



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



NOV 23 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

/S/ Andrea Buck for

FROM: Stuart Wright
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Memorandum Report: *Assessment of Hospital Reporting of Present on Admission Indicators on Medicare Claims*, OEI-06-09-00310

This memorandum report provides information requested by officials of the Centers for Medicare & Medicaid Services (CMS) about hospital reporting of Present on Admission (POA) indicators. The Office of Inspector General (OIG) analyzed the POA indicators for Medicare Inpatient Prospective System (IPPS) claims collected as part of a national, random sample of patients discharged in October 2008. The indicators were collected in the course of developing OIG's November 2010 report, *Adverse Events in Hospitals: National Incidence among Medicare Beneficiaries*, OEI-06-09-00090. Little is known about the accuracy of POA indicators, which will be important for Medicare's efforts to align payment incentives with patient outcomes.

SUMMARY

OIG's November 2010 report found that an estimated 13.5 percent of Medicare beneficiaries hospitalized in October 2008 experienced adverse events, defined as serious harm from medical care resulting in prolonged hospitalization, permanent disability, life-sustaining intervention, or death. An additional 13.5 percent of hospitalized beneficiaries experienced temporary harm events, defined as requiring intervention but not resulting in lasting harm. To determine these rates, we examined medical records for a national, random sample of 780 hospitalized Medicare beneficiaries discharged in October 2008. This memorandum supplements our prior work by providing national estimates of the extent to which hospital coding staff misreported POA indicators on IPPS claims.

We reviewed 5,491 POA indicators from 698 sample claims. Hospital coders incorrectly reported 3 percent of the 5,491 POA indicators reviewed, resulting in at least one incorrect indicator on each of 129 claims (18 percent). By dividing the POA indicator errors into three groups based on noted similarities, we determined that 21 percent related to the assessment of developing or chronic conditions, 32 percent involved errors in assigning POA indicators to exempted conditions, and 47 percent involved other reporting errors not associated with developing or chronic conditions or

with exemptions. The 3-percent national POA indicator error rate is relatively low, particularly given that our review assessed claims submitted early in the implementation of the POA reporting requirement. However, POA indicators provide an opportunity for monitoring hospital quality of care and are critical to CMS's efforts to link payment to quality; they must be accurate to serve these purposes. Encouraging hospitals to assess POA reporting practices related to developing conditions and exemption codes, and to retrain staff as needed, could help to ensure accuracy.

BACKGROUND

POA Indicators

Pursuant to Section 5001(c) of the Deficit Reduction Act of 2006 (DRA), hospitals may not receive increased Medicare reimbursement for certain conditions when they develop during the hospital stay and are not present at the time of admission (referred to as “hospital-acquired conditions”). A list of non-reimbursable hospital-acquired conditions is updated annually and includes conditions that CMS determines to be reasonably preventable.¹ To distinguish between conditions that are present at the time of admission and those that develop during hospitalization, CMS requires hospitals to report POA indicators for every diagnosis code (i.e., International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM)) submitted on claims reimbursed through the Medicare IPPS beginning in October 2007.² Hospitals must include a POA indicator for all diagnosis codes. Certain diagnoses are exempted from POA reporting: conditions that do not represent a current disease or injury (such as a prior diagnosis of cancer) or are always present at the admission of a particular person (such as a congenital disorder).

In addition to providing a necessary framework for the DRA-mandated payment policy, POA indicators provide information for monitoring quality of care. A number of provisions in the Patient Protection and Affordable Care Act of 2010 (ACA) address quality measurement and will rely, in part, on accurate reporting of POA indicators.³ Further, hospitals can use information about the types and frequency of conditions that develop during hospital stays to monitor trends or to narrow case reviews to those most likely to reveal poor care.

CMS requires hospital coders to assign one of five POA indicators to each patient diagnosis on Medicare inpatient claims (see Table 1). Accurately determining whether conditions are present on admission requires a high level of precision in patient assessment and medical documentation.⁴ To correctly implement the POA policy, hospitals must train clinicians, such as nurses and physicians, to clearly document preexisting conditions in records and train coders to accurately assign POA indicators.⁵

¹ CMS payment policy regarding hospital-acquired conditions became effective October 1, 2008. DRA, P.L. 109-362, § 5001(c), Social Security Act, § 1886(d)(4)(D), 42 U.S.C. § 1395ww(d)(4)(D); 73 Fed. Reg. 48434, 48471–48491 (Aug. 19, 2008).

