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Paying close attention to COVID-19 POA indicators

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We can all agree that throughout the pandemic, coding of COVID-19 records has been challenging for inpatient coding professionals. In part, this is due to the barrage of new COVID-19-related ICD-10-CM/PCS codes and associated coding guidelines released by CMS at intervals during the public health emergency.

Coding professionals have to continually be aware of the evolution in the clinical understanding of COVID-19 testing (e.g., antigen, antibody, false-negative) and the COVID-19 disease process (e.g., cerebral infarction in the COVID-19 patient was due to formation of emboli as a result of the virus) in order to accurately sequence diagnoses, code etiology and manifestation(s), and assign present on admission (POA) indicators in the inpatient setting. In this article we will focus on coding issues related to POA indicators for the hospitalized, inpatient COVID-19 population.

In our consulting work with hospitals and health systems over the past year, we noted some interesting findings upon review of COVID-19 reported data. Records with either a principal or secondary diagnosis code of U07.1 (COVID-19) occasionally had an associated POA indicator of "no" or "unknown."

Did these records document patients admitted to the hospital without COVID-19, but who then contracted COVID-19 at some point after admission? In most cases, the facility had found no instances of nosocomial-acquired COVID-19. After reviewing these records, we identified several potential POA scenarios that may cause confusion for coders.

Scenario 1
A patient was admitted for elective surgery after undergoing preoperative COVID-19 screening 72 hours prior to admission. On hospital day number three, the patient began exhibiting symptoms of respiratory illness, was tested for COVID-19, and subsequently found to be positive for COVID-19. A POA indicator of "no" was assigned to the secondary diagnosis of U07.1 (COVID-19). The record indicated that no query or clarification had been issued to the physician regarding the POA status for COVID-19.

According to The Centers for Disease Control and Prevention (CDC), symptoms of COVID-19 may appear 2-14 days after exposure. In this scenario, it is critical to ask the physician if COVID-19 was or was not POA since it is possible the patient was exposed after undergoing the preoperative screening.

Scenario 2
A patient was admitted to the hospital with COVID-19-like symptoms, but initially tested negative for COVID-19. Several days later, however, the patient was retested and found to be positive for COVID-19. A POA indicator of "no" was assigned to the U07.1 diagnosis code. No query or clarification was issued to the physician regarding the POA status for COVID-19.

Due to the clinical difficulties of COVID-19 testing (e.g., false negative results), a POA query to the physician is warranted in this case. In addition, coders should be mindful of the POA reporting guidelines found in appendix I of the *2021 ICD-10-CM Official Guidelines for Coding and Reporting*. These guidelines state, "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 . . .for a period of time after admission."

Scenario 3
A patient was admitted to the hospital via the emergency department (ED) with a non-COVID-19 related illness. The patient tested negative via a rapid antigen COVID-19 test performed in the ED. One day after admission, the patient received a polymerase chain reaction (PCR) COVID-19 test which was positive. The physician recorded a diagnosis of COVID-19. The POA indicator of "unknown" was assigned to the secondary diagnosis code of U07.1.

The POA guidelines state: "'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." It appears that confusion about the POA status ensued based on the conflicting test results; therefore, the physician should be queried about the POA status instead of assigning the POA indicator of unknown.

Scenario 4
In another similar scenario, a patient was admitted through the ED with extreme shortness of breath and acute respiratory distress. The chest x-ray showed bilateral infiltrates. The initial COVID-19 test on the day of admission was negative. The patient was treated for acute hypoxic respiratory failure and pneumonia. A second COVID-19 test was performed on hospital day four and the results returned positive. A POA indicator of "no" was assigned to the U07.1 diagnosis code without a query for clarification to the attending physician.

Due to the complexities of the condition and incubation period of COVID-19, it cannot be assumed the infection occurred after admission based simply on the date of the test. It would be appropriate to query the physician for clarification for accurate POA classification.

A good question to pose to the physician is as follows:

Please clarify if COVID-19 was:

- POA at the time of the order to admit patient to inpatient status
- Not POA and developed during the inpatient stay
- Clinically unable to determine if the condition was present on admission

Coders should also consider the POA indicator of "W" (clinically undetermined), as it relates to COVID-19. This POA designation should be based on explicit physician documentation in the medical record or in response to a query regarding the POA status for a diagnosis of COVID-19. The coding professional cannot make a decision on their own that the diagnosis was clinically undetermined.

Strategies to promote accuracy

We recommend the following strategies to promote accurate POA indicator assignment for COVID-19 diagnoses:

- Perform a retrospective review of cases with a diagnosis of COVID-19 and POA indicators of "no" and "unknown" to ascertain if the assigned POA indicators are accurate. Work with the respective physicians for any cases that appear incorrect and need clinical clarification of the POA status.

- Take a proactive stance by flagging cases with a diagnosis of COVID-19 and a POA status of "no" or "unknown" to ensure a second level prebill review is performed. This allows for error correction and/or querying the physician for clarification of accurate POA indicator.

- Work closely with your hospital's CDI staff to concurrently obtain clarification of POA status from physicians for especially complex situations such as those detailed in this article. In addition, CDI technology can assist CDI professionals in identifying situations when physicians should be queried about POA since they will need to identify POA status as they enter COVID-19 diagnoses into their CDI system.

- Finally, collaborate with your hospital's internal infection control providers and infectious disease physicians. Infection control providers can weigh in on potential hospital-acquired infections and infectious disease physicians can provide counsel and information on COVID-19 infections and testing.

It is critically important to assign the most accurate POA indicator for COVID-19. An incorrectly assigned POA flag of "not present on admission" effectively reports that the patient contracted COVID-19 during the hospital stay. If this is the case, then it should be accurately reported. However, if the patient did not contract COVID-19 after admission, reporting it as such may have a negative impact on the facility's quality performance reporting and ultimately its reputation.

***Editor's note**: Howard is the senior inpatient consultant with 3M Health Information Systems, and Belley is the manager of compliance/audits and content with 3M Health Information Systems. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries. For questions, contact editor Amanda Norris at anorris@hcpro.com.*