Appendix I
Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. 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.

These guidelines are not a substitute for the provider's clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

General Reporting Requirements

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.

Present on admission is defined as 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.

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.

Reporting Options

Y - Yes
N - No
U - Unknown
W – Clinically undetermined
Unreported/Not used (or "1" for Medicare usage) – (Exempt from POA reporting)

Reporting Definitions

Y = present at the time of inpatient admission
N = not present at the time of inpatient admission
U = documentation is insufficient to determine if condition is present on admission
W = provider is unable to clinically determine whether condition was present on admission or not

Timeframe for POA Identification and Documentation

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.

If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

Assigning the POA Indicator

Condition is on the "Exempt from Reporting" list

Leave the "present on admission" field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented

Assign Y for 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 diagnosed prior to inpatient admission

Assign "Y" for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission

Assign "Y" for 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 constitute an underlying cause of a symptom that is present at the time of admission.

Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

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.

Chronic condition with acute exacerbation during the admission

If the code is a combination code that identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to combination codes.

If the combination code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of CHF), assign "Y."

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".

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".

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.

Combination Codes

Assign "N" if any part of the combination code was not present on admission (e.g., obstructive chronic bronchitis 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 diabetic nephropathy is admitted with uncontrolled diabetes)

If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign "Y".

For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later).

Same Diagnosis Code for Two or More Conditions

When the same ICD-9-CM diagnosis code applies to two or more conditions during the same encounter (e.g. bilateral condition, or two separate conditions classified to the same ICD-9-CM diagnosis code):

Assign "Y" if all conditions represented by the single ICD-9-CM code were present on admission (e.g. bilateral fracture of the same bone, same site, and both fractures were present on admission)

Assign "N" if any of the conditions represented by the single ICD-9-CM code was not present on admission (e.g. dehydration with hyponatremia is assigned to code 276.1, but only one of these conditions was present on admission).

Obstetrical conditions

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., Code 642.7, Pre-eclampsia or eclampsia superimposed on pre-existing hypertension).

If the obstetrical code includes information that is not a diagnosis, do not consider that information in the POA determination.

(e.g. Code 652.1x, Breech or other malpresentation successfully converted to cephalic presentation should be reported as present on admission if the fetus was breech on admission but was converted to cephalic presentation after admission (since the conversion to cephalic presentation does not represent a diagnosis, the fact that the conversion occurred after admission has no bearing on the POA determination).

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).

Congenital conditions and anomalies

Assign "Y" for congenital conditions and anomalies. Congenital conditions are always considered present on admission.

External cause of injury codes

Assign "Y" for any E code representing an external cause of injury or poisoning 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 E code representing an external cause of injury or poisoning 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)

Categories and Codes
Exempt from
Diagnosis Present on Admission Requirement

Note: "Diagnosis present on admission" for these code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission

137-139, Late effects of infectious and parasitic diseases

268.1, Rickets, late effect

326, Late effects of intracranial abscess or pyogenic infection

412, Old myocardial infarction

438, Late effects of cerebrovascular disease

650, Normal delivery

660.7, Failed forceps or vacuum extractor, unspecified

677, Late effect of complication of pregnancy, childbirth, and the puerperium

905-909, Late effects of injuries, poisonings, toxic effects, and other external causes

V02, Carrier or suspected carrier of infectious diseases

V03, Need for prophylactic vaccination and inoculation against bacterial diseases

V04, Need for prophylactic vaccination and inoculation against certain viral diseases

V05, Need for other prophylactic vaccination and inoculation against single diseases

V06, Need for prophylactic vaccination and inoculation against combinations of diseases

V07, Need for isolation and other prophylactic measures

V10, Personal history of malignant neoplasm

V11, Personal history of mental disorder

V12, Personal history of certain other diseases

V13, Personal history of other diseases

V14, Personal history of allergy to medicinal agents

V15.01-V15.09, Other personal history, Allergy, other than to medicinal agents

V15.1, Other personal history, Surgery to heart and great vessels

V15.2, Other personal history, Surgery to other major organs

V15.3, Other personal history, Irradiation

V15.4, Other personal history, Psychological trauma

V15.5, Other personal history, Injury

V15.6, Other personal history, Poisoning

V15.7, Other personal history, Contraception

V15.80, Other personal history, History of failed moderate sedation

V15.81, Other personal history, Noncompliance with medical treatment

V15.82, Other personal history, History of tobacco use

V15.83, Other personal history, Underimmunization status

V15.84, Other personal history, Contact with and (suspected) exposure to asbestos

V15.85, Other personal history, Contact with and (suspected) exposure to potentially hazardous body fluids