² CMS, “Present on Admission Indicator,” *Medicare Claims Processing*, Transmittal 1240 (Change Request 5499, May 11, 2007). Accessed at <https://www.cms.gov/transmittals/downloads/r1240cp.pdf> on January 3, 2012.

³ ACA, P.L. 111-146, §§ 3001 and 3008.

⁴ C. Zahn, et al., “Modifying DRG-PPS to Include Only Diagnoses Present on Admission: Financial Implications and Challenge,” *Medical Care*, 45 (4), 2007.

⁵ L.A. Wiedemann, “Preparing for POA Reporting: How One Facility Educated Its Staff on the Importance of the New Requirement,” *Journal of American Health Information Management Association*, 78 (7), 2007.

Indicator	Description
Y	Condition was present at time of inpatient admission
N	Condition was not present at time of inpatient admission
U	Documentation insufficient to determine whether condition was present at the time of inpatient admission
W	Provider unable to clinically determine whether the condition was present at the time of inpatient admission
1	Diagnosis is exempt from POA reporting

Source: CMS Fact Sheet, *POA Reporting by IPSS Hospitals*, October 2008.

OIG Study of Adverse Events in Hospitals

Beginning in 2008, OIG released a series of reports regarding adverse events in hospitals. For the report *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*, we conducted nurse and physician reviews of medical records for a nationally representative sample of 780 Medicare beneficiaries hospitalized in October 2008. We found that an estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events. An additional 13.5 percent experienced temporary harm events.⁶

METHODOLOGY

For this report, OIG contracted with certified coders to review the claims and associated medical records for the same sample of beneficiaries examined in the adverse events study. For the 780 beneficiaries selected for the adverse events study, OIG reviewed 698 claims submitted under the Medicare IPSS.⁷ Each claim included between 1 and 9 diagnoses for a combined total 5,491 POA indicators (all of which were reviewed).⁸ We made appropriate statistical adjustments and projected the error rates to the population of claims submitted to the Medicare IPSS in October 2008. We did not attempt to assess the effect of inaccurate POA indicators on claim costs.

The coders analyzed POA indicators for all valid diagnosis codes within the sample using a standardized protocol to review the medical records and the associated Medicare claims. We based review standards on the guidelines in place in October 2008. The coders utilized all available information to determine whether conditions were present on admission, and consulted with the project director (a coder and medical review expert) and contracted physicians in making determinations. The coders documented all miscoded POA indicators and described circumstances in individual cases that may have contributed to the errors. In some cases, misreported POA indicators may not be a reflection that the hospital coders did not follow coding criteria, but rather that documentation in the medical record was not sufficient for the coders to accurately reflect the beneficiary's condition upon admission.

⁶ OIG, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*, OEI-06-09-00090, November 2010.

⁷ We excluded from review 82 of the 780 claims. We excluded 72 claims because they were not covered under the Medicare IPSS. We also excluded 10 claims that we suspected did not accurately reflect hospital coding of POA indicators. Each of these 10 claims had all POA indicators coded as "exempt," but staff at the hospitals submitting these claims stated during telephone calls that the hospitals did not submit these claims with all POA indicators coded as exempt.

⁸ We excluded from review 47 of 5,538 submitted indicators because the associated diagnosis codes were invalid.

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* approved by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

Hospital Coding Staff Incorrectly Reported 3 Percent of POA Indicators, With Errors Distributed Across 18 Percent of Sample Medicare Claims⁹

Among Medicare inpatient claims for the review month, 18 percent (129 sample claims) included at least one inaccurate POA indicator. Of the 5,491 POA indicators reviewed, we identified 180 reporting errors (3 percent). About half of the POA reporting errors had one of two distinctive traits: developing or chronic conditions (21 percent) or incorrect use of exemption codes (32 percent). The remaining errors (47 percent) did not appear to be associated with any particular codes or conditions, but demonstrate other errors in reviewing medical record documentation. Table 2 provides the estimated percentages and 95-percent confidence intervals for the three error groups.

