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## Application of CMS “Present on Admission” Rule to Trauma Centers

**Background:** CMS is transforming from a passive payer to an active purchaser of high quality, efficient health care that promotes quality while avoiding unnecessary costs. This approach to health care delivery is fully supported by professional societies of hospitals and health care providers, such as the National Foundation for Trauma Care. In an effort to improve quality of care, beginning October 1, 2008, CMS does not assign a patient to a higher DRG based on the occurrence of selected conditions, if that condition was acquired during the hospitalization (Hospital Acquired Conditions – HAC).<sup>1</sup> In order to identify those conditions, a “Present on Admission (POA)” POA indicator is assigned to principal diagnosis, secondary diagnoses, and external cause of injury codes (only if E-code is reported as an additional diagnosis). To be classified as POA, the condition must be present at the time the order for inpatient admission occurs. The concept underlying this rule is that HAC can be prevented with due diligence on part of health care providers.

There are several HAC in different stages of development that are particularly relevant to trauma patients, such as:

1. Catheter associated Urinary Tract Infection
2. Catheter associated Blood Stream Infection
3. Ventilator associated Pneumonia
4. Conditions associated with Clostridium Difficile
5. Deep Venous Thrombosis/Pulmonary Embolism (DVT/PE)
6. Staph Aureus Septicemia
7. Delirium
8. Surgical Site Infection

**Implications for Trauma Centers:** The most important implication of this rule is that hospitals will no longer receive reimbursements to treat these conditions. However, trauma patients are uniquely predisposed to develop several HAC listed above despite the best possible care at trauma centers. For example, patients with traumatic brain injuries frequently become unconscious at the scene of injury, may aspirate as a result, and require endotracheal intubation by paramedics in the field under sub-optimal conditions. At the trauma center, these patients require prolonged airway management and ventilator support. In addition, they may not be able to receive adequate anticoagulant prophylaxis against DVT/PE due to presence of intracranial hemorrhage. Hence, these patients are more likely to develop DVT/PE and ventilator-assisted pneumonia resulting in prolonged hospitalization and increased treatment costs. The CMS rule states that since these conditions were not present on admission, increased costs of hospitalization attributable to these conditions will not be reimbursed. Thus, trauma centers and patients will be saddled with costs associated with more days in the intensive care unit, use of antibiotics, radiology, and laboratory examinations. In addition, this approach will stimulate inappropriate over-triage and transfer of patients at risk from community hospitals to higher level trauma centers to avoid the potential fiscal loss of caring for these patients.<sup>2</sup>



Trauma patients are at particularly high-risk for acquiring HAC for several reasons:

1. Emergent nature of patient presentation, initial assessment, and interventions preclude determinations of all conditions that may or may not be present on admission. For example, DVT/PE are increasingly diagnosed within hours of injury suggesting that these conditions were present on admission but undiagnosed.
2. Life or limb-saving nature of interventions precludes undertaking usual sterile precautions and use of pre-procedure prophylactic antibiotics. Thus, there is an increased risk of infectious complications.
3. Physiologic and metabolic alterations, such as hyperglycemia, associated with major trauma lead to alterations in immune functions that increase the risk of infections and bleeding.
4. Risk of bleeding complications related to the injury, particularly intracranial bleeding, precludes early use of anticoagulants to prevent DVT/PE.
5. Common occurrence of head injuries (up to half of patients) and prevalence of alcohol and drug use in this patient population (up to 60% of patients) increases the risk of delirium in this patient population.

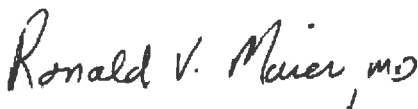
**Potential Solutions:** CMS can mitigate financial losses to already cash-strapped and threatened trauma centers by adopting one or more of the following approaches:

1. Exempting state recognized trauma centers, as defined by CMS, from POA rules. This would be consistent with the CMS approach to exempt hospitals that provide critical services to high-risk, under served populations, such as Critical Access Hospitals and Rural Health Clinics.
2. Exempting sub-groups of trauma patients, as defined by UB FL 14, Type 5 "Trauma Center". Examples include those with altered mental status, life or limb threatening injuries, or hemodynamic instability, in whom providers are unable to clinically determine whether the condition is present at the time of inpatient admission. In such cases, POA indicator code "W" may be used when coding the diagnoses.
3. Using risk-adjusted benchmarks for each HAC applicable to the trauma patient population, and exempting trauma centers that experience HCA within statistical limits of those benchmarks. The Trauma Quality Improvement Program (TQIP) of the American College of Surgeons is currently in the process of developing such benchmarks.

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<sup>1</sup> Centers for Medicare and Medicaid Services. Hospital Acquired Conditions (present on Admission Indicators). Accessed January 22, 2009. <http://www.cms.hhs.gov/HospitalAcqCond/>

<sup>2</sup> Pho K. Medicare's Mistake: No-pay rules punish hospitals for the inevitable. *USA Today*. January 14, 2009



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