V15.86, Other personal history, Contact with and (suspected) exposure to lead

V15.88, Other personal history, History of fall

V15.89, Other personal history, Other

V15.9 Unspecified personal history presenting hazards to health

V16, Family history of malignant neoplasm

V17, Family history of certain chronic disabling diseases

V18, Family history of certain other specific conditions

V19, Family history of other conditions

V20, Health supervision of infant or child

V21, Constitutional states in development

V22, Normal pregnancy

V23, Supervision of high-risk pregnancy

V24, Postpartum care and examination

V25, Encounter for contraceptive management

V26, Procreative management

V27, Outcome of delivery

V28, Antenatal screening

V29, Observation and evaluation of newborns for suspected condition not found

V30-V39, Liveborn infants according to type of birth

V42, Organ or tissue replaced by transplant

V43, Organ or tissue replaced by other means

V44, Artificial opening status

V45, Other postprocedural states

V46, Other dependence on machines

V49.60-V49.77, Upper and lower limb amputation status

V49.81-V49.84, Other specified conditions influencing health status

V50, Elective surgery for purposes other than remedying health states

V51, Aftercare involving the use of plastic surgery

V52, Fitting and adjustment of prosthetic device and implant

V53, Fitting and adjustment of other device

V54, Other orthopedic aftercare

V55, Attention to artificial openings

V56, Encounter for dialysis and dialysis catheter care

V57, Care involving use of rehabilitation procedures

V58, Encounter for other and unspecified procedures and aftercare

V59, Donors

V60, Housing, household, and economic circumstances

V61, Other family circumstances

V62, Other psychosocial circumstances

V64, Persons encountering health services for specific procedures, not carried out

V65, Other persons seeking consultation

V66, Convalescence and palliative care

V67, Follow-up examination

V68, Encounters for administrative purposes

V69, Problems related to lifestyle

V70, General medical examination

V71, Observation and evaluation for suspected condition not found

V72, Special investigations and examinations

V73, Special screening examination for viral and chlamydial diseases

V74, Special screening examination for bacterial and spirochetal diseases

V75, Special screening examination for other infectious diseases

V76, Special screening for malignant neoplasms

V77, Special screening for endocrine, nutritional, metabolic, and immunity disorders

V78, Special screening for disorders of blood and blood-forming organs

V79, Special screening for mental disorders and developmental handicaps

V80, Special screening for neurological, eye, and ear diseases

V81, Special screening for cardiovascular, respiratory, and genitourinary diseases

V82, Special screening for other conditions

V83, Genetic carrier status

V84, Genetic susceptibility to disease

V85, Body Mass Index

V86 Estrogen receptor status

V87.32, Contact with and (suspected) exposure to algae bloom

V87.4, Personal history of drug therapy

V88, Acquired absence of cervix and uterus

V89, Suspected maternal and fetal conditions not found

E000, External cause status

E001-E030, Activity

E800-E807, Railway accidents

E810-E819, Motor vehicle traffic accidents

E820-E825, Motor vehicle nontraffic accidents

E826-E829, Other road vehicle accidents

E830-E838, Water transport accidents

E840-E845, Air and space transport accidents

E846-E848, Vehicle accidents not elsewhere classifiable

E849.0-E849.6, Place of occurrence

E849.8-E849.9, Place of occurrence

E883.1, Accidental fall into well

E883.2, Accidental fall into storm drain or manhole

E884.0, Fall from playground equipment

E884.1, Fall from cliff

E885.0, Fall from (nonmotorized) scooter

E885.1, Fall from roller skates

E885.2, Fall from skateboard

E885.3, Fall from skis

E885.4, Fall from snowboard

E886.0, Fall on same level from collision, pushing, or shoving, by or with other person, In sports

E890.0-E890.9, Conflagration in private dwelling

E893.0, Accident caused by ignition of clothing, from controlled fire in private dwelling

E893.2, Accident caused by ignition of clothing, from controlled fire not in building or structure

E894, Ignition of highly inflammable material

E895, Accident caused by controlled fire in private dwelling

E897, Accident caused by controlled fire not in building or structure

E898.0-E898.1, Accident caused by other specified fire and flames

E917.0, Striking against or struck accidentally by objects or persons, in sports without subsequent fall

E917.1, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic without subsequent fall

E917.2, Striking against or struck accidentally by objects or persons, in running water without subsequent fall

E917.5, Striking against or struck accidentally by objects or persons, object in sports with subsequent fall

E917.6, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic with subsequent fall

E919.0-E919.1, Accidents caused by machinery

E919.3-E919.9, Accidents caused by machinery

E921.0-E921.9, Accident caused by explosion of pressure vessel

E922.0-E922.9, Accident caused by firearm and air gun missile

E924.1, Caustic and corrosive substances

E926.2, Visible and ultraviolet light sources

E928.0-E928.8, Other and unspecified environmental and accidental causes

E929.0-E929.9, Late effects of accidental injury

E959, Late effects of self-inflicted injury

E970-E978, Legal intervention

E979, Terrorism

E981.0-E981.8, Poisoning by gases in domestic use, undetermined whether accidentally or purposely inflicted

E982.0-E982.9, Poisoning by other gases, undetermined whether accidentally or purposely inflicted

E985.0-E985.7, Injury by firearms, air guns and explosives, undetermined whether accidentally or purposely inflicted

E987.0, Falling from high place, undetermined whether accidentally or purposely inflicted, residential premises
E987.2, Falling from high place, undetermined whether accidentally or purposely inflicted, natural sites

E989, Late effects of injury, undetermined whether accidentally or purposely inflicted

E990-E999, Injury resulting from operations of war

POA Examples

The POA examples have been removed from the guidelines.