Error Group	Percentage	95-Percent Confidence Interval	
		Lower	Upper
Developing or Chronic Condition	21.1%	14.8%	28.6%
Exemption Code	31.7%	23.0%	40.3%
Other Coding Errors	47.2%	39.3%	55.1%

Source: OIG analysis of 5,491 POA indicators.

Twenty-One Percent of POA Reporting Errors Involved Patients’ Developing or Chronic Conditions

Thirty-eight of 180 inaccurate POA indicators in our sample may have resulted from uncertainty regarding how to assign POA indicators for health conditions that were developing at the time of admission and for certain cases of chronic health conditions. Thirty-two cases involved conditions that were developing at the time of admission, when hospital coders used differing criteria for assigning POA indicators, such as which symptoms patients exhibited at admission, when diagnostic tests were performed, and when physicians documented the diagnosis. The diagnoses associated with these misreported POA indicators included systemic inflammatory response syndrome, septic shock, blood infections, urinary tract infections, pneumonia, pressure ulcers, constipation, and malnutrition—all conditions that may develop over a period of time. For the remaining six cases in this group, hospital coders made POA errors for patients receiving an initial diagnosis of a chronic illness, such as diabetes, and for patients experiencing an exacerbation of a chronic condition, such as congestive heart failure.

Thirty-Two Percent of the POA Indicator Errors Involved Exemption Codes

Fifty-seven of the 180 inaccurate POA indicators in our sample resulted from misapplication of the CMS exemption provision. In 49 of these cases, the hospital coder assigned a POA indicator code (“Y,” “N,” “U,” or “W”), when he or she should have identified the diagnosis as exempt (“1”).

⁹ The 95-percent confidence interval is 2.86–3.94 percent for miscoded POA indicators. For claims with at least one POA coding error, the 95-percent confidence interval is 15.78–21.73 percent.

Exempt diagnoses are not easily categorized by POA indicators, as they typically provide contextual information, such as how an injury occurred, or relate to a past diagnosis, such as a history of cancer. Exempt diagnoses should be assigned a “1” POA indicator; yet, in several of these cases, the hospital coder listed a POA indicator of “U” (documentation insufficient). For the remaining eight miscoding errors involving exemption codes, the hospital coders coded the diagnoses as exempt when they were not on the published list of exemptions and should have been assigned POA indicators.

Forty-Seven Percent of Inaccurately Reported POA Indicators Were Not Associated With Specific Codes or Conditions and Demonstrated Other Errors Associated With Medical Record Documentation

For 85 of the 180 misreported POA indicators in our sample, the OIG coders found documentation in the medical record that contradicted the POA designation. The medical records for 50 of these cases clearly indicated the presence or absence of the diagnosis at the time of admission. This suggests that hospital coders may have failed to notice or disregarded information necessary to make an accurate POA assessment. For another 22 of the errors in this group, the OIG coders found the relevant information in laboratory results or other time-specific information that marked the presence or absence of the condition at the time of admission. However, the physicians who diagnosed the patients did not indicate clearly when the conditions developed, and per the coding standards, the hospital coders may have been unable to determine the correct POA indicator independently. The remaining 13 miscoded POA indicators included a range of other issues, such as a diagnosis that changed during the hospital stay.

CONCLUSION

We found that hospital coders inaccurately reported 3 percent of the POA indicators reviewed, resulting in the presence of at least one inaccurate indicator on 18 percent of claims. The 3-percent error rate is relatively low, particularly given that our review assessed POA indicators early in implementation of the POA reporting requirement. POA indicators provide an opportunity for monitoring hospital quality of care and are critical to CMS’s efforts to link payment to quality, but they must be accurate to serve these purposes. Encouraging hospitals to assess POA reporting practices related to developing conditions and exemption codes, and to retrain staff as needed, could help to ensure accuracy.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-06-09-00310 in all correspondence.