A work group, facilitated by Donna Pickett (NCHS) and Sue Bowman (AHIMA), was convened to develop recommendations for standardized reporting guidelines for the "present on admission" flag on the UB-04. This work group presents the following recommendation for NUBC consideration:

- **The "present on admission" (POA) flag should apply only to inpatient admissions to facilities licensed as general acute-care hospitals.**

Rationale: Since there are many types of facilities that provide "inpatient" care, such as SNFs, rehabilitation hospitals, psychiatric hospitals, etc., it is necessary to define the facilities that the POA data element applies to.

- **"Present on admission" should include both those conditions that were known at the time of admission as well as those that were clearly present but not diagnosed until after admission**.

Rationale: Conditions that have not yet been diagnosed at the time of admission, but clearly did not develop after admission, should be considered to be present on admission even though they are not identified on the emergency room record, history and physical, or other documents created at the time of admission. For example, if a patient presents with a lump and it is diagnosed as a malignant neoplasm during the hospitalization, the malignant neoplasm should be considered to be present on admission. Also, conditions that are suspected at the time of admission and subsequently confirmed during the hospitalization, should be considered to be present on admission (e.g., patient presents with chest pain and the physician confirms after admission that the patient has a myocardial infarction).

- **"Present on admission" should be defined as present at time of order for inpatient admission** (conditions that develop during an outpatient encounter, including the emergency department, will be considered to be present on admission).

Rationale: The purpose of collecting this data element is to differentiate between conditions present at admission and conditions that developed during an inpatient admission. The work group discussed "present on admission" vs. "present on arrival" extensively and concluded that variable payer requirements regarding the inclusion of outpatient services on the inpatient claim, and issues with the multiple types of outpatient encounter that can lead to inpatient admission (emergency department, observation, outpatient surgery, hospital-owned physician practices or clinics, etc.), would cause a "present on arrival" approach difficult to implement and would result in data inconsistency. "Present on admission" would result in more accurate and comparable data and would be consistent with the current reporting practices in California and New York.

- **"Present on admission" flag should be applied to the principal diagnosis as well as all secondary diagnoses.**

Rationale: There are a few ICD-9-CM coding conventions that result in a condition not present at the time of admission being reported as the principal diagnosis. Therefore, because of these special situations, it is important to indicate whether or not the principal diagnosis is present on admission.

- **There should be four reporting options: yes, no, unknown, and not applicable.** The American Health Information Management Association, American Hospital Association, and National Center for Health Statistics will develop a list of ICD-9-CM codes for which POA is not applicable, and the "not applicable" option may only be reported for one of the codes on this list. This list will be included in the POA guidelines published in the *ICD-9-CM Official Guidelines for Coding and Reporting* and updated as needed.

Rationale: There are certain codes, particularly in the "Supplementary Classification of Factors Influencing Health Status" chapter ("V" codes), to which the POA concept is not applicable. The use of the POA flag for these categories of codes would result in confusion as to the appropriate POA option, increased coding errors, and unnecessary work. For example, "personal history of malignant neoplasm" cannot develop after admission.

The POA flag should be reported for the E (External Cause) codes. E code categories for which the POA flag is not applicable would be included in the "not applicable" list mentioned above.

Rationale: Reporting this information for E codes would provide valuable information regarding whether a patient safety event or medical error occurred during inpatient hospitalization.

- **NUBC should encourage CMS to collect and use the POA data for Medicare patients**

Rationale: The data will be reported more consistently across the country if it is required for Medicare reporting purposes.

- **If a hospital chooses to submit POA information to a payer that has no use for that information, the payer should not reject the claim simply because it contains POA information.**

Rationale: Hospitals should be permitted to submit POA data to any payer, regardless of whether that payer is currently using this information.

- **Comprehensive guidelines on POA reporting should be published in the *ICD-9-CM Official Guidelines for Coding and Reporting* to assist coding professionals in accurate and consistent reporting of POA data. These guidelines will be updated as needed to address identified coding errors or areas of confusion.**

Rationale: Coders are used to relying on the official coding guidelines as a resource during the coding process, so this would be an appropriate place to include the POA coding guidelines.

The work group discussed whether the POA data element should be required on all inpatient claims or just on those claims subject to a regulatory or payer-mandated requirement. Some work group members felt that POA information should be required on all inpatient claims because it would be limited value if it is not reported consistently across the country. Others felt it should only be reported when required by a state or federal regulation or payer because of the cost involved in collecting and reporting POA information. It was suggested that this issue might be outside the scope of the work group's charge (the work group was asked only to develop standardized reporting guidelines), and so no recommendation regarding this issue is being brought forth by the work group.