Present on Admission (POA)

"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."

- "There is no required timeframe as to when a provider 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."
  - Even if it is several days before a definitive diagnosis is documented, it does not mean that the condition was not present on admission. POA status should be based on the applicable POA guideline or on the provider's best clinical judgment.
  - If the documentation is unclear as to whether a condition was present on admission or not, query the provider for clarification.
- Reporting Definitions
  - Y = present at the time of inpatient admission
  - N = not present at the time of inpatient admission
    - Diagnosis can be included in HACs and PSIs
  - U = documentation is insufficient to determine if the condition is present on admission
    - Diagnosis can be included in HACs and PSIs
  - W = provider is unable to clinically determine whether the condition was present on admission or not

Brundage Group suggests reviewing whether your coding team utilizes the "**W**."
W tracks as a **YES** from a POA perspective and is commonly clinically appropriate.

Reference: ICD-10-CM Official Guidelines for Coding and Reporting FY 2023 and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding

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