMOVAL OF CATHETER OR PACKING
- B. OTHER SPECIFIED PROCEDURE
- C. UNSPECIFIED PROCEDURE

ICD-9-CM DIAGNOSIS CODES

34931 Accidental puncture or laceration of dura during a procedure

E8700 Accidental cut/puncture/perforation/hemorrhage during surgical operation

E-code use

- In the course of a gastroscopy, the physician's scope causes a esophageal varices to significantly bleed resulting in an acute blood loss anemia, which the physician stated was a complication of the procedure

ICD-9-CM DIAGNOSIS CODES

99811 Hemorrhage complicating a procedure

2851 Acute posthemorrhagic anemia

E8704 Accidental cut/puncture/perforation/hemorrhage during endoscopic examination

998.2 – Index to Diseases

Examples

- Complications
 - **accidental** puncture or laceration during a procedure 998.2
 - mechanical
 - catheter NEC 996.59
 - during a procedure 998.2
- Perforation, perforative (nontraumatic)
 - by
 - instrument (any) during a procedure, **accidental** 998.2
- Injury
 - blood vessel NEC 904.9
 - due to **accidental** puncture or laceration during procedure 998.2
 - instrumental (**during surgery**) 998.2
- Paralysis, paralytic (complete) (incomplete) 344.9
 - diaphragm (flaccid) 519.4
 - due to **accidental** section of phrenic nerve during procedure 998.2

998.2

998.2 Accidental puncture or laceration during a procedure

Accidental perforation by catheter or other instrument during a procedure on:
blood vessel
nerve
organ

EXCLUDES

iatrogenic [postoperative] pneumothorax ([512.1](#))
puncture or laceration caused by implanted device intentionally left in
operation wound ([996.0-996.5](#))
specified complications classified elsewhere, such as:
broad ligament laceration syndrome ([620.6](#))
dural tear ([349.31](#))
incidental durotomy ([349.31](#))
trauma from instruments during delivery ([664.0-665.9](#))

Accidental Lacerations During Surgery

Coding Clinic, 2nd Quarter 2007, pp. 11–12

- **Question: During an procedure, the surgeon noted, “a small capsular injury of the spleen, which was hemostatic.”**
 - This injury did not require repair.
- **An esophagogastroduodenscopy (EGD) was then performed for evaluation of the distal esophagus since the mass had adhered at the gastroesophageal junction.**
 - The EGD revealed a serosal injury to the stomach, which was repaired with interrupted Lembert sutures. The surgeon did not include the intraoperative tears in the diagnostic statement. What are the appropriate code assignments?

Coding Clinic Answer

- **Answer: Query the provider, and if the provider states the tear is not clinically significant, omit codes for both the diagnosis and procedure.**
 - When a tear is documented in the operative report, such as a small serosal tear of the stomach, the surgeon should be queried as to whether the small tear was an **incidental occurrence inherent in the surgical procedure** or whether the tear should be considered by the physician to be a **complication of the procedure**.
 - If the provider documents that the seromuscular tear is a complication of the surgery, assign code 998.2, Accidental puncture or laceration during a procedure, as an additional diagnosis. This advice is consistent with that previously published in *Coding Clinic, 3rd Quarter 1990, p. 18*.

A Compliant Complications Query

2013 ACDIS-AHIMA Practice Brief

- **Clinical scenario:** During the removal of an abdominal mass, the surgeon documents, in the description of the operative procedure, a “serosal injury to the stomach was repaired with interrupted sutures.”
- **Query:** In the description of the operative procedure a serosal injury to the stomach was noted and repaired with interrupted sutures. Was this serosal injury and repair:
 - A complication of the procedure _____
 - Integral to the above procedure _____
 - Not clinically significant _____
 - Other _____
 - Clinically Undetermined _____Please document your response in the health record or below accompanied by clinical substantiation.
- **Rationale:** This is an example of a query necessary to determine the clinical significance of a condition resulting from a procedure.

<http://www.tinyurl.com/2013QueryPB>

Review of the ICD-10-CM Guidelines For POA Reporting

- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.
- Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.
- If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

Timeframes For Reporting

- There is no required timeframe as to when a provider (per the definition of “provider” used in these guidelines) must identify or document a condition to be present on admission.
 - In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission.
 - In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission.
 - Determination of whether the condition was present on admission or not will be based on the applicable POA guideline as identified in this document, or **on the provider’s best clinical judgment.**

ICD-10-CM Official Guidelines Assigning “Y” to the POA Status

- Any condition the provider explicitly documents as being present on admission.
 - Assign N for any condition the provider explicitly documents as not present at the time of admission.
- Conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

ICD-10-CM Official Guidelines

Assigning “Y” to the POA Status

- Conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.
 - Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or
 - **Diagnoses that constitute an underlying cause of a symptom that is present at the time of admission.**
- A condition that develops during an outpatient encounter prior to a written order for inpatient admission.

