The questions below were developed by a collaborative workgroup of representatives from the following organizations: Amphion Medical Consulting, the Rural Wisconsin Health Cooperative, the Wisconsin Health Information Management Association, the Wisconsin Hospital Association, and the Wisconsin Medical Society.

Questions Related to the Present on Admission Indicator

1. Pt is admitted and one of the secondary diagnoses is UTI, no mention on H&P, per se, only acute renal failure. They subsequently ran a culture and positive for Staph, resistance to penicillins, also Strep and Pseudomonas infections. Would this be an N due to lack of documentation, although organisms were most likely POA?

I want to make sure I have understand your question totally ---- Do you mean BOTH the UTI AND the 041 code are N --- or just the 041 code?

N to both, although common sense is telling me this had to be going on when patient was admitted, just not documented by physician - which is probably the "hook". Length of stay was 3 days. All these diagnoses came out on Discharge Summary.

The consensus of the workgroup was that both the UTI and 041 would be POA given the guideline that refers to combination codes: “For infection codes that included the causal organism, assign “y” if the infection (or signs of the infection) was POA, even if the culture results may not be known until after admission.” **Since this is not a combination code scenario we would like clarification whether individual bacteria codes are POA when an infection was known on admission.**

2. The POA Reporting Guidelines that are a supplement to the ICD-9-CM Official guidelines for Coding and Reporting state the following:

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.

If we understand the POA guidelines correctly, information from an audiologist may be used to assign an accurate POA code in the absence of the same information from the attending physician or surgeon. In other words a coder would not have to query the attending to utilize the documentation from the audiologist. However, if nursing provided some insightful documentation that was not confirmed by the physician then the physician should be queried, since an RN is not legally accountable for establishing a patient's diagnosis in WI.

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Other valuable sources of information in the medical records are notes from nutritionists and social workers. In addition, some hospitals ask the patient to complete an assessment form that provides medical history information as well. Can documentation from other health care professionals who are not legally able to diagnose be used as source documents to ascertain POA status? In addition, can patient self-assessments be used to assign POA status?

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