Visit to Florida Hospital Association
May 11, 2007
Topic: Present on Admission Indicator

Participants
There were approximately 20 participants from FHA member hospitals. The majority of the participants were HIM directors or coding managers. There were two physicians present.

Kim Streit, VP of Information Services, facilitated the meeting.

Discussion Topics
The discussion topics included education, vendors, administrative costs, physician documentation, data use, and coordination of processes across an organization.

Education
Suggestions for physician education included a blast fax to all physicians, PowerPoints at physician department meetings and new physician orientation, physician champions, letters from administrators, and newsletters. Flyers and posters have been posted in physician lounges. Physicians are informed that the POA indicators affect the AHRQ Patient Safety Indicator results and the 3M Potentially Preventable and Readmission profiles. Teaching hospitals also use grand rounds as a vehicle to educate. The two physicians present emphasized that when presenting to physicians focus on profiling and financial implications. Use sample medical records and demonstrate if you document one way a specific POA code will be applied, and if you document an alternate way then an alternate POA code is applied. Explain implications of the codes.

It was recommended to educate the emergency room physicians first as it all starts there! ER physicians need to document all of a patient's conditions not just the conditions they are treating.

Many hospitals have created a new position referred to as a clinical documentation specialist who works with physicians on the patient units to improve their documentation. These individuals are experienced coders with good clinical knowledge, or nurses who are coders. Emphasis is placed on physician accountability for record documentation, and that the record should reflect the care that was provided (documentation should not be omitted to avoid POA or documentation of hospital-acquired conditions).

Some hospitals have developed an internal POA implementation and monitoring team that includes the CEO, CFO, coding or HIM director, quality director, and the CMO. They work to support the coding staff and physicians and deal with the following issues:

decreased coding productivity, increased AR days, hiring of more coders, impact on P4P, risk adjustment, profiling and CMS payment. They establish an internal process for the monitoring of records coded with a POA of "No." FHA sent out an alert to hospital executives on these topics and also developed a PowerPoint for executives.

FHA developed a PowerPoint for coders that I hope to access. They presented this via an audioconference. Many coders need increased clinical education, and increased use of the query process. Other helpful tools include the AHIMA Communities of Practice, a POA listserv, POA FAQs, coding peer review, internal and external audits, new coder orientation, and use of physician coding advisors (the two physicians in attendance have a role in this). The consensus of the group is that coders need a minimum of three months practice with POA coding before they can accurately submit the information on claims or for state reporting. Sometimes there is a disconnect between clinical evidence and coding guidelines which can lead to a disconnect between risk management and coding. Each hospital has to decide how to deal with this

Education for the quality department, risk management, and strategic planning included routine HIM updates on how the process is going, how the POA affects the PSIs and the 3M reports, how it impacts compliance activities, and audit processes for the data. This helps the quality and planning staffs understand what to expect in the output.

Vendor Issues

Vendor names that were frequently mentioned include Meditech, 3M, McKesson, Cerner, and QuadraMed. There have been significant vendor issues. Initially the encoder vendors could not interface with the medical abstracting vendor who could not interface with the billing software. Most of this has been resolved. Some of the vendors have very labor-intensive approaches to POA coding such as multiple unnecessary keystrokes to apply the code. Vendors have not standardized on how they approach POA programming and some facilities have incurred incredible costs for the programming. Vendors have not built-in logic for the combination codes.

Administrative Costs

There are increased administrative costs for coder and physician training, and to hire additional coders. It is estimated there is a 10-15% decrease in productivity due to POA. If you have a staff of 10 coders it is estimated you will need 1 to 1.5 additional coders to adequately code POA. This does not take into account increased coding time needed for coding under CMS's severity-adjusted DRGs. Part of the decreased productivity is due to the number of increased physician queries.

5510 Research Park Dr P.O. Box 259038 Madison, WI 53725-9038 P (608) 274-1820
Toll Free (800) 231-8340
F (608) 274-8554

Physician Documentation

In general, physicians are lacking in their documentation of complications. This increases the need for coders to query the physicians. If the physician does not respond to the coder this leads to compliance and risk management issues.

Florida uses non-physician documentation to assign POA since their administrative rule specifically states they can do this. **This issue needs to be resolved in WI since we are following the national guidelines, which are not as specific**. I have already forwarded a document to Donna Pickett and Sue Bowman via NAHDO to address this issue.

Data Use

This is a major concern with unknown implications. There is concern that ACHA (the Florida state data agency) will not use the data appropriately. There is also concern that this data will be misused in public reporting and by payers. There are data integrity issues due to the fact that this is a new process for all of the Florida hospitals. If the data is used before accuracy is established there could be very negative consequences, including the misuse of the data by trial attorneys.

Coordination of Processes Across the Organization

What I understood from this part of the conversation is that physicians need to document accurately and completely so that coders can code accurately and completely so that the AHRQ quality indicators other quality reports, compliance audits, and payment are accurate. If physicians do not document accurately and completely the consequences could be worse than if they do, even if they have a number of complications. CMS and other payers will be auditing.

POA Query Form

I obtained a copy of a POA physician query form and another physician education handout for Orlando Regional Healthcare. I will share these with the POA workgroup, the Data Submitter User's group, and post on our Web site. They are tools that can be adapted for specific hospital use.

Coding Specific Information

- Clinically undetermined is only assigned by the physician
- The national guidelines need additional clarification regarding the following conditions: newborn codes in general (jaundice in particular), OB delivery codes, malnutrition, and chemical imbalances.
- The national guidelines need to add these conditions to the excluded list: fetal distress, wrapped nuchal cord, antepartum conditions with delivery on current admission, old MI, and subsequent MI.

5510 Research Park Dr P.O. Box 259038 Madison, WI 53725-9038 P (608) 274-1820
Toll Free (800) 231-8340
F (608) 274-8554

- A coding manager or some other auditor is routinely checking records with POA that are on the CMS list, are in the AHRQ PSI numerators, and any infection. Many of these records are sent back to physicians for further clarification.

5510 Research Park Dr P.O. Box 259038 Madison, WI 53725-9038 P (608) 274-1820
Toll Free (800) 231-8340
F (608) 274-8554