ICD-10-CM Official Guidelines Assigning “Y” to the POA Status

Congenital conditions and anomalies

- Assign “Y” for congenital conditions and anomalies except for categories Q00-Q99, Congenital anomalies, which are on the exempt list. Congenital conditions are always considered present on admission.

ICD-10-CM Official 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.
- If a single code identifies both an acute and chronic condition, see the POA guidelines for combination codes.

Coding Clinic For ICD-10-CM Progression of A Disease

- **Question:** The patient was admitted with acute respiratory failure, acute kidney injury due to acute tubular necrosis and chronic kidney disease, stage 3.
 - The patient had a prolonged hospitalization and during the hospital course, he advanced to end stage renal disease (ESRD) and was started on hemodialysis.
 - The provider stated, “Concerning possible renal recovery, it appears unlikely he will ever be dialysis independent given his history of CKD prior to his acute on chronic kidney injury and also because he is almost three months from his initial renal insult with no signs of renal recovery.” Since the chronic kidney disease, stage 3 had progressed to ESRD, requiring dialysis, what is the appropriate present on admission (POA) indicator for the ESRD?
- **Answer:** Assign POA indicator Y, for the ESRD.
 - The patient experienced deterioration or worsening of the same condition.
 - Even though chronic kidney disease stage 3 and ESRD are assigned different codes, only one code is reported for the highest or most severe stage.
 - This advice is similar to that previously published in *Coding Clinic*, First Quarter 2009, page 19, regarding a deteriorating pressure ulcer

Coding Clinic, First Quarter 2013 Page: 18

ICD-10-CM Official Guidelines

Uncertain Diagnoses

- Conditions **documented** as possible, probable, suspected, or rule out **at the time of discharge**
 - If the **final diagnosis** contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings suspected at the time of inpatient admission, assign “Y.”
 - If the **final diagnosis** contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings that were not present on admission, assign “N”.

ICD-10-CM Official Guidelines

Impending or Threatened Conditions

- Conditions **documented** as impending or threatened **at the time of discharge**
 - If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign “Y”.
 - If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were not present on admission, assign “N”.

ICD-10-CM Official Guidelines

External Cause of Injury Codes

- Assign “Y” for any external cause code representing an external cause of morbidity that occurred prior to inpatient admission (e.g., patient fell out of bed at home, **patient fell out of bed in emergency room prior to admission**)
- Assign “N” for any external cause code representing an external cause of morbidity that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission)

ICD-10-CM Official Guidelines

Combination Codes

- Assign “N” if any part of the combination code was not present on admission (e.g., COPD 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)
- Assign “Y” if all parts of the combination code were present on admission (e.g., patient with acute prostatitis admitted with hematuria)

ICD-10-CM Official Guidelines

Same Diagnosis - 2 or More Conditions

- When the same ICD-10-CM diagnosis code applies to two or more conditions during the same encounter (e.g. two separate conditions classified to the same ICD-10-CM diagnosis code):
 - Assign “Y” if all conditions represented by the single ICD-10-CM code were present on admission (e.g. bilateral unspecified age-related cataracts).
 - Assign “N” if any of the conditions represented by the single ICD-10-CM code was not present on admission (e.g. traumatic secondary and recurrent hemorrhage and seroma is assigned to a single code T79.2, but only one of the conditions was present on admission).

ICD-10-CM Official Guidelines

Obstetrics

- Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator.
 - The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.
- If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign “Y”.
- If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign “N”.
- If the obstetrical code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission assign “N”. (e.g., Category O11, Pre-existing hypertension with pre-eclampsia)

