

## ICD-10-CM “Present on Admission Reporting Guidelines”

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As was true with the “Present on Admission (POA) Reporting Guidelines” for ICD-9-CM, the guidelines published for use with ICD-10-CM codes are used as a supplement to the Official Guidelines for Coding and Reporting. The POA guidelines do not replace guidelines in the main body of the ICD-10-CM Official Guidelines for Coding and Reporting and are not intended to provide guidance on how a condition should be coded, but rather how to apply a POA indicator to the final set of diagnosis codes.<sup>1</sup>

The POA guidelines for ICD-10-CM do not tell the coder which conditions should have an indicator of “present on admit” applied. But it should be noted that the guidelines do explain that diagnoses which develop during an outpatient encounter that precipitates the patient’s inpatient admission (in the Emergency Department, the Observation wing, or the Outpatient Surgery) are considered POA (present on admit) just as they are within the ICD-9-CM POA reporting guidelines.

The final set of diagnosis codes, principal diagnosis and all secondary diagnoses as well as external cause of injury codes, should have POA indicators assigned. Those codes that are exempt from assigning a POA indicator are exempt because they represent a circumstance or a factor influencing health status and do not represent a current disease or injury; and, therefore, are always present on admit.

Not addressed, as yet, in the POA guidelines for ICD-10-CM is that fact that the 7<sup>th</sup> character for many codes applies to subsequent encounters and sequela of diagnoses. If the 7<sup>th</sup> character codes were addressed, it would make the POA exempt list considerably more lengthy.

The documentation used by coders to determine the POA indicators to apply to diagnosis codes may come from any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis. If the documentation does not appear to be clear on the “present on admission” status of a condition, the health care provider should be queried for further clarification.

Should the provider not be able to make a definitive diagnosis for several days after admit, the condition may still be considered “present on admit” depending upon the applicable POA guideline or the provider’s clinical judgment.

The ICD-9-CM POA guidelines explain that information not considered a diagnosis should not be considered in the POA determination. This remark is made under the Obstetrical conditions guidelines for ICD-9-CM and is not repeated in the Obstetrical conditions guidelines for ICD-10-CM.

The wording regarding applying POA indicators to External Cause of Injury codes has changed to describe the external cause code as representing an external cause of morbidity that occurred prior to inpatient admission.

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<sup>1</sup> APPENDIX I – Present on Admission Reporting Guidelines (Effective with 2011 update.)