ICD-10-CM Official Guidelines

Perinatal Conditions

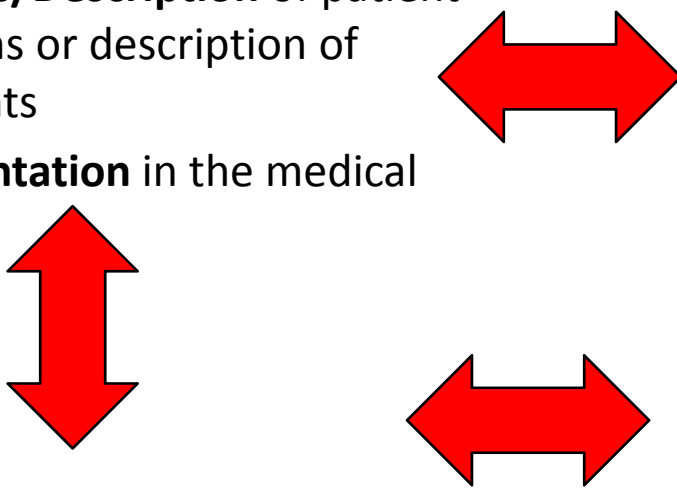
- Newborns are not considered to be admitted until after birth.
 - Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned “Y”. This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal).

ICD-10-CM Official Guidelines

Uncertain vs. Clinically Undetermined

- Documentation does not indicate whether condition was present on admission
 - Assign “U” when the medical record documentation is unclear as to whether the condition was present on admission. “U” should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.
- Documentation states that it cannot be determined whether the condition was or was not present on admission
 - Assign “W” when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

CDI Foundations Responsibilities

- **Physician/provider**
 - **Definition** of diagnostic or therapeutic terminology
 - **Diagnosis/Description** of patient conditions or description of treatments
 - **Documentation** in the medical record
 - **Everyone**
 - **Defense** when held accountable by outside entities
 - **Clinical documentation, ancillary, and coding staff (Facility)**
 - **Deciphering** inconsistent, incomplete, imprecise, **unreliable**, conflicting, or illegible documentation and clarifying it prior to claim submission
 - **Delineation** of documented diagnoses or treatments in the context of the patient's conditions and treatments within the limitations of HIPAA-associated transaction sets
 - **Deployment** of ICD-9-CM and CPT/HCPCS (outpatient) codes based upon physician/provider documentation
- 



Managing an Effective Query Process

2008 Version

Note: This practice brief updates the 2001 practice brief “Developing a Physician Query Process,” with a continued focus on compliance.

In today’s changing healthcare environment, health information management (HIM) professionals face increased demands to produce accurate coded data. Therefore, establishing and managing an effective query process is an integral component of ensuring data integrity. A query is defined as a question posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient’s health record. Documentation can be greatly improved by a properly functioning query process.

This practice brief offers HIM professionals important components to consider in the management of an effective query process. It is intended to offer guiding principles to implement the query process while in no way prescribing what must be done.

Background

The “ICD-9-CM Official Guidelines for Coding and Reporting” are the official rules for coding and reporting ICD-9-CM. They are approved by the four organizations that make up the ICD-9-CM Coordinating Committee: the American

<http://tinyurl.com/2008AHIMAquery>

2008 AHIMA Query Practice Brief

- In general, query forms should not be designed to ask questions about a diagnosis or procedure that can be responded to in a yes/no fashion.
- The exception is present on admission (POA) queries when the diagnosis has already been documented.
 - The problem with this is that a “No” answer does not allow for the option of “Clinically Undetermined”

2008 AHIMA Query Practice Brief

- Multiple choice formats that employ checkboxes may be used as long as all clinically reasonable choices are listed, regardless of the impact on reimbursement or quality reporting.
 - The choices should also include an “other” option, with a line that allows the provider to add free text.
 - Providers should also be given the choice of “unable to determine.”
 - This format is designed to make multiple choice questions as open ended as possible.

Sample POA Query

Documentation Integrity – Coder-to-Provider Communication Form Present on Admission/Hospital Acquired Conditions

Patient:			
MRN#:		Encounter #:	
Discharge Date:			
Provider:			
Query Date:			

This query is being generated as to establish the present on admission status on a condition(s) or circumstances (E-codes) documented during this inpatient admission. Please clarify if the following diagnosis was either present at the time of INPATIENT (not observation) admission, not present at the time of inpatient (not observation) admission or clinically undetermined.

Date	Diagnosis or Circumstances Documented	“Y” or Yes; “N” or “No”, “CU” or “Clinically Undetermined”

Summary

- POA status is important
- POA status is required
- POA status reflects the quality of our care
- POA status is ultimately the responsibility of the physician and coder with support by the CDI process
- POA status is something we can do



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Read more

HEN Resources

This page provides a collection of tools and resources for hospitals participating in the Hospital Engagement Network. For details or questions regarding any of these tools, please contact **Jean Roland**, Quality Improvement Specialist.

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› CAUTI Nurse Driven Protocol

Thank You!

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